### Sales Offices

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

### Customer Service

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Numbers</th>
<th>Email Address</th>
<th>Address Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baton Rouge</td>
<td>225.293.0625</td>
<td><a href="mailto:help@bcbsla.com">help@bcbsla.com</a></td>
<td>5525 Reitz Avenue, Baton Rouge, Louisiana 70809-3802</td>
</tr>
<tr>
<td></td>
<td>800.599.2583</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company
Group Proposal

A DRIVING FORCE FOR YOUR INSURANCE NEEDS

Plans effective 10/1/2010
Welcome to LADA / LADIT
PPO Plans
tureBLUE Options
BlueSaver – HSA-Qualified High-Deductible Plans
Point of Service (POS) Plans
Special Options & Features
Care Management Programs
General Conditions

Special note: This information is presented for general information only. It is not a contract, nor is it intended to be construed as a contract. If there is any discrepancy between the information in this brochure and the benefit plan, the benefit plan will prevail. Premium will vary with the level of benefits chosen. For complete information, please refer to the benefit plan.

Benefits are based on allowable charges. Allowable charge is defined as the lesser of the billed charge or the amount established or negotiated by Blue Cross and Blue Shield of Louisiana, as the maximum amount allowed for all provider services covered under the terms of the benefit plan. PPO refers to benefit plan #40HR1537. trueBLUE refers to benefit plan #40HR1543. BlueSaver refers to benefit plan #40HR1541. HMO refers to benefit plan #131HR01225. POS refers to benefit plan #131HR01228.

NOTICE
Health care services may be provided to you at a network health care 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 the www.bcbsla.com or by calling the customer service telephone number on the back of your i.d. card.
LADA/LADIT has been serving the needs of Louisiana automobile dealers for more than half a century. Blue Cross and Blue Shield of Louisiana has also served Louisianians for more than 70 years and continues to serve more local customers every day than any other Louisiana health insurance carrier. Since 1980, LADA/LADIT has teamed with Blue Cross and Blue Shield of Louisiana and its subsidiaries to bring you the high quality healthcare coverage you deserve.

VALUABLE PROTECTION, FLEXIBLE OPTIONS
Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc., give you the choices you deserve when it comes to your health. Our wide range of benefits lets you choose the products to fit your needs and budget:

- Preferred Provider Organization (PPO) plans
- trueBLUE – an affordable alternative for small groups
- Point of Service (POS) and HMO plans through HMO Louisiana, Inc.
- BlueSaver (HSA plan)
- preventive and wellness care
- prescription drug program
- optional dental program
- simplified claims processing
- life insurance through Southern National Life Insurance Co., Inc.
- competitive rates

SOLID PROVIDER NETWORKS
Our roots with the Louisiana medical community date back to 1934, when the forerunner of today’s company was founded. Because of our longstanding relationship with hospitals, physicians and other providers in the state, we are able to offer special features to our members and pass on the cost savings.
With our Preferred Provider Organization (PPO) coverage, you get:
• solid coverage for everyday medical expenses
• simplified claims processing
• hospitalization benefits
• coverage backed by the strength of the Cross and Shield

PPO Plans

COMPREHENSIVE MAJOR MEDICAL COVERAGE
Choose from a number of options to customize your group’s coverage with benefits that best fit the needs of your employees. Also, you can take advantage of our strong provider networks, which in turn brings you greater savings in premium costs.

PREVENTIVE AND WELLNESS CARE BENEFITS
Blue Cross and Blue Shield of Louisiana is committed to preventive medicine. To promote preventive care, a number of preventive and wellness care benefits are included with all PPO options. Blue Cross pays 100 percent of the allowable charge, with no deductible applied, on the following services when rendered by a preferred provider:
• one routine physical exam per benefit period (calendar year) per member
• well baby care
• one routine mammography exam every 12 months or as ordered by the physician
• one digital rectal exam and prostate specific antigen (PSA) screening test per benefit period (age 50 and older), or more frequently if recommended by physician
• one routine gynecological exam per benefit period
• one hemoccult (colon) test per benefit period
• one routine Pap smear per benefit period
• immunizations as ordered by a physician
• one routine Pap smear per benefit period
• one routine mammography exam every 12 months, or as ordered by the physician
• autism Screening
• breast cancer screening
• cervical cancer screening
• depression (adults) screening
• HIV screening
• Lipid disorders (adults) screening
• Phenylketonuria (PKU) screening
• Type 2 Diabetes Mellitus (adults) screening
• visual impairment in children younger than age 5 years screening
**PHYSICIAN OFFICE VISIT COPAYMENT OPTION**

A physician office visit copayment option of $15, $20, $25, $30 or $40 is available for groups with a deductible of $500 or less. Additionally, a copayment option of $30 or $40 is available for groups choosing a $750 deductible and a $40 copayment option is available for groups choosing a $1,000 deductible. Under the copayment option, members with PPO coverage who use a preferred provider only pay a flat copayment for eligible office visit services. Blue Cross then pays the remainder of the allowable charge for the eligible medical expense minus the copayment. Please refer to the rate sheet for option(s) quoted.

The copayment applies to the following services when performed in a physician’s office or clinic:

- office visit charges and consultation
- certain laboratory tests
- surgical procedures
- injections, allergy serums and vials of allergy medications
- radiation treatments
- X-rays
- machine tests
- treatment of mental disorders
- treatment of alcohol and/or drug abuse (if covered)

The physician office visit does not apply to allergy testing, physical therapy, occupational therapy, speech therapy, prescription drugs, medical/surgical supplies or preventive and wellness care.

**BENEFIT PERIOD DEDUCTIBLES**

The following deductibles are available: $250, $500, $750, $1,000, $1,500 or $2,000. The deductible applies for the benefit period January 1 through December 31. Please ask your producer or Blue Cross representative for details.

Each covered family member will have an individual deductible. Once a member reaches his/her deductible for the benefit period, benefits begin based on the coinsurance option chosen below. Once three covered family members reach their deductibles, no other covered member has to satisfy a deductible for the remainder of that benefit period (calendar year).

**COINSURANCE OPTIONS**

Groups can choose one of four PPO coinsurance coverage options, with benefits based on allowable charges for covered medical services:

<table>
<thead>
<tr>
<th></th>
<th>in-network coinsurance</th>
<th>non-network coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue Cross Member</td>
<td>Blue Cross Member</td>
</tr>
<tr>
<td>PPO 90/70</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>PPO 80/60</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>PPO 70/50</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>PPO 60/40</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**OUT-OF-POCKET MAXIMUM**

Each family member will have an out-of-pocket maximum for the benefit period. When a member’s out-of-pocket expenses for coinsurance reach the selected maximum during any benefit period, covered medical expenses will be paid at 100 percent of the allowable charge for the remainder of that benefit period. Below is a listing of out-of-pocket maximum choices:

- $1,000, after deductible
- $1,500, after deductible
- $2,000, after deductible
- $3,000, after deductible
- $4,000, after deductible
- $5,000, after deductible

For extra protection, there is an aggregate out-of-pocket maximum for family coverage.

- $1,000 out-of-pocket maximum option: $2,500 family maximum
- all other options: two times the individual maximum
PRESCRIPTION DRUG COVERAGE — CONVENIENCE, SIMPLICITY

Prescription drugs are a regular medical expense for many people. That's why the PPO plans provide 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 Blue Cross and Blue Shield of Louisiana ID card and a valid prescription to a participating retail pharmacy. Some retail pharmacies have contracted to accept a negotiated amount as payment in full for covered prescription drugs that they dispense. These pharmacies are "participating pharmacies." Benefits are based on allowable charge for covered prescription drugs purchased from participating pharmacies. No claim forms are necessary and there is no waiting on reimbursement checks. 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 copayments also apply to prescriptions filled through the mail-order pharmacy. When ordering maintenance drugs by mail, the copayment, which is shown on the rate sheet, covers up to a 90-day supply or the manufacturer's recommended dosage. A separate copayment is required for each dispensing.

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

For retail pharmacies, you can receive up to a 30-day supply or the manufacturer's recommended dosage. When ordering drugs by mail, your copayment covers up to a 90-day supply or the manufacturer's recommended dosage. Each time you fill a prescription, a new copayment applies. The copayment covers applicable sales taxes. Oral contraceptives are also covered.

ADVANCED FEATURES

Mail-Order System: Our program’s national mail-order system uses 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 prescription drug information online. Refills can be ordered by mail, phone or via the Internet at www.express-scripts.com.

CHOOSE YOUR PHARMACY

Our prescription drug program is part of a nationwide network of pharmacies. We do, however, offer coverage for prescriptions filled at non-participating pharmacies. At these locations, benefits for covered prescriptions usually will be based on the negotiated plan price 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 pharmacy network information, call 1.866.781.7533 or visit the Express Scripts* website at www.express-scripts.com.

Limitations/Exclusions include, but are not limited to: (see your contract for a complete list)

• drugs used for cosmetic purposes or weight reduction
• investigative drugs
• fertility drugs

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

* Express Scripts, Inc. is an independent company, which serves as the pharmacy benefit manager for Blue Cross and Blue Shield of Louisiana.
## THE DETAILS

All 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, safety, cost and pharmacoeconomic factors. As an added cost savings you can choose a prescription drug deductible of $100 or $250. The following example describes each tier and the copayment that applies.

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Description</th>
<th>Retail Copayment Example</th>
<th>Mail-Order Copayment Example</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>$7</td>
<td>$21</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Primarily brand-name drugs, although some generic drugs may fall into this tier</td>
<td>$25</td>
<td>$75</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Brand-name or generic prescription 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>$40</td>
<td>$120</td>
</tr>
<tr>
<td>Tier 4</td>
<td>A prescription drug that is a multi-source brand drug</td>
<td>$55</td>
<td>$165</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 tier</td>
<td>$50</td>
<td>$150</td>
</tr>
</tbody>
</table>

## STEP THERAPY

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.

## PRIOR AUTHORIZATION

Certain prescription drugs and supplies require prior authorization. Please check your Schedule of Benefits, visit the website at [www.bcbsla.com](http://www.bcbsla.com) or call the Customer Service number on the back of your ID card to see what drugs and supplies require prior authorization.

## 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.
THE trueBLUE DIFFERENCE

trueBLUE offers options to fit your needs and budget. trueBLUE’s unique benefit design is divided into two benefit categories: (1) inpatient/outpatient services and (2) prescription drugs. Services and supplies rendered in an inpatient setting and services performed on an outpatient basis are included in the Inpatient/Outpatient benefit category (see example below). Brand-name and generic prescription drugs are included in the Prescription Drugs benefit category.

(1) INPATIENT/OUTPATIENT
- physician & allied provider charges
- X-rays
- lab tests
- hospital and allied facility charges
- emergency room services
- prescription drugs administered in an inpatient setting

(2) PRESCRIPTION DRUGS
- brand-name & generic prescription drugs

trueBLUE: THE AFFORDABLE ALTERNATIVE

We found a way to make trueBLUE so affordable through a simple cost-sharing idea. Like other comprehensive plans, trueBLUE requires that a deductible first be met before benefits are paid. A deductible is an amount that the member must pay out-of-pocket in a benefit period (calendar year) before coverage begins. In such cases, the member pays the first dollars of his or her coverage. Once the deductible is met, the costs of healthcare are shared between Blue Cross and the member on a percentage basis. This shared percentage is called the coinsurance. Unlike other plans, a separate deductible applies to each of the two benefit categories above.

DEDUCTIBLES AND COINSURANCE

trueBLUE PPO plans offer a variety of deductibles:
- $500
- $750
- $1,000

You choose one deductible amount for each of the two benefit categories. This deductible must be met for each benefit category before coinsurance begins.
for that category. Once the deductible is met for the Inpatient/Outpatient benefit category, trueBLUE pays 80 percent of the allowable charge for covered services received by a PPO provider and 60 percent of the allowable charge for covered services received by a non-PPO provider in the applicable benefit category.

Once the deductible is met in the Prescription Drugs benefit category, trueBLUE plans pay 50 percent for brand-name prescription drugs and 100 percent for generic prescription drugs. For example, if you choose a $500 deductible:

(1) INPATIENT/OUTPATIENT
$500 deductible
once met, trueBLUE PPO pays
80% in-network
60% out-of-network

(2) PRESCRIPTION DRUGS
$500 deductible
once met, trueBLUE PPO pays
50% brand-name prescription drugs
100% generic prescription drugs

The deductible applies to a January 1 through December 31 calendar-year benefit period. Each covered family member has an individual deductible; once three family members reach their deductibles, no other member has to satisfy a deductible within the same category for that benefit period. The family deductible applies separately to the Inpatient/Outpatient and Prescription Drug benefit categories.

OUT-OF-POCKET MAXIMUMS
trueBLUE also allows you to choose one out-of-pocket maximum for each benefit category: $1,000 or $2,000. Once this maximum is reached, trueBLUE pays 100 percent of the allowable charge for covered expenses. For example, if you choose a $1,000 deductible out-of-pocket maximum:

(1) INPATIENT/OUTPATIENT
$1,000 out-of-pocket max
once reached, trueBLUE pays 100% of allowable charges for covered services

(2) PRESCRIPTION DRUGS
$1,000 out-of-pocket max
once reached, trueBLUE pays 100% for brand-name prescription drugs
100% for generic prescription drugs

For extra protection, there is a combined out-of-pocket maximum for family coverage for the Inpatient/Outpatient benefit category. If the member’s individual out-of-pocket maximum is $1,000, the family out-of-pocket maximum is two-and-a-half times that amount. If the member’s individual out-of-pocket maximum is $2,000 or more, the family out-of-pocket maximum is twice that amount.

- $1,000 X 2 ½ = $2,500
- $2,000 X 2 = $4,000

There is no family out-of-pocket maximum for prescription drugs.

PREVENTIVE CARE
Blue Cross and Blue Shield of Louisiana is committed to preventive care. Detecting illnesses in their early stages ensures better health for our members and reduces medical costs for everyone. To promote preventive care, trueBLUE covers a full array of wellness services. Blue Cross pays 100 percent of the allowable charge, with no deductible needed, on the following services when rendered by a preferred provider:

- one routine physical exam per benefit period (calendar year)
- well baby care
- one routine mammography exam every 12 months or as recommended by the member’s physician
- one digital rectal exam and prostate specific antigen (PSA) screening test per benefit period (age 50 and older), or more frequently, if recommended by physician
- one routine gynecological (pelvic) exam per benefit period
- one routine hemoccult (colon) test per benefit period
- one routine Pap smear per benefit period
- immunizations as ordered by a physician
- one routine Pap smear per benefit period
- one routine mammography exam every 12 months, or as ordered by the physician
- autism Screening
- breast cancer screening
- cervical cancer screening
- depression (adults) screening
- HIV screening
- Lipid disorders (adults) screening
- Phenylketonuria (PKU) screening
- Type 2 Diabetes Mellitus (adults) screening
- visual impairment in children younger than age 5 years screening

Wellness services received from non-PPO providers are subject to out-of-network coinsurance levels.
LADA BlueSaver® is a high-deductible health plan that works with a health savings account. It provides the comfort of reliable healthcare coverage today while members build a financial cushion for their medical and non-medical needs of tomorrow.

**BlueSaver: An Investment in Your Health**

There’s been quite a buzz lately over HSAs – health savings accounts. An HSA is a personal tax-free savings account to which contributions are made to cover medical and non-medical expenses. To participate in an HSA, members must be covered by a qualified high-deductible health plan and open an HSA with a financial institution. HSA account holders (or anyone on their behalf) may contribute up to $3,050 annually to their HSA if they have qualified self-only coverage, or up to $6,150 annually if they have qualified family health coverage. Members 55 or older by the end of the taxable year may contribute an extra $1,000 to the HSA as a catch-up contribution. (These amounts are for 2011, may change annually, and are subject to additional IRS rules. Check with your tax advisor.) Money in an HSA can be used to pay for qualified medical expenses without tax and penalty and may also be withdrawn for non-medical expenses with tax and penalty. Check with your tax advisor about eligibility and potential tax savings.

BlueSaver works with your HSA to act as a savings fund for tax-qualified medical expenses, including those not usually covered by insurance. Funds in the account that are not used for medical expenses can accumulate tax-free from year to year until retirement. BlueSaver provides the opportunity to reduce taxes, invest money and reduce out-of-pocket medical expenses.

In addition to sound, affordable healthcare coverage, BlueSaver offers:

- choice of deductibles
- choice of coinsurance
- prescription drug benefits
- preventive and wellness care
- inpatient and outpatient coverage
- wide selection of doctors, hospitals and specialists
- nationwide access to your health benefits

**PPO Coverage**

After you meet your individual or family deductible, covered expenses will be paid at either 100 percent or 80 percent (depending on the option you choose for your group) of the allowable charge for care received from our PPO network of physicians and hospitals. Once a family has met its family deductible, BlueSaver starts paying benefits for all family members, regardless of
whether each individual has met his or her benefit period (calendar year) deductible. For purposes of this benefit plan, “family” includes all available classes of coverage except single member or subscriber-only coverage. No benefits are eligible for payment on any member until the total family benefit period deductible amount has been met.

When covered services are received outside of our PPO network, benefits are paid at either 80 percent or 60 percent (whichever option was chosen for your group) of the allowable charges. The 80/60 coinsurance option is not available for all deductible amounts.

The out-of-pocket maximum* includes your deductible and coinsurance. After you meet your out-of-pocket maximum, covered services will be paid at 100 percent of the allowable charge for the remainder of that benefit period. Please see the BlueSaver proposal presented by your producer for specific deductibles and out-of-pocket maximums quoted.

* In order to comply with federal and state regulations, deductibles and out-of-pocket maximums may have to be adjusted annually to reflect changes in the Consumer Price Index.

COVERED SERVICES INCLUDE, BUT ARE NOT LIMITED TO:
- hospital room and board and general nursing services
- use of an operating room, treatment room, recovery room and emergency room
- anesthesia and its administration
- laboratory tests
- oxygen and its administration
- diagnostic services such as radiology, laboratory and pathology services
- telemetry unit for heart patients or an isolation unit
- outpatient medical services rendered in the home, office or other outpatient visits for examination, diagnosis and treatment of an illness or injury, other than pre-operative and post-operative medical visits
- eligible organ, tissue and bone marrow transplants
- drugs and medicines
- intravenous injections and solutions
- transfusion fees and equipment
- medical and surgical supplies
- use of special care units

AND …
- blood, blood plasma, blood derivatives and blood processing
- prescription drugs and medicines for use outside the hospital
- outpatient private-duty nursing by a registered nurse or licensed practical nurse up to $5,000 per calendar year
- prosthetic appliances, durable medical equipment and orthotic devices
- licensed ambulance services for emergency transportation to or from the nearest hospital
- oral surgery benefits for accidental injury to sound natural teeth, extraction of impacted teeth and other services as listed in your benefit plan
- certain X-rays and laboratory tests performed in a doctor’s office or clinic
- a full list of state-mandated benefits

PLUS THESE DOCTOR EXPENSES:
- office visits for covered illness or injury
- surgeon’s and assistant surgeon’s fees
- consulting doctor’s fees
- laboratory and X-ray analysis
- anesthesiologist’s fees
- hospital visits by the doctor

PRESCRIPTION DRUG COVERAGE
After the deductible is met, BlueSaver provides coverage for the allowable charge for prescription drugs as follows:
- 100/80 coinsurance: generic = 100% / 0%, brand-name = 80% / 20%
- 80/60 coinsurance: generic = 80% / 20%, brand-name = 60% / 40%

Certain exclusions apply. See the Benefit Plan for a detailed listing.
PREVENTIVE AND WELLNESS CARE BENEFITS

Blue Cross and Blue Shield of Louisiana is committed to preventive medicine. To promote preventive care, a number of preventive and wellness care benefits are included with all BlueSaver options. Blue Cross pays 100 percent of the allowable charge, with no deductible applied, on the following services when rendered by a preferred provider.

- one routine physical exam per member per benefit period (calendar year)
- well baby care
- one routine mammography exam every 12 months or as ordered by the physician
- one digital rectal exam and prostate specific antigen (PSA) screening test per benefit period (age 50 and older), or more frequently if recommended by physician
- one routine gynecological exam per benefit period
- one hemoccult (colon) test per benefit period
- one routine Pap smear per benefit period
- immunizations as ordered by a physician
- one routine Pap smear per benefit period
- one routine mammography exam every 12 months, or as ordered by the physician
- autism Screening
- breast cancer screening
- cervical cancer screening
- depression (adults) screening
- HIV screening
- Lipid disorders (adults) screening
- Phenylketonuria (PKU) screening
- Type 2 Diabetes Mellitus (adults) screening
- visual impairment in children younger than age 5 years screening

PPO NETWORK

Choosing care from our PPO provider network has special advantages. This network, which includes hospitals, physicians, and other providers across the state, is a “preferred provider” system. The PPO network has earned national accreditation from the American Accreditation Healthcare Commission/Utilization Review Accreditation Committee, better known as URAC. When receiving covered services from PPO providers, your benefits are paid at a higher coinsurance level. Covered care outside the network is paid at a lower coinsurance level.
Quality healthcare coverage does not have to be expensive. Our HMO plan offers an attractive benefit plan with access to a quality network of physicians, hospitals and allied providers at minimal out-of-pocket expense.

**POINT OF SERVICE (POS) PLANS**

Our LADA Point of Service (POS) plan from Louisiana Blue Health Plans offers managed care with the power of choice. If you’re looking for health insurance with the affordability of an HMO, combined with the choices of traditional coverage, then our point of service plan is the product that’s right for you and your employees. POS delivers quality, cost-effective healthcare while maximizing your healthcare dollar.

The LADA POS 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 to ensure the highest level of benefits. 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. The LADA POS plan allows your employees to seek care outside of the network and still receive lower level benefits.

LADA members also enjoy freedom from paperwork hassles. When they see a physician in the HMO Louisiana network, they pay one copayment for covered services and that is all — no claims filing, no deductibles and no waiting for reimbursement checks. The network physicians submit all claims and handle authorizations, and our special managed care unit does the rest.
**Primary Care Physicians**

**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 visits to chiropractors, therapists (physical and occupational), speech therapists/pathologists, therapy assistants and federally qualified rural health clinics. Members may also visit network specialists without a referral from their PCP. A specialist copayment applies.

LADA POS members may also receive care outside the HMO Louisiana network and receive non-network benefits. If the member needs specialty care that is not available in the HMO Louisiana network, he or she must have an authorization from HMO Louisiana in order to receive network benefits. Otherwise, benefits will be paid at the lower non-network level. In most cases, a simple phone call from the PCP or specialist is all that is necessary. If a member is unsure whether or not an authorization is necessary, he or she should call our Customer Service Department.

To find a PCP or specialist, visit our website at [www.bcbsla.com](http://www.bcbsla.com), click on Find a Doctor or Hospital on the home page, then select Search our Directory.

**BENEFITS**

There are three levels of benefits for covered services: (1) network benefits, (2) non-network benefits, and (3) dependent out-of-area benefits for dependents living outside the service area.

**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.

**Non-Network Benefits**

Members who go to a doctor or hospital that is not in the HMO Louisiana network will receive non-network benefits, which will be paid at a lower level. There is a calendar-year deductible each year. Once the deductible is met, coinsurance percentage payments are shared between the member and HMO Louisiana. Once the member has reached the out-of-pocket maximum, the plan will pay 100 percent of the allowable charges for covered benefits.

**Dependent Out-of-Area Benefits**

For added convenience, HMO Louisiana offers a third 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 this coverage 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-pocket deductible. Once this deductible is met, coinsurance percentage payments are shared for covered services. Typically, HMO Louisiana pays 80 percent of allowable charges and the member pays 20 percent, up to the out-of-pocket limit. Please see page 18 and the quote sheet for the Mental and Nervous coverage and Alcohol and Drug Abuse benefits.

**PREVENTIVE CARE**

HMO Louisiana is committed to preventive care. Detecting illnesses in their earliest stages ensures better health for our members and reduces medical costs for everyone. To promote preventive care, POS covers a full array of wellness services.

**WELLNESS BENEFITS**

**Network**

The following benefits are included with all plans.

- one routine physical exam per benefit period (calendar year)
- well baby care
- one routine mammography exam every 12 months, or as ordered by the physician
- one routine digital rectal exam and prostate specific antigen (PSA) screening test per benefit period (age
50 or over or as recommended by the PCP)
- two routine gynecological exams per benefit period
- one routine hemoccult (colon) test per benefit period
- one routine Pap smear per benefit period
- immunizations as ordered by a physician
- one routine Pap smear per benefit period
- one routine mammography exam every 12 months, or as ordered by the physician
- autism Screening
- breast cancer screening
- cervical cancer screening
- depression (adults) screening
- HIV screening
- Lipid disorders (adults) screening
- Phenylketonuria (PKU) screening
- Type 2 Diabetes Mellitus (adults) screening
- visual impairment in children younger than age 5 years screening

**Non-Network**
Benefits are subject to the non-network deductible

### PRESCRIPTION DRUG PROGRAM

All LADA POS 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, safety, cost and pharmacoeconomic factors. The following example describes each tier and the copayment that applies.

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Description</th>
<th>Retail Copayment Example</th>
<th>Mail-Order Copayment Example</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>$7</td>
<td>$21</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Primarily brand-name drugs, although some generic drugs may fall into this tier</td>
<td>$25</td>
<td>$75</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Brand-name or generic prescription 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>$40</td>
<td>$120</td>
</tr>
<tr>
<td>Tier 4</td>
<td>A prescription drug that is a multi-source brand drug</td>
<td>$55</td>
<td>$165</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>$50</td>
<td>$150</td>
</tr>
</tbody>
</table>

and coinsurance:
- one routine mammography exam every 12 months or as ordered by the physician
- one routine digital rectal exam and prostate specific antigen (PSA) screening test per benefit period (age 50 and older or as recommended by the PCP)
- two routine gynecological exams per benefit period
- one routine hemoccult (colon) test per benefit period
- one routine Pap smear per benefit period
- immunizations

*deductible does not apply

**Dependent Out-Of-Area Coverage**

All items listed above for network benefits also are covered for members classified as out-of-area dependents subject to deductible and coinsurance amounts shown on the schedule of benefits. The deductible does not apply to PSA test, Pap smear or mammography exam.

**Mail-Order Pharmacy & Other 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.

**EMERGENCY CARE BENEFITS**

As always, in emergency situations the first priority is to seek treatment at the nearest facility. Members or their providers must submit a request for 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. Emergency inpatient admissions must be submitted for authorization by you or your provider within 48 hours of hospital entry by calling HMO Louisiana. When members visit an emergency room in the HMO Louisiana network, they are required to pay a copayment. If the emergency room visit results in an inpatient hospital admission, the emergency room copayment is waived.

**URGENT CARE BENEFITS**

Since our members occasionally need non-emergency medical care after hours, the LADA POS plan includes coverage for “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, stomach aches and nausea.

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 examination.

*Express Scripts, Inc. is an independent company, which serves as the pharmacy benefit manager for HMO Louisiana, Inc.*
Special Options & Features for all LADA Members

OWNER 24-HOUR COVERAGE
For the protection of employers, Blue Cross 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.

To qualify, company owners must:
• have legally opted to be excluded from Workers’ Compensation coverage for the group;
• provide Blue Cross with written verification of their exclusion from Workers’ Compensation coverage;
• provide Blue Cross with written verification of their ownership interest; and
• meet the eligibility requirements of the group.
Company owners must notify Blue Cross if they no longer meet these qualifications.

MENTAL DISORDERS/SUBSTANCE ABUSE TREATMENT
Coverage for mental disorders, substance abuse is the same as or better than any other illness. Coinsurance payments accrue to the out-of-pocket maximum.

ACCESS TO ACUTE CARE HOSPITAL NETWORK
Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. contract with most hospitals throughout the state. These member acute care hospitals will routinely file claims for you. Members also have access to a broad network of out-of-state hospitals contracting with other Cross and Shield Plans throughout the country. A 30 percent reduction in benefits will be applied for services received from non-network hospitals.

THE BLUECARD® PROGRAM
When our members travel, they take their healthcare benefits with them – across the country and around the world. The BlueCard® Program, offered exclusively to Cross and Shield members, features a global network of healthcare providers. BlueCard® is a national program that allows our members to receive healthcare services while traveling in another Blue Plan’s service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide, through a single electronic network. So our members have peace of mind knowing they’ll find the care they need if they get sick or injured on the road.

It’s easy for members to access a provider outside of their service area:
• They can visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com/coverage/bluecard; or
• Call the BlueCard Access line at 1.800.810.BLUE.

PREGNANCY CARE
Pregnancy care (for the policyholder and spouse) is usually included in all plans. Groups with fewer than 15 employees on the payroll can exclude pregnancy benefits, if desired. If a group’s number of employees reaches 15 or more, pregnancy care will automatically be added (as required by law). Specified pregnancy complications are covered regardless of whether the pregnancy option is chosen.

REHABILITATIVE CARE BENEFITS
Rehabilitative care is covered as a standard part of the benefit package. Regular coinsurance, deductible and out-of-pocket limits apply. See benefit plan for a complete list of covered services.

DUAL CHOICE OPTION
Certain LADA groups are eligible to select more than one product offering for their employees, such as GroupCare and BlueSaver. Please call your Blue Cross representative for details.

ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS
Eligible organ, tissue and bone marrow transplants are covered. Members have access to the Blue Quality Centers for Transplant, a network of major hospitals and research institutions located throughout the country. Patient care is coordinated with Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. case management, physicians and institutions. Eligible organ, tissue and bone marrow transplants will be covered up to including acquisition expenses. See the organ, tissue and bone marrow transplant section of your benefit plan for complete details and qualifications.
Customer Service

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

We constantly strive for an exceptional customer experience, with a goal of not just meeting, but exceeding customer expectations. If you have a question about your health plan, visit our website at www.bcbsla.com and click on the Answer Button.

- The Answer Button takes you to a portfolio of useful web-based tools for managing your account or researching medical conditions.
- Members whose employers have signed up for AccessBlue, our online self-service portal, can handle many routine customer service needs 24 hours a day, seven days a week.

You may also e-mail us any time at help@bcbsla.com. For telephone service, call us between 8 a.m. and 5 p.m., Monday through Friday, at 1.800.599.BLUE (2583), which is listed on the back of your ID card.

VALUE-ADDED SERVICES

Vision, Hearing and Dental Discount Network

Members can take advantage of special discounts on vision, hearing and dental services. Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. have contracted with certain providers to give members discounts on vision, hearing and dental services. Members simply present their ID card to one of the participating providers and immediately receive significant savings. Since these are discount programs only, there are no claim forms, no deductibles and no waiting for reimbursement! Please note that these services are not eligible for benefits under the benefit plan.

WalkingWorksSM

Walking works — in a lot of ways. A brisk-paced walk can help you and your family look and feel better, increase energy and even lower your risk for certain diseases. Log onto www.walkingworks.com to learn how you can set your own walking goal and get a pedometer to help you meet it. You can start tracking your progress today!

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 to 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 it affects 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.
Our team of doctors, nurses and in-house pharmacists oversees our members’ care through the following functions:

**AUTHORIZATION OF ELECTIVE ADMISSIONS**

If you need to be hospitalized for a condition other than an emergency, your admission to the hospital requires “authorization,” which must be obtained before you are admitted. 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. In the case of an emergency admission, authorization must be requested within 48 hours of the admission by you or your provider.

**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 hospital stay. Our Care Management Department works directly with the patient, the hospital and the admitting physician to assess the continued necessity of hospitalization. If a patient chooses to stay in the hospital after it is determined to be unnecessary, he or she may be responsible for all expenses incurred during the remainder of the stay.

**CASE MANAGEMENT**

Case Management is a special service performed at the discretion of our company. Case Management oversees the treatment of unusually complex, difficult or lengthy illness. 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. Our Case Management program is accredited by URAC (the American Accreditation HealthCare Commission). This mark of distinction is viewed as a benchmark for quality among managed care organizations and makes us one of the first Blue Cross plans in the nation to receive this accreditation.

**LADA / LADIT Plans**

*Care Management programs that ensure your care is appropriate.*
AUTHORIZATION OF COVERED SERVICES

Certain services, drugs and visits to certain providers require authorization from Blue Cross or HMO Louisiana, Inc. before they can be obtained. The authorization process allows our medical staff to review a procedure or service and determine whether it is in the best interest of the patient. Please see your benefit plan and Schedule of Benefits for a list of procedures, services and supplies that require authorization.

RETROSPECTIVE REVIEW

A retrospective review may be performed to assess the medical need for services that have already been rendered.

HEALTH AND WELLNESS

Because prevention is key in keeping LADA / LADIT members healthy, the Health and Quality Management component of our program sponsors wellness activities such as health events, preventive health screening services and member education. We use systems and decision support tools that identify eligible members for specific healthcare programs, which are often referred to as Disease Management Programs, such as respiratory health, diabetes and hepatitis C. The programs include identification of and communication with members with these long-term, chronic illnesses. Members receive educational materials and interventions that promote maintenance of their wellness. Members in need of direct nurse intervention are referred to our Case Management program. Other ongoing health education and wellness initiatives include:

- Quarterly member newsletters that feature preventive health services reminders, healthy living articles, healthy recipes and lifestyle articles
- Reminder calls and letters to individual members for screening services
- Active participation in the Louisiana Childhood Immunization Coalition
General Conditions

**ELIGIBLE GROUPS**

PPO, BlueSaver, trueBLUE and Point of Service plan options with Association rates are available to companies that are members of the Louisiana Automobile Dealers Association. Coverage can, however, be sold to a non-LADA/LADIT member who agrees to become a member by the time of enrollment.

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 and approval. 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 where employees pay part of the premium, at least 75 percent (60 percent with spouse-elsewhere credit) of its full-time eligible employees must participate. If the employer pays 100 percent of the premium, then 100 percent of the eligible, full-time employees are required to participate. These percentage requirements are for the initial and ongoing enrollment. Other specific conditions that may apply are contained within the group master application or the company’s underwriting guidelines.

**ELIGIBLE EMPLOYEES**

All full-time employees working a minimum of 30 hours per week and their qualified dependents may apply. Individuals on retainer (such as attorneys, accountants, business consultants and 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 Blue Cross, they will be used for group premium, case management or reinsurance purposes.

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. Grandchildren to be eligible they also must reside with and be in legal custody of the employee.

Children and grandchildren (in legal custody of and residing with the employee) who are mentally or physically disabled also are eligible for coverage. They must be incapable of self-support prior to attaining either of the limiting ages stated above.

See benefit plan for details on other dependents who may qualify.

GROUP RATES

Initial rates are guaranteed for 12 months. At the end of the rating period, a group’s rates may be adjusted due to factors including:

• 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

RENEWABILITY

All benefit plans are renewable at the employer’s option, except in the cases of:

• non-payment of premium
• fraud or misrepresentation
• non-compliance with plan provisions, including not meeting minimum participation and eligibility requirements
• non-renewal of LADIT membership
• termination of all employer plans in that class of business (90 days advance notice will be given)

The employer, Blue Cross and Blue Shield of Louisiana, or HMO Louisiana, Inc. may terminate the contract with 60 days advance notice.

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, applicant employees 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 within 30 days prior to the group’s anniversary date and must answer all health questions on the employee application form. These questions will not be used to reject the application.

SPECIAL ENROLLMENT

In certain circumstances, an employee may enroll himself/herself, 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). Apply for coverage during the group’s open enrollment period within 30 days prior to the group’s anniversary date.

PREF-XISTING 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.

PREF-XISTING 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 (60 days for mental disorders)
• new-hire enrollees if application is received when first eligible – 180-day exclusion period (60 days for mental disorders)
• special enrollees – 180-day exclusion period (60 days for mental disorders)
• late enrollees – 18-month exclusion period (60 days for mental disorders)

PREF-XISTING CONDITION EXCLUSIONS DO NOT APPLY TO:
• newborns, provided a complete request for enrollment is received in the home office within 30 days of the birth, or 180 days of birth if policy covers older children;
• adopted children, provided a complete request for enrollment is received in the home office within 30 days of adoption or placement of adoption; or
• pregnancy
• anyone under 19 years of age

BENEFIT PLAN LIMITATIONS AND EXCLUSIONS

Limitations and exclusions include charges exceeding the allowable charge, investigational treatments, sales tax (excluding covered prescription drugs) or interest, infertility treatments, cosmetic surgery or treatment, weight reduction programs, eyeglasses or lenses, contact lenses, correction for refractive errors of the eyes, fertility drugs, treatment of impotence, custodial care, and services that are not medically necessary. Other limitations and exclusions are described in the benefit plan.

PRIOR CREDITABLE COVERAGE

Credit will be given for all or part of the pre-existing condition exclusion period if proof of prior creditable coverage is provided. This credit will apply when the other eligible creditable coverage was in force within 63 days prior to the member’s effective date under this coverage.