Group Point of Service Plan

community BLUE
Baton Rouge

HMO Louisiana, Inc.

A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.

01100 01207 10//11R Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

WHAT'S INSIDE

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 and HMO Louisiana, Inc., as the maximum amount allowed for all provider services covered under the terms of the benefit plan.

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 those 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 phone number on the back of your ID card.

WELCOME TO COMMUNITY BLUE!

Community Blue POS – Quality Patient-Centered Care

HMO Louisiana, Inc. is proud to present Community Blue – our innovative point-of-service plan with a very selective network of providers.

When you choose Community Blue, you're choosing a plan that saves you money over our traditional plans. Community Blue plans are for people who value quality, wellness, preventive care and personal accountability – all of which can save you money on healthcare.

HOW IS COMMUNITY BLUE DIFFERENT?

Community Blue plans are built around an innovative way of delivering healthcare that's sometimes called the "medical home" or "patient-centered medical home." This simply means you have a special network and a dedicated health support team providing care centered on you – the patient. You get high-quality coordinated care delivered by doctors in the Community Blue network. Your needs and preferences come first, and you have a voice in your care options.

Coordinated care also means that Community Blue doctors take a shared and efficient approach to your care. Your doctors can easily see full medical history through electronic medical records. This leads to smarter, more thorough diagnoses and better outcomes for you. Your doctors also will help you make the best decisions for your care.

DEDICATED NETWORK OF QUALITY PROVIDERS

Members choose a Primary Care Physician (PCP) to deliver and coordinate their care within the Community Blue network. The PCP will refer members to specialists, file claims and authorize any special care or services required. If the member does not choose a PCP, we will assign one for the member.

What is coordinated care?

When you choose a coordinated care plan like Community Blue, you're choosing to work with a smaller group of doctors for your health needs. This "narrow network" helps to make sure that your doctors meet all of your needs and preferences. You get better, higher quality care, even when you move from doctor to doctor.

Your Primary Care Physician (PCP)

A PCP is the most important member of your health support team. When applying for Community Blue, you'll need to select a PCP in your network.

Your PCP will:

- **Stay up to date on your health history**
- **Maintain your health records**
- **Provide basic care and prescribe medicine when you need it**
- **Help you make the best choices about your health and healthcare**
- **Send you to a specialist when needed to help coordinate your care**
- **Help keep your health costs low**

BENEFITS

NETWORK BENEFITS

Staying in your Community Blue network is very important. Because you've chosen a "narrow network" of doctors, your benefits are maximized when you see those doctors. *You will spend much more money when you go out of network.*

As a Community Blue member, you don't need to file any claims. Your network doctor or other network healthcare provider will file claims for you. You will only be responsible for copayments, coinsurance and your deductible (if it applies to you).

Community Blue doctors have agreed to:

- Accept your copayment, coinsurance or deductible (when they apply) PLUS a payment from HMO Louisiana as payment-in-full for services covered by your plan. In other words, you won't be **billed for the balance**.
- Take part in cost-saving programs that ensure your care is the highest quality, but comes at a reasonable price.

What is balance billing?

For the services covered by your plan, we have negotiated rates with doctors and other healthcare providers in your network. What we have agreed to pay is called the "allowable charge."

When you go outside of the network, you're not protected by these negotiated rates. The doctor you see might decide to bill you for more than your plan pays. **You will be responsible for paying that bill.**

OUT-OF-NETWORK BENEFITS

When you visit a doctor or hospital that is not in the Community Blue network, you will receive low-level benefits. In other words, your plan will pay for your care at a lower level. You can expect to pay much more out of pocket if you go out of the Community Blue network.

You must meet an annual deductible (an amount you must pay out-of-pocket every year) for services you get outside of your Community Blue network. Once you meet your deductible, you will pay coinsurance (a percentage of your healthcare costs). HMO Louisiana will share part of your coinsurance payments. If you reach your out-of-pocket maximum, HMO Louisiana will pay 100 percent of the allowable charges for covered services for the rest of the calendar year.

What to expect when you go out of your network:

- Your HMO Louisiana benefit payment for covered services may be reduced.
- You may be responsible for paying your doctor or other healthcare provider for all charges.
- You may have to pay the difference between what your plan pays and what you may be charged.
- You may need to file your own claims.

BENEFITS *(continued)*

DEPENDENT OUT-OF-AREA BENEFITS

For added convenience, Community Blue offers a third benefit level for members with dependents living outside of the designated service area. If a member wants to add dependent out-of-area benefits 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 nationwide. These out-of-area members have an out-of-area deductible. Once this deductible is met, coinsurance percentage payments are shared for covered services. HMO Louisiana pays 80 percent of allowable charges and the member pays 20 percent, up to the out-of-pocket limit. Wellness benefits are covered at 100 percent.

URGENT CARE BENEFITS

Sometimes members need non-emergency medical care after hours. This is referred to as "urgent care." Urgent care is needed for a sudden, acute and unexpected medical condition that requires timely diagnosis or treatment, but does not pose an immediate threat to life or limb. Some examples of urgent care situations are:

- Ear infections
- Sprains
- Stomach aches
- Colds and flu
- Nausea
- Minor burns

When a member visits an urgent care center in the Community Blue network, a $60 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 wellness care.

EMERGENCY CARE BENEFITS

As always, in emergency situations the first priority is to seek treatment at the nearest facility. An emergency medical condition, as defined by state law, is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

1) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;
2) Serious impairment to bodily function;
3) Serious dysfunction of any bodily organ or part.

Some examples of emergencies are:

- Severe bleeding
- Chest pains
- Poisonings
- Stroke
- Convulsions
- Burns
- Choking

When a member visits an emergency room, he or she is required to pay a copayment. If the visit results in an inpatient admission, the emergency room copayment is waived. Providers 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.

HOSPITAL ADMISSIONS FROM THE EMERGENCY ROOM

If a member is admitted to the hospital from the emergency room, network benefits will apply if the hospital is in the Community Blue network. If the hospital is not in the Community Blue network, low-level benefits will apply if the member was stable at the time of admission. If the member was not stable at the time of admission, high-level benefits will apply, but the member may be required to move to a Community Blue network hospital once he or she is stable, or be subject to a $500 daily penalty.

HOSPITAL AUTHORIZATION FOR PLANNED INPATIENT STAYS

As long as you are hospitalized at your Community Blue hospital, you don't need to arrange **prior authorization** for your stay. The hospital staff will handle this for you. If you're planning an inpatient stay, your Community Blue hospital will get authorization before you check in.

Always check with your health support team that they've received authorization for your hospital stay.

If you choose a hospital other than a Community Blue hospital, you are responsible for getting prior authorization before a planned inpatient stay, or within two business days after an emergency admission. You will not receive the full coverage that you would at a Community Blue hospital. For questions, call 1-800-495-2583.

Prior authorization

To make sure you are getting the right care from a healthcare provider, we sometimes ask for prior authorization.

When you have prior authorization, you know what you can expect to pay. Also, you can rest assured that your plan will cover your care.

LAB SERVICES

The Community Blue plan has a restricted laboratory network. You will receive high-level benefits when your lab work is performed by your network doctor or hospital. Low-level benefits will apply if:

- you receive lab work from a provider who is not in the network; or
- your out-of-network provider sends your lab work to a laboratory that is not in the Community Blue network.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Mental and nervous/substance abuse benefits will be treated the same as, or better than, any other illness. All mental health and substance abuse benefits are provided through Magellan Behavioral Health, which is an independent company providing mental health services for HMO Louisiana, Inc.

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. Community Blue provides coverage through a select group of network pharmacies.

Two methods are available for filling prescriptions:

1. Simply present the Community Blue ID card and a valid prescription to a network pharmacy. No claim forms are necessary, and there is no waiting for reimbursement checks. For participating retail pharmacies, the copayment covers up to a 30-day supply at the maximum amount allowed by your plan. 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 maximum amount allowed by your plan.

COPAYMENTS

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

The example below describes each tier and the copayment that applies. Because this product focuses on high quality and low cost, we encourage members to buy generic drugs when possible. When a member or his physician requests a brand-name drug when a generic equivalent exists, they will pay the $7 generic copayment plus the difference in cost between the generic and brand drug.

ADVANCED FEATURES

Mail-Order Pharmacy System

Our program's national mail-order pharmacy system, Express Scripts, offers the most advanced data processing and

TIER LEVEL	DESCRIPTION	RETAIL COPAYMENT *(up to 30-day supply)*	MAIL-ORDER COPAYMENT *(up to 90-day supply)*
Tier 1	Value drugs (low-cost generic drugs may include some low-cost brand-name drugs)**	$7	$21
Tier 2	Primarily brand-name drugs, although some generic drugs may fall into this tier	$30	$90
Tier 3	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 as well as multi-source brand drugs	$70	$210
Tier 4	Specialty drugs - biotechnology medications or other drug products that often require special ordering, handling, patient education and/or customer service	10% up to $100	Not Available

Prescription drug deductibles available: $0, $100 or $250 per calendar year

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

*** Copayment waived for certain generic drugs used to treat certain chronic conditions.*

dispensing system in the industry. It features rapid at-home prescription delivery, toll-free 24-hour telephone 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.

PHARMACY NETWORK

Our prescription drug program includes select network 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 network pharmacy, less the applicable copayment. Members may have to pay the balance above the allowable charge at non-participating pharmacies.

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

SPECIALTY PHARMACY NETWORK

Community Blue 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.

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.

QUANTITY PER DISPENSING (QPD) LIMITATIONS AND 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 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
- drugs for sexual dysfunction

Please refer to the benefit plan for a complete list of limitations and exclusions.

PREVENTIVE AND WELLNESS BENEFITS

Community Blue is committed to preventive care. Detecting illnesses in their earliest stages helps ensure better health for our members and reduces medical costs. To promote preventive care, Community Blue covers a wide range of wellness services.

When members go to a provider in the Community Blue network, the following benefits are fully covered with no copayments or deductibles.

If a member goes to a provider that is not in the Community Blue network, deductible and/or coinsurance will apply.

SERVICE	FREQUENCY LIMIT	AGE LIMIT
Routine physical exam	No limit	No limit
Pap Smear	One per year	No limit
Prostate-specific antigen (PSA) test	No limit	No limit
Routine mammogram, if recommended by a physician	One per year	No limit
Immunizations recommended by a physician	No limit	No limit
Well-baby care for dependent children	No limit	Up to age 24 months
Colonoscopy for adult men and women	One every 10 years	Ages 50 – 75
Asymptomatic bacteriuria for pregnant women	No limit	No limit
Congenital hypothyroidism screening	No limit	Newborns less than age 1
Chlamydial and gonorrhea screenings for women	One per year	No limit
Hearing screening	One per year	Ages 0 – 21
Hepatitis B virus infection screening for pregnant women	No limit	No limit
HIV screening	No limit	No limit
Lipid disorders screening in adults	No limit	No limit
Osteoporosis screening in postmenopausal women	One per year	Age 60 and older
Sickle cell disease screening	No limit	Newborns less than age 1
Syphilis infection screening	One per year	No limit
Type 2 diabetes mellitus screening in adults	No limit	No limit
Visual impairment screening	One per year	Ages 0 – 21
Lead screening	One per year	Ages 0 – 6
Developmental screenings	No limit	Ages 0 – 3
Autism screenings	No limit	Ages 1 – 2
Tuberculosis screening	One per year	Ages 0 – 21

· Subject to age requirement limits for certain preventive services.
· Effective at the first plan renewal on or after October 1, 2010, for Non-Grandfathered plans only.
· Benefits indicated for pregnant women available only if member has pregnancy benefits.

CARE MANAGEMENT PROGRAMS

Our in-house medical team of doctors, pharmacists and nurses provide wellness and preventive services for healthy customers and Disease Management programs for those who experience chronic illness.

CASE MANAGEMENT

Through our case management program, we assess, plan and assist with options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. We help by:

- Resolving barriers to achieve most favorable outcome
- Assisting with coordination of complex treatment plans
- Screening members for behavioral health issues
- Addressing medical necessity issues
- Supporting the member with the healthcare team
- Providing health information to members for informed decision-making

DISEASE MANAGEMENT

Our Disease Management Programs work to improve the healthcare of members with diabetes or heart failure by discovering chronic conditions earlier. We work with members to slow down their diseases and decrease problems. **Community Blue features five disease management programs to help members learn to better manage their conditions through support, information and medication management. Conditions include Asthma, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, Heart Disease and Diabetes.** These programs also follow guidelines suggested by the American Heart Association, the American College of Cardiology and the American Diabetes Association.

In addition to improving the quality of health for our members through these programs, Community Blue also offers certain generic medications used to treat these conditions at no extra charge to members.

UTILIZATION REVIEW

Our comprehensive approach ensures that members receive necessary care without unnecessary exposure to risks when applicable. We use evidence-based clinical criteria to reduce unjustified variation in care, which:

- Decreases differences
- Reduces gaps in knowledge
- Improves quality
- Supports evidence-based decision making
- Reduces gaps in knowledge
- Improves quality
- Supports evidence-based decision making

Key Differences Between Case Management and Disease Management

Case Management focuses on one individual to maximize health outcome - its duration is usually shorter and associated with a single episode of illness.

Disease Management tries to improve the health of an entire population with a certain condition - participation lasts two years or longer to make lifestyle changes and then sustain the change over time.

Case Management and Disease Management
1.800.317.2299

COMMUNITY BLUE GROUP PLANS

COVERED BENEFITS	PROVIDED IN THE COMMUNITY BLUE NETWORK		
	Plan 1	**Plan 2**	**Plan 3**
Calendar-Year Deductible (Family Aggregate)	$500 Individual $1,500 Family	$750 Individual $2,250 Family	$750 Individual $2,250 Family
Out-of-Pocket Calendar Year Maximum (Excludes Deductible) (Family Aggregate)	$2,500 Individual $5,000 Family	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
OFFICE VISITS			
Office Visits	$25 Co-pay Per Visit	$25 Co-pay Per Visit	$35 Co-pay Per Visit
Specialist Office Visits	$40 Co-pay Per Visit	$40 Co-pay Per Visit	$50 Co-pay Per Visit
Vision Care	Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)
Lab and Low Tech Imaging (Incl. Independent Lab or Free-standing Imaging) ***Note: Restricted Lab In-Network***	100%	100%	100%
High Tech Imaging Services (Incl. Free-standing Imaging)	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
PREVENTIVE AND WELLNESS CARE (PPACA Required Benefits)**			
Office Visits	No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%
Lab and X-ray	No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%
OUTPATIENT SERVICES PERFORMED AT AN OUTPATIENT FACILITY AND ASCs			
Facility Charges and Professional Services	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
Lab, Low and High-tech Imaging	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
INPATIENT SERVICES			
Hospital***	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
Inpatient Rehabilitation	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
MENTAL HEALTH and SUBSTANCE ABUSE SERVICES			
Office Visit	$25 Co-pay Per Visit	$25 Co-pay Per Visit	$35 Co-pay Per Visit
Inpatient	No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%
Outpatient	No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%
BENEFITS THAT REQUIRE AUTHORIZATION (does not include list of outpatient services or drugs requiring authorization)			
Organ and Tissue Transplants	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
Skilled Nursing Facility (90 day Maximum Per Calendar Year	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
Home Health (60 Visit Max Per Calendar Year)	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
Hospice (180 Day Max Per Calendar Year)	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*
OTHER COVERED SERVICES			
Prenatal Visits and Delivery (Optional for Grps with 14 employees or less)	Specialist Co-pay Per Pregnancy in addition to the Inpatient Hospital Deductible and Coinsurance for any related hospitalization		
Emergency Room	$350 Co-pay Visit Waived if Admitted	$350 Co-pay Visit Waived if Admitted	$350 Co-pay Visit Waived if Admitted
Rehabilitative Speech Therapy – Excludes Inpatient	$25 Co-pay Per Visit	$25 Co-pay Per Visit	$35 Co-pay Per Visit
Physical/Occupational Therapy – Excludes Inpatient	$25 Co-pay Per Visit	$25 Co-pay Per Visit	$35 Co-pay Per Visit
Urgent Care Center	$60 Co-pay Per Visit	$60 Co-pay Per Visit	$60 Co-pay Per Visit
Ambulance	$50 Co-pay Per Day Per Provider	$50 Co-pay Per Day Per Provider	$50 Co-pay Per Day Per Provider

This is only an outline. All benefits are subject to the terms and conditions of the contract. In the case of a discrepancy, the contract will prevail. All benefits based on Allowable Charges. In-Network and Out-of-Network Deductible and Out-of-Pocket Amounts do not integrate.

COMPARISON CHART

PROVIDED IN THE COMMUNITY BLUE NETWORK			OUT-OF-NETWORK	DEPENDENT OUT-OF-AREA
Plan 4	Plan 5	Plan 6	All Plans	
$1,000 Individual $3,000 Family	$1,000 Individual $3,000 Family	$1,500 Individual $4,500 Family	$5,000 Individual $10,000 Family	$250 Individual $750 Family
$3,500 Individual $7,000 Family	$3,500 Individual $7,000 Family	$4,000 Individual / $8,000 Family	$10,000 Individual $15,000 Family	$1,000 Individual $3,000 Family
$30 Co-pay Per Visit	$40 Co-pay Per Visit	$40 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$45 Co-pay Per Visit	$55 Co-pay Per Visit	$55 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)	Specialist Co-pay (1 Every 24 Mos.)
100%	100%	100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%	Deductible then 60/40 Coinsurance*	100%
No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%	Deductible then 60/40 Coinsurance*	100%
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$30 Co-pay Per Visit	$40 Co-pay Per Visit	$40 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
No Co-pay, 100%	No Co-pay, 100%	No Co-pay, 100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Not Available	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Specialist Co-pay Per Pregnancy in addition to the Inpatient Hospital Deductible and Coinsurance for any related hospitalization			Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$350 Co-pay Visit Waived if Admitted	$350 Co-pay Visit Waived if Admitted	$350 Co-pay Visit Waived if Admitted	$350 Co-pay Visit Waived if Admitted	Deductible then 80/20 Coinsurance*
$30 Co-pay Per Visit	$40 Co-pay Per Visit	$40 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$30 Co-pay Per Visit	$40 Co-pay Per Visit	$40 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$60 Co-pay Per Visit	$60 Co-pay Per Visit	$60 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
$50 Co-pay Per Day Per Provider	$50 Co-pay Per Day Per Provider	$50 Co-pay Per Day Per Provider	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*

** Coinsurance accrues to the Out-of-Pocket Maximum ** Patient Protection and Affordable Care Act *** If admitted to a non-Community Blue Hospital, through the Emergency Room, member may incur a daily penalty if he chooses to stay at the facility once stabilized. Member may incur a reduction in benefits for obtaining care at a non-Community Blue Hospital. A penalty may apply when a Hospital Admission is not Authorized as required.*

OTHER FEATURES

OWNER 24-HOUR COVERAGE

For the protection of employers, Community Blue 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 ultrasounds, 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. Miscarriages and ectopic pregnancies are covered for all members regardless of whether the pregnancy option is chosen.

Please see the quote sheet for option(s) quoted.

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 Community Blue case management, physicians and institutions. Eligible organ, tissue and bone marrow transplants include covered acquisition expenses. See the organ, tissue and bone marrow transplant section of the benefit plan for complete details and qualifications.

CARE AWAY FROM HOME

Community Blue 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 Community Blue 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, call HMO Louisiana Customer Service at 1.800.495.2583 or visit www.bcbs.com/coverage/bluecard.

ONLINE TOOLS

MY ACCOUNT

Our members want more ways to manage their health information. That's why we offer password-protected online tools that allow you to review and manage your healthcare information 24 hours a day, seven days a week.

To register your online account, go to www.bcbsla.com and click LOG IN for instructions on how to register. If you need help registering or logging in, call the 24-hour support line at **1.800.821.2753**.

Your online account tools help you manage your health with access to claims activity, online health records, health education, treatment options, wellness programs and discounts.

CLAIMS REVIEW

See your latest plan activity or search past claims on the Review Claims screen:

- View your claims and the claims of covered dependents under 18.
- Easily see your costs in the highlighted columns.
- Search past claims by date, provider, etc.
- See claims payment status.

ONLINE HEALTH RECORDS

Use our free online health records to track your health history and to give new healthcare providers insight into your past care.

Personal Health Record

This free tool is an easy, secure way to keep track of your past conditions and treatments, as well as medications and emergency contact information.

Blue Health Record

Your Blue Health Record provides a quick three-year summary of your medical care, based on claims and organized by episode of care.

HEALTH EDUCATION

It's important to understand your health and stay informed about ways to improve it. When you click on Healthcare Advisor*, you can:

- Learn what questions to ask your doctor.
- Research health topics.
- Read health news and alerts.
- Use wellness calculators.
- Look up common treatments.

*Healthcare Advisor is powered by WebMD Health Services, an independent company that provides information on coverage and health topics for Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.

TREATMENT OPTIONS

When you visit Healthcare Advisor, you will also find tools to help you choose the best hospital for your needs and estimate the cost of your treatment.

Choose the Treatment Options menu item to:

- Estimate costs for hundreds of common conditions, procedures, tests and healthcare visits.
- Find hospital facilities that are best for your situation and condition.

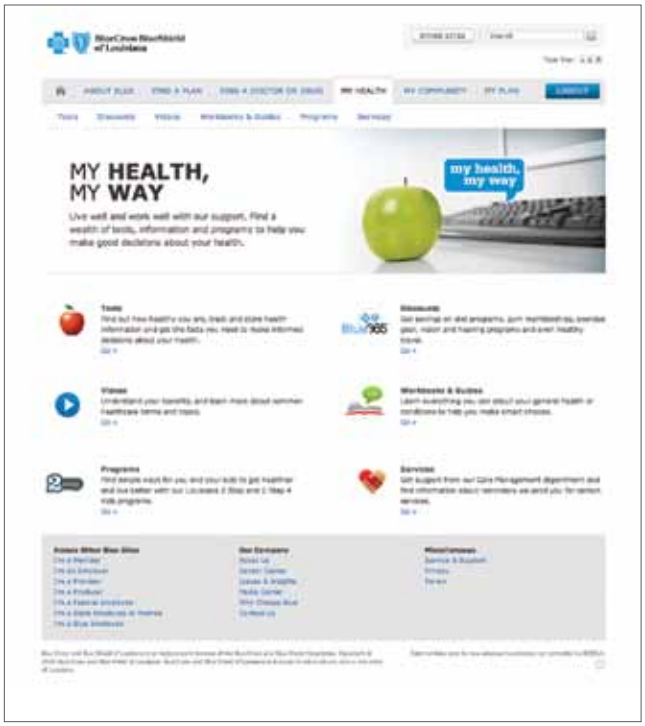
WELLNESS PROGRAMS

MY HEALTH, MY WAY

Good health begins with our My Health, My Way wellness program, which includes:

- A Personalized Health Assessment (PHA) to help you learn more about your health status and ways to address health risks.
- Interactive tools that let you track your weight, exercise and food intake.
- Fitness and nutrition plans that can be customized for you and your family.
- Online videos on topics such as back care, nutrition, smoking cessation, stress management and weight management.
- Exclusive access to a national program, Blue 365®, providing discounts and savings on fitness club memberships, nutrition programs and products, financial well-being services, family care services and healthy travel. You can even save on elective procedures for vision and hearing.
- It's all secure, confidental and at no extra charge to you!

Find out more at www.bcbsla.com under Health & Wellness Tools.



LOUISIANA 2 STEP

Louisiana ranks high in the nation in adult obesity and in deaths from diabetes. These are some of the reasons why Blue Cross created the Louisiana 2 Step, a statewide public health education campaign to encourage all Louisianians to *eat right* and *move more.*

The award-winning interactive website at www.Louisiana2Step.com and the fun companion site at www.2Step4Kids.com communicate this message in age-appropriate formats. The 2 Step can also support your My Health, My Way wellness goals.

Security and Confidentiality: *The Personal Health Assessment has been engineered to provide the same level of protection for your confidential health information that online banking and consumer websites offer their clients and account-holders. If you are identified as someone who may benefit from Care Management Services, your information may be shared with medical personnel, and you may be contacted by a Care Management nurse.*

The information you provide in the PHA will be used only as permitted by law. This information will not adversely affect your enrollment in your health plan.

DISCOUNT NETWORKS

Blue365®

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. Blue Cross members enjoy special discounts on many services.

Blue365 is a national program that's part of every 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. Members can also save 40 to 50 percent off the overall national average price for Lasik surgery through QualSight LASIK.

Financial Health

- Save 25 percent on federal tax preparation when you prepare your own taxes with H&R Block At Home™. With H&R Block At Home online solutions, you can do your own taxes by following the simple, step-by-step Q&A that searches for hundreds of deductions to help you receive the maximum refund!

Family Care

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

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 these healthy choices after logging in *My Account* at www.bcbsla.com/ogb. Just click My Health, then Wellness Discounts.

DENTAL DISCOUNT NETWORK

Members can take advantage of special discounts on dental services by simply presenting their ID card to a participating provider and immediately receiving significant savings. To find a dental discount provider, visit www.bcbsla.com.

GENERAL CONDITIONS

- *Eligible Groups*
- *Eligible Employees*
- *Eligible Dependents*
- *Group Rates*
- *Renewability*
- *Coordination of Benefits*
- *Health Questions*
- *Prior Group Coverage*
- *Special Enrollment*
- *Late Enrollee*
- *Pre-Existing Condition Exclusions*
- *Benefit Plan Limitations and Exclusions*

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.

Groups must be domiciled in East Baton Rouge, West Baton Rouge and Ascension parishes.

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 to set group premiums or for 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 for persons 19 and older.

ELIGIBLE DEPENDENTS

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

Unmarried 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 age 26.

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.

RENEWABILITY

All benefit plans are renewable at the employer's option. 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.

PRIOR GROUP COVERAGE

When the employer is replacing another group insurer, HMO Louisiana adheres to all replacement requirements. Credit will be given for any time served toward a waiting period for pre-existing conditions. This applies to employees listed on the current invoice of the previous insurer. If an employee declines coverage for himself/herself, spouse or dependent child(ren) because of certain other health insurance coverage, he/she may in the future be able to enroll himself/herself, spouse or dependent child(ren) in this health plan, provided that a complete request for enrollment is received within 30 days after the other coverage ends. In addition, if an employee gains a new dependent as a result of marriage, birth, adoption or placement for adoption, he/she may be able to enroll himself/herself, spouse and dependent child(ren) in this plan, provided a complete request for enrollment is received within 30 days after marriage or within 30 days after birth, adoption or placement of adoption.

GENERAL CONDITIONS *(continued)*

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 within 30 days prior to the group's anniversary date, but will have an 18-month exclusion for pre-existing conditions.

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 (except on covered prescription drugs)
- interest
- infertility treatments
- cosmetic surgery or treatment
- corrective eyeglasses or lenses
- contact lenses
- fertility drugs
- treatment of impotence
- custodial care and services that are not medically necessary

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 and subject to prior creditable coverage:

- 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

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;
- adopted children, provided a complete request for enrollment is received within 30 days of adoption or placement of adoption; or
- pregnancy, if pregnancy benefits are applicable.
- dependents under the age of 19.

CUSTOMER SERVICE

CUSTOMER SERVICE INFORMATION

We are committed to your satisfaction and are always open to your comments and suggestions. If you have any questions or complaints about your health benefits plan, please let us know. Call one of our Customer Service representatives or visit our website at www.bcbsla.com and submit your question on our secure online Customer Inquiry Form. Click on Customer, then choose Customer Inquiry Form and follow the directions.

YOUR PROVIDER DIRECTORY

Please refer to your Community Blue Provider Directory to find doctors and other healthcare providers in your network. It also has important information about your responsibilities as a Community Blue member.

For specific information about your health benefits plan, please read your contract and Schedule of Benefits. Customer Service representatives are also available to help you with any questions you may have at **1 (800) 495-BLUE (2583) or (225) 293-BLUE (2583)**.

Our network is always changing. To get the most up-to-date listing of Community Blue providers, visit **www.bcbsla.com** and click **Find a doctor or a drug** to search our online directory.

Get the most up-to-date directory
Visit www.bcbsla.com and click Find a doctor or a drug to search our online directory. We update our online directory every day.

You can also download the **Blue Cross Hospital and Doctor Finder App** for Apple mobile devices (such as an iPhone or iPad) from the App Store. Keep your network in the palm of your hand!

community BLUE
Baton Rouge

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 MENU OF 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 such as deductibles, coinsurance and non-covered items
- Access account 24/7 to check account balances, claim status, submit questions and review qualified medical expenses

EMPLOYER MENU OF 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

MENU OF 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 an employee 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

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

HELPFUL TIPS FOR COMMUNITY BLUE MEMBERS

Always make sure that your doctor or healthcare provider is in your network by calling Customer Service at 1 (800) 495-BLUE (2583) or (225) 293-BLUE (2583).

Visit www.bcbsla.com and click Find a doctor or a drug to search our online directory. We update our online directory every day.

HMO Louisiana, Inc.
5525 Reitz Ave.
Baton Rouge, LA 70816
www.bcbsla.com

Customer Service
1 (800) 495-BLUE (2583)
(225) 293-BLUE (2583)
Available Monday through Friday, 8 a.m. to 5 p.m.

CHECKLIST FOR GETTING CARE

Remember these important points to get the most out of your Community Blue benefit plan and help you avoid costly mistakes:

✓	Community Blue has a restricted network of doctors, hospitals, labs and pharmacies. **You must stay in this network** or you could pay significantly more for your care.
✓	Always **confirm that your provider participates** in the Community Blue network before you receive healthcare services.
✓	If you are hospitalized following an ER visit and the hospital is not in the Community Blue network, once your condition is stable you must move to a Community Blue hospital or **you will pay $500 per day in penalties.**
✓	**Choose generic drugs when you can.** If you choose a brand-name drug when a generic equivalent exists, you will pay the difference in cost.
✓	If you have a chronic condition such as asthma, COPD, coronary heart disease, heart failure or diabetes and participate in one of our disease management programs, **you have access to free value drugs.**
✓	**Community Blue has a restricted lab network.** Be sure to have your lab work performed and analyzed at a Community Blue facility.
✓	**Do not file your own claim.** Doctors and other healthcare providers will file the claim for you. If you are given a receipt or a copy of the claim, keep it for your records.
✓	Let your doctor and hospital know that **your health benefit plan requires your hospital admissions to be authorized.**
✓	**Go to your Primary Care Physician for your care first**, then go to an urgent care clinic or emergency room only if needed.
✓	Providers with multiple locations may not participate at all locations. You should always **verify your provider's participation** by calling the Customer Service number on your member ID card.
✓	Some hospital-based physicians may not be in the Community Blue network. Visit **www.bcbsla.com/hbp** for more information on facility-based physicians.

CUSTOMER SERVICE

BATON ROUGE

225.293.0625

800.495.2583

help@bcbsla.com

5525 Reitz Avenue
Baton Rouge, Louisiana 70809-3802

community BLUE

HMO Louisiana, Inc.

A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.