



LOUISIANA CLERKS OF COURT INSURANCE TRUST

WELCOME TO THE
LOUISIANA CLERKS
OF COURT
INSURANCE TRUST,
SPONSORED BY THE
LOUISIANA CLERKS
OF COURT
ASSOCIATION



MEDICAL



DENTAL

LIFE

2010
RETIREE & SURVIVOR
ENROLLMENT GUIDE

Table of Contents

For enrollment and claim questions, contact Member Services at 1-800-763-4868, Monday thru Friday, 7:30 a.m. – 4:00 p.m. CST.

Important Information Pg 2

Supplemental Medical and Prescription Plan for those enrolled in Medicare Pg 3

Aetna Supplemental Medical Plan and RX
 Customer Service, Monday thru Friday, 7:00 a.m. – 5:00 p.m. CST
 Group Medicare Supplement Policy # 474226 SCD86
 Medicare Supplement: 1-800-557-5078
 Group RX Policy # AE396225
 RX Plan: 1-800-282-5366



Medical Benefit Information for those not enrolled in Medicare Pg 4-5

BMS/Blue Cross Blue Shield of Louisiana
 Customer Service, Monday thru Friday, 8:00 a.m. – 4:00 p.m. CST
 Group Policy # LCCIT707
 1-800-603-2299
www.bcbsla.com
www.bmshealth.com



Dental Benefit Information Pg 6

Standard Insurance through Ameritas
 Customer Service, Monday thru Friday, 8:00 a.m. – 7:00 p.m. CST
 Group Policy # 145101
 1-800-547-9515
www.standard.com



Retiree and Voluntary Life Insurance Pg 6

Standard Insurance
 Customer Service, Monday thru Friday, 9:00 a.m. – 7:00 p.m. CST
 Group Policy # 145101
 1-800-628-8600
www.standard.com



Annual and Enrollment Notices Pg 7-11

LCCIT Member Services & Plan Administrator



HUNT INSURANCE GROUP, LLC
 PO Box 12909, Tallahassee, FL 32317



IMPORTANT INFORMATION REGARDING YOUR ANNUAL ENROLLMENT

- Those currently enrolled in the Medicare Advantage Plan through LCCIT will automatically be enrolled in the new Aetna Supplemental Medical Plan.
- If you are enrolled in Medicare and do not wish to enroll in the Supplemental and Prescription Plan you must opt out by contacting LCCIT Member Services at 800-763-4868, or complete the Insurance Enrollment Change Form, mark box 19 and submit the form in the return envelope in your enrollment packet.
- If you are currently enrolled in dental and/or life, your dental and life benefits will remain the same unless you submit a form indicating changes.

You may only add or change coverage under the following circumstances:

- You get married, legally separated or divorced
- You add a dependent child through birth, adoption or placement for adoption
- Your spouse or dependent child dies
- Your spouse has a change in employment or status that affects benefits coverage
- You experience an involuntary loss of other group benefit coverage

If you are enrolled in Medicare parts A & B, you may only enroll in the Medicare Supplement Plan. This plan coordinates directly with Medicare and includes a Medicare Part D prescription plan.

- Those currently enrolled in the Medicare Advantage Plan through LCCIT will automatically be enrolled in the new Aetna Supplemental Medical Plan.
- If you are enrolled in Medicare and do not wish to enroll in the Supplemental and Prescription Plan you must opt out by contacting LCCIT Member Services at 800-763-4868, or complete the Insurance Enrollment Change Form, mark box 19 and submit the form in the return envelope in your enrollment packet.

Following are highlights of the plan.

Aetna Supplemental Medical Plan

PLAN FEATURE	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medicare Part A Deductible (calendar year)	\$0	\$1,100	\$0
Medicare Part B Deductible (calendar year)	\$0	\$155	\$0
Hospitalization (Part A) <ul style="list-style-type: none"> • First 60 days • Day 61 through the 90th day • Day 91 and after 	All but \$1,100 All but \$275 / day All but \$550 / day	\$1,100 \$275 / day \$550 / day	\$0 \$0 \$0
Skilled Nursing Facility Care Part A (per benefit period) Requirements must be met <ul style="list-style-type: none"> • First 20 days • Day 21 through the 100th day • Day 101 and after 	All approved amounts All but \$137.50 / day \$0	\$0 \$137.50 / day Not Covered	\$0 \$0 All costs
Part B - Medical Services Physicians Services Part B excess charges (generally 15% above Medicare-Approved amounts when using providers that do not participate with Medicare)	Generally 80% \$0	Generally 20% Covered 100%	\$0 \$0
Part B - Preventative Care	80%	20%	\$0
Part B - Laboratory Services	100%	\$0	\$0
Home Health Care	100%	\$0	\$0
Durable Medical Equipment	80%	20%	\$0
Foreign Travel Emergency \$50,000 lifetime limit	\$0	Covered 100%	\$250
Part D Prescription Coverage *Precertification and Step Therapy required			
Prescriptions—Retail Pharmacy Order	\$10 copay generic \$20 copay preferred brand \$40 copay non-preferred brand		
Prescriptions—Mail Order	\$20 copay generic \$40 copay preferred brand \$80 copay non-preferred brand		
Catastrophic Coverage Catastrophic Coverage benefits start once \$4,550 in true out-of-pocket costs is incurred.	Greater of \$2.50 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$6.30 or 5% for all other covered drugs.		

Have Questions? Call M-F 1-800-763-4868 (7:30 AM -4:00 PM CST) for assistance with your benefits!

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If you are not enrolled in Medicare, you may choose between two medical options. Check with your parish clerk to verify what options are being offered. If you choose dependent coverage, your dependents must be covered by the same health plan you choose.

Following are highlights of both plans.

Medical Option 1 - High Deductible

PLAN FEATURE	IN-NETWORK COVERAGE	NON-NETWORK COVERAGE
Deductible (calendar year)	\$1,200 individual \$2,400 family	Same \$1,200/\$2,400
Coinsurance	80% paid by plan	60% paid by plan
Out-of-Pocket Limit (calendar year)	\$3,000 individual \$6,000 family	Same \$3,000/\$6,000
Office Visit Primary Physician Specialist	Deductible, then coinsurance Deductible, then coinsurance	Deductible, then coinsurance Deductible, then coinsurance
Preventive Care	100% paid; deductible waived	Not covered
Chiropractic Care (limited to 30 visits per calendar year)	Deductible, then coinsurance	Deductible, then coinsurance
Maternity Care	Deductible, then coinsurance	Deductible, then coinsurance
Inpatient Hospital Services	Deductible, then coinsurance	Deductible, then coinsurance
Outpatient Hospital Services	Deductible, then coinsurance	Deductible, then coinsurance
Emergency Room or Urgent Care Facility	Deductible, then coinsurance	Deductible, then 80% coinsurance
Ambulance Services	Deductible, then coinsurance	Deductible, then coinsurance
Diagnostic Services (X-Ray & Lab)	Deductible, then coinsurance	Deductible, then coinsurance
Prescriptions	Deductible, then coinsurance	Deductible, then 80% coinsurance
Lifetime Maximum	\$2,000,000	

NOTES:

1. Non-precertified hospital expenses incur a penalty of \$500 per occurrence.
2. When a Network Provider cannot provide necessary treatment or supplies, then covered expenses rendered by a Non-Network Provider may be reimbursed at the In-Network Coverage level.
3. Services performed by Contract Providers contracted to In-Network Hospitals, and performed at that Hospital, such as Anesthesiology, Radiology, Pathology, and Emergency Room Physicians, shall be reimbursed at the In-Network Coverage level.
4. If enrolled in coverage for more than just employee coverage, you will need to satisfy family limits only.

Medical Option 2 - Modified Plan

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PLAN FEATURE	IN-NETWORK COVERAGE	NON-NETWORK COVERAGE
Deductible (calendar year)	\$500 individual \$1,000 family	\$1,000 individual \$3,000 family
Coinsurance	80% paid by plan	50% paid by plan
Out-of-Pocket Limit (calendar year)	\$3,000 individual \$6,000 family	\$5,000 individual \$10,000 family
Office Visit Primary Physician Specialist	\$40 copay Deductible, then coinsurance	Deductible, then coinsurance Deductible, then coinsurance
Preventive Care	100% paid; deductible waived	Not covered
Chiropractic Care (limited to 30 visits per calendar year)	Deductible, then coinsurance	Deductible, then coinsurance
Maternity Care	Deductible, then coinsurance	Deductible, then coinsurance
Inpatient Hospital Services	Deductible, then coinsurance	Deductible, then coinsurance
Outpatient Hospital Services	Deductible, then coinsurance	Deductible, then coinsurance
Emergency Room Urgent Care Facility	\$200 copay, then 80% \$50 copay, then 80%	Deductible, then 80% coinsurance
Ambulance Services	\$50 copay (land), then 80% \$150 copay (air or water), then 80%	\$50 copay (land), then 80% \$150 copay (air or water), then 80%
Diagnostic Services (X-Ray & Lab)	Deductible, then coinsurance	Deductible, then coinsurance
Prescriptions—Retail	\$10 copay generic \$40 copay preferred brand \$60 copay non-preferred brand	\$10 copay generic \$40 copay preferred brand \$60 copay non-preferred brand
Prescriptions—Mail Order	\$20 copay generic \$80 copay preferred brand \$120 copay non-preferred brand	\$20 copay generic \$80 copay preferred brand \$120 copay non-preferred brand
Prescriptions—Other	Zantac 75—paid at 100% Self-injectable drugs—80%	Zantac 75—paid at 100% Self-injectable drugs—80%
Lifetime Maximum	\$2,000,000	

NOTES:

1. Non-precertified hospital expenses incur a penalty of \$500 per occurrence.
2. When a Network Provider cannot provide necessary treatment or supplies, then covered expenses rendered by a Non-Network Provider may be reimbursed at the In-Network Coverage level.
3. Services performed by Contract Providers contracted to In-Network Hospitals, and performed at that Hospital, such as Anesthesiology, Radiology, Pathology, and Emergency Room Physicians, shall be reimbursed at the In-Network Coverage level.

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Dental

The Standard (through Ameritas) offers enhanced dental benefits, available to you and your eligible dependents.

COVERAGE TYPE:	IN-NETWORK	OUT-OF-NETWORK ¹
Type A – Preventive Care	100% paid by plan	100% of UCR ² paid by plan
Type B – Basic Services ³	80%	80% of UCR ²
Type C – Major Services ³	60%	60% of UCR ²
Type D - Orthodontia	60%	60% of UCR ²
Individual Deductible	\$50	\$50
Family Deductible	\$150	\$150
Annual Maximum Benefit Per Person	\$1,500	\$1,500

¹ “In-Network Benefits” means benefits under this plan for covered dental services that are provided by a Participating Provider. “Out-of-Network Benefits” means benefits under this plan for covered dental services that are not provided by a Participating Provider.
² Out of Network allowances are based upon the Usual, Customary & Reasonable rate charged by 9 out of 10 dentists in your geographical area.
³ Deductible applies to Type B and C services.

Life Insurance Benefit

The Life insurance benefit is payable to the designated beneficiary upon the death of the insured.

LIFE BENEFIT AMOUNT	
If you retired on or after July 1, 2008	The amount of your Life Insurance Benefit is equal to 50% of the amount of life insurance you were eligible to receive on your last day of Active Work, unless your insurance has already been reduced because of age (life benefits will reduce to 50% at age 70).
If you retired prior to July 1, 2008	The amount of your Life Insurance Benefit is equal to the amount of life insurance you were eligible to receive on your last day of Active Work.

Additional Life Insurance

For those who retired on or after July 1, 2008, you were eligible to choose one of the following benefits at retirement:

- Option 1: \$5,000
- Option 2: \$10,000

Upon retirement or termination of employment, coverage is portable at similar rates, or may be converted to an individual policy.

Have Questions? Call M-F 1-800-763-4868 (7:30 AM -4:00 PM CST) for assistance with your benefits!

Annual and Enrollment Notices

MEDICAL PREEXISTING CONDITION EXCLUSION

This plan does not cover charges incurred for pre-existing conditions. A pre-existing condition means any condition, whether physical or mental, related to, caused by or a complication of the condition, for which medical advice, diagnosis, care or treatment (including prescribed drugs) was recommended or received within a six month period beginning prior to the date of enrollment. Pregnancy is not considered a pre-existing condition. Pre-existing conditions will be covered after twelve months of coverage for new hires and those enrolling after a qualifying event, or after eighteen months of coverage for late enrollees coming on the plan at open enrollment.

Limitations in benefits due to pre-existing conditions may be reduced or waived by demonstrating prior creditable coverage. Creditable coverage means coverage of an individual under another group health plan, an individual health insurance policy, COBRA, Medicare, Medicaid, State Children's Health Insurance Program (S-CHIP), or similar public health program, which is not followed by a significant break in coverage of 63 or more consecutive days.

You have the right to request a Certificate of Creditable Coverage from your prior plan or issuer. When you or your dependents first enroll in the LCCIT plan, you should submit a copy of your Certificate of Creditable Coverage along with your enrollment, or send it to the claims payor as soon as possible.

The LCCIT will assist members in obtaining a Certificate from a prior plan or issuer, if necessary. Members may request a Certificate of Creditable Coverage for up to 24 months following the date of termination of employment. Active members may request a Certificate at any time by contacting Member Services.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (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. If you would like more information on WHCRA benefits, call your BMS Plan Administrator at 1-800-603-2299.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the LCCIT Employee Benefit Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because

of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiary who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
 - The parent-employee dies;
 - The parent-employee’s hours of employment are reduced;
 - The parent-employee’s employment ends for any reason other than his or her gross misconduct;
 - The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
 - The parents become divorced or legally separated; or
 - The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide written notice to: Renee Graff, LA Clerks of Court Insurance Trust, 11745 Bricksome Avenue, Suite B-1, Baton Rouge, Louisiana 70816.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage:

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage and sent to: Renee Graff, LA Clerks of Court Insurance Trust, 11745 Bricksome Avenue, Suite B-1, Baton Rouge, Louisiana 70816.

Second qualifying event extension of 18-month period of continuation coverage

If you or anyone in your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had he first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website).

Keep Your Plan Informed of Address Changes

COBRA Plan Administrator:

Renee Graff, LA Clerks of Court Insurance Trust, 11745 Bricksome Avenue, Suite B-1,
Baton Rouge, LA 70816, (800) 256-6660

Contact for Administration of Health and Dental Plan:

LCCIT Member Services, Hunt Insurance Group, LLC, P.O. Box 12909,
Tallahassee, FL 32317-2909, (800) 763-4868

PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Louisiana Clerks of Court Insurance Trust (the “Plan Sponsor”) sponsors the Louisiana Clerks of Court Insurance Trust Employee Benefit Plan (the “Plan”). Members of the Louisiana Clerks of Court Insurance Trust’s workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this plan amendment:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased. The Plan Sponsor shall have access to PHI from the Plan only as permitted under this plan amendment or as otherwise required or permitted by HIPAA.

Provision of Protected Health Information to Plan Sponsor

I. Permitted Disclosure of Enrollment/Disenrollment Information

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a

health insurance issuer or HMO offered by the Plan.

II. Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CPR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CPR § 164.514 (b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

III. Permitted and Required Uses and Disclosure of Protected Health Information for Plan

Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment- related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

IV. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:

- a. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
- c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- e. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
- g. Make available the information required to provide an accounting of disclosures in accordance with 45 CPR § 164.528.
- h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- j. Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

V. Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall allow designated employees in the Louisiana Clerks of Court Insurance Trust access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. Designated classes of employees include:

LOUISIANA CLERKS OF COURT INSURANCE TRUST

ADMINISTERED BY:

HUNT INSURANCE GROUP, LLC

PO Box 12909

TALLAHASSEE, FL 32317

1-800-763-4868



The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the insurer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents and/or policy contracts will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Hunt Insurance Group. Copyright© 2009 by Hunt Insurance Group, LLC. These materials may not be reproduced in any way without the written permission of Hunt Insurance Group, LLC.