



**BlueCross BlueShield
of Louisiana**

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



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



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GROUP MEMBER ENROLLMENT GUIDE

Important Information

Customer Service: 1-800-495-2583

Authorizations: 1-800-523-6435

Corporate Headquarters: 225-295-3307

Corporate Headquarters physical address:

5525 Reitz Avenue

Baton Rouge, LA 70809

Corporate Headquarters Mailing Address:

P.O. Box 98029

Baton Rouge, LA 70898-9029

Website: www.bcbsla.com

Hours of Operation:

Corporate Headquarters: 8:00 a.m. – 4:30 p.m., Monday - Friday

Customer Service: 8:00 a.m. – 5:30 p.m., Monday - Friday

Dear New Member:

Thank you for choosing us for your insurance needs. This Member Enrollment Guide is designed to handle all details necessary for you to become our newest member. Included is an instruction page, your enrollment form and important notices.

Your decision to enroll puts you in good company. Founded in 1934, Blue Cross and Blue Shield of Louisiana is the oldest domestic health insurer in Louisiana. We're a Louisiana-owned and -operated company, employing more than 2,000 residents and serving more than 1.4 million Louisianians.

Our longstanding relationship with hospitals, physicians and other health care providers in the state, allow us to offer special features and pass on the cost savings to you. Remember, staying in your network is very important, and will help you avoid costly surprises. You can find a list of network providers at www.bcbsla.com/findcare.

After you complete the enrollment process, you will receive your ID card and your certificate of coverage. Carry your ID card with you at all times for instant recognition from doctors and hospitals. Your certificate of coverage gives a full explanation of your health, dental, life, disability or vision benefits of which you are enrolled in.

As a member, your ID card is honored throughout Louisiana. You can travel with confidence knowing that if you need care, the Cross and Shield is recognized by health care providers throughout the United States and in more than 200 countries throughout the world.

We appreciate your business and look forward to providing you with prompt claims payment and exceptional customer service. Thank you for your confidence in our company, and thank you for **Choosing Blue**. All of us at Blue Cross and Blue Shield of Louisiana look forward to serving you today and for many years to come.

Instructions for Enrollee/Change Form

Please read thoroughly before completing the enrollment application/change form. Be sure to complete the enrollee information on the top of each page. Any incomplete forms will be returned for completion.

Check either “Employee Enrollment” or “Employee Change Form.”

<p><i>Employers</i> <i>For all employees, including new hires, the top of pages 2 thru 6 must be completed in full.</i> <i>Enrollment and New Hires:</i> <i>Enrollee’s ID Number with their social security number and Group Number/Subgroup must be identified</i> <i>Changes:</i> <i>Enrollee’s ID Number with their employee’s member number and Group Number/Subgroup must be identified</i> <i>If employee is waiving coverage, only complete Section B, Section C (Waiver of Coverage) and Section J</i></p>	
<p>Section A Coverage Selections</p>	<ul style="list-style-type: none"> • Select coverage options offered by your employer. • For Medical coverage, indicate your deductible/coinsurance amounts or the medical plan number, where applicable. • For Life and Disability, indicate product(s). • For Dental Coverage, indicate your group plan number and/or group product name. • For Vision Coverage, indicate your group plan number or your voluntary plan number
<p>Section B Employee Information</p>	<ul style="list-style-type: none"> • If you are a <u>new member</u>, complete the entire section. • If you are an <u>established member making changes or adding a dependent</u>, you only need to fill in your first and last name. • Hire date: if you are a rehire, note the date of your rehire in this section, not your original hire date. • Marital status: Other: Select this box if you are divorced or widowed.
<p>Section C Enrollment Events</p>	<ul style="list-style-type: none"> • Select “New” if this is your group’s initial enrollment with Blue Cross and Blue Shield of Louisiana, Southern National Life Insurance Company and/or HMO Louisiana or if you are a new hire serving eligibility. • Select “Late” if you are enrolling during open enrollment or if you are changing products. • Select “Rehire” if you are a rehire and be sure to indicate your new hire date in Section B. • Select “Special Enrollee” if you have experienced a qualifying event and indicate the event at the bottom of Section C. <ul style="list-style-type: none"> ◦ Select Class ◦ If you are unsure what your class is, check with your group leader. ◦ Check the appropriate box for the product and coverage type in which you are enrolling. ◦ Select “I decline” for the product(s) in which you are not enrolling. ◦ For a change of status, mark the appropriate box under “Change” in Section C. Indicate your qualifying event, if applicable, be sure to give the day, month and year of the event.

<p style="text-align: center;">Section D Employee Information</p>	<p><i>To Be Completed By Employer</i></p> <ul style="list-style-type: none"> • Group Leaders must complete this section if an employee is MAKING A CHANGE. • The group leader’s signature is required for any changes indicated in this section. • Product Selection Change: If your group offers more than one medical plan and an employee is changing plans during open enrollment. You may need to also change the class of the employee. • Subgroup Change: If your group has billing set up for multiple locations or divisions and an employee is changing locations, the employee will be changing subgroups. Based on your billing subgroup number, indicate the subgroup they are moving from and the subgroup they are moving to. You may need to also change the class of the employee. • Class Change: Changes may result in a change to the employee’s classification. Indicate the new class. • Annual Salary Change: Include both the “from and to” annual salary amount. If life or disability benefits include commissions, bonus, tips, tokens or overtime be sure to include as part of your salary amount. If you are unsure of your benefits, check with your Human Resources department for guidance.
<p style="text-align: center;">Section E Family Members</p>	<ul style="list-style-type: none"> • In the first column, indicate the family members who are enrolling (E) or changing (C). • Complete each applicable section in full. • An out-of-area dependent is a dependent who lives out-of-state. • Note specific product if not changing all products.
<p style="text-align: center;">Section F Life Insurance Information</p>	<ul style="list-style-type: none"> • If your group maintains beneficiary files you should check with your Human Resource department for guidance on how to document beneficiary information. • If the insurance company (Southern National Life Insurance Company, Inc.) maintains beneficiary files for your group you should fill out section F • Applicable to both scenarios above: <ul style="list-style-type: none"> ○ If you are splitting your life insurance among beneficiaries, you must indicate the percentage that should go to each beneficiary. ○ If you do not indicate a beneficiary, the beneficiary will automatically be designated as the “estate of.” ○ Beneficiary information noted will apply to <u>all life</u> products applied for with SNL.
<p style="text-align: center;">Section G Other Coverage Information</p>	<p>Complete this section only if you or your dependents have other coverage.</p> <ul style="list-style-type: none"> • Please give the complete names of your dependents. We cannot accept “mother,” “daughter,” etc. If yes, indicate which insurance company and policy holder.
<p style="text-align: center;">Section H Medical History</p>	<ul style="list-style-type: none"> • Complete this section if you are required to answer medical questions based on the type of coverage you applied for. • If applying for life or disability and you are required to answer medical questions because you are applying late or because you have applied for an amount above the guaranteed issue amount, you only need to answer questions with an (*). • Provide an explanation of medical conditions you checked using the Medical Questionnaire Guide. If the guide is not available, provide details in the second table listed.
<p style="text-align: center;">Section I PCP Selection</p>	<ul style="list-style-type: none"> • Please indicate a primary care physician. If you do not select one, a PCP will be appointed for you. • Required for Community Blue and BlueConnect products.
<p style="text-align: center;">Section J Coverage Conditions</p>	<ul style="list-style-type: none"> • Please carefully read this section and sign and date.



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EMPLOYEE ENROLLMENT EMPLOYEE CHANGE FORM

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

Group Number/Subgroup

/

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana

- GroupCare PPO (Plan)
BlueSaver (Plan)
Premier Blue (Plan)
True Blue (Plan)

HMO Louisiana, Inc.*

- HMO (Plan)
POS (Plan)
Community Blue (Plan)
BlueConnect HMO (Plan)
BlueConnect POS (Plan)

- Dental (Plan)
Vision (Plan)

Southern National Life Insurance Company, Inc.

- Group Term Life
Short Term Disability with Life
Long Term Disability
Voluntary Short Term Disability
Voluntary Long Term Disability
Voluntary Life
Voluntary High Limit AD&D

SECTION B - EMPLOYEE INFORMATION

Enrollee's Last Name, First, MI, Sex (M/F), Birthdate (MM/DD/YYYY), Hire Date, Job Title, Social Security Number, Mailing Address, City, State, ZIP, E-mail Address, Annual Salary, Marital Status, Retired from Current Employer, Date Retired, Current Employer Name, Primary Language Spoken In The Home, Home Phone, Work Phone

SECTION C - ENROLLMENT EVENTS

ENROLLMENT Requested Effective Date Group # New Late Rehire Special Enrollee (Go to Qualifying Event Section Below.)

Class (Select One): Active Management Non-Management Retiree Other

Please check all that apply. Benefit options are dependent upon employer elections. I am enrolling for:

Table with columns: Medical, Dental, Vision, Group Life, STD, LTD, Voluntary Life, Company Use Only, Vol STD, Vol LTD, Vol High Limit & AD&D, Company Use Only. Rows include Employee (EE), Spouse (SP), Dependent Child(ren), Family, and I Decline.

WAIVER OF MEDICAL COVERAGE I decline to enroll for this coverage due to:

- Spouse's Group Employer Plan Plan Name Policy Number COBRA from Prior Employer Tri-Care Retiree from Prior Employer
Individual Plan Medicare Medicaid VA Eligibility Other

CHANGE (Please complete Section D): Requested Effective Date

Type of Change: Name Address Add Dependent Subgroup Class Salary Change Qualifying Event (Complete next section)

QUALIFYING EVENT: Marriage Birth Adoption Placement for Adoption Date of Qualifying Event

If you lost other coverage due to: Divorce Death Termination or reduction in work hours Employer contributions for coverage ended
(Please complete Section G) Other COBRA or other continuation coverage exhausted

*NOTICE FOR ENROLLEES ON HMO PLANS THAT DO NOT CONTAIN A POINT-OF-SERVICE BENEFIT: 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, WHEN THOSE HEALTH CARE SERVICES AND DRUGS REQUIRE AN AUTHORIZATION BY THE PLAN

SECTION D - CHANGE INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

The information below must be completed by the Employer if an employee is making a change.

Product Selection Change _____ Subgroup Change: Move From _____ Move To _____

Annual Salary Change From \$ _____ to \$ _____

Class Change From _____ To: _____

Employer Name _____ Employer Signature _____ Date ____/____/____

SECTION E - FAMILY MEMBERS TO BE ENROLLED OR CHANGED

Enroll or Change (Please circle the appropriate answer)	Dependent's Full Name (Last, First, MI)	E-MAIL*	RELATIONSHIP (If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.)	Birthdate			Social Security Number	Lives With You? If "No" Give Address/Location**	Mentally Or Physically Incapacitated***	Out Of Area Dependent/ Student
				Mo	Day	Yr				
E C			<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner					N/A	N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

*E-mail addresses are being collected to enable our Companies 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.

**Address/Location _____

***If your dependent is mentally or physically incapacitated, please provide the following medical documentation from your doctor: • Diagnosis of condition(s) causing incapacitation • Anticipated length of incapacitation

SECTION F - LIFE INSURANCE BENEFICIARY INFORMATION

Your employer will provide you with the opportunity to elect a beneficiary or beneficiaries on a separate beneficiary designation form or system.

SECTION G - OTHER COVERAGE INFORMATION

Do you or any Dependents have other health insurance? Yes No Other Group? Yes No If yes to either give: _____ Policyholder _____ Insurance Company _____
 BCBSLA or HMOLA? Yes No

Is this a qualifying event application due to loss of other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Members Covered	Coverage Start Date	Coverage End Date	Prior Insurance Carrier and Policy Number	Type of Coverage (Refer to Instruction Page) <input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
If yes, complete the information on the right. If more than one prior carrier, please provide a certificate of coverage from other carrier(s).					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit

Are you or any of your dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	Covered by: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	Dates Medicare became effective A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	Medicare Numbers A. _____ B. _____ C. _____ D. _____
If yes, complete the information on the right. Please provide a clear copy of the Medicare card.		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____
		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____

Are you or any of your Dependents currently receiving disability/workers' comp benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Date Coverage Began / /	Name	Date Coverage Began / /
If yes, complete the information on the right.		/ /		/ /
		/ /		/ /
		/ /		/ /

SECTION H - MEDICAL HISTORY

Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana Inc. (HMOLA), and/or Southern National Life Insurance Company, Inc. (SNLIC) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNLIC and used or disclosed in connection with future underwriting/renewal efforts.

IMPORTANT! FOR EACH "YES" RESPONSE, PROVIDE DETAILS ON PAGE 5

- **For Life and Disability Coverage:** If applying only for life and disability coverage as a late enrollee or for a benefit above the guarantee issue amount, you are required to answer medical questions indicated with an * only.
- **For Medical Coverage:** Medical questions are required for late enrollees on large groups as defined by the Affordable Care Act. Contact your Human Resources department if you are unsure of your group size.

Your Height* _____ Your Weight* _____ Spouse's Height* _____ Spouse's Weight* _____

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:

*1. Diabetes mellitus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*8. Abnormal blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*2. Any type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*9. Heart trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Any blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*4. A stroke (CVA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*11. Lung problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Circulatory problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*6. Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*13. Hepatitis or any liver disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:

*14. Asthma, bronchitis or chronic sinus trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*28. Any female reproductive problems or female infertility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*15. Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Pelvic pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*16. Arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Gall stones or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*17. Rheumatism/Bursitis or Sciatica?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Any bodily deformities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*32. Ulcers, stomach, colon or other intestinal disorders, adhesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*19. Any back and/or orthopedic condition or muscular diseases, back pain or joint pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Any eye conditions (excluding corrective lenses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*20. Any tumors, cysts or growths?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Any ear condition or impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Endocrine disorder thyroid problem or goiter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Hemorrhoids/rectal ailments or varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*37. Alcohol or substance abuse, detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. A hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*25. Seizures, Fainting Spells?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
*26. Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Irregular/excessive menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MISCELLANEOUS:

*39. Are you expecting a biological child within the next 9 months (male or female applicant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*43. Have you, or anyone on this application, ever had any health, life or disability insurance postponed, rated, ridered, declined, cancelled, or had reinstatement refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Have you, or anyone on this application, used tobacco in any form within the last 6 months including electronic cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*44. Have you, or anyone on this application, ever had any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*41. Are you presently taking medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
*42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials or hazardous wastes or materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Enrollee's Last Name _____ First Name _____ Subscriber Number _____ Group Number/Subgroup _____ / _____

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE - ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	A	B	C	D	E	F	G

IF MEDICAL QUESTIONNAIRE IS UNAVAILABLE, PROVIDE DETAILS FOR EACH "YES" RESPONSE IN THE FORMAT BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Medications, Frequency, Dosage

SECTION I - PRIMARY CARE PHYSICIAN (PCP) SELECTION

Recommended for all products. It is required for Community Blue or BlueConnect products. If you do not select a PCP, one will be selected for you.

Enrollee Name	Social Security Number	Physician Name	Physician Address

SECTION J - COVERAGE CONDITIONS

1. I, the undersigned, do hereby enroll for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNLIC) for myself and any family members listed on this enrollment form. I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made an intentional misrepresentation of material fact in this enrollment/change form. I further understand that if enrolled for coverage with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. or Southern National Life Insurance Company, Inc. that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that Blue Cross Blue Shield of Louisiana, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are all independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the "Association" permitting the individual companies to use the Blue Cross and Blue Shield service marks in the state of Louisiana and that the companies are not contracting as an agent of the Association.
2. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be necessary. The information given on this application is true and correct to the best of my knowledge and belief.
3. I understand that if I am declining enrollment for myself or my Dependents (including spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. In addition, if I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my Dependents provided that I request enrollment within 30 days after the marriage, birth adoption or placement for adoption.
4. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance For People With Medicare."
5. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.
6. **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.
7. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or Dependent(s) if any, are true and correct to the best of my knowledge and belief.

X _____ Date _____
Enrollee's Signature **Enrollee's Signature Date**



**Have you selected a PCP? Recommended for all products.
 It is required for Community Blue or BlueConnect products.**

OFFICE USE ONLY	HEALTH EFFECTIVE DATE		UW INT. HLTH. DT.
	DENTAL	VISION	OUT OF ELIG.? <input type="checkbox"/> YES <input type="checkbox"/> NO

Attach additional pages if necessary



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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.

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 the number listed on the back of your ID card.

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
- 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 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.
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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.

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. 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 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. 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.)

Initial Notice about Special Enrollment Rights and Pre-existing Condition Exclusions

This notice is applicable to only those enrolling in fully insured small and large group health products. Applicable to grandfathered- and nongrandfathered-plans.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify eligible plan participants about two (2) important plan provisions. The first notice is about the right to enroll in the plan under its “special enrollment provision” if you decline coverage or if you acquire a new dependent. The second notice advises you of the plan’s “pre-existing condition exclusion rules” that may temporarily exclude coverage for certain pre-existing conditions.

Notice of Special Enrollment Rights

Loss of Other Coverage for Large Group Members and Loss of Minimal Essential Coverage for Small Group Members (Excluding Medicaid or State Children’s Health Insurance Program) - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). You must request enrollment within thirty (30) days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Individuals who lose other coverage because they do not pay their premium or required contributions or lose other coverage for cause (such as filing fraudulent claims or intentional misrepresentation of a material fact in connection with the plan) are not special enrollees and have no special enrollment rights.

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program – If you decline enrollment for yourself or for an eligible dependent (including your spouse) because Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. You must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. You must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

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Additional Small Business Health Options Program (SHOP) Special Enrollment Allowances. If you are a member of a SHOP (On-Exchange) group, you are also allowed to enroll in SHOP group coverage and enroll dependents in the following circumstances:

- Enrollment or non-enrollment in your employer's SHOP policy that was due to an error, misrepresentation or inaction of an officer, employee or agent of the SHOP or the U.S. Department of Health and Human Services, or their instrumentalities; or
- Gaining access to new Qualified Health Plans because of a permanent move; or
- Being an Indian, as defined in Section 4 of the Indian Health Care Improvement Act; or
- Meeting other exceptional circumstances as determined by the SHOP.

To request special enrollment or obtain more information, contact your employer (plan administrator) or our Customer Service Center at 1-800-599-2583.

Notice of Pre-Existing Condition Exclusion Rules

We do not exclude benefits because of a pre-existing condition for group policies that become effective in 2014 and later. If you are on a group plan and your employer group health plan was in effect with us prior to 2014, treatment of pre-existing conditions, with exception of mental disorders, may continue to be excluded until your group's renewal date in 2014. Please check with your group leader to learn your group renewal date and see your Policy or Schedule of Benefits for additional information about your plan's pre-existing condition exclusion period.

If you are part of a group plan that imposes a pre-existing condition exclusion, this means that if you have a medical or mental condition before coming to this plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This pre-existing condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the ninety (90) day period immediately prior to your enrollment date. Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information. Generally, this ninety (90) day period ends the day before your coverage becomes effective. However, if you were serving an eligibility waiting period for coverage, the ninety (90) day period ends on the day before the eligibility waiting period begins. The pre-existing condition exclusion does not apply to pregnancy (if your plan offers maternity coverage) nor to an individual who is under age 19, regardless of whether the individual is an employee or a dependent.

This pre-existing condition exclusion period for medical conditions may last up to 180 days (eighteen (18) months if you are a late enrollee) from your first day of coverage or, if you were serving an eligibility waiting period, from the first day of your eligibility waiting period. However, you can reduce the length of these exclusion periods by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion periods if you have not experienced a break in coverage of at least sixty-three (63) days. To reduce the exclusion periods by your creditable coverage, you should give us a copy of any Certificates of Creditable Coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage.

A Blue Cross and Blue Shield of Louisiana Prior Carrier Health Coverage Form (23XX1938) may be submitted for determination of creditable coverage in place of a Certificate of Creditable Coverage. Please contact us if you need help demonstrating creditable coverage.

If your group health plan is or becomes self-insured at the time of your request for enrollment into the plan, your pre-existing condition provisions may differ from the language stated above. For self-insured plans, the plan administrator is responsible for issuing the information on your pre-existing condition exclusion rules.

Each HIPAA Certificate (or other evidence of creditable coverage) may be reviewed to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Customer Service Center at 1-800-599-2583 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

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 co-payment 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.

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.

Choice of Primary Care Physicians

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

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Other HMO Louisiana Policies. 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

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. Mental health and substance abuse benefits must obtain authorization from Magellan Health Services, which is explained in your Policy or Schedule of Benefits. Your Policy or Schedule of Benefits also defines other 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 for policies that become effective in 2014 and later. If you are on a group plan and your employer group health plan was in effect with us prior to 2014, treatment of pre-existing conditions, with exception of mental disorders, may not be covered until your group's renewal date in 2014. Please check with your group leader to learn your group renewal date and see your Policy or Schedule of Benefits for additional information about your plan's pre-existing condition period. The pre-existing condition period is waived for persons under 19.

If you have any questions about this disclosure or your HMOLA coverage, please call Customer Service at 1-800-599-2583 between 8:00 a.m. and 5:00 p.m., Monday through Friday.



Non Network Physician Notice

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

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

<p align="center">IDAHO – Medicaid</p> <p>Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>
<p align="center">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa Phone: 1-800-889-9949</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278</p>
<p align="center">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884</p>	
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p> <p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofc/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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