BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

BlueSaver®

INDIVIDUAL MEMBER ENROLLMENT GUIDE

01MK1737 R01/08

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

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

APPLICATION FOR INDIVIDUAL HEALTH COVERAGE

BlueSaver®

COMPLETE IN BLACK INK ONLY

01 ____________ 02 ____________ 03 ____________ 04 ____________

OFFICE USE ONLY							
CONTRACT NUMBER	CONTRACT DATE	GROUP NUMBER	MOP	WC	CLASS	CONTROL NUMBER	PARISH
ENROLL / RATE CODE	TOTAL FEES	CONVERSION DATE	U.W. INT.	DATE	CLERK	MED. INFO. ON FILE	AREA CD.
	List Bill: ❑ YES, Co. Name and Number					REQUESTED EFF. DATE	AGENT #

SOCIAL SECURITY NO.	LAST NAME (Print)	FIRST (Print)	MIDDLE (Print)	AC ( ) PHONE NO.

STREET ADDRESS	CITY	STATE	ZIP CODE	DO YOU WANT COMBINED BILLING? ❑ YES ❑ NO

DATE OF BIRTH	MONTH	DAY	YEAR	❑ MALE ❑ FEMALE	MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ OTHER	OCCUPATION

COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED

NAME: FIRST AND LAST	SOCIAL SECURITY NUMBER	DATE OF BIRTH	IF DEPENDENT CHILD IS OVER 20, INDICATE IF FULL-TIME STUDENT AND DEPENDS UPON YOU FOR SUPPORT. IF DEPENDENT IS NOT NATURAL CHILD, ATTACH CERTIFIED DOCUMENTATION OF LEGAL CUSTODY OR ADOPTION.	FULL-TIME STUDENT	DEPENDS UPON YOU FOR SUPPORT?	DATE DEPENDENCY BEGAN	RESIDES WITH YOU?
SPOUSE			❑ HUSBAND ❑ WIFE				
			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER____	❑ YES ❑ NO	❑ YES ❑ NO		❑ YES ❑ NO
			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER____	❑ YES ❑ NO	❑ YES ❑ NO		❑ YES ❑ NO
			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER____	❑ YES ❑ NO	❑ YES ❑ NO		❑ YES ❑ NO
			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER____	❑ YES ❑ NO	❑ YES ❑ NO		❑ YES ❑ NO
			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER____	❑ YES ❑ NO	❑ YES ❑ NO		❑ YES ❑ NO

METHOD OF PAYMENT
(List Bill Must Be Monthly)
❑ MONTHLY ❑ SEMI-ANNUALLY
❑ QUARTERLY ❑ ANNUALLY
❑ BANK DRAFT

DO YOU OR YOUR DEPENDENTS HAVE, OR HAD WITHIN 63 DAYS, OTHER HEALTH INSURANCE INCLUDING MEDICARE?
❑ YES ❑ NO IF YES, GIVE CONTRACT NUMBER AND PLAN NAME:____________
IF COVERAGE WITHIN 63 DAYS (PORTABILITY), COMPLETE FORM 23XX1938.
HAVE YOU/DEPENDENT EVER HAD BLUE CROSS AND BLUE SHIELD COVERAGE? ❑ YES ❑ NO
POLICYHOLDER NAME____________ POLICY NUMBER____________

RATE CALCULATION
BlueSaver ________
EF $25.00
TOTAL ________

BENEFIT DESIGN: CHECK CLASS AND COMPLETE ONE OF THE FOLLOWING PLANS

CLASS (CHECK ONE) ❑ APPLICANT ONLY ❑ APPLICANT AND SPOUSE ❑ APPLICANT AND ELIGIBLE CHILDREN ❑ APPLICANT AND SPOUSE AND ELIGIBLE CHILDREN (FAMILY)

BlueSaver Plan
❑ PPO (80/60)........ ________ **DEDUCTIBLE**
❑ PPO (100/80)........ ________ **DEDUCTIBLE**
PREGNANCY OPTION........❑ YES ❑ NO

HAVE YOU USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS?............❑ YES ❑ NO
HAS YOUR SPOUSE USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS? .....❑ YES ❑ NO

RISK LEVEL: ❑ PREFERRED ❑ STANDARD 1 ❑ STANDARD 2 ❑ STANDARD 3

SUBMITTED WITH APPLICATION: $________ PERSONAL CHECK $________ MONEY ORDER
$________ OTHER, EXPLAIN ____________

OPTION: OPEN A HEALTH SAVINGS ACCOUNT

I intend to open a Health Savings Account ❑ YES ❑ NO Please open an account with *MySmartSaver* Health Savings Account ❑ YES ❑ NO

1. I, the undersigned, do hereby apply for membership in Louisiana Health Service & Indemnity Company ("LHSIC"), for myself and my dependents, if any listed on this application. If the application is accepted a contract will be issued. I understand that this application, any Change of Status Card and Contract, together with any riders and endorsements issued by LHSIC constitute my contract with LHSIC. I understand the contract as it pertains to me and my dependents may be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if a material misrepresentation of fact exists in the application or any Change of Status Card.
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.** ❑

I understand that this is an application for coverage and is not binding on LHSIC. I understand that LHSIC 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 LHSIC.

IMPORTANT! Please answer all questions below for all persons included in this application. For each positive response, underline the appropriate statement or condition and complete the medical questionnaire on page 3. 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 used or disclosed in connection with future underwriting or renewal efforts.

Your Height: ____________ Your Weight: ____________ Spouse's Height: ____________ Spouse's Weight: ____________

HAS ANYONE APPLYING FOR COVERAGE EVER HAD:

1. Diabetes Mellitus? ❑ Yes ❑ No
2. Any type of Cancer? ❑ Yes ❑ No
3. Any blood disorder? ❑ Yes ❑ No
4. A stroke (CVA)? ❑ Yes ❑ No
5. Circulatory problems? ❑ Yes ❑ No
6. Epilepsy? ❑ Yes ❑ No
7. Been diagnosed with Rheumatic Fever? ❑ Yes ❑ No
8. Been diagnosed with abnormal blood pressure? ❑ Yes ❑ No
9. Heart Trouble? ❑ Yes ❑ No
10. Been diagnosed with Tuberculosis? ❑ Yes ❑ No
11. Had or have other lung problems? ❑ Yes ❑ No
12. Tested positively for HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? ❑ Yes ❑ No
13. Been diagnosed with either Hepatitis or a liver disorder? ❑ Yes ❑ No

HAS ANYONE APPLYING FOR COVERAGE HAD IN THE LAST 5 YEARS:

14. Been diagnosed with asthma, bronchitis or chronic sinus trouble? ❑ Yes ❑ No
15. Been diagnosed with allergies? ❑ Yes ❑ No
16. Been treated for arthritis? ❑ Yes ❑ No
17. Been treated for Rheumatism/Bursitis or Sciatica? ❑ Yes ❑ No
18. Had any bodily deformities? ❑ Yes ❑ No
19. Had any back/orthopedic condition or muscular diseases? ❑ Yes ❑ No
20. Had any known tumors or cysts? ❑ Yes ❑ No
21. Been treated for kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? ❑ Yes ❑ No
22. Been diagnosed with an endocrine disorder thyroid problem or goiter? ❑ Yes ❑ No
23. Been treated for hemorrhoids/rectal ailments or varicose veins? ❑ Yes ❑ No
24. Had a hernia? ❑ Yes ❑ No
25. Had seizures, fainting spells? ❑ Yes ❑ No
26. Had headaches? ❑ Yes ❑ No
27. Had irregular/excessive menstrual bleeding? ❑ Yes ❑ No
28. Had any other female reproductive problems? ❑ Yes ❑ No
29. Had pelvic pain? ❑ Yes ❑ No
30. Had gall stones or gall bladder disorder? ❑ Yes ❑ No
31. Had abdominal pain? ❑ Yes ❑ No
32. Had ulcers, stomach, colon or other intestinal disorders, adhesions? ❑ Yes ❑ No
33. Had any eye conditions (excluding corrective lenses)? ❑ Yes ❑ No
34. Had any ear condition or impairment? ❑ Yes ❑ No
35. Had a mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? ❑ Yes ❑ No
36. Had candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases? ❑ Yes ❑ No
37. Suffered from or received treatment for alcohol or substance abuse, detoxification? ❑ Yes ❑ No
38. Had any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures? ❑ Yes ❑ No

MISCELLANEOUS

39. Are you expecting a biological child within the next 9 months (male or female applicant)? ❑ Yes ❑ No
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months? ❑ Yes ❑ No
41. Are you presently taking medications for conditions not mentioned in other questions? ❑ Yes ❑ No
42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials, hazardous wastes or materials? ❑ Yes ❑ No
43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused? ❑ Yes ❑ No
44. Any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, optometrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years? ❑ Yes ❑ No

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE

Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.

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 enrollment form or 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 E-Mail Address ______

Met with applicant in person: ❑ Yes ❑ No

Physical Requested: ❑ Yes ❑ No

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.

Applicant's Signature ______ Date ______

Print Name (Applicant) ______ E-Mail Address ______

Relationship to Applicant ______

PRIOR CARRIER HEALTH COVERAGE FORM

COMPLETE IN BLACK INK ONLY

Prior carrier coverage is used to reduce pre-existing condition exclusion periods by giving credit for time served under qualified plans. This form may be submitted for creditable coverage determination in place of a Certificate of Creditable Coverage (if permitted by the group employer plan). In order to correctly calculate creditable coverage, it is critical the information you provide is accurate, otherwise claim benefit determinations may be incorrect. You can call your prior carriers or prior employers to obtain the needed information. Please complete this form for each prior carrier enrollment occurring within the last 24 months for both you and your dependents. This form may also be used to report prior carrier dental coverage information if you are enrolling into a group dental plan. **NOTE: Do not complete this form for limited scope policies such as vision, long-term care, specified disease (e.g. cancer), fixed indemnity (e.g. $100 per day) since they are not qualified plans.**

INSTRUCTIONS
Section 1: Personal Information: Please provide your name, social security number, daytime phone number, your current Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. group policy number, if known.
Section 2a: Prior Carrier Information: Provide the requested prior carrier information.
Section 2b: Member Information: Do not complete the last two columns of this section (*If Group Policy, If Individual Policy)* if you and your dependents have been covered under your prior plan for 18 months or more. If coverage under the prior plan is less than 18 months, we require an additional date in order to determine whether coverage is creditable. Use the following instructions to determine what date should be provided. If you and your dependents enrolled into your *prior group health plan* when initially offered, generally upon hire, then you must also provide the date your waiting period began or if applicable, your plan affiliation date. If you or your dependents enrolled into the prior group plan as a late or special enrollee, you have no waiting period, therefore indicate "N/A". If your prior coverage is under an *individual policy (*a plan not sponsored by an employer) then you must provide the date you submitted a substantially complete application to the carrier.

If you have not yet terminated the other coverage, please give the date the coverage will be terminated (additional information may be requested at the time of termination).

Waiting Periods When Coverage Never Becomes Effective: Because waiting periods do not count as lapses in coverage, you possibly could have additional creditable coverage that may be added to qualifying creditable coverage identified through using this form. Please speak to your agent or broker if within the last 24-month period, you terminated employment during your group's waiting period OR if within the last 24-month period, your application for an individual policy did not become effective due to either your or the issuer's rejection. The agent should assist you in determining whether we need to adjust your creditable coverage calculation.

SECTION 1: PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER

DAYTIME PHONE NUMBER	CURRENT GROUP NUMBER, IF APPLICABLE

SECTION 2A: PRIOR CARRIER INFORMATION

PRIOR CARRIER NAME	ADDRESS

POLICY NUMBER	PRIOR CARRIER PHONE NUMBER	PLAN TYPE: ☐ Group Employer Plan ☐ COBRA ☐ Individual Plan ☐ Other (describe) ________

SECTION 2B: PRIOR CARRIER MEMBER INFORMATION

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	***If Group Policy***, Date waiting period/affiliation period began M/D/Y (if any) or N/A	***If Individual Policy,*** Date a Substantially Complete Application Submitted M/D/Y or N/A
SUBSCRIBER							
SPOUSE							

(OVER)

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	***If Group Policy***, Date waiting period/affiliation period began M/D/Y (if any) or N/A	***If Individual Policy,*** Date a Substantially Complete Application Submitted M/D/Y or N/A
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

SECTION 3: AUTHORIZATION & CERTIFICATION BY SUBSCRIBER

I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify all information provided with my prior carriers or employers. I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. as a result of misrepresented information on this form.

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.

Subscriber Signature ______________________________ Date ________________________

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AUTHORIZATION TO DRAW CHECKS ON MY ACCOUNT

As a convenience to me, I authorize Blue Cross and Blue Shield of Louisiana to start an automatic monthly charge to my account at the Bank (or other financial institution) I have named. I also authorize the Bank to debit the amount of those charges to my account.

I understand and agree that:

1. The Bank's rights with respect to each charge will be the same as if personally executed by me.
2. This authorization will remain in effect until I provide written notification to Blue Cross and Blue Shield of Louisiana that I wish to revoke it. I will allow Blue Cross and Blue Shield of Louisiana thirty (30) days to act on this notice.
3. Blue Cross and Blue Shield of Louisiana and my bank may discontinue this service.
4. I understand that if any such check be dishonored by my Bank and any monthly amount due Blue Cross and Blue Shield of Louisiana is not paid within the time stipulated in the policy, said policy shall become null and void except as otherwise provided therein.

Name(s): **X** ______________________________

(Please Print)

X ______________________________

(Signature) (Date)

____

(Application Number - If Applicable)

____

(Name of Bank or Financial Institution) (City)

____

(Checking Account Number)

____

(Blue Cross and Blue Shield of Louisiana Contract Number)

Attach Blank Check Marked "Void"

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

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

YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

Blue Cross and Blue Shield of Louisiana, 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 is 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.

40XX0908 R02/07

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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 mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, coinsurance, and co-payments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or co-payment 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 1-800-599-2583.

40XX0941 R04/05

CUSTOMER NOTICE OF OUR INFORMATION PRIVACY POLICIES AND PRACTICES

Information Only – No Response Necessary

Effective Date: July 1, 2001

Blue Cross and Blue Shield of Louisiana and its affiliates, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., know that our customers expect privacy and security regarding all of their personal and financial information. It is important to us that we protect the privacy and security of your information.

This notice will tell you about how we collect, use, secure, and share your personal information, which is information about you that identifies you and that we obtain from you and others when we provide insurance products and services to you. We will inform you of our policies for collecting, using, securing and sharing nonpublic personal financial information the first time we do business with you and every year that you are our customer.

What Information We Collect and From Whom We Collect It

We collect personal information about you that includes your name, address, Social Security number, health, and financial information. This information is obtained from the forms you fill out, from telephone or person-to-person interviews with you, and from your agent. We also obtain your personal information through claims documents, payment history and other records available to us to determine which products and services are appropriate for you. We may also receive personal information about you from our affiliates and other companies.

What Information We Share and To Whom We Share It

We may share your information, even after you are no longer our customer, with our affiliates as well as companies we do business with. We only share your information that we are allowed to by law. For example, we may share your information with persons, such as your agent, or companies who perform marketing or other services for us related to the products and services we provide you. We may also share your information with other financial institutions with which we have joint marketing agreements to provide our products and services.

How We Protect Information

Within our companies, only our employees who need to know about your information in order to provide our products and services to you are allowed to have access to your information. We keep your information safe and secure so that unauthorized individuals do not have access to it. We maintain physical, electronic, and procedural safeguards that comply with legal requirements to protect your information.

This notice is being sent to individual policyholders. For members under group plans, their employer is the designated recipient of this notice.

This notice has been sent to you in response to the Gramm-Leach-Bliley legislation. For a more comprehensive Notice regarding our Company's privacy practices and policies, please read the "Notice of Privacy Practices Regarding Medical Information" located on our website www.bcbsla.com or call the Privacy Office at (225) 298-1751 to obtain a copy.

01MK1446 R03/04

BlueCross BlueShield of Louisiana

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HMO Louisiana, Inc.

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

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 now 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
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans

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.

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 April 14, 2003, 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; 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.

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.

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.

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 : 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 an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- 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. You are not entitled to inspect and/or copy:

- any psychotherapy notes;
- any information compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding;
- any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a); or
- certain other records as specified in the HIPAA Privacy Regulation.

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 after April 13, 2003, 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 and never for a disclosure that occurred before April 14, 2003. 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.

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 Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

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) 295-2599

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