BlueChoice 65, BlueChoice 65 SELECT, BlueChoice 65 PLUS, BlueChoice 65 SELECT PLUS

APPLICATION

Medicare Supplement Programs

This booklet contains three forms necessary to apply for Medicare Supplement coverage.

Upon completion of the forms, your agent will return this application booklet and your check or money order to Blue Cross and Blue Shield of Louisiana.

Attention: If the policy you are applying for is to replace your present policy, you must sign the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance" form printed at the back of this booklet. Detach the last page for your records.

Louisiana

APPLICATION FOR BLUECHOICE 65/BLUECHOICE 65 SELECT/ BLUECHOICE 65 PLUS/BLUECHOICE 65 SELECT PLUS HEALTH COVERAGE

OFFICE USE ONLY	CONTRACT NUMBER	CONTRACT DATE	LIST BILL NO.	MED. INFO ON FILE ❑ YES ❑ NO	U.W. INT. & DATE
		REQUESTED EFF. DATE	AGENT NO.	PARISH	AREA CD

SECTION A. PERSONAL INFORMATION (PLEASE PRINT)

SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MIDDLE NAME	AC PHONE NO. ( )
STREET ADDRESS	CITY		STATE	ZIP CODE
MAILING ADDRESS	CITY		STATE	ZIP CODE
EMAIL ADDRESS				

DATE OF BIRTH MO DAY YEAR	❑ MALE ❑ FEMALE	MARITAL STATUS ❑ SINGLE ❑ MARRIED	ARE YOU ENTITLED TO MEDICAID? ❑ YES ❑ NO QMB ASSISTANCE ❑ YES ❑ NO SLMB ASSISTANCE ❑ YES ❑ NO

EFFECTIVE DATE OF MEDICARE PART A MO DAY YR	EFFECTIVE DATE OF MEDICARE PART B MO DAY YR	YOUR MEDICARE NUMBER	ARE YOU CURRENTLY RECEIVING DISABILITY/WORKERS COMP. BENEFITS? ❑ YES ❑ NO
01	01		

METHOD OF PAYMENT: PREMIUM $_____ ❑ MONTHLY ❑ SEMI-MONTHLY ❑ QUARTERLY ❑ ANNUALLY

SECTION B. BENEFIT DESIGN: CHECK ONE OF THE FOLLOWING PLANS

BLUECHOICE 65 PLAN ❑ PLAN A ❑ PLAN B ❑ PLAN F+ ❑ PLAN G ❑ PLAN N **BLUECHOICE 65 PLUS PLAN** ❑ PLAN G✦

BLUECHOICE 65 SELECT PLANS* ❑ PLAN B ❑ PLAN F+ ❑ PLAN G ❑ PLAN N **BLUECHOICE 65 SELECT PLUS PLAN*** ❑ PLAN G✦

SECTION C. PROXY INFORMATION

1. I the undersigned, do hereby apply for membership in Louisiana Health Service & Indemnity Company (LHSIC), for myself. I understand that this application, any Change of Status Card and the Contract, together with any riders and endorsements issued by LHSIC constitute my contract with LHSIC. I understand the contract may be terminated within three years of the original effective date of the Member's coverage and all fees, less claims paid, will be refunded if a material misrepresentation of facts as to that Member(s) exists in the application or any Change of Status Card.
2. I understand that the coverage applied for is not part of a group health plan and that the agreement is between LHSIC and myself.
3. PROXY - I hereby constitute and appoint the directors of LHSIC, 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.** ❑
4. 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.
5. I acknowledge that I have received both an outline of Medicare Supplement coverage and a "Guide to Health Insurance for People with Medicare."
6. If choosing BlueChoice 65 SELECT or BlueChoice 65 SELECT PLUS, I acknowledge that I have received a listing of network hospitals participating in the BlueChoice 65 SELECT or BlueChoice 65 SELECT PLUS program and disclosure information on the BlueChoice 65 SELECT or BlueChoice 65 SELECT PLUS program. I acknowledge that I reside within a 50-mile geographical radius of a BlueChoice 65 SELECT hospital.
7. I understand that BlueChoice 65 SELECT or BlueChoice 65 SELECT PLUS plan benefits will not be provided for the Part A Medicare deductibles and coinsurance when hospitalized in a non-network hospital, except in the case of emergencies.

*To purchase a BlueChoice 65 SELECT or BlueChoice 65 SELECT PLUS plan, you must reside within a 50 mile geographical radius from the nearest Select network hospital.

+Plans F and F Select are not available to those that become newly Medicare eligible on or after January 1, 2020.

✦Plus Plan G and Select Plus Plan G include dental services. Advantage Plus Network is administered by United Concordia Companies, Inc. United Concordia is an independent company that administers dental benefits on behalf of Blue Cross and Blue Shield of Louisiana members.

SECTION D. GUARANTEED ISSUE

If you are eligible to receive a Medicare Supplement policy on a guaranteed issue basis according to the law, you do not have to answer the questions in the Health History or the Medical Questionnaire sections below. Otherwise, you must respond to the questions for your application to be considered. If you do not know if you are eligible for a guaranteed issue Medicare Supplement policy and you choose to fill out these sections, and you happen to be so eligible, the responses you provide will not be taken into consideration by Blue Cross and Blue Shield of Louisiana when making a decision about your coverage.

SECTION E. HEALTH HISTORY For each YES or positive response, complete Section F. Medical Details

1. Height_____ Weight_____

2. Has anyone applying for coverage been advised by a physician to receive medical treatment or undergo a surgical operation that has not been performed? ❑ Yes ❑ No

3. Are you currently a patient in a hospital, nursing home, or medical care facility? ❑ Yes ❑ No
   Have you been a patient in any of these facilities two or more times in the past two years? ❑ Yes ❑ No

4. Has anyone applying for coverage been treated for **(Including but not limited to)**: ❑ Yes ❑ No If yes, check below condition(s) and provide details in section F for each condition.
   - ❑ Diabetes requiring insulin
   - ❑ Cancer/leukemia/lymphoma
   - ❑ Blood or circulatory disorder (coronary/carotid artery disease, etc.,excludes high blood pressure)
   - ❑ Stroke or TIA
   - ❑ Organ transplant
   - ❑ Heart condition (heart attack, congestive heart failure, valve replacement, etc.)
   - ❑ Lung disorder (COPD/Emphysema)
   - ❑ Hepatitis/liver disorder
   - ❑ Kidney disease requiring dialysis or kidney failure
   - ❑ Multiple sclerosis
   - ❑ Crohn's disease or ulcerative colitis
   - ❑ Rheumatoid arthritis
   - ❑ Autoimmune disease (systemic lupus, scleroderma, etc.)
   - ❑ Cystic fibrosis
   - ❑ Muscular dystrophy/disease
   - ❑ Parkinson's disease
   - ❑ ALS (Lou Gehrig's Disease)
   - ❑ Alzheimers/dementia/brain disease
   - ❑ Aneurysm
   - ❑ Joint replacement

5. Have you been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection? ❑ Yes ❑ No

6. Do you take prescription drugs on a regular (daily or weekly) basis? ❑ Yes ❑ No
   If YES, please list drug name(s) and reason why taken in Section F. Medical Details.

7. Medicare Disability (List Medicare Disability Reason below and complete Section F. Medical Details)_____

   _____

   _____

SECTION F. MEDICAL DETAILS

IMPORTANT! Please answer all questions below for each YES or positive response in Section E. Health History. 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.

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

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

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1. Condition:	4. Surgery recommended:
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Comments:	

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

SECTION 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.

THIS APPLICATION HAS BEEN COMPLETED IN MY PRESENCE

_____ _____
Producer's Signature Date

_____ _____
Print Name Date

_____
Producer's Email Address

Taken over the phone: ❑ Yes ❑ No

If Yes, complete form 01MK6332, the Required Applicant Attestation for Over the Phone Medicare Supplement Application.

I acknowledge receipt of the documents stated in this application. 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.

_____ _____
Applicant's Signature Date

_____
Print Name (Applicant)

_____
Relationship to Applicant

Louisiana

Supplementary Application for Medicare Supplement Coverage

Instructions:

- Carefully read the Statements in Section 1.
- Answer the questions in Section 2 to the best of your knowledge.
- Sign the form.
- Agent must complete Section 3 and sign.

SECTION 1 Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION 2 Questions (To Be Answered By Applicant)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. (Please mark Yes or No below with an "X")
To the best of your knowledge,

1. (a) Did you turn 65 in the last 6 months? ❑ YES ❑ NO
   (b) Did you enroll in Medicare Part B in the last 6 months ❑ YES ❑ NO
   (c) If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program?
   (NOTE TO APPLICANT: If you are a participant in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
   ❑ YES ❑ NO

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? ❑ YES ❑ NO

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ YES ❑ NO

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START—/—/— END —/—/—

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ YES ❑ NO

(c) Was this your first time in this type of Medicare plan? ❑ YES ❑ NO

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ❑ YES ❑ NO

4. (a) Do you have another Medicare supplement policy in force? ❑ YES ❑ NO

(b) If so, with what company, and what plan do you have? _____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❑ YES ❑ NO

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ❑ YES ❑ NO

(a) If so, with what company and what kind of policy? _____

_____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START—/—/— END—/—/—

SECTION 3 Agent Must Complete This Section

Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

_____

2. List policies sold in the past five (5) years which are no longer in force.

_____

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 enrollmen form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____ _____

Applicant's Name (Print) Agent/Broker's Signature Date

X_____ _____

Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Blue Cross and Blue Shield of Louisiana* • P. O. Box 98029 • Baton Rouge, LA 70898-9029

Instructions:

- **This form (and copy on opposite page) should be completed only if you plan to replace your existing Medicare supplement policy. Your agent will fill in the information required.**
- **After your agent completes the form, sign it at the bottom.**
- **Detach copy for your records.**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Louisiana. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT, BROKER OR AUTHORIZED REPRESENTATIVE

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage, or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits
____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment

_____

____ Other: (Please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

_____
Signature of Agent, Broker, or other Representative

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

_____
Date

_____
Applicant's Name (Print)

X _____
Applicant's Signature

_____
Date

COMPANY COPY

23XX2472 R01/06

*Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Blue Cross and Blue Shield of Louisiana* • P. O. Box 98029 • Baton Rouge, LA 70898-9029

Instructions:

- **This form (and copy on opposite page) should be completed only if you plan to replace your existing Medicare supplement policy. Your agent will fill in the information required.**
- **After your agent completes the form, sign it at the bottom.**
- **Detach copy for your records.**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Louisiana. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT, BROKER OR AUTHORIZED REPRESENTATIVE

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage, or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits
____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment

_____

____ Other: (Please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

_____
Signature of Agent, Broker, or other Representative

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

_____
Date

_____
Applicant's Name (Print)

X _____
Applicant's Signature

_____
Date

APPLICANT RETAINS THIS COPY

23XX2472 R01/06 *Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

BLUECHOICE 65 ANNUAL OPEN ENROLLMENT NOTICE
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

1. If you have an existing Medicare supplement policy, you will have an annual open enrollment period beginning your birthday and lasting for a period of sixty-three (63) calendar days, during which you may purchase any Medicare supplement policy offered in this state by the same insurer with which you have your existing Medicare supplement policy.

   If during this annual open enrollment period, you seek to purchase a Medicare supplement policy that is a standardized policy identified by a plan letter indicating benefits that are equal or less than the benefits indicated by the plan letter or your existing Medicare supplement policy, We will not deny or condition the issuance or effectiveness of the coverage or discriminate in the pricing of the coverage due to your health status, claims experience, receipt of health care, or medical condition.

2. If you are eligible for Medicare coverage and do not have an existing Medicare supplement policy but maintained health insurance coverage through your employer at the time you became eligible for Medicare, you shall have an open enrollment period beginning on any of the following: (i) The termination date of your employer-based plan. (ii) The date your employer-based plan ceases to provide some or all health benefits to you. (iii) The date you leave the employer-based plan. The open enrollment period shall last for sixty-three (63) calendar days.

   If during this annual open enrollment period, you seek to purchase a Medicare supplement policy that is a standardized policy identified by a plan letter for which federal law currently provides a guaranteed issue right at the time you initially were eligible for Medicare coverage, We will not deny or condition the issuance or effectiveness of the coverage or discriminate in the pricing of the coverage due to your health status, claims experience, receipt of health care, or medical condition.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana

■ BALANCE BILLING DISCLOSURE NOTICE REQUIRED BY LOUISIANA LAW

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES AND NONCOVERED SERVICES.

SPECIFIC INFORMATION ABOUT NETWORK AND NON-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT BCBSLA.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF YOUR ID CARD.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOWS YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

■ YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS UNDER FEDERAL LAW

When you get emergency care or get treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is a balance or surprise bill? Surprise or balance billing is when an out-of-network provider bills you for more than what your plan pays a network provider for the same care.

Out-of-network providers may bill you for more than what your plan pays a network provider for the same kind of care. Out-of-network providers cannot send you an unexpected bill when you cannot choose who treats you. Out-of-network providers who see you in a true health emergency cannot send you a bill for more than what your plan pays. In most cases, out-of-network providers who see you in a network hospital cannot send you a bill for more than what your plan pays without your consent.

You are protected from balance billing for:

- Emergency services: If you must get care in a true emergency from an out-of-network provider, the most the provider may bill you is your plan's copayment, coinsurance or deductible for network care. You cannot be balance billed for these emergency services. This includes care you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed.
- Certain services at a network hospital or ambulatory surgical center: When you get services from a network hospital or ambulatory surgical center, certain providers there may be out-of-network. **In most cases, out-of-network providers who see you in a network hospital (anesthesiologists, emergency room doctors, neonatologists, pathologists, radiologists and others) cannot send you a surprise bill.** These providers may not ask you to give up your protections not to be balance billed.

If you get other care at these network facilities, out-of-network providers cannot balance bill you unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:
You are only responsible for paying any copayments, coinsurance or deductible that you would pay if the provider was in your network. Your health plan will pay the out-of-network providers and facilities. Your health plan generally must:

- Cover emergency services without requiring you to get approval for care in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay a network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your network deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact **1-800-985-3059** or visit **cms.gov/nosurprises** for more information about your rights under federal law.

Find more information about surprise or balance billing at **bcbsla.com/hbp.**

Louisiana HMO Louisiana

YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

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

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

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

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

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

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

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

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

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

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

SUMMARY OF PRIVACY PRACTICES NOTICE

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

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

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

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

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

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

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

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

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

Our Legal Duty

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

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

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

Uses and Disclosures of Medical Information

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

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:

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

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

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

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

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

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

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

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

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

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

Examples of our business associates include:

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

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

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

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

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

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

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

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

Individual Rights

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

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

Generally, a "designated record set" contains:

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

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

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

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

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

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

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

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

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

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

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

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints.

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
Toll free 1-855-258-3746
Fax: (225) 298-1590

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

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

Member Data Protection Statement

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

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

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

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

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

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

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

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

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

Nondiscrimination Notice

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GUARANTEED RENEWABLE

This contract is automatically guaranteed renewable, subject to all the terms and provisions of the Contract, upon payment of fees when due. If approved, no pre-existing or probationary periods are part of this Contract.

LIMITATIONS AND EXCLUSIONS

Benefits will not be provided for charges covered by or available under the provisions of Medicare.

FOR CUSTOMER SERVICE CALL:
1-800-258-3365

RECEIPT

BlueChoice 65:
- ☐ Plan A
- ☐ Plan B
- ☐ Plan F+
- ☐ Plan G
- ☐ Plan N

(Please mark plan above)

BlueChoice 65 Select:
- ☐ Plan B
- ☐ Plan F+
- ☐ Plan G
- ☐ Plan N

(Please mark plan above)

BlueChoice 65 Plus:
- ☐ Plan G✦

(Please mark plan above)

BlueChoice 65 Select Plus:
- ☐ Plan G✦

(Please mark plan above)

Make check payable to:
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029 • Baton Rouge, Louisiana 70898-9029

Date: _____

Received of: _____

$ _____ for _____ month's initial premium

_____
Agent/Broker

+ Plans F and F Select are not available to those that become newly Medicare eligible on or after January 1, 2020.

✦ Plus Plan G and Select Plus Plan G include dental services. Advantage Plus Network is administered by United Concordia Companies, Inc. United Concordia is an independent company that administers dental benefits on behalf of Blue Cross and Blue Shield of Louisiana members.

Louisiana