Designed with YOU in Mind

2023 Employee Benefits Guide

Louisiana Assessors' Association

WHAT'S INSIDE

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WELCOME!

We recognize the importance of providing our employees the opportunity to participate in a comprehensive and competitive benefits program. A competitive benefits program is key to our continued growth as an organization and offers our employees benefits in support of overall health and financial security. We continually review new developments in employee benefit programs and periodically add new benefits or change existing benefits to provide the maximum value to our employees.

Your benefits package is an important and significant part of your total compensation. This benefits guide has been prepared to summarize the benefit plans available to eligible employees for the 2023 Plan Year. Please read this information carefully. This benefits guide is not intended to be comprehensive, so please refer to the plan documents pertaining to each plan for more information. If you have any questions not answered by this guide, or if you need assistance with your benefits, please contact the Benefit Resource Center at 855.874.0110 or the Louisiana Assessors' Insurance Fund at 225.928.8886 or toll free at 800-925.4446.

PLANS AT A GLANCE

Medical
The Health Plan Medical PPO Plan - Louisiana Assessors' Ins. Fund provides a medical plan that includes a $500 deductible per individual and 90% coverage when using an in-network provider. In addition, you have a $30 copay for a physician office visit.

Dental
The Health Plan provides rich benefits with the freedom of seeing any dentist (contracted or not); Your benefits will be greater when you receive care from a contracted dentist.

Vision
Guardian through VSP provides coverage for eye exams and vision hardware (lenses and frames) subject to plan limitations.

Long Term Disability
MetLife covers 60% of your earnings up to $5,000 per month, after a 90 day waiting period.

Basic Life & AD&D
Louisiana Assessors' Ins. Fund provides eligible full-time employees with Basic Life and AD&D insurance through Guardian Life.

Voluntary Life
You may purchase additional Group Term Life insurance coverage through Guardian Life.

Voluntary Dependent Life
You may purchase Voluntary Life Insurance coverage through Guardian Life for your spouse and / or children, when you purchase voluntary life coverage for yourself.

Critical Illness
Guardian Life Critical Illness Insurance provides you with a lump sum benefit in the event you or your covered dependents are diagnosed with a specific medical condition. You may use this benefit as you see fit to help pay for costs not typically covered by other types of insurance.

Accident Insurance
Guardian Life Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

BENEFITS ENROLLMENT

Eligibility

Full-time Employees who work 30 hours or more per week are eligible for coverage as described on the next few pages, or may waive coverage. Benefits begin on the first of the month following your date of hire.

Dependents are defined as:

- Your legal spouse or your domestic partner
- Dependent "child" up to age 26. Child means:
  - a natural child
  - a stepchild
  - an adopted child
  - a child of your child (must be dependent on your for federal income tax purposes)
  - a child of any age who is medically certified as Disabled and dependent on the parent
  - any other child included as an eligible dependent under the contract

What is Open Enrollment?

Open Enrollment is a once-a-year opportunity to make changes to your current benefits and to review which dependents you will be covering during the new plan year. All changes you request will take effect January 1st.

Enrollment

Eligible employees can make benefit elections and changes during open enrollment and after a life status change event.

What happens if I don't enroll?

If your enrollment is not completed during the Open Enrollment period (which occurs in December for the next plan year), or within 31 days of your eligibility date (see life status change events), you will have to wait until the next Open Enrollment to apply for coverage.

Making Election Changes During the Year

In most cases, your benefit elections remain in effect until the next annual open enrollment period. You will not be able to make any plan changes unless you experience a change in life status.

Life Status Change Events

Events described in IRS regulations allow you to make a change to your benefit coverage if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment / ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

You have 31 days from the date of the event (60 days if it's due to loss of coverage from Medicaid or CHIP) to report and update your benefits with the Human Resources department. You will be required to provide documentation.

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance.

Our Benefits Specialists can help you choose the right plan for you and your family, translate confusing jargon, answer questions about which benefits are on your plan and which aren't, work directly with insurance carriers to resolve tricky issues regarding claims and denials of service—and more!

Benefit Resource Center

BRCSouthwest@usi.com | Toll Free: 855-874-0110

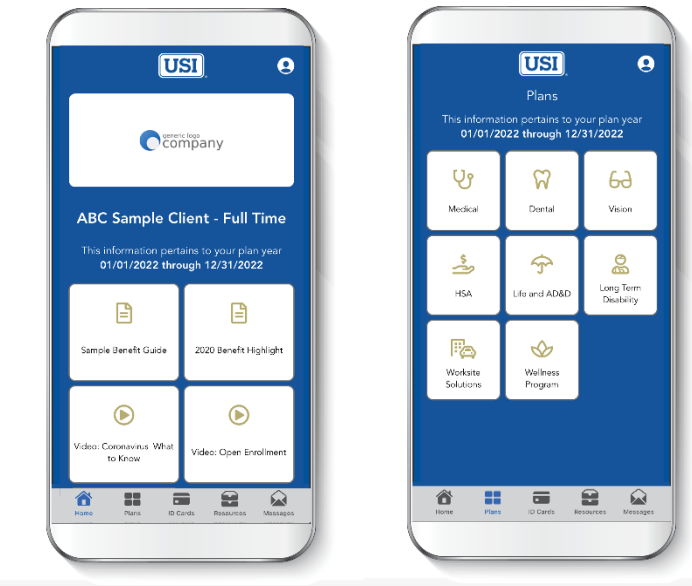
Benefits Information When You Need It Most

Louisiana Assessors' Association

FIND IT IN THE APP STORE

Search for '**MyBenefits2GO**' and download our free app.

Enter this code when prompted: **N91770**



HIGHLIGHTS OF THE MyBenefits2GO APP

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app

MyBenefits2GO: FREE MOBILE BENEFITS APP FOR ANDROID AND IPHONE

The MyBenefits2GO app gives you on-the-go access to your benefit and insurance policy details, HR contact information and more!

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.

Getting In Touch

The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Lightening Wallets

The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Keeping Up-to-Date

The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Staying Organized

The app gives you access to benefit plan information and ID cards—all in one place.

Louisiana Assessors' Association

EMPOWER HEALTH SERVICES

The Empower Health Services Individual Screening Program allows you to identify health risks early and better understand your overall wellness.

This biometric screening is available annually to all employees, spouses, retirees and retiree spouses between January and April. All screenings may be completed at a local LabCorp Patient Service Center.

Your Screening Package Includes:

- **Panel C** - Testing that consists of a 37-component blood chemistry profile. In addition to identifying signs of heart disease and diabetes, Panel C tests for liver and kidney malfunction, and thyroid, blood, and nutrition disorders. See chart below for details.
- **Hemoglobin A1c** - Assesses blood sugar levels over the past 90 to 120 days. This test can help diagnose type 2 diabetes and prediabetes.
- **Prostate Specific Antigen (PSA)** - Screens for signs of prostate cancer in men. (Included for all men age 40+)

The following provides a breakdown of the blood-testing components included in the Panel C:

Heart & Diabetes	Complete Blood Count	Kidney, Liver & Thyroid	Nutrition
Glucose	Red Blood Cells	BUN & Creatinine	Calcium
Total Cholesterol	White Blood Cells	T4 & Potassium	Total Protein
HDL (Good Chol.)	Hemoglobin	Phosphorus & eGFR	Albumin
Non-HDL	Hematocrit	Chloride & Sodium	Uric Acid
LDL (Bad Chol.)	Platelet Count	Alkaline Phosphatase	Iron
Cholesterol Ratio	Red Blood Cell Distribution	Total & Direct Bilirubin	Magnesium
Triglycerides	MCH, MCHC, MCV	SGOT, SGPT, Gamma GTP & LD	

Additional information coming soon about next year's program!

HST'S PATIENT ADVOCACY CENTER

"I'm so thankful the PAC was there to help resolve my balance bill. I really can't say enough about the support and communication they provided throughout this process"

- Jane B., CA

The Patient Advocacy Center (PAC) is a member-driven service offered as part of our Value-Driven Health Plan Services. In the rare instances of balance billing, where a provider tries to collect any amount greater than the amount the patient is responsible for, the Patient Advocate's role is to educate providers on the Value-Driven Health Plan Services and work directly with them to achieve a resolution all the while keeping the member apprised.

PATIENT ADVOCATES

Our team of Patient Advocates are always working hard to ensure providers are charging you a fair price for your medical services and that you only receive a bill for your patient responsibility.

BENEFTITS OF HST'S PAC:

- Less than 2% of claims are disputed
- A dedicated Patient Advocate represents you through completion
- Accessible via phone, text, email, and HSTConnect mobile app

HST
A MULTIPLAN COMPANY

HMKT0001

hstechnology.com

PATIENT ADVOCACY CENTER (PAC)

FREQUENTLY ASKED QUESTIONS

WHO IS HST?

HST, a MultiPlan company, has been engaged by your Employer to review some healthcare medical bills and verify that all billed charges are fair for both you and the provider. For example, we identify any inflated or duplicate charges on your bill.

WILL THE PROVIDER KNOW THAT AN HST PATIENT ADVOCATE IS INVOLVED IN MY CASE?

Yes. We will contact the provider to inform them that an HST Patient Advocate has been appointed as the liaison between the member and the provider. We will ask that that all communications to you, the member, should be redirected to the Patient Advocate.

WILL MY CREDIT BE AFFECTED?

No. The Federal Fair Credit Reporting Act mandates that neither the provider nor their agents may threaten the patient's credit rating or report them as delinquent while the claim is being disputed.

WILL I BE NOTIFIED WHEN THE DISPUTE HAS BEEN RESOLVED?

Yes. Your HST Patient Advocate will notify you of the final resolution.

DO NOT PAY THE BILL!

If you receive a balance bill, contact HST's PAC. A representative will guide you through the process and handle all further communications with the provider on your behalf.

INFORMATION TO PROVIDE THE PAC

- Your full name
- Date of service
- Copy of bill; EOB when available
- Your daytime phone number and email address

WE'RE HERE FOR YOU

- Phone: (888) 837-2237
- Fax: (949) 891-0420
- Email: pac@hstechnology.com
- Monday-Friday 7:00am–5:00pm PST
- HSTConnect (mobile app)

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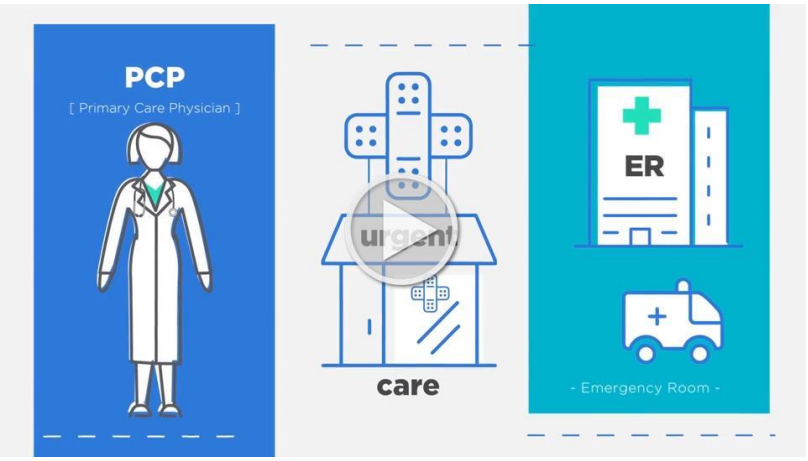
FLIMP VIDEOS

Flimp videos are hosted online, so you must have an internet connection to view. You can either use the Hyperlink or open your phone's camera, hold it over the QR Code and you can view the video.

Primary Care / Urgent Care / ER



Video Hyperlink

https://flimp.me/HubDeliverablesPCUCER

QR Code

How to Read an EOB

Video Hyperlink

https://flimp.me/HubDeliverablesReadEOB

QR Code

LOUISIANA ASSESSORS' ASSOCIATION

2022 Medical & Dental Plan Changes

Physical Therapy:

Currently reads: Treatment or services rendered by a physical therapist, under direct supervision of a physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free standing duly licensed outpatient therapy facility. Coverage ends once a maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

2022 Update: Within a 12-month period, after a procedure, up to 24 visits as prescribed by a physician.

Massage Therapy by a Physical Therapist:

Currently reads: Not currently covered

2022 Coverage Added: Tied in to Physical Therapy and follow the same guidelines.

Naturopathic Medicine / Functional Medicine:

Currently reads: Not currently covered

2022 Coverage Added: Copay of $45 and allow Meds to be covered through RxBenefits.

Dental & Orth Annual Maximum:

Increasing annual maximums to $5,000 per person

Ortho paid at 60% up to $5,000 Lifetime Max per person

Hearing Aid Coverage:

After plan deductible is met, covered at 100% up to plan max of $2,000 per ear; and 1 hearing aid per ear every 3 years.

Medical Plan Out of Pocket Maximum:

In-Network:	Individual/$2,500	Family/$7,500
Out-of-Network:	Individual/$8,550	Family/$17,100
Out-of-Area	Individual/$5,000	Family/$15,000

Covid Infusions Covered as of May 1, 2021

MEDICAL BENEFITS

The Preferred Provider Organization (PPO) medical plan uses The Health Plan through a CIGNA network for benefits. Benefits are provided at a preferred or non-preferred level, depending whether or not you receive care from an in-network physician. While Plan highlights are provided below, please refer to the Summary Plan Description for plan details.

The Health Plan	PPO Plan	
	In-Network	Out-of-Network
Annual Deductible Individual Family	$500 $1,500	$500 $1,500
Coinsurance Plan Pays	90% after deductible	60% after deductible
Out-of-Pocket Max Individual Family Out of Area: Individual $5,000 / Family $15,000	Includes deductible $2,500 $7,500	Includes deductible $8,550 $17,100
You Pay:		
Physician Office Visits Primary Care Physician Specialist	$30 copay $45 copay	40% coinsurance after deductible
Preventive Care	Covered at 100%	40% coinsurance after deductible
Outpatient Lab and X-ray	10% coinsurance after deductible	40% coinsurance after deductible
Urgent Care	$45 copay per visit	40% coinsurance after deductible
Emergency Room	$100 copay (waived if admitted)	
Hospital Inpatient stay Outpatient surgery	10% after deductible $200 copay then 10% coinsurance	40% coinsurance after deductible
Hearing Aid Benefit	After plan deductible is met, covered at 100% up to plan max of $2,000 per ear; and 1 hearing aid per ear every 3 years.	
Retail Drugs (1-34 day supply) Generic Preferred Brand Non-Preferred Brand Specialty	$10 copay $35 copay $50 copay 10% coinsurance or $100 (whichever is less)	
Retail Drugs (34-90 day supply) Generic Preferred Brand Non-Preferred Brand	$25.00 copay $87.50 copay $125.00 copay	

EMERGENCY ROOM OR URGENT CARE?

More than 10 percent of all emergency room visits could have been better addressed in an urgent care facility or a doctor's office. Your health plan with Insurance Committee of the Assessors' Insurance Fund covers both emergency room and urgent care visits. If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

Emergency Room

The emergency room (ER) is equipped to handle **life-threatening injuries and illnesses** and other serious medical conditions. Patients are generally seen according to the seriousness of their conditions in relation to other patients.

Go to the nearest ER if you experience any of the following:

- Compound fractures
- Shortness of breath
- Broken bones
- Poisoning
- Seizures
- Chest pain or difficulty breathing
- Uncontrollable bleeding

Cost with The Health Plan Medical PPO: $100 copay per visit

Urgent Care

Urgent care centers also offer after-hour care. Unlike emergency rooms, they are not equipped to handle life-threatening situations. Rather, they are designed to address **conditions where delaying treatment could cause serious problems or discomfort.**

These conditions can be treated in an urgent care center:

- Cuts that require stitches
- Diagnostic tests (x-rays, labs)
- Ear infections
- Fever or the flu
- Sprains or strains
- Vomiting, diarrhea or dehydration
- Urinary tract infections

Cost with The Health Plan Medical PPO: $45 copay per visit

Choosing the appropriate place of care not only ensures prompt and adequate medical attention, it also helps reduce unnecessary medical expenses. Although urgent care centers are usually more cost-effective, they are not a substitute for emergency care.

RxBenefits

Prescription Benefit Coverage

Louisiana Assessors' Association | Administered by RxBenefits, Inc. and Caremark, Effective January 1, 2023

Note: *Members may contact RxBenefits Member Services at 1.800.334.8134 or visit caremark.com . If there are any additional questions, please contact your Human Resource Department.*

Prescription Plan

Retail Pharmacy Coverage (01-34-day supply)	In Network Pharmacy
Generic	$10.00
Preferred Brand	$35.00
Non-Preferred Brand	$50.00

Retail Pharmacy Coverage (35-90-day supply)	In Network Pharmacy
Generic	$25.00
Preferred Brand	$87.50
Non-Preferred Brand	$125.00

Mail Order Extended Supply (01-90-day supply)	In Network Pharmacy
Generic	$25.00
Preferred Brand	$87.50
Non-Preferred Brand	$125.00

Accumulations

Deductible Embedded	$100 Individual

Maximum Out of Pocket (MOOP) Embedded	$2500 Individual/ $7500 Family

Annual Calendar Year Deductible for Brand name drugs only.
The calendar year MOOP applies to pharmacy and medical claims. Each individual family member must meet the single MOOP unless the family MOOP has been met. Once met, your covered prescriptions are paid at 100%.

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through a participating Specialty Plus Network pharmacy. These medications are limited to a 1-30 day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-insurance as listed below.

Specialty Medication	Caremark
Specialty	30% Co-insurance

Retail and Mail Order Pharmacies

Louisiana Assessors' Association participates in the Caremark pharmacy network. Contact RxBenefits Member Services at 1.800.334.8134 to inquire about a specific pharmacy.

Manufacturer Copay Assistance Program (MCAP)

Some specialty medications may qualify for third-party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, you will not receive credit toward your maximum out of pocket or deductible for any copayment or co-insurance amounts that are applied to a manufacturer coupon or rebate. Your employer has elected to enroll in Caremark's True Accum + PrudentRX program(s).

PrudentRx

Specialty medications are used to treat complex chronic conditions; they mimic compounds found within the human body. These high-cost oral or injectable medications are typically biology-based and highly complex. Louisiana Assessors' Association is offering the PrudentRx Co-Pay program to help you manage the cost of these medications by applying financial co-pay assistance from drug manufacturers. By enrolling in the PrudentRx program, your out-of-pocket costs for covered medications would be $0.

Please contact PrudentRx at 888.203.1768 so a patient advocate can assist you with completing your enrollment.

Maintenance Drug

A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., antihypertensive medication taken daily to control high blood pressure).

Preventive Medications

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles, maximum out of pockets, or other limitations such as annual caps or limits. You may contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at *caremark.com* to check drug costs and coverage.

Compound Drugs

For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

High Dollar Claim Review, Prior Authorization and Appeals program (HDCR)

Medication costs exceeding $1,000 per 30-day supply and $3,000 per 90-day supply require prior authorization.

Low Clinical Value Drug List (LCV)

Separate formulary exclusion list including low clinical value drugs, me too drugs, new to market drugs, and non-essential.

Formulary

A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee, and/or customized by Caremark or RxBenefits. This list reflects the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your prescription drug coverage, the Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Standard with ACSF Formulary may not be covered. Your formulary is Standard with ACSF.

The following lists are not all-inclusive, but rather are lists of the most commonly used prescription drugs. These lists are subject to change. The Caremark formulary provides an up-to-date list of medications that may be covered by the program. The Caremark formulary may be found online at caremark.com. You may also contact RxBenefits Member Services at 1.800.334.8134 to learn whether a specific drug is covered.

Covered Drugs and Supplies

The following examples of Covered Drugs and supplies may be available with your prescription benefit coverage. FDA-approved pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist. Please contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at caremark.com to check coverage.

- ACA Preventative Services List
- ADHD/ADD
- Androgen
- Anti-Obesity/Anorexiants/Appetite Suppressant
- Contraceptives
- Diabetic Medication (Insulin/Non-Insulin)
- Diabetic Supplies (Blood Glucose Meters)
- Diabetic Supplies (Lancets, Test Strips)
- Diabetic Supplies (Syringes & Needles)
- Diabetic Supplies (Pumps & Supplies)
- Erectile Dysfunction
- Fluoride
- Growth Hormones
- HSDD (i.e., Addyi)
- Insomnia/Sedatives/Hypnotics
- Legend Drug Compounds
- Legend Vitamins (Rx)
- Migraine Medications
- Narcolepsy
- Pain/Narcotics/Opioids
- Smoking Cessation Products
- Specialty Medications
- Topical Acne Medications

Covered Drug Limitations

Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling RxBenefits toll-free at 1.800.334.8134. Several hundred drugs are subject to quantity limitations for patient safety based on FDA guidelines.

- Erectile Dysfunction
- HSDD (i.e., Addyi)
- Pain/Narcotics/Opioids
- Smoking Cessation Products

For more information about specific drugs subject to coverage limitations, please call RxBenefits Member Services at 1.800.334.8134 or visit caremark.com.

Prior Authorization and Appeals

If a prescription drug claim is wholly or partially denied, you or your authorized representative has the right to appeal the decision. You or your authorized representative may appeal the denial no later than 180 days after receiving notice of an adverse claim decision. Appeals of prescription drug claims are handled by RxBenefits and are decided in accordance with the terms of the plan document. Following a clinical review, one of four actions will occur: the medication is approved, the medication claim is denied, the doctor may decide to withdraw and prescribe a different medication, or the reviewer can dismiss the claim due to lack of communication from the prescriber. If denied, the appeal process is available.

The Appeal Process

If denied, the member may appeal the decision. Upon appeal, a second pharmacist reviewer will evaluate the prior authorization and make a decision (approved/denied). If denied a second time, a final appeal may be made, which is forwarded to an outside medical reviewer. If denied, there are no further appeals.

Your doctor may initiate the Prior Authorization, quantity limit, high dollar claim review or any other rejection process by calling RxBenefits at 1.800.334.8134.

Louisiana Assessors' Association

Exclusions

Coverage is not provided for:

- Allergy Serums (Injectable & Oral)
- Anabolic Steroids
- Blood Products/Blood Serum
- Bulk Powder Compounds
- Cosmetics
- Diabetic Supplies (Alcohol Swabs)
- Experimental Medications
- Fertility Medications (Injectable & Oral)
- Glucose (Oral)
- Medical / Therapeutic Devices (Inc. DME)
- Needles & Syringes (Non-Insulin)
- Non-ACA Vaccines
- Nutritional Supplements
- OTCs
- Periodontal Products
- Respiratory Supplies

Retail and Mail Order Pharmacies

Louisiana Assessors' Association participates in the Caremark pharmacy network. Contact RxBenefits Member Services at 1.800.334.8134 to inquire about a specific pharmacy.

Pharmacy Identification Card (ID Card)

Your pharmacy ID card enables you to participate in the prescription drug card program. Present your separate pharmacy ID card to the pharmacist when obtaining a prescription to ensure you get the benefit of the prescription drug card program. Please contact RxBenefits Member Services at 1-800-334-8134 for pharmacy processing information.

Definitions:

Co-Insurance

The percentage of charges a Participant is required to pay for covered prescription drugs.

Copayment (Copay)

The specified charge you are required to pay for a Covered Drug.

Brand-Name

A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

Generic Drug

A generic drug is identical to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Although a generic drug is chemically identical to its branded counterpart, it is typically sold at substantial discounts from the branded drug's price.

Over-the-Counter Drug (OTC)

Any medical substance that can be purchased without a prescription. OTC medications are not covered by your plan unless otherwise stated.

Non-Preferred Brand

Non-Preferred Brand is a Brand Name prescription drug that does not appear on the formulary of Brand Name Drugs designated by Caremark as Preferred. Members may pay a higher cost for Non-Preferred Brand-Name Prescription Drugs than for Preferred Brand-Name prescription Drugs.

Preferred Brand Drug

Preferred Brand Drug is a prescription drug that appears on the formulary of Brand-Name Prescription Drugs designated by Caremark Preferred. This list is subject to periodic review and modifications by Caremark. Members may obtain a copy of this list by contacting RxBenefits Member Services at 1.800.334.8134 or by registering on caremark.com.

Members pay a lower copay/coinsurance for Preferred Brand-Name Prescription Drugs than for Non-Preferred Brand-Name Prescription Drugs.

For More Information About the Prescription Benefit Coverage

Louisiana Assessors' Association has partnered with Caremark and RxBenefits to provide prescription drug benefits. Caremark serves as the pharmacy benefit manager and RxBenefits administers the prescription drug program.

The website, caremark.com, is designed to help you explore ways to track your prescription benefits. You may use the site to locate pharmacies and compare prescription drug costs.

Questions?

Contact RxBenefits Member Services for information regarding the prescription drug program at 1.800.334.8134.

RxBenefits, Inc. does not provide legal advice. Nothing herein or in any other documents provided by RxBenefits, Inc. should be construed, or relied upon, as legal advice. It is the responsibility of the employer/plan sponsor and not RxBenefits, Inc. to determine the contents of its group health plan document and related summary plan description. The employer/plan sponsor should consult with its legal counsel regarding the contents of its group health plan and summary plan description, and the legal requirements that may be applicable thereto. For plan members with questions about plan coverage, please consult your HR Department.

Our Clinical Team is Here for You

Always Ready to Help

Health, Wellness, Prevention, Risk Reduction

At THP, we have staff and resources available to help you meet your goals for personal wellness and achieve optimum health through routine screenings. Our health library has:

- Interactive tools
- Quick Search Topics
- Symptom Checker
- A to Z Health topics and a key word search to help you locate the information you need

You will receive targeted email campaigns monthly to provide education and easy to follow instructions to you and your family about specific risks and available covered screenings. Topics cover a wide variety of themes and include topics for men, women, and children.

We additionally have an interactive approach to health risk assessment that allows you to take a private screening to determine your risks related to medical and behavioral conditions, functional status and social determinants of health by phone, mail or email. Your results are kept private and are used to determine your eligibility for programs that are free to members and described below.

The online Health library can be found at *https://www.healthplan.org/for-you-and-family/health-wellness/health-library-1*.

If you are interested in taking a health risk assessment, please call us at 1.800.624.6961, ext. 7644 from Monday through Friday 8 am to 5 pm EST or email us at ASO_HRAReturns@healthplan.org.

Chronic Disease Management

If you are living with diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and depression, you don't have to go through it alone. THP has a team of nurses who are here for you. They can provide you with educational materials, telephone calls and guidance. Nurses can help you better understand your condition, manage your symptoms and follow your health care providers plan of care.

To enroll in a Chronic Disease Management Program, please call 1.877.903.7504 Monday through Friday from 8 am to 5 pm EST. Or you can enroll online at *healthplan.org/disease-management-form*. Members with diabetes, cardiac conditions (CAD, CHF) and respiratory conditions (COPD or asthma) with or without associated depression are eligible for these programs.

1.800.624.6961
healthplan.org

Pregnancy Care

Members who are pregnant or are planning a pregnancy are eligible to enroll in this program. If you are pregnant or planning a pregnancy, we have a dedicated team of nurses who are here to help you. They can contact you by phone, email or mail. They can also give information through our secure portal. They can help with:

- Information and direction to assist with family planning and birth control
- What to expect during each trimester
- How to support a healthy pregnancy and full-term delivery
- Post-partum support
- Newborn care resources and developmental information to help you know what to expect during your baby's first year of life
- Screenings for at-risk conditions that may occur during pregnancy
- Customized care planning and coordination of care with your health care providers

If you would like more information on this program, please call 1.800.624.6961, ext. 7644 Monday through Friday from 8 am to 5 pm or complete the online enrollment form at *healthplan.org/pregnancy-enrollment-form.*

Medical/Behavioral Health Case Management

Are you having trouble navigating the health care system to get the help you or your minor child need? A nurse case manager is available to help you with medical, substance use or behavioral health care issues or conditions. Members also have access to tools and services in your community that may additionally be able to assist with local resources outside of your benefit package such as food resources and housing supports available through community-based organizations.

Our nurses will work with you and your health care providers to customize a plan of care that will

- Help you understand your disease or condition
- Manage or control your symptoms
- Follow your prescribed medication regimen
- Remove or overcome any barriers to care
- Help you take control of your health and live your best life

Information can be provided by phone, mail, secure email or in the secure member portal. To enroll in a case management program, please call 1.800.624.6961, ext. 7644 Monday through Friday from 8 am to 5 pm. You can also complete the online enrollment form at *healthplan.org/for-you-and-family/forms/member-case-management*. All members are eligible for case management services. Risk levels are taken into consideration for assignment to complex case management.

TheHealthPlan

Talk to a Nurse:

The nurse information line provides members with access to a THP nurse 24 hours a day, 7 days a week. The nurse information line is available to help support access to urgent and emergent care after hours.

Contact the nurse information line by calling 1.866.NURSEHP (1.866.687.7347). Or fill out the online form *healthplan.org/for-you-and-family/get-care/talk-nurse*. Please note it may be up to 24 hours before you receive a response when you submit the online form.

1.800.624.6961
healthplan.org

DENTAL BENEFITS

Louisiana Assessors' Ins. Fund offers a Dental PPO plan through The Health Plan for all employees. With the Dental PPO plan you also have the ability to obtain dental care services from the dentist of your choice (contracted or not). The dental plan provides a higher level of benefit if you choose to use an in-network provider.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he / she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

The Health Plan	PPO Dental In & Out-of-Network[1]
Annual Deductible Individual Family	 $50 $150
Calendar Year Plan Max	$5,000 per person
Preventive Services Routine cleanings, X-rays, etc.	Covered at 100% Deductible Waived for Preventive
Basic Services Fillings, root canal, etc.	You pay 20%
Major Restorative Implants, Crowns, bridges, etc.	You pay 50%
Orthodontia (adult & children) Coinsurance Lifetime Maximum	 You pay 40% $5,000 Lifetime Max per individual

[1]You can receive care from any licensed dentist, anywhere in the United States. If you choose a non-participating dentist, you will be responsible for the coinsurance amount listed above, as well as any charges above The Health Plan's maximum allowable charge for covered services.

VISION BENEFITS

Are you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer, sharper and brighter.

Vision examinations not only determine the need for corrective eye wear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development.

Dollar for dollar, you get the best value from your vision care plan when you visit a VSP network doctor. If you decide not to see a VSP doctor, the Out of Network plan copays will still apply. The choice is yours—either way, your vision benefits are a tremendous part of your overall benefits package.

Vision Benefit	In-Network	Out-of-Network
Annual Copay	$10 copay	N/A
Eye Exams	$0	Amount over $39
Frames	80% of amount over $150	Amount over $46
Lenses Single Vision Bifocal Trifocal Lenticular	$0 $0 $0 $0	Amount over $23 Amount over $37 Amount over $49 Amount over $64
Contacts (instead of glasses)	Amount over $150	Amount over $100
Laser Vision Correction	Up to 15% off the usual charge or 5% off promotional price—IN NETWORK ONLY	
Frequency		
Frames Lenses Contacts	Every 12 months Every 12 months Every 12 months	

Contact VSP at **www.vsp.com to find a Provider**

WHERE SHOULD I GO FOR CARE?

Helping you choose the right care center

Do you know where to seek care when an unexpected health situation happens? Make sure you are ready when you have to make an urgent healthcare decision. Review some of the choices of care that are available, so you know where to go the next time you need treatment. **Being prepared is important because knowing where to go for care can help you receive faster treatment and an overall better experience.**

Care Center	Why would I use this care center?	What type of care would they provide*?	What are the cost and time considerations?
Doctor's Office	You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.	• Routine checkups • Immunizations • Preventive services • Manage your general health	• Often requires a copayment and/or coinsurance • Normally requires an appointment • Little wait time with scheduled appointment
Convenience Care Clinic	You can't get to your doctor's office, but your condition is not urgent or an emergency. Convenience care clinics are often located in malls or retails stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.	• Common infections (e.g. strep throat) • Minor skin conditions (e.g. poison ivy) • Flu shots • Pregnancy tests • Minor cuts • Ear Aches	• Often requires a copayment and/or coinsurance similar to office visit • Walk in patients welcome with no appointments necessary, but wait times can vary
Urgent Care Clinic	You may need care quickly, but it is not an emergency, and your primary physician may not be available. Urgent care centers offer treatment for non-life threatening injuries or illnesses. Staffed by qualified physicians.	• Sprains • Strains • Minor broken bones (e.g. finger) • Minor infections • Minor burns	• Often requires a copayment and/or coinsurance usually higher than an office visit • Walk in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first
Emergency Room	You need immediate treatment of a very serious or critical condition. The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. Do not ignore an emergency. If a situation seems life threatening, take action. **Call 911 or your local emergency number right away.**	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble walking • Major burns • Spinal injuries • Severe head injury • Difficulty breathing • Major broken bones	• Often requires a much higher copayment and/or coinsurance than an office visit or urgent care visit • Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

EMPLOYER PROVIDED LIFE AND DISABILITY

Basic Life and AD&D

Although we don't like to think about it, should death occur, the survivors left behind could face serious financial hardships. Your family might need an alternative source of income to pay off your bills and meet their ongoing financial responsibilities. That is the purpose of life insurance - to provide funds for those left behind.

It is also possible that an accident could cause serious injury -the loss of limbs or eyesight, for example. There is special insurance coverage which pays benefits if an accident causes loss of life, limb or sight -it is called accidental death and dismemberment (AD&D) insurance. AD&D pays an amount equal to your life insurance benefit in the event of your accidental death. It also provides benefits for certain accidental injuries. As an eligible employee of Louisiana Assessors' Ins. Fund, you are provided with life and AD&D insurance coverage through Guardian Life at no cost to you. Refer to the chart below for the benefit amounts.

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
Description	All Eligible **Assessors**	All Eligible **Chief Deputies & Executive Director**	All Eligible Members with **income greater than $30,000**	All Eligible Members with **income less than $30,000 but greater than $20,000**	All Eligible Members with **income less than $20,000**	All **Qualified Retirees**
Employee Life	$400,000	$300,000	$150,000	$120,000	$40,000	Based on amount Inforce at retirement
Employee AD&D	$400,000	$300,000	$150,000	$120,000	$40,000	Equal to Life Amt
Reduction	50% at age 70	50% at age 70	50% at age 70	50% at age 70	50% at age 70	N/A
Spouse Life	$20,000	$20,000	$20,000	$20,000	$20,000	$5,000 if retired prior to 2017; $20,000 after 2017
Child Life Birth - 14 days 14 days - 26 years	$2,000 $10,000	$2,000 $10,000	$2,000 $10,000	$2,000 $10,000	$2,000 $10,000	$400 $2,000

Long Term Disability

The greatest threat to your earning power is illness or injury. If you are disabled for 90 days or longer due to a non-occupational illness or injury, Louisiana Assessors' Ins. Fund provides you with LTD benefits at no cost to you. The LTD plan is designed to provide you with a reasonable level of income replacement in case you can no longer work due to a disability. Louisiana Assessors' Ins. Fund pays the premiums for this plan. Highlights of the LTD plan include the following:

LONG TERM DISABILITY	
Monthly Benefit Percentage	60%
Benefit Maximum	$5,000
Elimination Period	90 days

VOLUNTARY LIFE INSURANCE

Voluntary Life Insurance

In addition to the basic life insurance plan, you are eligible to purchase additional amounts of individual term life insurance through Guardian Life Ins Co of America for yourself, your spouse and your children.
There are three points to consider when deciding how much life insurance coverage you might need:

- If you have dependents that rely on you, how much will they need to pay off your current debts such as your mortgage, car loans, or credit card balances?
- What will it cost your beneficiaries to maintain their current standard of living?
- What kind of future would you like to provide for your spouse or dependent children or others who rely on you for financial support?

Voluntary life benefits are non-taxable when funded with post-tax dollars. The price you pay for voluntary group term life insurance is a function of your age and your coverage amount. The table shows the price for voluntary life insurance.

Coverage For	Coverage Amount
Employee	Increments of $10,000 up to a maximum of $100,000
Spouse	Increments of $5,000 up to a maximum of $50,000 Not to exceed 50% of the employee election.
Child/ren	$10,000 Not to exceed 10% of employee amount

Important Things to Consider Regarding Your Life Insurance

- Remember to update your beneficiary annually.
- Benefits reduce with age beginning in the year you reach age 70.
- You must elect coverage for yourself in order to enroll in the dependent life benefits.
- You will be required to submit Evidence of Insurability if:
  - You declined voluntary life for you or your dependents during your initial eligibility period and would like to enroll for coverage now.
  - You elect to increase your current election in excess of the Guaranteed Issue amount.

MONTHLY RATE PER $1,000 OF COVERAGE	
AGE	**Employee & Spouse**
Under 30	$0.077
30 - 34	$0.092
35 - 39	$0.135
40 - 44	$0.187
45 - 49	$0.291
50 - 54	$0.511
55 - 59	$0.799
60 - 64	$1.233
65 - 69	$3.188
70 +	$5.527
AD&D	$0.042

Voluntary Child Life	
Coverage	**Monthly Rate**
$1,000	$0.182

Rate Calculator | Supplemental Life Insurance

To calculate your monthly (employee) Voluntary Life Insurance, divide your selected Life Benefit by 1,000. Round the results up to the next multiple of $1,000. Multiply this result by the applicable monthly rate, based on your age, from the rate table.

Annual Salary	+1000	Multiplier	X	Rate based on 40-44 age	=	Monthly Cost
30,000		30		.187		$5.61

Annual Salary	+1000	Multiplier	X	Rate based on age	=	Monthly Cost

WillPrep Services

Special bonus for participants in voluntary life plan

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to:

▪ Advanced Health Care Directives	▪ Financial Power of Attorney	▪ Wills and Living Wills
▪ Estate Taxes	▪ Guardianship and Conservatorship	▪ Resource Library
▪ Executors & Probate	▪ Healthcare Power of Attorney	▪ Trusts

For more information about WillPrep Services, go to www.ibhwillprep.com; User name: WillPrep; Password: GLIC09 or call 1-877-433-6789

*The Option of an attorney prepared will is available for a small fee.
WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of *WillPrep Services*. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the *WillPrep Services* at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

FLIMP VIDEOS

- Flimp videos are hosted online, so you must have an internet connection to view. You can either use the Hyperlink or open your phone's camera, hold it over the QR Code and you can view the video.

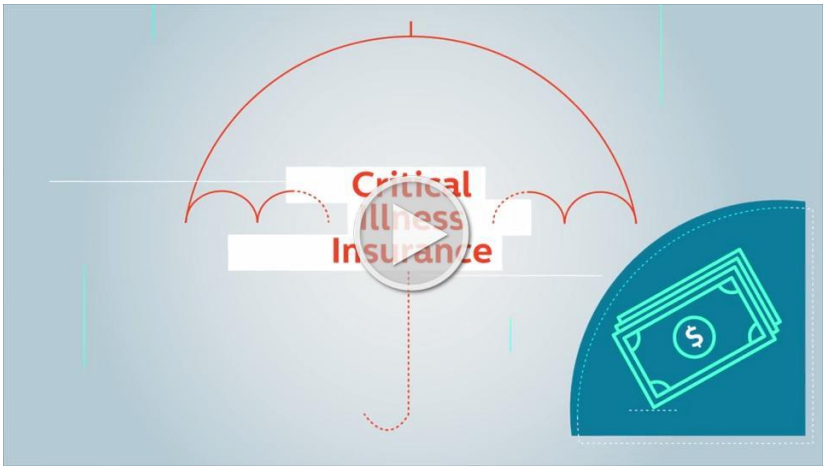
Accident Insurance

Video Hyperlink

https://flimp.me/HubDeliverablesAccident

QR Code

Critical Illness Insurance



Video Hyperlink

https://flimp.me/HubDeliverablesCI

QR Code

Critical Illness Benefit Summary

Group Number: 00541371

About Your Benefits:

It takes a lot to beat a serious illness. Unfortunately, it can also cost a lot. When you or a family member suffers a serious illness like a stroke or heart attack, Critical Illness Insurance can help with expenses that medical insurance doesn't cover like deductibles or out of pocket costs, or services like experimental treatment. Critical Illness supplements your medical and your disability income insurance. The lump sum benefit is paid when you need it most, upon diagnosis, so you can rest assured that you will have funds to offset upcoming out of pocket costs, and that you'll have the flexibility to elect treatments with less worry about the cost. Review your options and enroll today!

What Your Benefits Cover:

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $2,500 to $50,000 in $2,500 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	

CRITICAL ILLNESS	
Spouse/Domestic Partner Benefit	May choose a lump sum benefit of $2,500 to $50,000 in $2,500 increments up to 100% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue/ **Conditional Issue:** The 'Guarantee/Conditional' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	12 months prior, 12 months after
WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Child cost is included with employee election.

	Monthly Premiums Displayed *Election Cost Per Age Bracket*					
Issue Age	*< 30*	*30-39*	*40-49*	*50-59*	*60-69*	*70+*[†]
Employee						
$2,500	$3.17	$4.17	$7.09	$12.29	$18.47	$33.92
$5,000	$4.87	$6.67	$11.94	$21.21	$32.27	$61.12
$7,500	$6.57	$9.17	$16.79	$30.14	$46.07	$88.32
$10,000	$8.27	$11.67	$21.64	$39.06	$59.87	$115.52
$12,500	$9.97	$14.17	$26.49	$47.99	$73.67	$142.72
$15,000	$11.67	$16.67	$31.34	$56.91	$87.47	$169.92
$17,500	$13.37	$19.17	$36.19	$65.84	$101.27	$197.12
$20,000	$15.07	$21.67	$41.04	$74.76	$115.07	$224.32
$22,500	$16.77	$24.17	$45.89	$83.69	$128.87	$251.52
$25,000	$18.47	$26.67	$50.74	$92.61	$142.67	$278.72
$27,500	$20.17	$29.17	$55.59	$101.54	$156.47	$305.92
$30,000	$21.87	$31.67	$60.44	$110.46	$170.27	$333.12
$32,500	$23.57	$34.17	$65.29	$119.39	$184.07	$360.32
$35,000	$25.27	$36.67	$70.14	$128.31	$197.87	$387.52
$37,500	$26.97	$39.17	$74.99	$137.24	$211.67	$414.72
$40,000	$28.67	$41.67	$79.84	$146.16	$225.47	$441.92
$42,500	$30.37	$44.17	$84.69	$155.09	$239.27	$469.12
$45,000	$32.07	$46.67	$89.54	$164.01	$253.07	$496.32
$47,500	$33.77	$49.17	$94.39	$172.94	$266.87	$523.52
$50,000	$35.47	$51.67	$99.24	$181.86	$280.67	$550.72
Benefit Amount Up To 100% of Employee Amount to a Maximum of $50,000						
Spouse						
$2,500	$3.06	$4.07	$6.99	$12.19	$18.37	$33.82
$5,000	$4.76	$6.57	$11.84	$21.11	$32.17	$61.02
$7,500	$6.46	$9.07	$16.69	$30.04	$45.97	$88.22
$10,000	$8.16	$11.57	$21.54	$38.96	$59.77	$115.42
$12,500	$9.86	$14.07	$26.39	$47.89	$73.57	$142.62
$15,000	$11.56	$16.57	$31.24	$56.81	$87.37	$169.82
$17,500	$13.26	$19.07	$36.09	$65.74	$101.17	$197.02
$20,000	$14.96	$21.57	$40.94	$74.66	$114.97	$224.22
$22,500	$16.66	$24.07	$45.79	$83.59	$128.77	$251.42
$25,000	$18.36	$26.57	$50.64	$92.51	$142.57	$278.62
$27,500	$20.06	$29.07	$55.49	$101.44	$156.37	$305.82
$30,000	$21.76	$31.57	$60.34	$110.36	$170.17	$333.02
$32,500	$23.46	$34.07	$65.19	$119.29	$183.97	$360.22
$35,000	$25.16	$36.57	$70.04	$128.21	$197.77	$387.42
$37,500	$26.86	$39.07	$74.89	$137.14	$211.57	$414.62
$40,000	$28.56	$41.57	$79.74	$146.06	$225.37	$441.82
$42,500	$30.26	$44.07	$84.59	$154.99	$239.17	$469.02
$45,000	$31.96	$46.57	$89.44	$163.91	$252.97	$496.22
$47,500	$33.66	$49.07	$94.29	$172.84	$266.77	$523.42
$50,000	$35.36	$51.57	$99.14	$181.76	$280.57	$550.62

†Benefit reductions may apply. See plan details.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Group Number: 00541371

Accident Benefit Summary

About Your Benefits:

Accidents happen every day. Did you know almost 39 Million emergency room visits a year are due to an injury?[1] If you were injured from an accident, chances are you will have expenses that you were not anticipating-will you be prepared? Accident Insurance can help you deal with those expenses. Benefit payments can help you with your medical deductibles and co-pays, and cover household expenses like groceries, mortgage payments and childcare, which can begin to pile up if you have to take some time off from work. You are guaranteed coverage, so please enroll today!

[1]Injury Facts, 2011 Edition, National Safety Council.

What Your Benefits Cover:

	ACCIDENT
COVERAGE - DETAILS	
Your Monthly premium	$12.09
You and Spouse	$20.54
You and Child(ren)	$21.65
You, Spouse and Child(ren)	$30.10
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment. Ported Accident plan terminates at age 70.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $20,000 Spouse $10,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Accident Emergency Room Treatment	$150
Accident Follow-Up Visit - Doctor	$25 up to 6 treatments
Air Ambulance	$500
Ambulance	$100
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.	$100
Blood/Plasma/Platelets	$300

FEATURES (Cont.)	
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate.	20% increase to child benefits
Coma	$7,500
Concussions	$50
Dislocations	Schedule up to $3,600
Diagnostic Exam (Major)	$100
Emergency Dental Work	$200/Crown, $50/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$200
Family Care	$20/day up to 30 days
Fracture	Schedule up to $4,500
Hospital Admission	$750
Hospital Confinement	$175/day - up to 1 year
Hospital ICU Admission	$1,500
Hospital ICU Confinement	$350/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$50
Joint Replacement (hip/knee/shoulder)	$1,500/$750/$750
Knee Cartilage	$500
Laceration	Schedule up to $300
Lodging - The hospital must be more than 50 miles from the insured's residence.	$100/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery	Schedule up to $1,000 Hernia: $125
Surgery - Exploratory or Arthroscopic	$150
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$400, 3 times per accident
X - Ray	$20

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Accident Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

UNDERSTANDING YOUR BENEFITS (Cont.):

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

This plan will not pay benefits for any injury caused by or related to: declared or undeclared war, act of war or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony; intentionally self inflicted injury, while sane or insane; suicide, while sane or insane. The covered person being legally intoxicated. Treatment rendered or hospital confinement outside the United States or Canada. Travel of flight in any kind of aircraft including any aircraft owned by or for the employer except as a fare paying passenger on a common carrier. Participation in any kind of sporting activity for compensation or profit including coaching or officiating.

Riding in or driving any motor-driven vehicle in a race, stunt show or speed test. Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving. Injuries to a dependent child received during the birth. An accident that occurred before the covered person is covered by this plan. Sickness, disease, mental infirmity or medical or surgical treatment.

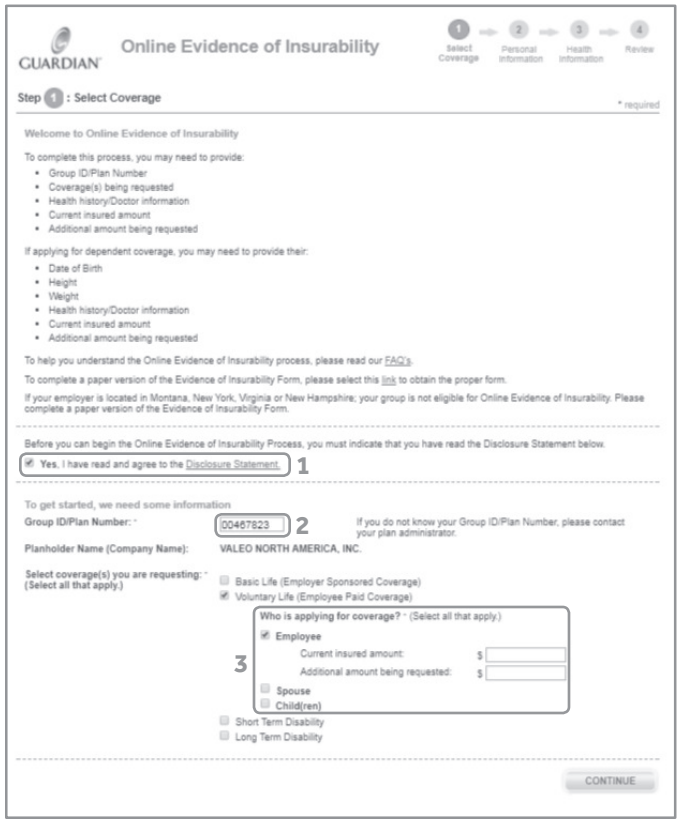
Contract # GP-1-AC-IC-12

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian

Online Evidence of Insurability

Go to guardianananytime.com/eoi



1. Click "Yes, I have read and agree to the Disclosure Statement."

If your employer is located in a state where online EOI is not available (NY, NH, VA and MT) please download the EOI form from GuardianAnytime.

2. Enter Group ID # shown above and click "Enter"
3. Select the coverages you are applying for and fill in your current and new election amounts

HELPFUL TIP: Enter "0" for current amount if this is a new election or if this is a request to increase your short term disability or long term disability coverage.

Click **"Continue".**

On the following screen, you will:

- Input your personal information
- Answer the health questions
- Review your answers, electronically provide your signature and click "Submit" to receive confirmation (PDF)
- Guardian will soon contact you directly regarding your application.

The Guardian Life Insurance Company of America

guardianananytime.com

New York, NY

2017-44837 (08/19)

ADDITIONAL NOTES: Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts. Electronic EOI is not available in the following states: New York, New Hampshire, Virginia and Montana Electronic EOI is available using most internet browsers.

BE A BETTER HEALTH CARE CONSUMER

Practice prevention. Get annual physicals, take any prescribed medication as directed, wash your hands often during cold & flu season and get a flu shot each year. Healthy lifestyle habits, like eating well, exercising, and not smoking, can be as good for your wallet as they are for your body and mind.

Understand the true costs of your care. Find out the actual costs of health care services & prescription drugs. You'll find that there are often cheaper treatment options (such as generic drugs) that can save you money while providing you the care you need. Go to www.abcbenefits.com to find helpful tools.

Stay in-network. When receiving medical care, be sure to use doctors, hospitals, pharmacies and labs that are inside your network. In-network providers and services will always cost less than those who are out of the network.

Talk with doctors. Share information openly with doctors and ask questions so that you can get the care you need, when you need it. Prepare questions before visiting your doctor to make the most of your visit.

Take responsibility for your self-care. Take an active role in your health by researching and understanding your health issues, following recommended treatment plans, and working to prevent further symptoms.

IMPORTANT CONTACTS

BENEFIT	CARRIER	CONTACT INFORMATION
Benefit Help	USI Benefit Resource Center	**855-874-0110** BRCSouthwest@usi.com
Medical	**The Health Plan** Group Number: 0180951100	**888-816-3096** www.healthplan.org
Pharmacy	**RxBenefits** Group Number Rx 2187	**800-344-8134**
Dental	**The Health Plan** Group Number: 0180951100	**888-816-3096** www.healthplan.org
Vision	**Guardian** Policy Number: 541371	**800-627-4200** www.guardiananytime.com
Disability Insurance	**MetLife** Policy Number: 146824	**800-275-4638** www.mtelife.com/mybenefits
Life & AD&D Insurance	**Guardian** Policy Number: 530357	**800-627-4200** www.guardiananytime.com
Voluntary Life & AD&D	**Guardian** Policy Number: 541371	**800-627-4200** www.guardiananytime.com
Accident Insurance	**Guardian** Policy Number: 541371	**800-627-4200** www.guardiananytime.com
Critical Illness	**Guardian** Policy Number: 541371	**800-627-4200** www.guardiananytime.com
Louisiana Assessors' Insurance Fund		**800-925-4446 or 225-928-8886** www.louisianaassessors.org/insurance.html

Remember!

Make sure to designate a beneficiary to ensure your wishes are clear as to who should receive the proceeds of any company sponsored life benefits in the event of your death. A single designation will be applied for all applicable life group plans.

This guide summarizes potions of plan provisions to assist you in understanding the plans and making your benefits selections. Final decisions about eligibility, participation, and plan benefits will be based on the provisions in the official plan documents and contracts. To the extent there are any inconsistencies between information provided in this guide and the applicable plan documents, the terms of the plan documents will govern. The company reserves the right to change or discontinue the benefit plans at any time and without notice. This guide is not intended as a contract of employment or a guarantee of future employment.

Access Your Employee Perks Program Today!

LAA
Louisiana Assessors' Association

More benefits. More savings. More of what makes you happy.

We're here to support your personal and financial well-being. You have access to group discounts on a variety of insurance products so you can protect what matters most, as well as exclusive deals and limited-time offers on the products, services, and experiences you need and love.

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Getting Started is Easy.

Access your voluntary insurance options and savings today!

VISIT
louisianaassessors.savings.beneplace.com

NEED HELP? CALL US: 1-800-683-2886

Dear Louisiana Assessors' Association Participant,

In an effort to coordinate benefits according to the Medical Plan: the below form needs to be completed and faxed back to **740-699-6163** by the end of December or mail the form to: The Health Plan – Attn: COB – 1110 Main Street – Wheeling, WV 26003-2704.

Claims for your spouse WILL NOT be processed by HealthSmart until this information is received.

Group #2027300 – WORKING SPOUSE VERIFICATION

I, _____, hereby acknowledge and agree that Louisiana Assessors' Association Employee Benefit Plan ("the Plan") for 2016 includes a Working Spouse Rule. As an LAA employee/retiree, this rule requires me to verify that, if my spouse is an eligible employee with access to "Comprehensive Medical Coverage" through his or her own employer, my spouse is no longer eligible to be covered by the Plan where the Plan will be the primary payer. My spouse may, however, be covered by the Plan where the Plan is a secondary payer. "Comprehensive Medical Coverage" means coverage for a broad set of medical services, including, but not limited to, doctor's visits, hospital admissions, day surgery, emergency services, mental health and substance abuse and prescription drug coverage and does not include a plan or policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges.

My signature below verifies that my spouse is:

- Not eligible for CMC through their employer so they will be enrolled in the LAA plan for primary coverage
- Eligible for CMC through their employer so they are not eligible for primary coverage with LAA; the Plan will be a secondary payer of medical claims

Other Medical Coverage Plan Name: _____

Other Coverage Plan Number: _____

Type of Coverage: Employee Only _____ Family _____

I further agree that should my spouse's eligibility for coverage change during the year, I am responsible to notify LAA of the change so that appropriate changes can be made to my health plan coverage. I further acknowledge that failure to properly report my spouse's eligibility for coverage under the Plan may entitle LAA to recover all benefits that were erroneously paid on my spouse's behalf.

_____ _____

Employee Signature Date

_____ Employee Printed Name

Insurance Committee of the Assessors' Insurance Fund

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 8 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, your plan's deductibles and coinsurance apply.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Insurance Committee of the Assessors' Insurance Fund 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 Insurance Committee of the Assessors' Insurance Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Insurance Committee of the Assessors' Insurance Fund has determined that the prescription drug coverage offered by the Pharmacy Benefit is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Pharmacy Benefit coverage will be affected. See Pharmacy Section within this Benefit Guide for an explanation of the benefit.

If you do decide to join a Medicare drug plan and drop your current Pharmacy Benefit coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Insurance Committee of the Assessors' Insurance Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. N**OTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Insurance Committee of the Assessors' Insurance Fund changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	Insurance Committee of the Assessors' Insurance Fund
Contact--Position/Office:	Pat Steele
Address:	3060 Valley Creek Baton Rouge, LA 70808
Phone Number:	225.928.8886

CMS Form 10182-CC **Updated April 1, 2011**

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage:	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
Insurance Committee of the Assessors' Insurance Fund	72-6014133	
5. Employer address	**6. Employer phone number**	
3060 Valley Creek	225.928.8886	
7. City	**8. State**	**9. ZIP code**
Baton Rouge	LA	70808
10. Who can we contact about employee health coverage at this job?		
Pat Steele		
11. Phone number (if different from above)	**12. Email address**	
	pat@louisianaassessors.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full-time employees
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Related or financial responsibility of the employees
  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other

factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTES

LAA

Louisiana Assessors' Association