Louisiana

HMO Louisiana

INDIVIDUAL MEMBER ENROLLMENT GUIDE

01MK6709 R01/19

Louisiana

APPLICATION FOR INDIVIDUAL COVERAGE

HMO Louisiana

OFFICE USE ONLY					
CONTRACT NUMBER	CONTRACT DATE	LIST BILL NUMBER	PARISH	AREA CD.
TOTAL FEES	U.W. INT. DATE	MED. INFO. ON FILE ❑ Yes ❑ No	REQUESTED EFF. DATE	AGENT#

SECTION A. BLUE CROSS AND BLUE SHIELD OF LOUISIANA PRODUCTS: CHOOSE ONE

Blue Max: ❑ $1500 ❑ $3000 ❑ $3100 ❑ $5000

Blue Saver: Single ❑ $3000 ❑ $3300 ❑ $4500 Family ❑ $6000 ❑ $6600 ❑ $9000

SECTION B. HMO OF LOUISIANA PRODUCTS: CHOOSE ONE

Blue POS: ❑ $1000 ❑ $2500 ❑ $3400 ❑ $3500 ❑ $3600 ❑ $4500 ❑ $6500

Community Blue POS: ❑ $1000 ❑ $2200 ❑ $2500 ❑ $4500

Blue Connect POS: ****❑ $1000 (N) ❑ $2200 (L,N,S) ❑ $2500 (L,N,S) ❑ $3400 (L,N,S) ❑ $4500 (L,S)

Signature Blue POS: ❑ $1000 ❑ $2200 ❑ $2500 ❑ $3400

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

SECTION C. ANCILLARY PRODUCTS:

Variable Income Plan (VIP) Preferred: ❑ $100 ❑ $200 ❑ $250
Budget: ❑ $100 ❑ $200 ❑ $250

Cancer and Serious Disease (CSD)
Plan F Comprehensive 80 Plan G Comprehensive 50

Blue Dental Certified: ❑ Preferred ❑ Essential ❑ Value
Blue Dental Traditional: ❑ Preferred ❑ Essential ❑ Value

SECTION D. LIST BILL

❑ Yes, Company Name and Number

SECTION E. OTHER COVERAGE

Have you or your dependent(s) had other medical coverage within the last 60 days that is **not terminating** before the new effective date, therefore will remain active?
❑ Yes ❑ No Policyholder _____ Contract No. _____ Insurance Co. _____ Dependent(s) covered on policy _____ Termination Date _____

Have you or your dependent(s) had other medical coverage within the last 60 days that is **terminating** before the new effective date?
❑ Yes ❑ No Policyholder _____ Contract No. _____ Insurance Co. _____ Dependent(s) covered on policy _____ Termination Date _____

Have you or your dependent(s) had other dental coverage in the last 12 months?
❑ Yes ❑ No Policyholder _____ Contract No. _____ Insurance Co. _____ Dependent(s) covered on policy _____ Termination Date _____

Does anyone on this application have Medicare A or B? ❑ Yes ❑ No Policyholder _____

SECTION F. PERSONAL INFORMATION (PLEASE PRINT)

Social Security No.	Last Name	First	MI	AC ( ) Phone No.

Physical Address	City	State	Zip Code	**Email Address	AC ( ) Phone No. *** ❑ Opt In

Mailing Address	City	State	Zip Code	Date of Birth Month / Day / Year	❑ Male ❑ Female	Marital Status ❑ Single ❑ Married

SECTION G. DEPENDENT INFORMATION: COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED

Last Name	First Name	MI	Relationship	Med	Dental	VIP	CSD	**Email Address	Social Security Number	Date of Birth Mo / Day / Year
Spouse			❑ Husband ❑ Wife	❑	❑	❑	❑			
Dependent 1			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑			
Dependent 2			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑			
Dependent 3			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑			
Dependent 4			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑			

*If you have checked "Other" and this is an adoption or guardianship, please submit legal papers.
**Email addresses are being collected to enable Blue Cross and Blue Shield of Louisiana to communicate with you electronically. Once enrolled for coverage, you will be able to manage your communication preferences. Minors will not receive electronic communications directly, however, if contact information for a legally responsible party is provided for a minor, that individual may receive electronic communications on behalf of the minor.
***By submitting my mobile number, I agree to receive information via text about my account and general marketing messages from Blue Cross and Blue Shield of Louisiana.
****Some Blue Connect POS plans are limited to certain markets: L = Lafayette, N = New Orleans, S = Shreveport

SECTION H. TOBACCO USE

Have you or your dependent(s) used any form of tobacco including electronic cigarettes 4 or more times a week in the last 6 months excluding religious or ceremonial uses? (Only for 18 year or older)

Applicant ❑ Yes ❑ No Spouse ❑ Yes ❑ No Dependent 1 ❑ Yes ❑ No Dependent 2 ❑ Yes ❑ No Dependent 3 ❑ Yes ❑ No Dependent 4 ❑ Yes ❑ No

SECTION I. PRIMARY CARE PHYSICIAN (PCP) SELECTION: Complete if enrolling in Community Blue, Blue Connect, Signature Blue, HMO or POS products. (If you do not select a PCP, one will be selected for you.)

APPLICANT NAME	PHYSICIAN ADDRESS	PHYSICIAN NAME

IMPORTANT! Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana in connection with this application may be retained by Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc., and used or disclosed in connection with future underwriting or renewal efforts. If you answer "yes" to any medical questions, please complete Section M. Medical Details.

SECTION J. VARIABLE INCOME PLAN (VIP) MEDICAL QUESTIONS

1. Is anyone applying for coverage expecting a biological child within the next 9 months, undergoing or expecting fertility treatments, or in the process of adopting (male or female)? ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

2. Has anyone applying for coverage ever been advised by a physician to receive treatment, undergo a surgical operation that has not been performed or is currently hospitalized? ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

3. Has anyone applying for coverage ever been treated for cancer, blood disorder, stroke (TIA), circulatory, epilepsy (seizures), organ transplant, heart trouble, tuberculosis, lung problems (COPD/emphysema), HIV, had known exposure to AIDS or HIV, received treatment for AIDS or ARC, hepatitis B or C/liver disorder, kidney disease requiring dialysis, multiple sclerosis, Crohn's Disease, ulcerative colitis, rheumatoid arthritis, autoimmune disease (systemic lupus, scleroderma, etc), cystic fibrosis, muscular dystrophy, Parkinson's Disease, ALS (Lou Gehrig's Disease), or Gaucher Disease? ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

4. Height and Weight

	Height	Weight
Applicant's Name		
Spouse's Name		

5. Does anyone applying for coverage take prescription drugs on a regular (daily or weekly) basis? If yes, please list drug names(s) and reason why taken below. ❑ Yes ❑ No

Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason

6. Within the last 5 years have you or anyone listed on the application received treatment, advice, medication, or surgical consultation for diabetes, hypertension (high blood pressure), high cholesterol, asthma, allergies requiring allergy injections, osteoarthritis, neurological condition, bodily deformities, back/orthopedic conditions, muscular disease, nerve disease, tumor, cyst, kidney stones, prostate disorders, endocrine disorder, hernia, migraines, irregular/excessive menstrual bleeding, breast diseases or disorders, abdominal pain, stomach or intestinal disorders, alcohol/substance use disorder, or mental/nervous disorder (autism, eating disorder, etc.)? ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

SECTION K. CANCER AND SERIOUS DISEASE (CSD)

Has anyone applying for coverage ever had or presently have cancer, leukemia, encephalitis, spinal meningitis, sickle cell anemia, tetanus, diphtheria, poliomyelitis, rabies, scarlet fever, small pox, polio or tularemia? ❑ Yes ❑ No
If Yes, please complete the Medical Details section.

SECTION L. METHOD OF PAYMENT

Initial Payment

❑ Check $_____ ❑ Money Order $_____ ❑ Bank Draft ❑ Credit Card

Recurring

❑ Bank Draft (Monthly)

SECTION M. MEDICAL DETAILS

Question Number:	Applicant Name:
1. Condition:	4. Surgery recommended:
2. Date Diagnosed:	5. Surgery and date performed:
3. Treatment and date rendered: (including medication)	6. Date released from care:
Comments:	

Question Number:	Applicant Name:
1. Condition:	4. Surgery recommended:
2. Date Diagnosed:	5. Surgery and date performed:
3. Treatment and date rendered: (including medication)	6. Date released from care:
Comments:	

Question Number:	Applicant Name:
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Comments:	

Question Number:	Applicant Name:
1. Condition:	4. Surgery recommended:
2. Date Diagnosed:	5. Surgery and date performed:
3. Treatment and date rendered: (including medication)	6. Date released from care:
Comments:	

SECTION N. AGREEMENT

1. I, the undersigned, do hereby apply for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA) or HMO of Louisiana, Inc., for myself and my family members listed on this application. I understand that this application, any Change of Status Card, and my contract policy, together with the certificate of coverage, any endorsements issued by Blue Cross and Blue Shield of Louisiana or HMO of Louisiana, Inc. may be terminated within three years of the original effective date of the member's coverage and all fees, less claims paid, will be refunded if I committed fraud or intentional misrepresentation of material fact in this application.
2. PROXY-I hereby constitute and appoint the directors present in person or by proxy given to another director(s), to vote on my behalf at membership meetings on any matters on which policyholders are entitled to vote. I acknowledge notice that the annual meeting of the policyholders is held on the third Tuesday in February or on the next business day following, if a legal holiday. Notice of any such meeting given to such director(s) constitutes notice to me. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder as hereafter provided. I understand that if I revoke my proxy, I may continue to pay my premium without affecting the revocation or my coverage. I understand that I may designate any other policyholder as my proxy by sending any form of writing to Louisiana Health Service & Indemnity Company at P.O. Box 98029, Baton Rouge, Louisiana 70898. Check this block if you do not want to grant your proxy. ❑
3. All information I provided herein is true and correct to the best of my knowledge, information and belief. I understand that this is an application for coverage and is not binding on Blue Cross and Blue Shield of Louisiana. I understand that Blue Cross and Blue Shield of Louisiana reserves the right to set the effective date for any Contract issued and that the Contract will not become effective until that date is established by Blue Cross and Blue Shield of Louisiana.
4. Premiums must be paid in US dollars. Policyholder will be assessed a $25 NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.
5. **We may require you to pay Company all past due amounts from the previous coverage owed to Company or Companies in its control group, before accepting you for this coverage.**

SECTION O. HEALTH SAVINGS ACCOUNT

Please open a MySmartSaver Health Savings Account: ❑ Yes ❑ No

SECTION P. FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have personally obtained the information shown on this application.

Producer's Signature _____ Date _____

Print Name _____ Phone No. _____

Producer's Email Address _____

❑ Taken over the phone

If applying for CSD or VIP coverage, all of the questions in the health history section have been read by or to me and the answers given are provided by the applicant and/or dependent(s) if any.

VIP APPLICANTS ONLY: I understand that I must have minimum essential health coverage to receive any benefits from a VIP policy. I acknowledge that I have other health coverage that meets the requirement of minimum essential coverage.

Applicant's Signature _____ Date _____

Print Name (Applicant) _____ Relationship to Applicant _____

INDIVIDUAL MEDICAL POLICY DISCLOSURE NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Louisiana HMO Louisiana

Non-Network Physician Notice

Healthcare services may be provided to You at a Network healthcare facility by facility-based Physicians who are not in Your health plan. You may be responsible for payment of all or part of the fees for those Non-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles, and non-covered services.

Specific information about Network and Non-network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number on the back of Your ID card.

Louisiana HMO Louisiana

YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc. shall not, solely on the basis of any genetic information concerning an individual or family member or solely on the basis of an individual's or family member's request for or receipt of genetic services, or refusal to submit to a genetic test or make available the results of a genetic test:

(1) Terminate, restrict, limit or apply conditions to the coverage provided under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;

(2) Cancel or refuse to renew the coverage of an individual or family member under the policy or plan;

(3) Deny coverage or exclude an individual or family member from coverage under the policy or plan;

(4) Impose a rider that excludes coverage for certain benefits or services under the policy or plan;

(5) Establish differentials in premium rates or cost-sharing for coverage under the policy or plan; or

(6) Otherwise discriminate against an individual or family members in the provision of insurance.

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc. are prohibited by law from requiring any applicant or subscriber to undergo genetic testing or to be subjected to questions relating to genetic information.

As provided by law, "genetic information" means all information about genes, gene products, inherited characteristics, or family history/pedigree as expressed in common language.

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Louisiana HMO Louisiana

WOMEN'S HEALTH AND CANCER RIGHTS ACT
ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving benefits in connection with a mastectomy and elects breast reconstruction, coverage will be provided for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
- prostheses; and
- treatment of physical complications of all stages of the mastectomy, including lymphedema.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

- were previously diagnosed with breast cancer;
- completed treatment for breast cancer;
- underwent bilateral mastectomy; and
- were subsequently determined to be clear of cancer.

These benefits will be provided in a manner determined in consultation with the attending physician and the patient, and subject to the same deductibles, coinsurance, and copayments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or copayment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

If you have questions about this notice or about the coverage described herein, please contact our Customer Service Department at the number listed on the back of your ID card.

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HMO Louisiana

HMO Louisiana, Inc.
Enrollment Notice

This notice is applicable only to those enrolling in fully insured HMO or POS products.

HMO Louisiana, Inc. (HMOLA) is required to disclose the following information to its members upon enrollment. This disclosure provides you with general information about your HMO/POS plan. Please refer to your Schedule of Benefits for specific copayment, deductible and coinsurance amounts and network information. Your Policy or Schedule of Benefits includes specific information about your covered benefits.

Copayment, Deductible and Coinsurance Amounts

As an HMOLA member, you are responsible for copayment, deductible and coinsurance amounts as outlined in your Policy or Certificate of Coverage. A copayment is a fixed dollar amount that you pay when you receive services from a network provider. Different copayment amounts apply to primary care physicians and specialists. You are generally responsible for a copayment when covered services are rendered by network providers. A deductible applies to out-of-network benefits. Use your plan's in-network providers to ensure the lowest member out-of-pocket cost. Using out-of-network providers may result in denial of benefits or higher member out-of-pocket costs. Please see your Policy or Certificate of Coverage for details.

Provider Networks

Community Blue Network. Community Blue members receive in-network benefits when they obtain services from the specially-developed Community Blue network of providers. Services obtained from providers outside of the Community Blue network are available but will result in higher out-of-pocket costs.

BlueConnect Network. BlueConnect members receive in-network benefits when they obtain services from the specially-developed BlueConnect network of providers. Services obtained from providers outside of the BlueConnect network are available but will result in higher out-of-pocket costs.

Signature Blue Network. Signature Blue members receive in-network benefits when they obtain services from the specially-developed Signature Blue network of providers. Services obtained from providers outside of the Signature Blue network are available but will result in higher out-of-pocket costs.

HMO Network. HMO members use the HMO network and will be denied coverage when they use out-of-network providers.

POS Network. POS members receive in-network benefits when they obtain services from the HMO network of providers and will have higher out-of-pocket expenses when they obtain services from outside of this network.

Please go to www.bcbsla.com for more information about our provider networks.

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Choice of Primary Care Physicians

Community Blue, Blue Connect, Signature Blue, HMO and POS. Community Blue, BlueConnect, Signature Blue, HMO and POS health plan members are required to select primary care physicians (PCPs) from their respective networks. If a PCP selection is not initially made, HMOLA will designate a PCP until one is selected by the member.

HMOLA members may select a PCP from the applicable HMO Louisiana, Inc. network of physicians from the following practice areas:

- Family Practice/General Practice: physicians who are trained in all aspects of primary medical treatment and are able to diagnose and treat patients in all age groups
- Internal Medicine: physicians who treat routine and complex adult medical conditions
- Pediatrics: physicians who specialize in the treatment of children
- Geriatrics: physicians who specialize in treating older adults
- Nurse Practitioner: nurses who are qualified to treat certain medical conditions directly, without a doctor's supervision; must be set up in our system as a network PCP
- Physician Assistant: clinical staff trained to treat common medical conditions, usually under a doctor's supervision, must be set up in our system as a network PCP

Members may choose a separate PCP for themselves, their spouse and each of their eligible dependents, or they may choose one PCP for the entire family.

Direct Access to Specialists

Our members may access most network specialists directly, without a referral from your PCP. Your Policy or Schedule of Benefits defines the specialists and services that require authorization prior to obtaining services.

Treatment of Pre-existing Conditions

We do not exclude benefits because of a pre-existing condition.

If you have any questions about this disclosure or your HMOLA coverage, please call Customer Service at 1-800-495-2583 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Louisiana HMO Louisiana SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.

SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice"– of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and health care (business) operations. In general, unless it is described in the accompanying Notice, we will not use or disclose your medical information without your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract/certificate of coverage
- Share data with your Quality Blue doctor
- Give your healthcare providers updates that help them treat you
- Connect you with Blue Cross health coaches
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans
- Remind you about important screenings, shots or tests
- Participate in research, if appropriate regulations are followed
- Improve our services

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your health care or in the payment of your health care.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

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BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC.
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Medical Information

We will refer to your "health information" throughout this Notice. When we say "health information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; (iii) the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
- The Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

We **have the right** to use and disclose your health information for:

Treatment: We may disclose your health information to a physician or other health care provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

Payment: We may use and disclose your health information to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your health information for health care operations. Health care operations include:

- reviewing and evaluating health care provider and health plan performance, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- health care quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operations, public health activities, and research;
- Sharing detailed medical claims and wellness information with your primary care physician to improve care and reduce costs.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to another health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention.
For example, we may share your information with your doctors for their licensing or credentialing activities.

Business Associates: We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims;
- A pharmacy benefits management company hired to assist us in managing pharmacy claims;
- A company hired to conduct data analysis to help us determine which of our programs and services are most helpful to customers, which should be changed and others that we should start.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement.
We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts (for example, to Red Cross during a natural disaster).

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.
We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

Health-Related Products and Services: Where permitted by law, we may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when:
  (1) an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and approved the research or
  (2) conducting research with de-identified or limited data sets to learn more about how to help members improve their health;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions. This may include an electronic copy in certain circumstances if you make this request in writing.

Generally, a "designated record set" contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your health care benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information, excluding disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.
We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

Breach Notification: In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, Region VI, 1301 Young Street, Suite 1169, Dallas, TX 75202. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

By mail:
Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 84656
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751
Fax: (225) 298-1590

E-mail: Privacy.Office@BCBSLA.com
(Individual Rights requests will not be accepted via e-mail.)

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Member Data Protection Statement

At Blue Cross and Blue Shield of Louisiana, our mission is to improve the health and lives of Louisianians – including how we store, use and protect our members' data. Blue Cross has strong processes in place, which all of our employees must follow to protect members' data in all forms (spoken, written and/or electronic).

Blue Cross approaches members' data protection from three perspectives – physical security, cybersecurity and privacy. Blue Cross recruits, hires and trains qualified staff who work together to safely store our members' information and make sure all employees are following the laws and regulations that protect it.

Blue Cross has extensive policies and procedures that outline the security and privacy standards and responsibilities for protecting members' data. Employees are trained on Blue Cross data protection protocols as soon as they start working here, and all employees have refresher training at least once a year.

Blue Cross does not give every employee access to members' information, and not all access is the same. How much member information any Blue Cross employee can access depends on his/her job and role within the company. Employees can only get to the information they need to do their jobs and not anything else. For example, a Customer Service adviser who needs member information to answer calls is able to see those records, but a business analyst working on internal projects would not need this access.

Spoken Data
Before Blue Cross employees give information over the phone or in person, they take steps to authenticate the identities of the people requesting information. This is to make sure the people calling are really who they say they are and that they have the right to request that information. Blue Cross has a process for our members to let us know whom they want to be an authorized delegate or legal representative. That means you are giving permission for them to contact Blue Cross and ask for information on your behalf.

Written Data
Blue Cross has strong privacy protection rules for paper documents. Employees are required to keep records in a safe place where they cannot be seen, for example in a locked file cabinet instead of lying on a desk. Blue Cross requires employees to go through their computers and securely destroy electronic files that are no longer needed. This prevents the information in these records from being stolen or accessed by the wrong people.

Electronic Data
Blue Cross IT staff uses the latest technology to keep electronic information secure by encrypting it within internal systems so that no one can get to it from outside the system. The IT staff members have processes in place to detect and prevent hackers from getting to our technical systems and monitor how employees access and use information within the organization.

If you have questions about how Blue Cross uses, stores or protects members' data, call our Information Governance Office at (225) 298-1751.

12PR0095 05/18

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)