HMO Plan
Group Proposal
SOLUTIONS FOR BUSINESSES

Plans effective 1/1/2013
This proposal is presented for general information only. It is not a benefit plan, nor intended to be construed as a benefit plan. If there is any discrepancy between this document and the benefit plan, the benefit plan will govern the benefits paid. For complete information, please refer to the benefit plan.

Premium will vary with the amount of benefits chosen. HMO refers to benefit plan #131HR01225. Cafeteria Plan refers to contract #28XX1592.

NOTICE
Healthcare services may be provided to you at a network healthcare facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles and non-covered services.

Specific information about in-network and out-of-network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number on the back of your ID card.
HMO Louisiana

FROM A COMPANY YOU ALREADY KNOW AND TRUST

A wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. is part of the largest and most experienced health insurer in the state. We’re proud to bring you our managed care portfolio that is backed by the strength and wisdom of a company doing business in Louisiana since 1934.

REAL CHOICES. REAL SAVINGS.

HMO Louisiana gives you the choices you deserve when it comes to your health. Our comprehensive network offers a high quality of care from doctors and hospitals 24 hours a day, seven days a week. We have negotiated with these select providers to bring you additional savings and enhanced benefits.

Our managed care plans help lower out-of-pocket costs by offering low copayment options and no deductibles for care received within our network. Our plans also feature a comprehensive wellness package, a prescription drug program and a series of program choices.

Information on the most current rating is available at www.standardandpoors.com or by calling Standard & Poor’s at 212.438.2400.
In today’s rapidly changing healthcare environment, healthcare choices can be confusing. So it is good to know there is a managed care product from a company you can count on.

Our HMO plan offers managed care with the power of choice.

If you are looking for excellent coverage at an affordable price, our HMO plan is the product that’s right for you and your employees. Our HMO allows access to quality, cost-effective healthcare coverage while maximizing your healthcare dollar.

The HMO plan features healthcare delivery to your employees from their individual primary care physician (PCP) who participates in the HMO Louisiana network. The PCP coordinates most of the healthcare needs of the member. The plan also features “direct access” to specialists in the HMO Louisiana network without the member first having to get a referral from the PCP.

HMO Louisiana members also enjoy freedom from paperwork hassles. The network physicians submit all claims and handle authorizations, and our special managed care unit does the rest.

**Consider the advantages of HMO:**

- predictable healthcare costs
- easy-access network
- physician copayments
- preventive and wellness benefits with little or no out-of-pocket costs
- prescription drug program
- deductible options available for lower premium
The advantages

The PCPs in the HMO Louisiana network are committed to total healthcare. They become closely involved with member care and, through preventive medicine, work to detect illnesses in their earliest stages. The PCP provides and coordinates most of the member’s healthcare needs, including routine exams, emergency care and hospitalization.

Consider these advantages offered by the PCP:

- **Convenience:** PCPs coordinate medical care and file claims for their services.
- **Low copayments:** Members pay only one pre-set fee for visits to the PCP’s office.

How it works

A primary care physician (PCP) is a general practitioner, family practitioner, internist or pediatrician. The member pays only the applicable PCP copayment for each office visit. The PCP copayment will also apply to certain other providers such as chiropractors, therapists (physical and occupational), speech therapists/pathologists, therapy assistants and federally qualified rural health clinics.

Members may also choose to visit network specialists in the HMO Louisiana network without a referral from their PCP. When visiting a specialist, the member pays only the applicable specialist copayment.

To find a PCP or specialist, visit our website at www.bcbsla.com.

Primary Care Physicians
There are two levels of HMO benefits for covered services: network benefits for employees and their families living in the service area and dependent out-of-area benefits for dependents living outside the service area.

**HMO NETWORK BENEFITS**

Members receive network benefits when they receive care from a provider within the HMO Louisiana network. These network providers will submit the claims, and the member is only responsible for the copayment or applicable coinsurance and deductible. **It is important to remember that before visiting a non-network provider, members must have approval from HMO Louisiana. Otherwise, no benefits will be paid.**

**DEPENDENT OUT-OF-AREA BENEFITS**

For added convenience, HMO Louisiana offers a second benefit level for employees with dependents living outside of the designated HMO Louisiana service area. If a member wants coverage for a dependent living outside the service area, the member must request it at the time of enrollment.

If dependent out-of-area coverage is selected, the dependent(s) living out of area receives strong benefits. These out-of-area members have an out-of-area deductible. Once this deductible is met, coinsurance percentage payments are shared for covered services: for instance, HMO Louisiana pays 80 percent of allowable charges and the member pays 20 percent, up to the out-of-pocket limit.

**URGENT CARE BENEFITS**

Sometimes members need non-emergency medical care after hours. This is referred to as “urgent care.” Urgent care is defined as a sudden, acute and unexpected medical condition that requires timely diagnosis and treatment, but does not pose an immediate threat to life or limb. Examples of urgent care include: colds and flu, sprains, stomachaches and nausea.

The HMO plan includes coverage for urgent care. When a member visits an urgent care center in the HMO Louisiana network, an urgent care copayment will apply.
Dependents who are classified as out-of-area will receive deductible/coinsurance-style benefits for urgent care visits.

An urgent care center is a clinic with extended office hours that provides urgent and minor emergency care to patients on an unscheduled basis without the need for an appointment. The urgent care center does not provide routine follow-up care or wellness examinations and refers patients back to their regular physicians for such routine follow-up and wellness care.

**EMERGENCY CARE BENEFITS**

As always, in emergency situations the first priority is to seek treatment at the nearest facility. When a member visits an emergency room, he or she is required to pay a copayment. If the visit results in an inpatient hospital admission, the emergency room copayment is waived. Members must request authorization from HMO Louisiana within 48 hours of an emergency room admission.

Dependents who are classified as out-of-area will receive deductible/coinsurance-style benefits for emergency room visits.

**MENTAL DISORDERS / SUBSTANCE ABUSE BENEFITS**

Mental disorders and substance abuse benefits are the same as, or better than medical/surgical benefits. All mental disorder and substance abuse benefits are provided through Magellan Behavioral Health, which is an independent company.

**ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS**

Eligible organ, tissue and bone marrow transplants will be covered, including a $50,000 acquisition expense maximum. See the organ, tissue and bone marrow transplant section of the benefit plan or contract for complete details and qualifications.

**OWNER 24-HOUR COVERAGE**

For the protection of employers, HMO Louisiana offers coverage for occupational injuries and diseases for qualified company owners. Coverage for services that are required to be covered in whole or in part by Workers' Compensation insurance is also available for owners, if the owner complies with La. R.S. 23:1035(A).

**PREGNANCY CARE**

Pregnancy care for employees and covered spouses is required by law in all group plans with 15 or more employees. Covered members pay only one copayment for all prenatal care, including lab work and ultrasound, plus any applicable hospital copayment for the delivery and care of the newborn baby. Groups with 14 employees or fewer on the payroll can exclude pregnancy benefits, if desired (please see quote sheet). Miscarriages and ectopic pregnancies are covered for all members regardless of whether the pregnancy option is chosen.

**CARE AWAY FROM HOME**

HMO Louisiana members have access to their benefits across the country through the BlueCard® Program. To meet the different healthcare needs of members and dependents who are away from home, the HMO plan offers separate benefits for short trips and long-term stays. Members simply refer to their ID cards for helpful information on accessing healthcare when they’re away from home.

To learn more about the BlueCard Program, call HMO Louisiana Customer Service at 1.800.376.7741 or visit www.bcbs.com/coverage/bluecard.
**Prescription Drug Program**

**PRESCRIPTION DRUG PROGRAM — CONVENIENCE, SIMPLICITY**

Prescription drugs are a regular medical expense for many people, so it is important to have easily accessible drug benefits. HMO Louisiana provides coverage through a prescription drug program where members pay a fixed copayment at the time of purchase.

Two methods are available for filling prescriptions:

1. Simply present the HMO Louisiana ID card and a valid prescription to a network pharmacy. No claim forms are necessary, and there is no waiting on reimbursement checks. For participating retail pharmacies, the copayment covers up to a 30-day supply or the manufacturer’s recommended dosage. A separate copayment is required for each dispensing.

2. Simple copayment-style coverage also applies to prescriptions filled through the Express Scripts, Inc.* mail-order pharmacy. Members pay a mail-order copayment equal to three times the retail copayment and receive up to a 90-day supply or the manufacturer’s recommended dosage.

**COPAYMENTS**

All HMO plans include a five-tier copayment structure for prescription drugs. Different copayments apply to each tier level. Tier placement is based on our evaluation of a particular medication’s clinical efficiency, outputs, cost and pharmacoeconomic factors.

The following examples describe each tier and the copayment that applies.

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Description</th>
<th>Retail Copayment Example (up to 30-day supply)</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Primarily generic drugs, although some brand-name drugs may fall into this tier</td>
<td></td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Primarily brand-name drugs, although some generic drugs may fall into this tier</td>
<td></td>
<td>$25</td>
<td>$25</td>
<td>$30</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Brand-name or generic drugs that may have a therapeutic alternative as a Tier 1 or Tier 2 drug; covered compounded drugs are included in this tier</td>
<td></td>
<td>$40</td>
<td>$45</td>
<td>$55</td>
</tr>
<tr>
<td>Tier 4</td>
<td>A prescription drug that is a multi-source brand drug</td>
<td></td>
<td>$55</td>
<td>$60</td>
<td>$70</td>
</tr>
<tr>
<td>Tier 5</td>
<td>Injectable prescription drugs, including those medications that are intended to be self-administered; however, insulin and injectable antihemophilic prescription drugs may be included in another drug tier</td>
<td></td>
<td>$50</td>
<td>$50</td>
<td>$50</td>
</tr>
</tbody>
</table>

Please refer to the rate sheet for additional copayment options.

*Express Scripts, Inc. is an independent company, which serves as the pharmacy benefit manager for HMO Louisiana, Inc.*
ADVANCED FEATURES

Mail-service system:
Our program’s national mail-service system, Express Scripts, offers the most advanced data processing and dispensing system in the industry. It features rapid at-home prescription delivery, toll-free 24-hour access to registered pharmacists and a toll-free drug information line. Refills can be ordered by mail, phone or on the internet at www.express-scripts.com.

Safeguarding patient health: Network pharmacies maintain an on-file prescription history for each member. Pharmacists work closely with both patients and prescribing physicians to help ensure safety and accuracy when filling their prescriptions.

BROAD PHARMACY NETWORK
Our prescription drug program is part of a nationwide network of pharmacies. We also cover prescriptions filled at non-participating pharmacies. At these locations, benefits for covered prescriptions are based on the discounted plan price, or “allowable charge,” that would have been charged at a participating pharmacy, less the applicable copayment. Members may have to pay the balance above the allowable charge at non-participating pharmacies.

For complete network provider information, call 1.866.781.7533 or visit the Express Scripts website at www.express-scripts.com.

SPECIALTY PHARMACY NETWORK
HMO Louisiana maintains a Specialty Pharmacy Network designed to help our members who are using specialty medications to treat chronic illnesses. Specialty drugs are biotechnology medications or other drug products that often require special ordering, handling, patient education and/or customer service. Specialty pharmacies are different from retail or mail-order pharmacies, as they handle these specialty drugs and medications that must be administered in a doctor’s office.

Members who purchase specialty medications outside of the Specialty Pharmacy Network may be required to pay full price for the medications and submit a paper claim for reimbursement. You can see a list of specialty medications online at www.bcbsla.com. Click on Customer, then Covered Drugs under QUICK LINKS. You may also call a Customer Service representative at the number on your ID card for a list of specialty drugs and pharmacies.

LEAD WITH GENERICS – A STEP THERAPY PROGRAM
In some cases, you may be required to try a certain prescription drug to treat a condition in order to receive coverage. If this drug does not work for your condition, we will cover a second prescribed medication.

QUANTITY PER DISPENSING LIMITATIONS & ALLOWANCES
Covered prescriptions have a quantity limit described in your benefit plan, typically up to a 30-day supply at a retail pharmacy and up to a 90-day supply for mail-order. These limits are based on the manufacturer’s recommended dosage and duration of therapy; common usage for episodic or intermittent treatment; FDA-approved recommendations and/or clinical studies; and/or as determined by HMO Louisiana. QPD limits/allowances are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Specialty drugs are limited to a 30-day supply for both retail and mail order or the manufacturer’s recommended dosage.

Note: Specialty drugs may be limited to a 30-day supply.

PRIOR AUTHORIZATION
Certain prescription drugs and supplies require prior authorization. Please check your Schedule of Benefits, visit the website at www.bcbsla.com or call the Customer Service number on your ID card to see what drugs and supplies require prior authorization.

LIMITATIONS/EXCLUSIONS
Certain prescription drugs are limited or excluded from coverage, including, but not limited to:

• drugs used for cosmetic purposes
• fertility drugs
• weight reduction drugs
• impotence drugs

Please refer to the benefit plan for a complete list of limitations and exclusions.
HMO Louisiana is strengthened by our Care Management programs that ensure your care is appropriate. Our team of doctors, nurses and in-house pharmacy staff oversees our members’ care through the following functions:

**EMERGENCY ADMISSIONS**
In the case of an emergency inpatient hospital admission, authorization must be requested within 48 hours of the admission by your provider.

**AUTHORIZATION OF ELECTIVE ADMISSIONS AND OTHER COVERED SERVICES**
If you need to be hospitalized for a condition other than an emergency, your admission to the hospital requires authorization prior to admission. Patients, physicians, hospitals and our Care Management Department all participate in the authorization process that is used to determine whether hospitalization is necessary and an appropriate length of stay. Certain services, drugs and visits to certain providers require authorization from HMO Louisiana before services can be performed. A comprehensive authorization list is included in your schedule of benefits. Failure to obtain required authorizations will result in a denial of benefits.

**CONCURRENT REVIEW**
The process of determining whether continued hospital care is appropriate, also called concurrent review, will be conducted from time to time during a lengthy hospital stay. Our Care Management Department works directly with the patient, the hospital and the admitting physician to assess the continued necessity of hospitalization.

**CASE MANAGEMENT**
Case management is a special service performed at the discretion of HMO Louisiana. Case management oversees the treatment of unusually complex, difficult or lengthy illnesses. The case management staff, with the member’s acceptance, can develop a long-term treatment plan to achieve the most efficient, effective use of medical resources. Members may call 1.800.317.2299 for assistance with case management.

**RETROSPECTIVE REVIEW**
A retrospective review may be performed to assess the medical need and correct billing level for services that have already been rendered.
PREVENTIVE AND WELLNESS CARE

The Patient Protection and Affordable Care Act is bringing numerous changes to the healthcare industry. We are working hard on behalf of our customers to implement healthcare reform provisions as regulations are defined. The list below is a sample of preventive services available to our customers and their enrolled dependents at no out-of-pocket cost when obtained from a network provider.

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency Limit</th>
<th>Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exam</td>
<td>One per year</td>
<td>No limit</td>
</tr>
<tr>
<td>Pap smear</td>
<td>One per year</td>
<td>No limit</td>
</tr>
<tr>
<td>Prostate-specific antigen (PSA) test</td>
<td>One per year</td>
<td>Age 50 and older</td>
</tr>
<tr>
<td>Routine mammogram, if recommended by a physician</td>
<td>One per year</td>
<td>No limit</td>
</tr>
<tr>
<td>Immunizations recommended by a physician</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>Well-baby care for dependent children</td>
<td>No limit</td>
<td>Up to age 24 months</td>
</tr>
<tr>
<td>Colonoscopy for adult men and women</td>
<td>One every 10 years</td>
<td>Age 50 and older</td>
</tr>
<tr>
<td>Asymptomatic bacteriuria for pregnant women</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>Congenital hypothyroidism screening</td>
<td>No limit</td>
<td>Newborns less than age 1</td>
</tr>
<tr>
<td>Chlamydial and gonorrhea screenings for women</td>
<td>One per year</td>
<td>No limit</td>
</tr>
<tr>
<td>Hearing screening</td>
<td>One per year</td>
<td>Ages 0 - 21</td>
</tr>
<tr>
<td>Hepatitis B virus infection screening for pregnant women</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>HIV screening</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>Lipid disorders screening in adults</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>Osteoporosis screening in postmenopausal women</td>
<td>One per year</td>
<td>Age 60 and older</td>
</tr>
<tr>
<td>Sickle cell disease screening</td>
<td>No limit</td>
<td>Newborns less than age 1</td>
</tr>
<tr>
<td>Syphilis infection screening</td>
<td>One per year</td>
<td>No limit</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus screening in adults</td>
<td>No limit</td>
<td>No limit</td>
</tr>
<tr>
<td>Visual impairment screening</td>
<td>One per year</td>
<td>Ages 0 - 21</td>
</tr>
<tr>
<td>Lead screening</td>
<td>One per year</td>
<td>Ages 0 - 6</td>
</tr>
<tr>
<td>Developmental screenings</td>
<td>No limit</td>
<td>Ages 0 - 3</td>
</tr>
<tr>
<td>Autism screenings</td>
<td>No limit</td>
<td>Ages 1 - 2</td>
</tr>
</tbody>
</table>

* Subject to age requirement limits for certain preventive services.
* Effective at the first plan renewal on or after October 1, 2012, for Non-Grandfathered plans only.
* Benefits indicated for pregnant women available only if member has pregnancy benefits.
PUT WELLNESS TO WORK AT YOUR WORKPLACE

BEHTER HEALTH, BETTER RESULTS

Every small business owner wants employees to be healthy. After all, they’re your friends and colleagues as well as your coworkers. But paying attention to your employees’ health is also good for your bottom line.

Just a few unhealthy employees can drive up healthcare expenses for the entire company. That’s where Blue Cross and Blue Shield of Louisiana and HMO Louisiana can help.

My Health, My Way, our new suite of health and wellness programs, supports your efforts to improve employee health, increase productivity and better manage benefit costs. And this program is offered at no extra charge.

Built right into your health benefits package, the core offerings of My Health, My Way include such services as:

• Personal Health Assessments (PHA) for your employees
• Healthy lifestyle resources
• Wellness trackers
• A listing of regional wellness events
• Information about local health resources
• Exclusive discount programs
• And more!

My Health, My Way. It’s a real solution to help your employees become more healthy and productive and to help you control your healthcare costs.

PERSONAL HEALTH ASSESSMENTS

The Personal Health Assessment (PHA) is generally an employee’s first experience with My Health, My Way. This 15-minute questionnaire helps employees understand their health risks and outlines steps to improve or maintain their wellbeing. The PHA takes various lifestyle and health factors into consideration, including medical history, blood pressure, cholesterol and glucose numbers, body measurements, lifestyle behaviors and other health risk measures.

Because each person is different, the PHA gives personalized confidential reports that pinpoint reasonable health goals and offer specific tools to address them.

EMPLOYER REPORTING

If your company has more than 25 participants, My Health, My Way can provide you with an aggregate report of your employees’ PHA information. Please note this report contains collective information only. Individual information is not provided. This report helps you understand the challenges and opportunities your workers face. It also provides a benchmark so you can measure improvement over time.

Security and Confidentiality:
The My Health, My Way PHA platform has been engineered to provide the same level of protection for each individual’s confidential health information that online banking and consumer websites provide to their clients and account-holders.
OTHER HEALTH RESOURCES

Your Blue Cross and HMO Louisiana members have access to a long list of extra health and wellness resources, including:

• **Exclusive discounts and savings** on fitness clubs, nutrition programs and products, financial wellbeing services, family care services and healthy travel through a national program.

• **Support for members with chronic conditions** from the doctors, pharmacists and nurses in our Care Management Department; and

• **A wide variety of online tools** to encourage and support a healthy lifestyle.

Your employees can explore these resources and more at www.BenefitsForBetterLiving.com.

Your Online Toolkit:

Blue Cross publishes an online **Sneak Into Shape Toolkit** that’s just one of the many resources for encouraging healthy lifestyles among employees. Go to www.BenefitsForBetterLiving.com/toolkit to learn more.

Return On Investment:

First-hand experience has made Blue Cross a believer in workplace wellness. Since we launched our own comprehensive workplace wellness program in 2006, we are proud to report high employee satisfaction rates, with 77 percent of our workforce saying they’re highly satisfied. In addition, we have seen:

• A 5 percent reduction in staff turnover

• A 13.6 percent reduction in workers’ compensation costs

• A 20 percent drop in disability costs

• Employee medical plan increases remaining consistently below national trends

• Employee weight loss of 4,661 pounds total in 2010

We are committed to the health and wellbeing of our customers. That is why we are offering you a program, at no extra charge, that will lift you to the cutting edge of workplace wellness and give your employees the tools they need to live the healthiest, most productive lives possible.
BLUE 365®

Living well means having healthy options every day. That’s why we offer Blue365® to take our members beyond health insurance and give them access to trusted health and wellness resources 365 days a year—and enjoy special member values on many services.

Blue365® is a national program that’s part of every HMO LA plan, offering exclusive access to information, discounts and savings, making it easier and more affordable to make healthy choices.

Health & Wellness

• **Fitness** — discounts on local health club memberships and free access to online tools
• **Diet/Weight Control** — savings on programs, products and consultations at Jenny Craig, eDiets and NutriSystem.
• **Vision Discounts** — With Blue365 our members can receive routine eye exams, frames, lenses, conventional contact lenses and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to more than 30,000 providers nationwide, including optometrists, ophthalmologists and many retail centers. BCBSLA members can also save 40 to 50 percent off the overall national average price for Lasik surgery through QualSight LASIK.

Family Care

• **Senior Care** — discounts on care advisory services
• **Child Safety** — resources for child safety and consumer product information
• **Long-Term Insurance** — free guidelines and information
• **Managing Medicare** — resources to understand coverage options from Medicare

Financial Well-Being

• **Plan for Your Future** — understanding Medicare-related health insurance options and how they affect your financial future
• **Financial Resources** — educational tools to prepare for long-term healthcare needs

Travel

• **Healthy Getaways** — special discounts on hotel programs and services
• **Worldwide Health Coverage** — access to doctors and hospitals across the globe
• **Travel Tips** — a wealth of online travel tips and resources

Members can explore all the healthy choices through the Wellness Discount link in AccessBlue at www.bcbsla.com.

Value-Added Service

DENTAL DISCOUNT NETWORK

Members can take advantage of special discounts on dental services. They simply present their ID card to one of the participating providers and immediately receive significant savings. To find a discount provider, visit www.bcbsla.com and click on Find a Doctor or Hospital. Under the Online Louisiana Directory, click on Search Our Directory. From the drop-down menu, choose Discount Dental. Please note that these services are not eligible for benefits under the benefit plan.

Customer Service

YOUR ANSWER IS JUST A CLICK OR A CALL AWAY...

Have a question about your claim? Want to know if a service is covered under your plan? Get the answers to your healthcare coverage questions using our secure online Customer Inquiry Form.

This form allows you to submit questions to our Customer Service Department securely and conveniently—any time of day or night. Simply log on to our website at www.bcbsla.com, click on Customer, then choose Customer Inquiry Form. Follow the directions on the screen to get started!

You can always call us between 8 a.m. and 5 p.m., Monday through Friday, at the number listed on your member ID card.

ONLINE SOLUTIONS THROUGH ACCESSBLUE

AccessBlue, our secure online portal, lets you manage your group plan with the click of a mouse. This self-service tool includes enrollment, which allows you to enter new hire applications, track their status, enter terminations, request member materials and more. Within this tool you can also choose the eBilling option, where you can preview invoices, make electronic payments and view your payment history.

Simply visit www.bcbsla.com and click on AccessBlue to get started.
ELIGIBLE GROUPS

All groups with two or more employees are eligible to apply for coverage. There are no industry restrictions. Firms that have been in business less than one year are subject to home-office rating. Firms that do not have a current carrier or are seasonal also are subject to home-office rating and approval. In some cases, firms with a significant number of employees living outside of Louisiana may not be eligible.

If a firm chooses a contributory plan, at least 75 percent of its full-time eligible employees must participate. For non-contributory plans, 100 percent participation is required. These percentage requirements are for the initial and ongoing enrollment. Other specific conditions that may apply are contained within the group master application.

ELIGIBLE EMPLOYEES

All full-time employees working a minimum of 30 hours per week and their eligible dependents may apply for coverage. Individuals on retainer (examples: attorneys, accountants, business consultants, 1099 contract employees) and members of boards of directors are not eligible.

Eligible employees, their eligible spouses and their eligible dependents cannot be individually denied coverage for any reason related to health status. If health question responses are requested by HMO Louisiana, they will be used for group premium and case management.

The effective date of coverage or benefit change will not be delayed because an employee is not actively at work due to health status. Exclusions for pre-existing conditions may apply.

ELIGIBLE DEPENDENTS

Insured employees may cover their spouses. They may also cover their children and grandchildren as long as they are under 26 years of age. For grandchildren to be eligible, they also must reside with and be in legal custody of the employee.

Children and grandchildren in the legal custody of and residing with the employee who are mentally or physically disabled are eligible for coverage beyond age 26. They must be incapable of self-support and enrolled in the plan prior to attaining age 26. They must also continue to meet the disability criteria.

See benefit plan for details on other dependents who may qualify.
GROUP RATES
Rates may increase after the first 12 months and every six months thereafter due to factors including but not limited to:
• demographic changes of the group, including age changes
• claims experience of all groups in the class of business
• a group’s claims experience, health status and duration of coverage
• an overall rise in medical costs
• regulatory considerations
• changes to benefit plan design
However, rates may increase more frequently than stated above as described in the benefit plan.

SPECIAL ENROLLMENT
In certain circumstances, an employee may enroll himself/herself or spouse, or dependent child(ren) in this health plan. These circumstances include, but are not limited to, the following:
• Loss of certain types of other coverage
• Acquiring a dependent
Please refer to the benefit plan for details on special enrollment rights.

LATE ENROLLEE
A “late enrollee” is an eligible employee or dependent who does not enroll for group health insurance coverage:
• when first eligible, and
• does not meet the qualifications of a “special enrollee.”
An eligible employee must be covered to add a dependent(s). Late enrollees may apply for coverage during the group’s open enrollment period. An 18-month exclusion period for pre-existing conditions may apply.

PRE-EXISTING CONDITION EXCLUSIONS
A Pre-existing Condition is defined as:
A physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 90-day period immediately prior to the eligible member’s enrollment date. Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a pre-existing condition.

Pre-existing Condition Exclusion Period
No benefits will be provided for any charges incurred for any pre-existing conditions subject to the following exclusion periods:
• initial enrollees of a new group policy — 180-day exclusion period
• new hire enrollees if application is made when first eligible — 180-day exclusion period
• special enrollees — 180-day exclusion period
• late enrollees — 18-month exclusion period
• mental disorders — 60-day exclusion period

RENEWABILITY
All benefit plans are renewable at the employer’s option. The employer or HMO Louisiana, Inc. can terminate the benefit plan with advance notice in the cases of:
• nonpayment of premium
• fraud or misrepresentation
• noncompliance with plan provisions, including not meeting minimum participation and eligibility requirements
• termination of all employer plans in that class of business (advance notice will be given)
• where there is no longer an enrollee who lives, resides or works in the service area

COORDINATION OF BENEFITS
Coordination of benefits will be conducted when a participant has additional group coverage. This provision helps keep premiums low by preventing duplicate payments for the same services.

HEALTH QUESTIONS
In groups with two to 19 employees, applicants and any eligible dependents must answer all health questions on the employee application form. In groups with 20 or more employees, employees who apply after the group’s initial eligibility period can apply during the group open enrollment period and must answer all health questions on the employee application form. These questions will not be used to reject the application. (See Late Enrollee information.)
Pre-existing Condition Exclusions Do Not Apply to:
• newborns, provided a complete request for enrollment is received by HMO Louisiana within 30 days of birth or within 180 days of birth if the policy covers older children;
• adopted children, provided a complete request for enrollment is received within 30 days of adoption or placement of adoption;
• pregnancy, if pregnancy benefits are applicable; or
• anyone under 19 years of age.

Benefit Plan Limitations and Exclusions
(See benefit plan for complete list)
Limitations and exclusions include but are not limited to:
• charges exceeding the allowable charge
• investigative surgery or treatments
• sales tax
• interest
• infertility treatments
• fertility drugs
• cosmetic surgery or treatment
• corrective eyeglasses or lenses
• contact lenses
• treatment of impotence
• custodial care and services

Blue Cross Cafeteria Plans
Want a benefit program that actually serves BOTH you and your employees? One that offers tax savings, convenience and customer support? It’s time to sample a Cafeteria Plan from Blue Cross and Blue Shield of Louisiana.
A Cafeteria Plan allows employees to set aside a portion of each paycheck—before paying taxes—into a flexible savings account to pay for qualified healthcare expenses not covered by insurance and for dependent care expenses for qualified dependents.

Employee Advantages
• Tax savings (federal and state income tax and social security tax)
• Taxable income is reduced—increases take-home pay
• Convenient way to save for healthcare expenses
• Access account 24/7 to check account balances, claim status, submit questions and review qualified medical expenses

Employer Advantages
• Save approximately 8 percent on every dollar employees redirect to their account
• Helps to cushion health insurance increases to lessen impact on employee’s paycheck
• Convenient access to reports, check registers and forms around the clock

Cafeteria Plans Include:
• Premium-Only Plan: Allows employees to have their premiums for most employer-sponsored health plans deducted from their paycheck on a pre-tax basis.
• Medical Reimbursement Account: Allows employees to redirect a portion of their salary on a pre-tax basis to pay for qualified medical out-of-pocket expenses not covered by insurance such as premiums, deductibles, copayments, contacts and glasses, and dental services.
• Dependent Care Assistance Plan: Allows employees to pay for dependent care with pre-tax dollars.

Cafeteria Plan Administration
As an added value, we offer full-service administration of your cafeteria plan. We provide plan documentation and complete all 5500 forms, if applicable, required by the IRS. We also perform all necessary Discrimination Testing to ensure your company’s compliance.

To request a Section 125 Cafeteria Plan Proposal, visit www.bcbsla.com. Click on Our Plans and follow the prompt to Cafeteria Plans.

www.ezflexplan.com/bcbsla
1.800.376.7734
**HMO GROUP PLANS**

Effective 1/1/2013

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<th>HMO Plan</th>
<th>PCP</th>
<th>Specialist</th>
<th>Urgent</th>
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*Inpatient Copay per day for three days; Outpatient copay per surgery. Copay also applies to Mental Health and Substance Abuse Inpatient Facility charges.

**Deductible and Coinsurance apply

- Mental Health and Substance Abuse Professional Services and Outpatient Facility charges are paid at 100%. Deductible is waived for these benefits.
- Prosthetic Appliances and Durable Medical Equipment benefits pay at deductible then 80/20 coinsurance.
<table>
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<tr>
<th>Deductible</th>
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<th>Out-of-Pocket Maximum (Excludes Deductible)</th>
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- Deductibles and Out-of-Pocket Maximums are based on a calendar year.
- All benefits based on Allowable Charges.
- Refer to brochure for prescription drug benefits.
- This is only an outline. All benefits are subject to the terms and conditions of the Benefit Plan. In the case of a discrepancy, the Benefit Plan will prevail. Exclusions and Limitations may apply.
SMALL EMPLOYER NOTICE

Change in Premium Amount

Premiums for this Benefit Plan may increase after the Group’s first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, we will give Group forty-five (45) days written notice of any change in premium rates (ninety (90) days written notice for employer groups with more than one-hundred (100) enrolled employees). We will send notice to the Group’s latest address shown in our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

Renewability of Coverage

Company may terminate this Benefit Plan if any one of the following occurs:

• Group commits fraud or makes an intentional misrepresentation.

• Group fails to comply with a material plan provision, including, but not limited to provisions relating to eligibility, employer contributions or Group participation rules.

If the sole reason for termination is that Group’s participation falls to less than two (2) employees (there is only one (1) employee covered (or owner, if covered)), termination of Group coverage will be effective on the Group’s next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice as described below.

• In the case of Network plans, there is no longer any enrollee under the Group benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.

• Group’s coverage is provided through a bona fide association and the employer’s membership in the association ends.

• Company ceases to offer this product or coverage in the market.
## Sales Offices

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone</th>
<th>Address</th>
</tr>
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| Alexandria  | 318.448.1660 | 4508 Coliseum Boulevard, Suite A  
Alexandria, Louisiana 71303 |
| Lake Charles| 337.562.0595 | 219 West Prien Lake Road  
Lake Charles, Louisiana 70601-8450 |
| Baton Rouge | 225.295.2556 | 5525 Reitz Avenue  
Baton Rouge, Louisiana 70809-3802 |
| Monroe      | 318.323.1479 | 3130 Mercedes Drive  
Monroe, Louisiana 71201 |
| Houma       | 985.223.3499 | 1437 St. Charles Street, Suite 135  
Houma, Louisiana 70360 |
| New Orleans | 504.832.5800 | 3501 North Causeway Boulevard, Suite 600  
Metairie, Louisiana 70002 |
| Lafayette   | 337.593.5727 | 5501 Johnston Street  
Lafayette, Louisiana 70503 |
| Shreveport  | 318.795.0573 | 411 Ashley Ridge Boulevard  
Shreveport, Louisiana 71106 |

## Customer Service

**Baton Rouge**  
800.495.2583  
help@bcbsla.com  
5525 Reitz Avenue  
Baton Rouge, Louisiana 70809-3802