

**LOUISIANA HBPA
MEDICAL BENEFIT PLAN**

Horsemen Helping Horsemen

**LOUISIANA HORSEMEN'S
MEDICAL BENEFIT TRUST**

TRUSTEES

Larry Robideaux

Christine Early

Sam Breaux

Gerald Romero

Sturges Ducoing

Sean Alfortish

H. Murray Woodward, Plan Administrator

**LOUISIANA HORSEMEN'S
BENEBOLENT & PROTECTIVE
ASSOCIATION 1993 INC.**

BOARD OF DIRECTORS

Sean Alfortish, President

Owners:

Evelyn Benoit
Carrol Castille
Christine Early
William Foreman
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Owner/Trainers:

Keith Bourgeois
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INTRODUCTION

The purpose of the Louisiana Horsemen's Medical Benefit Plan is to provide to members, their employees and other eligible applicants financial assistance with eligible medical and hospital expenses. Funding for the program is provided by Statute (R.S. 4:183) from the horsemen's share of the pari-mutuel handle at Louisiana race tracks.

The Louisiana Horsemen's Medical Benefit Plan is NOT an insurance program or an additional medical benefit plan. It is a self-funded assistance program for Louisiana horsemen actively racing in the state of Louisiana.

Section 1 – ELIGIBILITY

To be eligible for Plan benefits, an applicant must be licensed by, and in good standing with the Louisiana State Racing Commission (LSRC). In addition, an applicant must enroll in the Plan (Section 2) and satisfy the following eligibility requirements/conditions for participation:

A. OWNERS, TRAINERS, & OWNER/TRAINERS (Individually Licensed)

- (1) **Must have started a horse at least seven (7) times** at a Louisiana track, licensed by the LSRC, within the twelve (12) consecutive month period immediately preceding the filing of an application for benefits under the Plan; and
- (2) **Must be actively racing in Louisiana** at the time an application is submitted for benefits under the Plan.

NOTE: An applicant for Plan benefits will be deemed to be actively racing in Louisiana, if within the six (6) month period immediately preceding an application for benefits under the Plan, said applicant had:

B. OWNERS, TRAINERS, & OWNER/TRAINERS (Not Individually Licensed – e.g. Partnerships, Corporations, and other Licensed Business Entities)

To be eligible for Plan benefits under this Section, a partner, shareholder, limited partner, or other individual having ownership rights in the business entity must:

- (1) be individually licensed by the LSRC; **AND**
- (2) Demonstrate to the Plan Administrator that he/she owns the equivalent of 100% of a racehorse. For example, a 50% interest in each of two (two) horses or a 25% interest in each of four (4) horses, would be the equivalent of 100% of a race horse; **AND**
- (3) the Partnership, Corporation, or other Licensed Business Entity:

- * must have **started a horse at least fourteen (14) times** at a Louisiana track, licensed by the LSRC, within the twelve (12) consecutive month period immediately preceding the filing of an application for benefits under the Plan; **and**
- * must be actively racing in Louisiana at the time an application is submitted for benefits under the Plan.

NOTE: An applicant for Plan benefits will be deemed to be actively racing in Louisiana, if within the six (6) month period immediately preceding an application for benefits under the Plan, said applicant had:
 at least one (1) start **and** was eligible to receive benefits under the plan during the twelve(12) month period immediately preceding a six (6) month period of inactivity, if any.

C. EMPLOYEES OF MEMBERS (Assistant Trainer, Groom, Hot Walker, Exercise Rider, Pony Person, etc.)

- (1) **Must be on the payroll** as a full time employee of an owner or a trainer who is eligible to receive benefits under the Plan; **AND**
- (2) **Must be on the work list** of an owner or a trainer who is eligible to receive benefits under the Plan; **AND**
- (3) **Must have an affidavit completed, notarized and submitted** to the LA. Horseman Medical Trust.
- (4) **Must have met the requirements of (1), (2), and (3) hereof for a period of at least thirty (30) days** immediately preceding the date of which an application is submitted for benefits under the Plan.

Section 2 – ENROLLMENT

To be eligible, and to remain eligible, for Plan benefits an applicant MUST complete and file an enrollment application EVERY SIX (6) MONTHS. Enrollment periods begin on January 1st and July 1st annually, Enrollment application must be completed and signed by the applicant and, if required by the Plan Administrator, by the Owner or Trainer who is a member of the LHBPA.

Application forms are available at the LHBPA main office, 1535 Gentilly Blvd., New Orleans, LA 70119, and at the LHBPA field offices which are located on the grounds of all Louisiana tracks.

Section 3 – GENERAL LIMITATIONS and/or DISQUALIFICATION

If a person who is eligible for Plan benefits (covered person) has other medical and/or hospital insurance, major medical coverage, Medicare, or any other form of medical insurance coverage, only the portion of any medical and/or hospital expenses/charges incurred by a covered person which is in excess of the maximum amount covered by such other medical insurance or coverage **will be considered as eligible** expenses/charges under the provisions of this Plan.

If a covered person has any other such coverage or plan providing benefits, as a condition precedent to entitlement for benefits under this Plan, an application for benefits under such other coverage or plan **must first be made** and a statement or listing of the benefits provided by such other coverage or plan **must be attached** to any claim submitted for benefits under the Plan.

The Plan Administrator may grant an additional period for a claimant to provide any statement of listing of benefits provided by other coverage, **if** at the time, an application for benefits is made under this Plan, and the claimant notifies the Plan Administrator that such other coverage exists.

In the event that a covered person fails, refuses, and or otherwise neglects to first make application for benefits under any other such coverage or plan, or fails, refuses and/or neglects to disclose that he/she has such other coverage or plan at the time an application for benefits is made under this Plan, any claim for benefits under the Plan shall be denied and the applicant shall be disqualified from receiving any benefits whatsoever under this plan for a period of two (2) years following the date of disqualification.

CLAIMS FOR MEDICAL EXPENSES/CHARGES SUBMITTED LATER THAN NINETY (90) DAYS FOLLOWING THE DATE FOR FIRST TREATMENT WILL BE DENIED.

All applications for and/or assignments for benefits shall be on forms provided by the Plan Administrator, Louisiana Horsemen's Medical Benefit Plan, 1535 Gentilly Blvd., New Orleans LA 70119.

PRE-AUTHORIZATION, for the purpose of this Plan, means obtaining verification of eligibility from the Plan Administrator **prior** to receiving treatment. Failure to obtain Pre-Authorization when required under the provisions of this Plan may result in the reduction and/or denial of Plan benefits.

Section 4 – MAXIMUM TOTAL BENEFIT

On or after **March 9, 1999**, notwithstanding anything to the contrary contained herein, the maximum total benefit payable by this Plan for all eligible charges and/or expenses on behalf of any eligible participant shall not exceed the following during any calendar year:

\$12500 for a Member
\$12500 for a Spouse of a Member
\$10000 for an Employee of a Member
\$5000 for a Spouse of an Employee of a Member
\$3000 for Dependent Children of a Member or an Employee of a Member, provided that said dependent child is under the age of eighteen (18), or is a full time student, under the age of twenty-five (25).

Section 5 – CALENDAR YEAR DEDUCTIBLES

The Calendar Year Deductible is the amount, which **must be deducted** from all eligible expenses/charges *before* a covered person shall be entitled to receive benefits.

Unless specifically otherwise provided herein the Deductibles set forth in this Plan are applicable to each covered person in each calendar year and are not reimbursable as covered expenses/charges under this plan:

\$0 for Member
\$0 for Employee of a Member
\$0 for Member Spouse
\$0 for Employee Spouse
\$0 for Dependent Children

Section 6 – HOSPITAL BENEFITS (IN-PATIENT)

Note: Scheduled benefits under this section shall NOT be paid for in an in-patient surgical procedure unless:

- (1) the surgery is a covered procedure of this Plan; **and**
- (2) the procedure is Pre-Authorized by the Plan Administrator; **AND**
- (3) The treating physician certifies in writing to the Plan Administrator, by U.S. Mail, postage pre-paid, that because of the physical condition of the patient, or for other certifiable medical reasons, that the failure to perform the surgery on an in-patient basis would likely endanger the health and/or life of the patient.

The Plan Administrator may waive the Pre-Authorization requirement if a covered surgical procedure is preformed on an emergency basis without Pre-Authorization, **and** the treating physician certifies that the procedure was preformed on an emergency basis, provided, however, that the Plan Administrator is notified within 96 hours of the procedure having been preformed.

While confined to a licensed hospital for an illness, sickness, injury, or other medical procedure, which is not otherwise excluded from coverage under the terms of this Plan, the following are eligible hospital expenses/charges, **after the Plan Deductible requirements are met:**

A. MEMBER

Hospital Room and Board:

Up to but not exceeding twelve (12) days at no more than **\$150** per day.

Miscellaneous Hospital Charges:

Up to but not exceeding **\$600**

Laboratory and Diagnostic Services, X-Rays, Physicians and Surgeons Fees:

80% thereof but not to collectively exceed **\$1000**.

Anesthesia Fees

80% thereof but not to exceed **\$1000**.

Any remaining balance of all expenses/charges included in this Section hereof:

80% thereof but not to exceed **\$2500** per calendar year.

B. MEMBER SPOUSE:

Hospital Room and Board:

Up to but not exceeding twelve (12) days at no more than **\$150** per day.

Miscellaneous Hospital Charges:

Up to but not exceeding **\$600**

Laboratory and Diagnostic Services, X-Rays, Physicians and Surgeons Fees:

80% thereof but not to collectively exceed **\$1000**.

Anesthesia Fees

80% thereof but not to exceed **\$1000**.

Any remaining balance of all expenses/charges included in this Section hereof:

80% thereof but not to exceed **\$2500** per calendar year.

C. EMPLOYEE

Hospital Room and Board:

Up to but not exceeding twelve (12) days at no more than **\$150** per day.

Miscellaneous Hospital Charges:

Up to but not exceeding **\$600**

Laboratory and Diagnostic Services, X-Rays, Physicians and Surgeons Fees:

80% thereof but not to collectively exceed **\$1000**.

Anesthesia Fees

80% thereof but not to exceed **\$1000**.

Any remaining balance of all expenses/charges included in this Section hereof:

80% thereof but not to exceed **\$2500** per calendar year.

D. SPOUSE of EMPLOYEE of Member

Hospital Room and Board:

Up to but not exceeding twelve (12) days at no more than **\$150** per day.

Miscellaneous Hospital Charges:

Up to but not exceeding **\$600**

Laboratory and Diagnostic Services, X-Rays, Physicians and Surgeons Fees:

80% thereof but not to collectively exceed **\$1000**.

Anesthesia Fees

80% thereof but not to exceed **\$500**.

Any remaining balance of all expenses/charges included in this Section hereof:

80% thereof but not to exceed **\$2500** per calendar year.

E. DEPENDENT CHILD

Hospital Room and Board:

Up to but not exceeding twelve (12) days at no more than **\$150** per day.

Miscellaneous Hospital Charges:

Up to but not exceeding **\$600**

Laboratory and Diagnostic Services, X-Rays, Physicians and Surgeons Fees:

80% thereof but not to collectively exceed **\$1000**.

Anesthesia Fees

80% thereof but not to exceed **\$300**.

Any remaining balance of all expenses/charges included in this Section hereof:

80% thereof but not to exceed **\$2000** per calendar year.

Note: Notwithstanding the provisions of Subsections A, B, and C hereof, emergency room charges for treatment of accidental bodily injury shall be eligible for reimbursement ONLY under Out Patient Benefits (Section 7 hereof).

Section 7 – OUT PATIENT BENEFITS

After the Plan deductible requirements are met, accidental bodily injury, sickness, and/or all other medical treatments and procedures not specifically covered under any other Section of the Plan, and which are not otherwise excluded from coverage under the terms of the Plan, are eligible as covered expenses/charges incurred in connection with routine doctor's office visits are not covered under the Plan.

The following expenses/charges are specifically covered under this section.

A. EMPLOYEE

Emergency Out Patient Hospital Treatment:

80% thereof but not exceeding **\$500**. For emergency treatment provided within 48 hours of an accidental bodily injury. Work-related injuries and/or

accidental bodily injury arising out of and in the course of a covered person's employment are not covered.

Out Patient Treatment, Diagnostic X-Rays(s), Laboratory and physician Services:

80% there of but not to exceed **\$1000** per calendar year.

Out Patient Surgery:

Surgeon's Fees: up to but not exceeding **\$1000**.

Facility Charges: up to but not exceeding **\$1000**.

Anesthesia: up to but not exceeding **\$400**.

Any remaining balance of covered expenses/charges in this section hereof:

80% thereof but not exceeding **\$1000** per calendar year.

B. MEMBER AND MEMBER SPOUSE

80% there of but not exceeding **\$500**. For emergency treatment provided Within 48 hours of an accidental bodily injury. Work-related injuries and/or Accidental bodily injury arising out of and in the course of a covered Employment is not covered.

OUT PATIENT TREATMENT, DIAGNOSTIC X-RAYS(S), LABORATORY AND PHYSICIAN SERVICES:

80% there of but not to exceed **\$1500** per calendar year.

PATIENT SURGERY:

Surgeon is Fees: up to but not exceeding **\$1000**.

Facility Charges: up to but not exceeding **\$1000**.

Anesthesia: up to but not exceeding **\$400**.

Any remaining balance of covered expenses/charges in this section hereof:

80% thereof but not exceeding **\$1000** per calendar year.

C. Employee spouse; Emergency Out Patient Hospital Treatment:

80% there of but not exceeding **\$375** for emergency treatment provided within 48 hours of an accidental bodily injury. Work-related injuries and/or accidental bodily injury arising out of and in the course of a covered person's employment are not covered.

Out Patient Treatment, Diagnostic X-Rays(s), Laboratory and physician Services:

80% there of but not to exceed **\$600**. Per calendar year.

Out Patient Surgery:

Surgeon's Fees; up to but not exceeding **\$600** Facility Charges: up to but not exceeding **\$600**

Anesthesia: 400.00 up to but not exceeding **\$400**.

Any remaining balance of covered expenses/charges in this section hereof:

80% thereof but not exceeding **\$600** per calendar year.

D.DEPENDENT CHILD:

Emergency Out Patient Hospital Treatment:

80% there of but not exceeding **\$150**. For emergency treatment provided within 48 hours of an accidental bodily injury. Work-related injuries and/or

accidental bodily injury arising out of and in the course of a covered person's employment are not covered.

Out Patient Treatment, Diagnostic X-Rays(s), Laboratory and physician Services:

80% there of but not to exceed **\$450** per calendar year.

Out Patient Surgery:

Surgeon is Fees: up to but not exceeding **\$450**.

Facility Charges: up to but not exceeding **\$450**.

Anesthesia: up to but not exceeding **\$400**.

Any remaining balance of covered expenses/charges in this section hereof:

80% thereof but not exceeding **\$450** per calendar year.

Section 8 – MATERNITY BENEFITS

Notwithstanding any other provisions of the Plan to the contrary, and **provided that the claimant is eligible under the terms of the Plan on the delivery date**, a claim for maternity benefits and/or all related expenses/charges in connection therewith **shall be limited** to the following:

A. MEMBER AND MEMBER SPOUSE

If nine (9) months *prior* to the normal delivery dates, a cover person was entitled to receive benefits under this Plan, **and only after a \$2000, calendar year deductible is applied**; the scheduled benefit is as follows:

Normal Delivery:

80% of expenses/charges related thereto but not to exceed **\$2000** per calendar year.

B. EMPLOYEE

Providing that nine (9) months *prior* to the normal delivery date, a covered person was entitled to receive benefits under this Plan, **and provided that such covered person has been continuously eligible to receive benefits under this Plan for a period of not less than 270 days prior to the delivery date and only after a \$1500 calendar year deductible is applied**, the scheduled benefit is as follows:

Normal Delivery:

80% of expenses/charges related thereto but not to exceed **\$1500** per calendar year.

Miscarriage:

80% expenses/charges related thereto but not to exceed **\$750** per calendar year.

C. EMPLOYEE SPOUSE

Providing that nine (9) months prior to the normal delivery date, a covered person

Was entitled to receive benefits under this Plan, and provided that such covered person has been continuously eligible to receive benefits under this plan for a period of not less Than 270 day prior to the delivery date and only after a **\$500** calendar year deductible is applied, the scheduled benefit is as follows:

Normal Deliver:

80% of expenses/charges related thereto but not to exceed **\$1500** per calendar Year.

Miscarriage:

80% expenses/charges related thereto but not to exceed **\$750** per calendar Year.

Section 9 – PRESCRIPTION MEDICATIONS (Deductible Waived)

Reimbursement for prescribed medications approved by the plan shall be limited as follows:

A. MEMBER:

80% of covered expenses/charges up to but not exceeding **\$2500** per calendar year (Section 5 deductible waived).

B. EMPLOYEE:

80% of covered expenses/charges up to but not exceeding \$2000. Per calendar year

C.MEMBER SPOUSE

80% of covered expenses/charges up to but not exceeding **\$2500** per calendar year.

D.EMPLOYEE SPOUSE

80% of covered expenses/charges up to but not exceeding **\$500** per calendar year.

B. DEPENDENT CHILD

80% of covered expenses/charges up to but not exceeding **\$200** per calendar year.

Section 10 – DENTAL TREATMENT (Deductible Waived)

A. MEMBER:

Up to but not exceeding \$1500 for extraction, fillings and x-rays per calendar year.

Up to but not exceeding \$1200 for the cost of partial or full dentures.

B. EMPLOYEE:

Up to but not exceeding \$1000 for extraction, fillings and x-rays per calendar year.

Up to but not exceeding \$800 for the cost of partial or full dentures.

C.MEMBER SPOUSE;

Up to but not exceeding \$1500 for extraction, fillings and e-rays per calendar year.

Up to but not exceeding \$1200 for the cost of partial of full dentures.

D.EMPLOYEE SPOUSE

Up to but not exceeding \$500 for extraction, filling and x-rays per Calendar year.

E.MEMBER DEPENDENT CHILD ONLY

Up to but not exceeding \$200.

Section 11 – EYEGLASSES and/or EYE EXAMINATIONS (Deductible Waived)

A. MEMBER, MEMBER SPOUSE:

Expenses/charges incurred in connection with an eye examination (refraction), lenses, contact lenses, and/or frames shall be reimbursed up to but not exceeding **\$300** in any twelve (12) consecutive month period.

B. EMPLOYEE, EMPLOYEE SPOUSE:

Expenses/charges incurred in connection with an eye examination (refraction), lenses, contact lenses, and/or frames shall be reimbursed up to but not exceeding **\$150** in any twelve (12) consecutive month period.

C. **DEPENDENT CHILD** is excluded from coverage.

Section 12 – CHIROPRACTIC TREATMENT (Deductible Waived)

A. MEMBER ,MEMER SPOUSE,OR EMPLOYEE

Up to but not exceeding **\$300** for each treatment if the maximum benefit hereunder shall not exceed **\$300** in any calendar year.

B. All Other Covered Persons:

Chiropractic treatment is excluded from coverage.

Section 13 – Retired Members’ Benefits

Notwithstanding the provision of Section 1 to the contrary, a retired member over age 65, shall be eligible to receive the benefits under this Section provided that the retired member furnishes the Plan Administrator with documentation satisfactorily demonstrating that he/she had met the plan eligibility requirements as an active member during each of the five (5) years immediately preceding his/her retirement.

Benefits under this Section are supplemental to Medicare and are limited to the following:

- A. Medicare Part A Deductible: paid at 100%
- B. All other eligible expenses/charges which are not paid or reimbursed by Medicare, shall be paid or reimbursed under the provision of the Plan, pursuant to the schedule of benefits available to an active member, but only up to an amount not exceeding 80% of the maximum allowable benefit for active member under each Section of the Plan, but only up to but not exceeding a total maximum annual benefit of **\$7500**, for a retired member.
- C. **The RETIRED MEMBER’S SPOUSE** is eligible for coverage on Dental Prescriptions, and Optical benefits only.

Section 14 – DEATH BENEFITS

- A. **MEMBER ,MEMBER SPOUSE \$2500** if death occurs while covered by the Plan, and proof of death is furnished to the Plan Administrator in the form of a certified Death Certificate by the heirs and/or legal beneficiary of the deceased member or the deceased employee of a member.

EMPLOYEE; \$1000

EMPLOYEE SPOUSE; \$500

At the option of the Plan Administrator, any death benefit payable hereunder may be remitted directly to the funeral home and/or undertaker providing burial services for the said deceased.

B. All Other Covered Persons:

Death Benefits are excluded from coverage.

Section 15 - MISCELLANEOUS BENEFITS

- A. **MEMBERS and MEMBER SPOUSES AND EMPLOYEES only** are eligible for the following additional miscellaneous benefits

Ambulance Services/Charges/Fees:

80% there of but not to exceed **\$600**.

Hearing Aids and Exams:

80% there of but not to exceed **\$500.**

Artificial Limbs, Organs and Eyes:

80% there of but not to exceed **\$500.**

Electronic Pacemaker Equipment:

80% there of but not to exceed **\$500.**

Blood and Plasma:

80% there of but not to exceed **\$500.**

Physical Therapy:

80% there of but not to exceed **\$500.**

Mental Illness, Functional Nervous Disorders, Alcohol/Substance Abuse:

80% there of but not to exceed **\$500.**

Section 16 – EXCLUSIONS

The following medical or surgical procedures, actions, fee, prostheses, aids, services, treatments, appliances, etc., including those shown and/or set forth on the current Schedule of Exclusions maintained by the Plan Administrator, are excluded from coverage under the Plan. A partial list of exclusions is as follows:

- * **Abortion**
- * **Accidental Bodily Injury arising out of/or in the course of one's employment**
- * **Accidental Bodily Injury when covered by Automobile Insurance**
- * **Cosmetic Surgery**
- * **Equipment used in its administration**
- * **Intention Self-Inflicted Injuries (while sane or insane)**
- * **Liability Insurance, and/or Worker's Compensation Insurance claims.**
- * **Occupational Diseases**
- * **Pre-Existing Illness or Illnesses until after the expiration of one year following the written notification thereof of the Plan Administrator**
- * **Private Duty Nurses**
- * **Rental or Purchase of Medical and/or surgical Equipment, Oxygen and Well Baby Care**

For a more complete list of exclusions, contact the Plan Administrator.

Section 17 – MISCELLANEOUS PROVISIONS

- A. The LHBPA Medical Benefit Trust shall have the right at any time, by Resolution, with or without notice, to:
- * Change the classification of and/or any amount of any benefit available under the terms of the Plan; and/or
 - * Change the eligibility requirements for participation;
 - * Change any rules or regulations of the Plan; and/or

- * Terminate the Plan.
- B. The issuance of and/or the acceptance of any claim form for benefits under the Plan shall not constitute acceptance and/or acknowledgement of a covered person's eligibility for benefits, nor shall such be interpreted and/or payments under any provisions of the Plan.
- C. Each recipient of and/or applicant for benefits shall:
 - * Be deemed to have agreed to be bound by the Plan rules, provisions, schedules, regulations and/or other requirements including but not limited to its limitations and exclusions; and
 - * Be deemed to have accepted as final, any decision by the Plan Administrator or his/her designee, or the LHBPA Medical Benefit Trustees, with regard to eligibility, exclusions, limitations, entitlement, and coverage, interpretation of the Plan's provisions and/or payment of benefits hereunder.

Requests for information about any of the terms conditions and provisions of the Plan, or about payment of benefits or the Schedule of Exclusions, should be directed to the Plan Administrator, in writing, at the offices of the LHBPA Medical Trust, 1535 Gentilly Blvd., New Orleans, LA 70119

Phone: 504-945-1555
La. In-State: 800-845-4272
Fax: 504-945-1579

LOUISIANA HORSEMEN'S
BENEVOLENT & PROTECTIVE ASSOCIATION 1993, INC.
MAIN OFFICE:

1535 Gentilly Blvd.
New Orleans, LA 70119
Phone: 504-945-1555
La. In-State: 800-845-4272
Fax: 504-945-1579

FIELD OFFICES

Delta Downs Race Track: 337-589-5594
Evangeline Downs Race Track: 337-594-8049
Evangeline Training Center 337-886-6438
Fair Grounds Race Track: 504-943-0772
Louisiana Downs Race Track: 318-746-1149

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