

---

**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**LOUISIANA ASSESSORS' ASSOCIATION EMPLOYEE BENEFIT PLAN**

---

## TABLE OF CONTENTS

INTRODUCTION.....	1
GENERAL PLAN INFORMATION.....	3
SCHEDULE OF BENEFITS.....	4
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS....	11
MEDICAL BENEFITS.....	20
COST MANAGEMENT SERVICES.....	26
DEFINED TERMS.....	29
PLAN EXCLUSIONS.....	35
PRESCRIPTION DRUG BENEFITS.....	38
DENTAL BENEFITS.....	41
HOW TO SUBMIT A CLAIM.....	45
COORDINATION OF BENEFITS.....	47
THIRD PARTY RECOVERY PROVISION.....	50
CONTINUATION COVERAGE RIGHTS UNDER COBRA.....	52
RESPONSIBILITIES FOR PLAN ADMINISTRATION.....	59
IMPORTANT NOTICE ABOUT YOUR RESCRIPTION DRUG COVERAGE AND MEDICARE.....	63

**If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage starting in 2006. Please see page 63 for more details.**

## INTRODUCTION

This document is a description of Louisiana Assessors' Association Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## **GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Processor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

### **PLAN NAME**

Louisiana Assessors' Association Employee Benefit Plan

**PLAN NUMBER:** 501

**TAX ID NUMBER:** 72-6014133

**PLAN EFFECTIVE DATE:** January 1, 2000; Restated January 1, 2006

**PLAN YEAR ENDS:** December 31

### **EMPLOYER INFORMATION**

Louisiana Assessors' Association  
3060 Valley Creek Drive  
Baton Rouge, Louisiana 70808  
800-925-4446

### **PLAN ADMINISTRATOR**

Insurance Committee of the Assessors' Insurance Fund  
Louisiana Assessors' Association  
3060 Valley Creek Drive  
Baton Rouge, Louisiana 70808  
800-925-4446

### **CLAIMS PROCESSOR**

Benesys  
P.O. Box 81189  
Lafayette, Louisiana 70598-1198  
800-256-6799

## SCHEDULE OF BENEFITS

### Verification of Eligibility 800-256-6799

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

### MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

**Note: The following services must be precertified or reimbursement from the Plan may be reduced.**

#### Hospitalizations

**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.**

**Please see the Cost Management section in this booklet for details.**

The Plan is a plan which contains a Network Provider Organization. The PPO name is indicated on the front of your ID Card.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

If a Network Provider sends x-rays or lab work to a Non-Network Provider.

Under the following circumstances, Out-of-Area payments will be made for certain Non-Network Services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area at the time services are needed. For the purposes of the Plan, the service area is defined as the area within a 30 mile radius of the Employee's residence.

If a Covered Person has a Medical Emergency requiring immediate care.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

## **Deductibles/Copayments payable by Plan Participants**

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>	<b>OUT-OF-AREA PROVIDERS</b>
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	\$2,000,000		
<b>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</b>			
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>			
Per Covered Person	\$500	\$500	\$500
Per Family Unit	3 persons	3 persons	3 persons
Any covered expenses incurred at a Non-Network provider that are applied toward the Non-Network deductible amount will <u>not</u> be applied toward the satisfaction of the Network or Out-of-Area deductible amount. However, Network or Out-of-Area covered expenses that are applied toward the calendar year deductible amount will accumulate together, but these expenses will <u>not</u> be applied toward satisfaction of the Non-Network deductible amount.			
The Calendar Year deductible is waived for the following Covered Charges: <ul style="list-style-type: none"> <li>- Network and Out-of-Area Outpatient Surgery Charges</li> <li>- Second Surgical Opinion</li> <li>- Wellness Benefit (first \$100 of Network Provider Charges)</li> </ul>			
<b>COPAYMENTS</b>			
Hospital Inpatient services	\$100 per day confined, not to exceed 3 copayments per confinement.	\$100 per day confined, not to exceed 3 copayments per confinement.	\$100 per day confined, not to exceed 3 copayments per confinement.
Outpatient surgery services	\$200 per surgery	N/A	\$200 per surgery
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>			
Per Covered Person	\$2,500	\$10,000	\$5,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
Any covered expenses incurred at a Non-Network provider that are applied toward the Non-Network out-of-pocket amount will <u>not</u> be applied toward the satisfaction of the Network or Out-of-Area out-of-pocket amount. However, Network or Out-of-Area covered expenses that are applied toward the calendar year out-of-pocket amount will accumulate together, but these expenses will <u>not</u> be applied toward satisfaction of the Non-Network out-of-pocket amount.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.  Deductible(s) Cost containment penalties Copayments Any benefit considered at other than 60%, 80% or 90%.			
<b>COVERED CHARGES</b>			
<b>Hospital Services</b>			
Room and Board	Hospital Inpatient Copayment, then 90% after deductible	Hospital Inpatient Copayment, then 60% after deductible	Hospital Inpatient Copayment, then 80% after deductible
Room rate	the semiprivate room rate	the semiprivate room rate	the semiprivate room rate
Intensive Care Unit	Hospital Inpatient Copayment, then 90% after deductible	Hospital Inpatient Copayment, then 60% after deductible	Hospital Inpatient Copayment, then 80% after deductible
Room rate	Hospital's ICU Charge	Hospital's ICU Charge	Hospital's ICU Charge

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>	<b>OUT-OF-AREA PROVIDERS</b>
Outpatient Surgery – Hospital, Ambulatory Surgical Center Charges and any other charges in connection with an outpatient surgical procedure.	90% after \$200 Outpatient surgery Copayment. Deductible waived.	60% after deductible	90% after \$200 Outpatient surgery Copayment. Deductible waived.
<b>Skilled Nursing or Extended Care Facility</b> Room rate	90% after deductible one-half Hospital average semiprivate room and board rate  Confinement must begin within 14 days of a 3 day stay  60 days Calendar Year maximum	60% after deductible one-half Hospital average semiprivate room and board rate  Confinement must begin within 14 days of a 3 day stay  60 days Calendar Year maximum	80% after deductible one-half Hospital average semiprivate room and board rate  Confinement must begin within 14 days of a 3 day stay  60 days Calendar Year maximum
<b>Physician Services</b>			
Inpatient visits	90% after deductible	60% after deductible	80% after deductible
Inpatient surgery	90% after deductible	60% after deductible	80% after deductible
Outpatient Surgery	90% after \$200 Outpatient surgery Copayment. Deductible waived.	60% after deductible	80% after \$200 Outpatient surgery Copayment. Deductible waived.
Office visits	90% after deductible	60% after deductible	80% after deductible
Allergy testing	90% after deductible	60% after deductible	80% after deductible
Allergy serum and injections	90% after deductible	60% after deductible	80% after deductible
Attention Deficit Disorder	90% after deductible	60% after deductible	80% after deductible
Second and/or Third Surgical Opinion	100% deductible waived	100% deductible waived	100% deductible waived
<b>Home Health Care</b>	90% after deductible	60% after deductible	80% after deductible
<b>Inpatient Prescription Drugs</b>	90% after deductible	60% after deductible	80% after deductible
<b>Outpatient Private Duty Nursing</b>	90% after deductible	60% after deductible	80% after deductible
<b>Hospice Care</b>	90% after deductible	60% after deductible	80% after deductible
Bereavement Counseling	90% after deductible \$200 Calendar Year maximum	60% after deductible \$200 Calendar Year maximum	80% after deductible \$200 Calendar Year maximum
<b>Ambulance Service</b>	90% after deductible	60% after deductible	80% after deductible
<b>Jaw Joint/TMJ</b>	90% after deductible \$2,000 Calendar Year maximum	60% after deductible \$2,000 Calendar Year maximum	80% after deductible \$2,000 Calendar Year maximum
<b>Occupational Therapy</b>	90% after deductible	60% after deductible	80% after deductible
<b>Speech Therapy</b>	90% after deductible	60% after deductible	80% after deductible
<b>Physical Therapy</b>	90% after deductible	60% after deductible	80% after deductible
<b>Durable Medical Equipment</b>	90% after deductible	60% after deductible	80% after deductible
<b>Prosthetics</b>	90% after deductible	60% after deductible	80% after deductible

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>	<b>OUT-OF-AREA PROVIDERS</b>
<b>Orthotics – (see exclusion for Foot Care)</b>	90% after deductible	60% after deductible	80% after deductible
<b>Spinal Manipulation Chiropractic</b>	90% after deductible \$2,000 Calendar Year maximum	60% after deductible \$2,000 Calendar Year maximum	80% after deductible \$2,000 Calendar Year maximum
<b>Mental Disorders</b>			
Inpatient	Hospital Inpatient Copayment, then 90% after deductible 30 days Calendar Year maximum	Hospital Inpatient Copayment, then 60% after deductible 30 days Calendar Year maximum	Hospital Inpatient Copayment, then 80% after deductible 30 days Calendar Year maximum
Outpatient	60% after deductible 45 visits Calendar Year maximum	50% after deductible 45 visits Calendar Year maximum	60% after deductible 45 visits Calendar Year maximum
<b>Substance Abuse</b>			
Inpatient	Hospital Inpatient Copayment, then 90% after deductible	Hospital Inpatient Copayment, then 60% after deductible	Hospital Inpatient Copayment, then 80% after deductible
Outpatient	60% after deductible \$80 maximum considered per visit	50% after deductible \$80 maximum considered per visit	60% after deductible \$80 maximum considered per visit
Inpatient / Outpatient Combined	\$25,000 Lifetime maximum	\$25,000 Lifetime maximum	\$25,000 Lifetime maximum
<b>Preventive Care</b>			
Routine Well Adult Care	100% of first \$100 then 90% after deductible	60% after deductible	80% after deductible
Includes: office visits, annual pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, immunizations/flu shots and colon exam.			
Routine Well Child Care	100% of first \$100 then 90% after deductible	60% after deductible	80% after deductible
Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations through age 24.			
Routine Well Newborn Care	Not Covered	Not Covered	Not Covered
<b>Organ Transplants</b>	90% after deductible	60% after deductible	80% after deductible
<b>Pregnancy</b>	90% after deductible	60% after deductible	80% after deductible
<b>Infertility Benefits</b>	90% after deductible \$1,000 Calendar Year maximum	60% after deductible \$1,000 Calendar Year maximum	60% after deductible \$1,000 Calendar Year maximum
Includes: care, supplies and services for the diagnosis, treatment and charges for surgical correction of physiological abnormalities of infertility. Fertility Drugs are not covered.			

**PRESCRIPTION DRUG BENEFIT**

**Calendar Year Deductible**..... \$100

**Pharmacy and Specialty Pharmacy Option**

Generic drugs

Copayment..... \$10

Brand Name drugs

Copayment..... \$25

**Mail Order and Advantage 90 (limited to selected Pharmacies) Prescription Drug Option**

Generic drugs

Copayment..... \$25

Brand Name drugs

Copayment..... \$65

Prescription drugs *not* obtained with Prescription Drug Card must be submitted to the Drug Card Network and will be reimbursed at Contract rate less applicable copay and deductible less appropriate administration fee.

**DENTAL BENEFITS**

**Maximum Benefit Amount**

For Class A, B, and C Services:

Per person per Calendar  
Year ..... \$2,000

For Class D-Orthodontia:

Lifetime maximum per person ..... \$2,000

**Deductible Amount**

Calendar Year deductible,  
per person ..... \$50

per Family Unit ..... 3 members must meet

The deductible applies to these Classes of Service:

- Class B Services - Basic
- Class C Services - Major
- Class D Services - Orthodontia

**Dental Percentage Payable**

Class A Services - Preventive.....	100%
Class B Services - Basic.....	80%
Class C Services - Major.....	50%
Class D Services - Orthodontia.....	60%

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

### **ELIGIBILITY**

**Eligible Classes of Employees.** All Active and Retired Employees of the Employer. The following Classes of Employees:

- (1) Full-Time, Active Employees of the Employer who are eligible under the Employer's Retirement Plan. An Employee is considered to be Full-Time if he or she normally works at least 35 hours per week and is on the regular payroll of the Employer for that work.
- (2) Duly elected or appointed Assessors
- (3) Retired Assessors or Employees of the Employer. An eligible Retiree:
  - (a) is at least 55 years of age (or has at least 30 years of service regardless of age)
  - (b) has at least 12 years of service with the employer, and
  - (c) was covered under the Plan at the time of his retirement.

If such retired employee does not elect to continue coverage within the 30 days from the date he ceased 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.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 35 hours per week and is on the regular payroll of the Employer for that work.
- (2) is a duly elected or appointed Assessor
- (3) is a Retired Assessor or Employee of the Employer.
- (4) is in a class eligible for coverage.
- (5) completes the employment Waiting Period of 30 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

**Eligible Classes of Dependents.** A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a Full-Time Student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 24. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age. (See definition of Full-Time Student.)

The term "Spouse" shall mean the legally married spouse of an eligible Employee who has a valid marriage license (common law spouses are never eligible for coverage). The Plan Administrator may require documentation proving a legal marital relationship.

**Important:** If the Spouse of an active or retired participant is eligible for group health 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.

The term "children" shall includes:

- (a) a natural child following birth, or
- (b) a legally adopted child, or
- (c) any stepchild who resides with the employee, or
- (d) a child legally placed in the employee's home for the purpose of adoption by the employee, or
- (e) a child of the employee for which 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.

A child related by blood or marriage where either the covered employee or covered spouse is financially responsible for the care of the child (financial responsibility is defined as evidence of having included the child as an exemption on the most recent Federal Income Tax Return) and who was covered under the Plan on January 1, 2003, may continue to be covered under the Plan as long as the child continues to meet all the other Plan eligibility requirements as well.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## FUNDING

**Cost of the Plan.** The Employer may share the cost of Employee or Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

## PRE-EXISTING CONDITIONS

**NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator, Louisiana Assessors' Association, 3060 Valley Creek Drive, Baton Rouge, Louisiana, 70808, 800-925-4446.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months, or 18 months if a Late Enrollee after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

**A Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three months prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 30 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under any Creditable Coverage. A child has Creditable Coverage within 30 days if the child's expenses are covered under the parent's coverage during that period, either under this Plan or another plan, whether or not the child is ever enrolled in that Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-consecutive day period during all of which the individual was not covered under any Creditable Coverage.

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

This Plan does not cover Routine Well Newborn Care.

## TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins the first of the month after enrollment.

## SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Louisiana Assessors' Association, 3060 Valley Creek Drive, Baton Rouge, Louisiana, 70808, 800-925-4446.

## SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
  - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
  - (d)** The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
  - (e)** For purposes of these rules, a loss of eligibility occurs if:
    - (i)** The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
    - (ii)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
    - (iii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
    - (iv)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
    - (v)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

**(2) Dependent beneficiaries.** If:

- (a)** The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b)** A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a)** in the case of marriage, the date of marriage or the date of the completed request for enrollment is received, whichever is later;
- (b)** in the case of a Dependent's birth, as of the date of birth; or
- (c)** in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

## **EFFECTIVE DATE**

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1)** The Eligibility Requirement.
- (2)** The Active Employee Requirement.
- (3)** The Enrollment Requirements of the Plan.

### **Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## TERMINATION OF COVERAGE

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.**

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is eliminated.
- (3) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.)
- (4) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.

**Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff.** A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

**For disability leave only:** the end of the 12 calendar month period that follows the date the person last worked as an Active Employee.

**For leave of absence or layoff only:** the end of the 2 calendar month period that follows the date last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

**Rehiring a Terminated Employee.** 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 and continues his COBRA coverage until he again becomes eligible for coverage as an Employee, any, Pre-Existing Conditions Limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following

circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
  - (a) The 24 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.

**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 dependent(s) 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 covered employee eligible for retirement or retiree. 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.

## MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

**Deductible For A Common Accident.** This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

### BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

### OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

### MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

### COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 90% of the lowest private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, 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).

- (3) **Skilled Nursing/Extended Care Facility Care.** The room and board and nursing care furnished by a Skilled Nursing /Extended Care Facility will be payable if and when:
- (a) the patient is confined as a bed patient in the facility;
  - (b) the confinement starts within 14 days of a Hospital confinement of at least 3 days;
  - (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing/Extended Care Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.
- (a) Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
    - (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
    - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
    - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.
- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
- (a) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.
- (6) **Home Health Care Services and Supplies** prescribed by a physician as a plan of treatment and began within seven days after a hospital confinement (the seven day requirement may be waived if prior authorization is obtained from the Plan Administrator). 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/extended care 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.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children).

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary.
- (b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c) **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 Medical Care Facility as defined by this Plan.
- (d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (e) Initial **contact lenses** or glasses required following cataract surgery.
- (f) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. If purchased, the Plan will cover replacement only after a five-year period.
- (g) Care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of **infertility** as indicated in the Schedule of Benefits, including, but not limited to artificial insemination, in-vitro fertilization, or gamete intra-fallopian transfer.
- (h) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome.**
- (i) **Laboratory studies.**
- (j) Treatment of **Mental Disorders and Substance Abuse.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (k) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Treatment of an accidental injury to a sound, natural tooth, or for the setting of a jaw fracture or dislocation incurred while covered; this treatment must begin within three months of the accident and be completed within twelve months..

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O., or D.D.S.) certifies in advance to the Plan Administrator that hospitalization is medically necessary.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (l) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

- (m) Services, surgery, supplies and treatment for covered **organ transplants** for the recipient and donor if both are covered under this Plan. If the recipient is covered under this Plan and the donor is covered under another health plan, the donor's expenses will be covered under this Plan only if the other plan specifically excludes these expenses, or if there is otherwise no coverage for the donor's expenses. In no case will coverage for organ transplants be provided if the recipient is not covered under this Plan. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow, heart, heart/lung, liver, lung and pancreas. The following conditions shall apply:

Charges must be otherwise covered under this Plan, and

The participant who is the recipient must receive two opinions with regard to the need for transplant surgery. The opinions 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.

- (n) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Corrective shoes, arch supports or other corrective devices or appliances used to treat foot conditions are not covered.

- (o) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
- (p) **Prescription Drugs** (as defined).
- (q) Routine **Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

**Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.

**Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (r) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. Subsequent replacement is covered only if the attending physician certifies in writing that such replacement is medically necessary due to (1) a physical change in the condition of the patient's site of attachment, (2) the normal, physical growth of a dependent child, or (3) the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.
- (s) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (t) **Charges for a Rehabilitation Hospital**, provided all the following conditions are met:
  - (i) 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;
  - (ii) 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;
  - (iii) the patient requires close medical care by a physician and 24-hour-a-day nursing supervision; and
  - (iv) the patient's stay is approved by the Utilization Review organization.
- (u) Medically necessary treatment of **sexual dysfunction** resulting only from organic causes, including, but not limited to, treatment such as penile implants.
- (v) **Sleep Disorders** and related diagnostic testing
- (w) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or

nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

- (x) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (y) **Sterilization** procedures for covered Employee or Dependent Spouse only.
- (z) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (aa) **VAX-D therapy**.
- (bb) **Vision therapy** (nonsurgical treatment to the eye muscles).
- (cc) Diagnostic **x-rays**.

## COST MANAGEMENT SERVICES

### Cost Management Services Phone Number

**MediCor Managed Care, Inc.**  
**877-432-5663**

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 working day prior in advance of services being rendered or within 48 hours or the first working day after an emergency.

**Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.**

### UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons 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:  
  
Hospitalizations
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. 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 either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

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 Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review 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.

Since Elective Procedures may take additional time to review, please do not schedule your procedure until you have received pre-authorization.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator MediCor Managed Care, Inc. at 877-432-5663 **at least 1 working day prior 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
- 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 MediCor Managed Care, Inc. **within 48 hours or the first working day** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced to 60% of the first \$15,000 in covered hospital charges.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person 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 Covered Person 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.

## SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

## CASE MANAGEMENT

**Case Management.** The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A 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; and
- 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 Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the 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.**

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. Active Employee also includes duly elected or appointed Assessors performing the duties of an Assessor.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Brand Name** means a trade name medication.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Cosmetic Surgery** is surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Covered Person** is an Employee, Retiree or Dependent who is covered under this Plan.

**Creditable Coverage** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and eligible for the Employer's Retirement Plan. Also includes duly elected or appointed Assessor.

**Employer** is Louisiana Assessors' Association including any affiliate, subsidiary or Assessors' office thereof.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Full-Time Student** is 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.

**Generic drug** means a Prescription Drug which 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.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a

registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Infertility** means incapable of producing offspring.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically or Dentally Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is 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 Covered Person.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means Louisiana Assessors' Association Employee Benefit Plan, which is a benefits plan for certain Employees of Louisiana Assessors' Association and is described in this document.

**Plan Participant** is any Employee, Retiree or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on the effective date of the Plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three months prior to the person's Enrollment Date under this Plan (e.g. the three month look back period for an Enrollment Date of August 15 is May 15 through August 14). Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 30 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under any Creditable Coverage. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Retired Employee** is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer; and, if a contribution is required, elects to contribute to the Plan the necessary contribution from the Retired Employee. See Eligibility Requirements for further information.

**Sickness** is a person's Illness, disease or Pregnancy (including complications).

**Skilled Nursing/Extended Care Facility** is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Sound, Natural Tooth** is 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, as determined by the Plan Administrator. 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.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders 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.

**Total Disability (Totally Disabled)** means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**Note: All exclusions related to Dental are shown in the Dental Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

- (1) **Abortion.** Services, supplies, care or treatment in connection with an elective abortion.
- (2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (3) **Cosmetic Surgery.** Charges in connection with Cosmetic Surgery are excluded unless they are (1) incurred within twelve months following and as a result of accidental injury, (2) for correction of a congenital anomaly or (3) for breast reconstruction following a mastectomy performed for reasons of illness or injury, including surgery done on the healthy breast to achieve symmetrical appearance.
- (4) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (5) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (6) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (7) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (8) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (9) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (10) **Foot care.** Corrective shoes, arch supports or other corrective devices or appliances are excluded.
- (11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (12) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (13) **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.
- (14) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- (15) **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.
- (16) **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

- (17) **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.
- (18) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence that is due to other than organic causes.
- (19) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (20) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (21) **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.
- (22) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (23) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (24) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (25) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (26) Care and treatment of **Obesity**, weight reduction or physical fitness, including all surgical procedures performed for reasons of or in conjunction with obesity. Charges for 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.
- (27) **Occupational.** Care and treatment of an Injury or Sickness that is occupational, that is arises from work for wage or profit including self-employment. Any Injury or Sickness 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.
- (28) **Oral Statements.** Charges which are incurred based upon oral statements made by anyone involved in the administration of the Plan which are in conflict with the benefits described in this document.
- (29) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (30) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (31) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (32) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (33) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or

treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

- (34) **Sales Tax.** Sales tax on prescription drugs or on any other covered items.
- (35) **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.
- (36) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (37) **Sex changes.** 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.
- (38) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (39) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (40) Services of a **surrogate mother.**
- (41) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (42) **War.** Any loss that is due to a declared or undeclared act of war.

## **PRESCRIPTION DRUG BENEFITS**

### **Pharmacy Program Administration**

The plan has contracted a prescription benefit management company to administer the prescription drug benefit program. Prescription Drug Benefits include: Retail Pharmacy Services, Mail Service, Specialty Pharmacy Programs and other Managed Prescription Initiatives as deemed appropriate by the plan.

### **Deductibles/Copayments**

A deductible is an amount of money that is paid once a Calendar Year per Covered person. The copayment is applied to each covered pharmacy prescription drug, mail service prescription drug, or specialty pharmacy prescription drug charge and is shown in the schedule of benefits. The deductible/copayment amount is not a covered charge under the medical Plan.

### **Direct Member Reimbursement**

If a covered drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable will be the contracted discount rate of the covered prescription medication less the applicable deductible/copay less the appropriate paper claim administration fee. Plan participants should request and complete a Direct Member Reimbursement Form from the Plan Administrator and send this form with necessary documentation directly to the Prescription Benefit Management Company for reimbursement.

### **Mail Order Drug Benefit Option**

The mail service prescription drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc., as defined by the Prescription Benefit Manager.). This service provides a convenient and cost effective method of obtaining 90 day supplies of medications and offers Covered Persons significant savings

### **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.

### **Clinical Prior Authorization, Step Therapies, and Quantity Level Limitations**

To ensure prescriptions are utilized appropriately, certain medications may require approval or "Prior Authorization".

The use of certain quantity level limitations may be implemented to assist in controlling overuse, abuse, of specific medications by limiting the quantity of specific medications or therapeutic classes to enough medication to treat one acute or chronic treatment episode.

### **Covered Prescription Drugs**

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered unless through the Specialty Program.

## Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.
- (3) Drugs to treat impotency are covered only for males age 18 and over, and are limited to 30 days or 12 units (mail order 90 days or 36 units) whichever is less per claim.

## Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Immunization.** Immunization agents or biological sera.
- (9) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (10) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (13) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

- (16) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

## DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

**Family Unit Limit.** When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

### BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

### MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

### DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

## COVERED DENTAL SERVICES

### Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each 12 months.
- (2) Two bitewing x-rays every 12 months.
- (3) One full mouth or panoramic x-ray every 36 months.
- (4) One fluoride treatment each 12 months.
- (5) Emergency palliative treatment for pain.
- (6) Sealants, per tooth (limited to no more than 2 treatments per tooth and to unfilled permanent molars, only for dependents, maximum age up to 16).

**Class B Services:  
Basic Dental Procedures**

- (1) Oral surgery. Oral surgery is limited to removal of teeth (except that impacted wisdom teeth are not covered under dental but are covered under medical), preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (2) Periodontics (gum treatments). Periodontic scaling (per quadrant) and maintenance is limited to twice each 12 month period.
- (3) Endodontics (root canals).
- (4) Extractions, excluding extractions for orthodontic purposes. This service includes local anesthesia and routine post-operative care.
- (5) Recementing bridges, crowns or inlays.
- (6) Fillings, other than gold.
- (7) General anesthetics, upon demonstration of Medical Necessity.
- (8) Antibiotic drugs.
- (9) Repair of crowns, bridgework and removable dentures.
- (10) Rebasement or relining of removable dentures limited to once each 12 month period.
- (11) Space maintainers limited to one every 12 months for dependents up to age 14. Limited to initial appliances and all adjustments within six months after installation.
- (12) Tissue conditioning limited to once every 12 months.

**Class C Services:  
Major Dental Procedures**

- (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) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Installing partial, full or removable dentures to replace one or more natural teeth. The denture work must be finished within 12 months of the date the tooth is extracted.
- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Initial installation of fixed bridgework to replace one or more natural teeth.
- (7) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth 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.

#### **Class D Services: Orthodontic Treatment and Appliances**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for Employees and covered Dependent of any age and include preliminary study, including x-rays, extractions, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

#### **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

- (a) after the date the participant's coverage ends because the Plan terminates, or if coverage for that class of employees terminates, or
- (b) 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.

#### **ALTERNATE TREATMENT**

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

#### **EXCLUSIONS**

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Cosmetic.** Any service or treatment for cosmetic purposes. Facings on crowns or pontics posterior to the second bicuspid are always considered to be for cosmetic purposes.
- (4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (5) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (6) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

- (7) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- (8) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (9) **No listing.** Services which are not included in the list of covered dental services.
- (10) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (11) **Personalization.** Personalization of dentures.
- (12) **Replacement** of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five years of its placement. This exclusion does not apply to any such replacement required because of accidental bodily injury that a person sustains while covered.
- (13) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

## HOW TO SUBMIT A CLAIM

**Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.**

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician or Dentist complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
  - Name of Plan
  - Employee's name
  - Name of patient
  - Name, address, telephone number of the provider of care
  - Diagnosis
  - Type of services rendered, with diagnosis and/or procedure codes
  - Date of services
  - Charges
- (5) Send the above to the Claims Processor at this address:

Benesys  
P.O. Box 81189  
Lafayette, Louisiana 70598-1198  
800-256-6799

### WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Processor within 12 months of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Processor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Processor will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Processor shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

#### **CLAIMS REVIEW PROCEDURE**

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Processor within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

**Benefit plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable Charge.** For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

**Automobile limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

**Benefit plan payment order.** When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
  - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
  - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or

Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
  - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
    - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
    - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
  - (e) When a child's parents are divorced or legally separated, these rules will apply:
    - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
    - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
    - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
    - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
    - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
  - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) 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:

Joyce Ansley – No Medicare

Allen Ardoin – Medicare Part A only

Corra Barr – Medicare Part B only  
Lorene Beard – No Medicare  
Francis Foster – No Medicare  
Margaret Gill – Medicare Part B only  
Bennie Ruth Hall – No Medicare  
Lucy Martin – No Medicare

- (4) 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.
- (5) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**Claims determination period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

**Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**Exception to Medicaid.** In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

## THIRD PARTY RECOVERY PROVISION

### RIGHT OF SUBROGATION AND REFUND

**When this provision applies.** The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

**Amount subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's

100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:** "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Louisiana Assessors' Association Employee Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Louisiana Assessors' Association, 3060 Valley Creek Drive, Baton Rouge, Louisiana, 70808, 800-925-4446. COBRA continuation coverage for the Plan is administered by Benesys, P.O. Box 81189, Lafayette, Louisiana 70598-1198, 800-256-6799. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that

constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan

coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.**

***NOTICE PROCEDURES:***

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Louisiana Assessors' Association  
3060 Valley Creek Drive  
Baton Rouge, Louisiana 70808

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** Louisiana Assessors' Association Employee Benefit Plan is the benefit plan of Louisiana Assessors' Association, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Louisiana Assessors' Association to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Louisiana Assessors' Association shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall 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 shall 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, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

### DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Processor to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**CLAIMS PROCESSOR IS NOT A FIDUCIARY.** A Claims Processor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy

Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
    - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
    - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
    - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
    - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
  - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
  - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Louisiana Assessors' Association's workforce are designated as authorized to receive Protected Health Information from Louisiana Assessors' Association Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Members of the Louisiana Assessors' Insurance Committee, Attorney for the Louisiana Assessors' Insurance Fund, CPA for Louisiana Assessors' Insurance Fund, Insurance broker named as agent of record for LAIF..

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the following provisions apply:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

#### **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee Coverage:** Funding is derived solely from the funds of the Employer.

**For Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Processor.

#### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

#### **CLERICAL ERROR**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

## **Important Notice About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Louisiana Assessors' Association Employee Benefit Plan and new prescription drug coverage available January 1, 2006, for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
2. Louisiana Assessors' Association has completed an actuarial determination and concluded that the prescription drug coverage offered by the Louisiana Assessors' Association Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
3. Read this notice carefully—it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

**Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.**

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005, through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15<sup>th</sup> through December 31<sup>st</sup>.

**If you do decide to enroll in a Medicare prescription drug plan and drop your Louisiana Assessors' Association Employee Benefit Plan prescription drug coverage, be aware that you may not be able to get this coverage back.**

If you drop your coverage with Louisiana Assessors' Association Employee Benefit Plan and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. It might also be a good idea to contact your doctor and discuss the Medicare prescription drug plans available to you. Together, you may select the best choice for you.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will not still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Louisiana Assessors' Association Employee Benefit Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1 percent per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November 15<sup>th</sup> to enroll.

Contact the Plan Administrator if you have further questions. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage

changes. You also may request a copy.

**For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.**