Iowa Uniform Group Health Application

PLEASE PRINT

Effective Date _____/_____/_____

Agent No._____

Employer Data

Employer _____ Group Number _____ Phone _____

Street Address _____ City _____ State _____ Zip _____ Fax _____

Employee Data

Employee Name: First | | | | | | | | | | | | | | | | | | | | MI: |

Last | | | | | | | | | | | | | | | | | | | |

Home Address _____ City _____ State _____ Zip _____

Work Phone # (_____)_____-_____ Home Phone # (_____)_____-_____ Email _____

Birthdate _____/_____/_____ *(mm/dd/yy)* Height _____ft. _____in. Weight _____lbs. Gender ☐ M ☐ F

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed

☐ Common Law Marriage (Notarized Affidavit Required) ☐ Domestic Partner (Notarized Affidavit Required)

Social Security # | | | | - | | | - | | | | |

Date of Hire _____/_____/_____ *(mm/dd/yy)* Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ COBRA

Job Title _____ Average Hours Worked per Week _____ Salary/Wage $ _____

Primary Care Physician _____

Dependent Data

	Name (First, MI, Last)	Gender	Height	Weight (lbs.)	Birthdate	Social Security Number	Full-time student?
Spouse or Domestic Partner		☐ Male ☐ Female	_____ ft. _____ in.		____/____/____ (mm/dd/yy)		☐ Yes ☐ No
Dependent 1		☐ Male ☐ Female	_____ ft. _____ in.		____/____/____ (mm/dd/yy)		☐ Yes ☐ No
Dependent 2		☐ Male ☐ Female	_____ ft. _____ in.		____/____/____ (mm/dd/yy)		☐ Yes ☐ No
Dependent 3		☐ Male ☐ Female	_____ ft. _____ in.		____/____/____ (mm/dd/yy)		☐ Yes ☐ No

List Primary Care Physician Name for Spouse or Domestic Partner: _____ Dep. 1_____

Dep. 2 _____ Dep. 3 _____

Coverage Selected

Please indicate which eligible coverage(s) you are choosing:

Medical:	☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)
Dental:	☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)
Life:	☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)
Vision:	☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)
Disability:	☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Child(ren)

Select Medical option: ☐ HMO ☐ PPO ☐ POS ☐ HPDP ☐ Other: Health Plan Code_____ Deductible Amount _____

N-5401 9/12

Reason for Enrollment/Change

Name of Affected Party _____ Date of Event _____/_____/_____ *(mm/dd/yy)*

☐ New Hire/New Enrollee ☐ Late Enrollee ☐ Special Enrollee ☐ Loss of Coverage ☐ Marriage ☐ Birth/Adoption ☐ Death ☐ Divorce

☐ Employment Termination ☐ COBRA ☐ Cancel Coverage (reason) _____

☐ Other _____

Other Coverage

Medicare Coverage:

☐ Yes ☐ No Are you and/or anyone listed in the Dependent Data section Social Security disabled?

If yes, list names _____

☐ Yes ☐ No Are you and/or anyone listed in the Dependent Data section enrolled in Medicare?

If yes, complete following as appropriate:

Employee Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B) _____/_____/_____ Effective Date (Part D) _____/_____/_____

Spouse or Domestic Partner Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B) _____/_____/_____ Effective Date (Part D) _____/_____/_____

Dependent Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B) _____/_____/_____ Effective Date (Part D) _____/_____/_____

Concurrent Coverage:

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependents keep other coverage in addition to this coverage?

If yes, check all that apply. ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Disability

☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Children

Name of covered person(s) _____

Employer (if applicable) _____

Insurance Company/HMO Name and Address _____

Policy No. _____ Effective Date _____/_____/_____ End Date _____/_____/_____

Previous Coverage:

☐ Yes ☐ No Within the last 18 months, did you have health insurance coverage?

If yes, check all that apply. ☐ Employee ☐ Employee/Spouse or Domestic Partner ☐ Employee/Child(ren) ☐ Employee/Spouse or Domestic Partner/Children

Name of covered person(s) _____

Employer (if applicable) _____

Insurance Company/HMO Name and Address _____

Policy No. _____ Effective Date _____/_____/_____ End Date _____/_____/_____

Designated Beneficiaries

Group Term Life and/or Voluntary Term Life Beneficiary Designation

(NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security #*

Contingent Beneficiaries:

Name and Address	*Percentage*	*Relationship*	*Social Security #*

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to the Plan

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

Employee Name _____

Waiver of Coverage

I decline coverage for:

☐ Medical ☐ Dental
☐ Vision ☐ Life
☐ Disability

Declining coverage due to existence of another coverage:

☐ Spouse's or Domestic Partner's Employer's Plan ☐ Individual Plan ☐ Medicaid
☐ Covered by Medicare ☐ VA eligibility ☐ Tri-Care
☐ COBRA from prior employer ☐ Other, Explain: _____
OR ☐ I (we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Health Information Questions

Please answer each question fully and accurately. Incomplete answers could delay the processing of your requested coverage.

SECTION 1

Please provide the health history of you and any person named in this application who has been diagnosed or treated in the last **10 years** by placing an "X" in the following boxes. **Please further explain your selection in SECTION 3's Health Statement Table.**

☐ 1. AIDS/HIV
☐ 2. Allergy/Asthma
☐ 3. Arthritis
☐ 4. Bladder/Urinary Disorder
☐ 5. Blood, Bleeding, or Clotting Disorder
☐ 6. Bone/Joint/Muscular Disorder
☐ 7. Cancer
☐ 8. Cyst
☐ 9. Current Pregnancy: due date ___/___/___
☐ 10. Diabetes
☐ 11. Digestive/Intestinal Disorder
☐ 12. Drug or Alcohol Abuse
☐ 13. Eating Disorder
☐ 14. Endocrine/Pancreatic Disorder
☐ 15. Eye, Ear, Nose or Throat Disorder (excluding glasses)
☐ 16. Heart/Circulatory Disorder
☐ 17. High Blood Pressure
☐ 18. High Cholesterol
☐ 19. Infertility
☐ 20. Kidney Disorder (Dialysis or failure)
☐ 21. Liver (Cirrhosis, Hepatitis B, C, D or E)
☐ 22. Mental or Nervous Disorder
☐ 23. Migraine Headaches
☐ 24. Neck, Back, or Spine Disorder
☐ 25. Organ transplant
☐ 26. Respiratory/Lung Disorder
☐ 27. Skin Disorder
☐ 28. Stroke/Nervous System/Brain Disorder
☐ 29. Tumor
☐ 30. Tobacco Product Use
☐ 31. Vascular (blood vessel) Disorder

SECTION 2

Please answer yes or no to the following questions. **Please further explain your "Yes" selections in SECTION 3's Health Statement Table.**

☐ Yes ☐ No 32. Have you or any person named in this application received inpatient or outpatient services in the last three (3) years (excluding routine tests, physicals or inoculations)?

☐ Yes ☐ No 33. Do you or any person named in this application have tests, treatments, hospitalization or surgery planned or recommended in the future?

☐ Yes ☐ No 34. Do you or any person named in this application take any medicine, prescription drugs, or require shots/injections?

☐ Yes ☐ No 35. Do you or any person named in this application have any other medical conditions which has not yet been previously mentioned?

SECTION 3 Health Statement Table

For any of the "X" or "Yes" responses provided in SECTIONS 1 and 2 questions above, please provide full details in the following table per Question Number (Q#). If you need additional space, please attach another sheet. (An additional sheet must include your signature and the date on it as verification that the information is yours.)

Q#	Person Name	Condition	Date Diagnosed	Date Last Treated	Type of Treatment/Name of Medication and Type (e.g., oral, injectable, infusion, inhaled, or transdermal)	Is Medication Ongoing?	Is Treatment Ongoing?
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Employee Name _____

Authorization and Certification

I understand and agree with the following statements with regard to my application for coverage through an insurance Carrier:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later, but I must show proof of good health and coverage. This will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.
- I understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier. I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to the life or disability carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", including but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including but not limited to, all health and mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS related complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs, and tobacco, and the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent that the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of <u>all</u> information received and it will not be released to any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, <u>without</u> any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers, and their legal representatives to receive, use, and disclose my, my spouse's or domestic partner's, and my dependent child(ren)'s Protected Health Information for the purpose of insurance coverage. I authorize the Carriers to disclose my, my spouse's or domestic partner's, and my dependent child(ren)'s Protected Health Information between themselves, to reinsuring companies, and to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage: *(Either you or your broker must list all Carriers that are to receive this application for insurance.)*

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Carrier _____ Carrier _____ Carrier _____

Carrier <u>Wellmark Blue Cross and Blue Shield of Iowa</u> Carrier <u>Wellmark Health Plan of Iowa, Inc.</u> Carrier _____

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentation, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Carrier.

Print Name _____

Your Signature X_____ **Date Signed** _____/_____/_____

Your Rights & Responsibilities

Wellmark Blue Cross and Blue Shield believes it is important for you to understand your health care coverage and the rights you have as a user of our services. This is a summary of your rights and responsibilities when you apply for health insurance coverage. If you have questions, talk to your authorized Wellmark representative, or visit *www.wellmark.com*.

Genetic Information Nondiscrimination Act (GINA)

Do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic disease.

General Notice of Preexisting Condition Exclusion

The Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) regulations require we provide you with the following information specific to your employer's health plan. It is important that you read and understand the information contained in this section. After reviewing this material, additional questions should be directed to either Wellmark's Customer Service department or your employer group health plan sponsor. You can reach Customer Service toll-free by calling: 800-524-9242. You can also find this information in your Coverage Manual which you will receive after you enroll.

Preexisting Condition Exclusion Period			Look Back Period
Under Age 19	New Hires & Special Enrollees	Late Enrollees	
N/A on or after September 23, 2010	12 Months	18 Months	6 Months

Note: If you are a participant in a brand new group to Wellmark (size 2-100 employees) and your group has not provided group sponsored coverage within the last 63 days prior to group's effective date, a standard condition exclusion period of 12 months applies for all participants at initial enrollment. Please see your group administrator to determine if this applies to you as a participant.

What is a Preexisting Condition Exclusion?

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to the plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. Preexisting condition exclusions apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the look back period. The preexisting condition exclusion does not apply to pregnancy, or to a child under the age of 19, or to a child age 19 or older who is enrolled in the plan within 60 days after adoption or placement for adoption.

What is the Look Back Period?

The look back period is the period of time, as shown above, that ends on the day before the effective date of your coverage under our plan; or, if you have a waiting period before your coverage under our plan is effective, the period of time, as shown above, that ends on the day before the first date of the waiting period.

When Does a Preexisting Condition Exclusion Period Begin?

This preexisting condition exclusion period begins on the effective date of your coverage; or, if you have a waiting period before your coverage under our plan is effective, the exclusion period begins on the first day of the waiting period.

How Does Prior Creditable Coverage Impact Preexisting Condition Exclusion Periods?

You can reduce the length of the preexisting condition exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of at least 63 days. To reduce the exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage 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 you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

Why is the Pre-existing Condition Exclusion Not Applied to Individuals Under Age 19?

ACA requires that no pre-existing condition exclusion be applied to individuals under 19 effective the first plan year on or after September 23, 2010.

Wellmark is not providing any legal advice with regard to compliance with the requirements of the Affordable Care Act ("ACA") and Mental Health Parity and Addiction Equity Act ("MHPAEA"). Regulations and guidance on specific provisions of the ACA and MHPAEA have been and will continue to be provided by the U.S. Department of Health and Human Services ("HHS") and/or other agencies. The information provided reflects Wellmark's understanding of the most current information and is subject to change without further notice. Please note that plan benefits, rates, renewal rate adjustments, and rating impact calculations are subject to change and may be revised during a plan's rating period based on guidance and regulations issued by HHS or other agencies. Wellmark makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of ACA or MHPAEA. Any questions about Wellmark's approach to the ACA or MHPAEA may be referred to your Wellmark account representative.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself or 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). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and dependents, but, to do so, you must request enrollment within 31 days after the date of marriage. You must enroll within 60 days after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance. Also, to add a new dependent as a result of birth, adoption or placement for adoption, you must request enrollment of the new dependent within 60 days after the dependent's birth, adoption or placement for adoption. To request special enrollment or obtain more information contact Customer Service, Wellmark, Inc., PO Box 9232, Station 3E499, Des Moines, IA 50306-9232 or call 800-524-9242.

Notice of Women's Health and Cancer Rights Act

Members who have a mastectomy and elect breast reconstruction in connection with the mastectomy are covered, in a manner determined in consultation with the attending physician and the patient, for the following:

- 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 and coinsurance applicable to other medical and surgical benefits provided under this plan.

Privacy Practices Notice

The privacy of your medical information is important to Wellmark. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Make sure your employer has completed the "Employer Data" section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than Wellmark Blue Cross and Blue Shield and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until 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 contract holders 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 listed at the end of this section.

Organizations Covered By This Notice

This notice applies to the privacy practices of the group health plans, health insurers and HMO listed below. These organizations are each participants in an organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for the payment activities or health care operations relating to our organized health care arrangement.

Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Safeguard Steps Wellmark Has Taken

The steps Wellmark has taken to safeguard members' medical information include but are not limited to:

- Disseminated a Notice of Privacy Practices to insured members and posted it on the Wellmark Web site at *www.wellmark.com*
- Disseminated a Notice of Privacy Practices and other information practitioners and facilities need to know about Wellmark's privacy practices in the provider newsletter, *Blue Ink*, and on the Wellmark Web site
- Established a Privacy Office as a primary point of contact concerning questions or issues regarding privacy matters, including toll-free phone access and e-mail address, and published the contact information in the Notice of Privacy Practices on the Wellmark Web site
- Established internal policies and procedures for compliance with the Privacy Rule and disseminated the information to employees through corporate-wide privacy training, and department-specific training for Customer Service and other areas
- As a condition of employment, all members of Wellmark's workforce are required to sign a Confidentiality and Nondisclosure Agreement
- In daily interaction with members and providers, Wellmark provider and Customer Service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information
- Limited physical and information system access to medical information to people who need it to do their jobs
- Strict security regarding access to facility, personal computers, and medical information

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to establish premiums, to issue explanations of benefits to the person enrolled in the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or entity subject to the federal Privacy Rules so they can obtain payment or engage in these payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations include:

- Rating our risk and determining our premiums for your health plan;
- Quality assessment and improvement activities;

- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

Other Entities: We may disclose your medical information to another entity that has a relationship with you and is subject to the federal Privacy Rules for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your medical 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.
Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan: As a member of a group health plan, we may disclose your medical information and the medical information of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan to permit the plan sponsor to perform plan administration functions. Please see your Coverage Manual for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.
We may also disclose summary information about the members in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend, or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the members in your group health plan. The summary information will be stripped of demographic information about the members in the group health plan, but the plan sponsor may still be able to identify you or other members in your group health plan from the summary information.

Underwriting: We may receive your medical information for underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits. We will not use or disclose your genetic information, including family history, for underwriting purposes. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. In that case, our use and disclosure of your medical information will only be as described in this notice.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child-abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Health Related Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

Individual Rights
Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a cost-based fee for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information

we disclosed, the reason for the disclosure, and certain other information. 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 these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the contract holder of the health plan in which you participate. An explanation of benefits issued to the contract holder for health care that you received for which you did not request confidential communications or about the contract holder or others covered by the health plan in which you participate 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.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this section in written form.

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed at the end of this section. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical 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.

Privacy Office

Mailing Address:
Wellmark Blue Cross and Blue Shield
Privacy Office, Station 5W590
PO Box 9232
Des Moines, IA 50306-9232

Telephone:
877-610-6395 Outside Des Moines Area
515-376-5850 Des Moines Local Area
Fax: 515-376-9032
Email: *privacyoffice@wellmark.com*
Web site: *www.wellmark.com*