Agent Guide to Individual Products and Medicare Supplement Plans

Revised October 2011
This document contains confidential information

of Tennessee

Table of Contents

Introduction & Important Contacts List

The Agent's Guide will assist you in understanding and marketing BlueCross BlueShield of Tennessee, Inc. (BCBST) individual health care products.

This manual includes administrative guidelines for writing new business, billing and general policy information. The Underwriting Department retains the authority to differ from these guidelines based on a case-by-case basis. This manual is a reference, not a legal document. Updates to the Agent's Guide are available on our Website, bcbst.com, in the secure broker section.

Our Home Office Support Team and Field Agency Support Team Representatives are available to answer your questions. Please refer to the numbers below for more information.

For general information or questions about our products:

Under 65 Products: 1-800-351-9325, select option 2
Medicare Products: 1-800-351-9325, select option 1

For education and field agency support, please call the Field Agency Support Team Representative in your area:

North Central Tennessee/Outside Tennessee
DeAnna Benn
1-800-515-2121 ext. 6231
(423) 535-6231

West Tennessee
Charlotte Sommersby
1-800-515-2121 ext. 2215
(901) 544-2215

East Tennessee
Danielle Byers
1-800-515-2121 ext. 4645
(865) 588-4645

South Central Tennessee
Steven Johns
1-800-515-2121 ext. 6119
(423) 535-6119

Statewide Agency Support
Karen Tidwell
1-800-515-2121, ext. 3371
(423) 535-3371

Medicare Sales
LaShawn Hawkins, Agent Relations Consultant
(423) 535-5487

For questions about your commission account:

Jenene Bales
(423) 535-8003
FAX (423) 535-3178

Rhonda Ireland
(423) 535-8279
FAX (423) 535-3178

For questions about licensing or address changes:

Tracey Key
(423) 535-4342
FAX (423) 535-3178

For questions about errors & omissions:

MGA Insurance Services
1-800-593-7657
www.bcs-eo.com/tn

For agent advertising approvals or the Marketing Assistance Program, contact:

Ginger Pettway
(423) 535-3384

For Membership and Billing Questions:

Under 65, BlueCross65, and BlueElite Products
1-800-725-6849
(423) 591-9244 (Membership FAX)
(423) 591-9252 (Billing FAX)

Medicare Advantage Products
1-800-841-7434
FAX (423) 535-7601

For Sales Management:

Individual Sales
Charlie Goe, Business Segment Director
(423) 535-6237

Shirley Collier, Project Manager
1-800-515-2121, ext. 6417 or (423) 535-6417

Licensing Requirements

To solicit an application for insurance, an individual must hold a Tennessee agent's license. A licensed agent can quote a policy without being appointed and without an Agency Agreement, but the Agency Agreement must be signed before a policy is sold and the producing agent must be appointed to represent BCBST within 15 days.

All appointment paperwork must be included with the first application submitted by the agent.

An Agency Agreement can be with an individual or with an agency. If it is with an agency, the employer identification number must be listed and the producing agent must be appointed. If the Agency Agreement is with an individual, the social security number must be used.

To be appointed to represent BCBST, we must have the Producer Request for Appointment Form, copy of current TN Resident or Non-Resident license, proof of Errors & Omissions coverage, W-9 form, Electronic Funds Transfer Form with a voided check copy, Individual Agency Agreement, Medicare Supplement Products Agency Agreement, Addendum to Agency Agreement with Business Associate and Agent/Broker Conflict of Interest Certification and Disclosure Form. All forms with the exception of license and E&O can be found on the broker section of bcbst.com.

Agent Commission Information

For the Individual Under 65 business, beginning January 1, 2011 broker commissions are paid on an as collected basis. Broker commissions on Medicare supplement policies are annualized.

Agent or agency of record letters are **not** accepted on individual policies.

BCBST does reserve the right to modify commission payment schedules. Payment of your commissions is set out as part of your agreement with BCBST.

Under 65 Commissions

Commissions on first year and renewals are paid on an as collected basis. Once the premium payment is collected, you will receive the appropriate commission percentage on the next month's payment.

Medicare Supplement First Year Commissions

For each case sold, you will receive your monthly commission amount times 12 **based on premium received for the first full monthly billing.** By using the first full month's billed premium to calculate your commissions, you receive the full commission you are entitled to based on the actual monthly premium your customer pays.

Medicare Supplement Renewal Commissions

Annualized commissions for renewals will be based on the first month's premium posted for any following year after the initial year of coverage.

Short-Term Coverage Commissions

Commissions for short-term policies will be based on the one-time processed payment for the policy.

When Are Commissions Paid?

Commission statements will be available no later than the 10th of the month following the month in which the premium is posted. A schedule of commission cut-off dates is available on the broker section of bcbst.com. Please note that cut-off dates vary each month.

Please note that effective dates and the timing of payments can affect when you will receive commissions for a particular policy.

Commissions For Partial Premium Payments

Commissions are calculated and paid based on premiums received up to the amount of premium billed for the first full monthly billing. If the total premium for a particular due date has not been paid prior to commission processing, you will receive a pro-rated commission amount for that commission run. **However, once the premium is paid in full, you will receive the balance of your commissions for that due date.** This, of course, could mean that it may take more than one month to receive your full commissions for a policy that was not paid in full at the time of your commission payments.

Possible Commission Payment Delays

To ensure accuracy of every Individual policy issued, each policy is subject to a series of quality checks before the first billing is released. Commissions are calculated and paid based on premium processed up to the first full month's billing. If the policy has not billed, commissions cannot be determined. Consequently, if a policy is issued toward the end of the month when commission payments are calculated, the policy may still be in the quality assurance process and the billing not yet released. In this case, you should receive your commission with the next month's commission run.

For policies paid by bank draft, commissions will be paid on the next monthly commission statement after the first bank draft processes.

How Do I Verify the Status of New Policies Sold?

You can verify the status of new policies through BlueAccess on bcbst.com. Please see the Agent Online Tools section of the guide for more details.

How Do Policy Changes Affect Commission Payments?

Commissions for any policy changes within the year after you receive your commissions, whether first year or renewal, will be reflected at the time your next commission for that policy is paid. This would include any increase or decrease in benefits that would affect the amount billed and subsequently the amount of commission paid.

How Do Policy Terminations Affect Commission Payments?

On policies that are under a commission structure that is annualized, if a policy cancels within the year after you have received your full annual commission, a chargeback amount will be applied. This amount represents the prorated portion of the commission based on the termination date of the policy. It will appear as a negative adjustment at the end of your commission statement.

What Does a Negative Balance on the Commission Statement Mean?

Because some of your commissions are annualized and chargeback amounts are applied toward your commissions, you may see a negative balance on your commission statement. This is an amount that BCBST has overpaid you. You are required to repay any overpayment which results in a negative balance.

Any negative balance on your account will automatically be deducted from your earned commissions on future statements. If the negative balance remains longer than three months, you will receive a letter requesting payment of the outstanding negative balance.

Overview of Individual & Medicare Products

PersonalBlue℠

PersonalBlue offers a variety of traditional PPO and high-deductible plan offerings – and comprehensive benefits – so you can be confident in knowing that PersonalBlue plans will provide your clients with a plan that fits their needs and budget. Your clients can:

- Choose a traditional PPO plan at a variety of deductible levels ($1,000, $1,500, $2,500, $3,500, $5,000 or $7,500) or select a high-deductible health plan that is compatible with a health savings account
- Benefit from a choice of two networks (all plans offer Network P and Network S)
- Take advantage of unlimited wellness benefits, including immunizations, well care exams, cervical and prostate cancer screenings and mammography screenings
- Have access to prescription drug and behavioral health coverage with all plans
- Rest easy knowing that benefits are available for office surgeries, routine diagnostic lab tests, X-rays and even advanced radiological imaging – like CAT scans, CT scans, MRI's, PET scans, nuclear medicine and other similar technologies
- Add optional maternity, dental, vision and life insurance coverage

Short-Term Personal Health Coverage

Short-Term Personal Health Coverage is ideal for dependents who have aged off their parents' medical insurance or people who are between jobs or waiting for group or other coverage to begin. Coverage is available for one, two or three month periods. Applicants are limited to the purchase of four consecutive short-term policies, with combined coverage not to exceed 12 months. If additional coverage is needed, the applicant must wait six months before applying for another short-term policy. This product offers four different deductible and coinsurance plan designs. Prescription drugs are covered subject to the medical deductible and coinsurance.

Pre-existing conditions are not covered, and there is no credit for prior creditable coverage. Any condition that occurs during a member's initial short-term policy will not be covered under subsequent short-term policies.

Short-Term Personal Health Coverage uses Blue Network P providers and the RX03 pharmacy network. Dental, vision and maternity coverage are not available on these plans.

These policies are considered creditable coverage for individual HIPAA coverage as long as they are not the last type of coverage the individual had. The last coverage must be employer-sponsored group or governmental health coverage to meet the HIPAA eligibility requirements.

Personal Dental Coverage

Personal Dental Coverage is available as a stand-alone benefit, or it may be purchased with our underwritten and guaranteed issue individual health insurance. Personal Dental Coverage can be added at any time.

Personal Dental Coverage is available for adults and children (ages 2 through 17) and features an annual deductible of $50 per person or $150 per family. Preventive and diagnostic services are not subject to this deductible. Benefits are paid based on a Maximum Allowable Charge (MAC), as specified in the Schedule of Benefits up to an annual of maximum of $1,000 per person once the deductible has been met. The member can choose any dentist, but they may find greater savings by going to an in-network dentist. No coverage is offered for orthodontia services.

If an individual purchases dental coverage with a medical policy, everyone covered under the medical policy will be enrolled. A monthly premium per each eligible person will be added to their medical premium. Applicants simply check the "dental" box on the individual health coverage application APP-IHCA.

Individuals may apply for stand-alone Personal Dental Coverage online, or by completing and returning the application found in COMM-537. Applicants may not be covered under any other individual or group dental policy or plan of benefits.

Personal VisionBlue Coverage

Personal VisionBlue is available with the purchase of BCBST medical or dental coverage or may be added to an existing BCBST policy. It is only available in Tennessee. Premiums will be included on the monthly billing statement for each member covered under an existing BCBST plan. All members on the policy will be covered. If terminated, coverage is cancelled for all members on the policy. If VisionBlue coverage is terminated, it may not be re-added to the same policy.

Personal VisionBlue Coverage offers a choice of two plans:

Personal VisionBlue Plan Exam Only
This plan includes a routine vision exam for each member covered under the plan every 12 months for a $10 copay from network providers. Other services, such as the purchase of glasses and contacts, receive discounted pricing when a network provider is used. Additional discounts are also available from network providers.

Personal VisionBlue Plan Exam Plus Materials
This plan provides both an eye exam and materials for each member covered under the plan. A $10 copay for an eye exam and a $25 copay for eyeglass lenses are available from network providers. An allowance of $100 for frames or contact lenses is also available under the plan when a network provider is used. Out-of-network allowances are available, but are not as large as when the network is used. Additional discounts on lens options and non-covered items are also available from the network providers.

Guaranteed Issue Plans

These plans are for people who have lost group coverage, TennCare coverage or had their job transferred overseas and have exhausted their COBRA coverage or state continuation coverage (if it was available). These plans do not have any pre-existing condition waiting periods or exclusions like the underwritten plans. Applicants must meet strict eligibility requirements covered later in this guide. BCBST offers two guaranteed issue products, SimplyBlue and Personal Health Coverage.

SimplyBlue & SimplyBlue*Plus* Guaranteed Issue plans offer a lower-cost, basic level of coverage and include Blue Network S providers. Personal Dental Coverage and Personal VisionBlue are available on all SimplyBlue and SimplyBlue*Plus* plans for an additional monthly premium.

The **Personal Health Coverage Guaranteed Issue** plans offer a richer medical and pharmacy benefit design, including copay coverage for generic, preferred brand and non-preferred brand drugs. These plans use Blue Network P providers and the RX03 pharmacy network. Optional maternity coverage is available on two of the three plans for an additional monthly premium. Personal Dental Coverage and Personal VisionBlue are available for an additional monthly premium.

Medicare Plans

BCBST's Medicare sales department offers a full portfolio of products to compliment original Medicare including: Medicare Advantage plans (medical only and medical and Medicare Part D prescription drug plans), Medicare Part D Prescription Drug plans and Medicare Supplement plans. The Medicare Advantage plans (BlueAdvantage*) and Medicare Part D Prescription Drug Plans (BlueRx℠) require agents to go through an annual training, testing and credentialing process. Training must be completed in order to market the BlueAdvantage plans. BlueRx was removed from the agent portfolio but training is required to retain renewal commissions on existing BlueRx business. For more information on this training, please contact Medicare Broker Credentialing at Medicare_Broker_Credentialing_GM@bcbst.com or call the agent line at 1-800-351-9325 and choose Option 1 for Medicare Products. For information on these products, please visit BlueAccess on bcbst.com.

BlueElite℠ includes three standard Medicare Supplement plans, A, D and F. These plans do not offer any prescription drug coverage.

Underwritten Individual Under 65 Product Guidelines

Eligibility Requirements

To be eligible to enroll in any Individual Under 65 products, applicants:

- Must be residents of Tennessee (must have a street address in Tennessee, post office boxes do not qualify)
- Must not reside outside the United States for more than six months out of the year
- Must not be covered under any other individual, group or government-sponsored health policy, plan or benefits program, including Medicare
- Must maintain a work/student visa and/or a valid green card and must have lived in the United States for a minimum of 6 months if not a United States citizen*

**See Underwriting Guidelines for Brokers/Agents*

BCBST will decline applicants age 19 or older who are currently pregnant. If eligible, these individuals can apply for Guaranteed Issue coverage.

Applicants who are not replacing health insurance coverage: Applicants age 45 or over, who have had no health insurance coverage within the past year, may be asked to submit medical records to verify current state of health.

Eligible Dependents: Applicants can apply to cover their dependents through age 25, or to age 26.

Eligible dependents include the applicant's current spouse, as recognized under Tennessee law. Dependents also include the applicant's or the spouse's (1) natural children; (2) legally adopted children (including children placed with them for the purpose of adoption); (3) stepchild(ren)); or (4) children for whom the applicant or his or her spouse is the legal guardian.

Eligibility for Applicants age 50 or over: Individuals age 50 or over (and do not use tobacco products*) must have consulted a physician for a complete physical exam within the past 2 years to be considered for coverage. Physical exam for females must include height/weight, mammogram, pap smear, cholesterol screening and blood pressure readings. Physical exam for males must include height/weight, cholesterol screening, blood pressure readings and PSA results.

**See section under "tobacco use" for requirements for tobacco users.*

Eligibility for Applicants age 65 or over: All applicants age 65 and over will be required to submit medical records which document medical history and current state of health. This applies only to the underwritten products. It does not apply to any of our Medicare products. Applicants enrolled in Medicare are not eligible for individual under 65 products.

Effective Dates

The applicant has four choices for the effective date of the policy:

1. First day of the month following approval.
2. Day after approval.
3. Day after their BCBST Short-Term policy terminates.
4. Other requested effective date.

On the first two options above, the effective dates may be moved forward one time. This request may be up to 45 days from the original effective date. This request must be received in writing from the applicant and must be received within the free look period of the policy. Proof of other coverage must be provided to move an effective date forward.

If an applicant requests a specific effective date, this date cannot be changed once the policy has been approved. If the requested date is prior to our receipt date, it will be changed to the day after receipt. In addition, the applicant will be responsible for all premiums due from this effective date.

If the applicant elects to have his underwritten policy become effective the day after his short-term policy (written through us) terminates, we will allow the length of time he was covered under any consecutive short-term policies to be applied towards the pre-existing condition waiting period of the underwritten policy.

Non-Tobacco Rates

To qualify for a non-tobacco rate, each eligible person must not have smoked cigarettes, used tobacco in any form or used products containing nicotine within the past 12 consecutive months.

12-Month Pre-Existing Condition Waiting Periods

All underwritten policies include a 12-month waiting period during which no benefits will be paid for pre-existing conditions.* A pre-existing condition is any physical or mental condition that was present during the 12 month period before coverage became effective for which: (1) medical advice, diagnosis, care or treatment was recommended or received; or (2) symptoms existed and a reasonably prudent person would have sought medical advice, diagnosis, care or treatment from a Provider of health care services. **Please make sure applicants understand this waiting period when they apply for coverage under one of these plans.** *Applicants will be given credit toward the standard 12-month pre-existing condition waiting period upon enrollment if (1) the applicant is rolling off a BCBST commercial group plan; (2) and has not had a gap in BCBST coverage; and (3) any gap between the BCBST group and individual plan does not exceed 31 days. It is important to keep in mind that these individuals will still have to pass underwriting, and are still subject to any exclusion riders and rate-ups that may be applicable.

Note: Dependents under age 19 applying for a new policy will not have a pre-existing condition waiting period, nor will they be subject to benefit exclusion riders. They will still go through underwriting and be subject to rate-ups, if applicable.

Benefit Exclusion Riders

BCBST may deem it necessary to place a benefit exclusion rider on the policy for an applicant or covered dependent age 19 or older. Services, supplies, treatment, charges or medications may be exluded from coverage. **Please make sure that applicants understand that no benefits will be paid on this condition(s) for the life of the policy.** The member may request removal of the exclusion rider through the reconsideration process. Underwriting decisions will be based upon specific criteria related to the medical conditions(s) in question. Please refer to the underwriting Guidelines for Broker/Agents and Reconsideration Guidelines sections for more information.

Personal Dental Coverage Guidelines

Personal Dental Coverage may be added at initial enrollment or any time during the life of the policy. It can be deleted without terminating the medical policy. The APP-IHCC change application must be used to add or remove dental when a subscriber also has a medical policy. Those only applying for stand-alone Personal Dental Coverage may do so online, or by completing the application found in COMM-537. Applications for children under the age of 2 will not be accepted.

When added, Personal Dental Coverage will apply to all individuals covered under the medical policy. Adult rates apply to anyone age 18 and over. Child rates apply to anyone age 2 through 17. The appropriate monthly dental premium for each individual will be added to the monthly medical premium.

Personal VisionBlue Guidelines

With Medical Coverage: Personal VisionBlue Coverage may be added to a medical policy at initial enrollment or any time during the life of the policy. It can be deleted without terminating the medical policy. Once dropped, the vision coverage cannot be added back to the medical policy at a later date. The APP-IHCC change application must be used to add or remove vision when a subscriber also has a medical policy. When added to a medical policy, VisionBlue will apply to all individuals covered under the medical policy. The appropriate monthly vision premium for each individual will be added to the monthly medical premium.

With Personal Dental Coverage: Personal VisionBlue Coverage may be added to a stand-alone dental policy at initial enrollment or any time during the life of the policy. It can be deleted without terminating the personal dental policy. Once dropped, the vision coverage cannot be added back to the dental policy at a later date. The APP-144 Personal Dental Change Application must be used to add or remove vision when a subscriber also has a stand-alone dental policy. When added to the dental policy, VisionBlue will apply to all individuals covered under the dental policy. The appropriate monthly vision premium for each individual will be added to the monthly dental premium.

Maternity Rider Guidelines

The maternity rider can be included as part of the coverage at the time the policy is issued, or when one of the following qualifying events occurs:

1) **Within 31 days of marriage (a copy of the marriage certificate must be provided);**
2) **Within 31 days of a spouse's loss of employer sponsored coverage (a copy of the certificate of creditable coverage must be provided); or**
3) **When a dependent reaches his/her age limit and splits from the parent's policy, they are permitted to add maternity coverage. A change form must be submitted within 31 days of the dependent's termination date.**

The maternity rider may be requested on the original application or added or deleted by completing the APP-IHCC change application. Individuals cannot be pregnant at the time of application.

Once the maternity rider has been removed, the rider cannot be added back unless one of the qualifying events above occurs.

Maternity Benefits: Under the rider all maternity benefits will be paid on the same basis as any other condition and subject to all policy provisions.

Maternity 10-Month Waiting Period: This waiting period applies to claims for maternity benefits only. It is completely separate from the 12-month pre-existing condition waiting period. If the delivery date occurs after the 10-month waiting period has been satisfied, any charges billed as part of the global maternity bill on the delivery date will be covered. Benefits do not apply to services billed separately and received during the 10-month waiting period.

Adding Dependents

After the applicant is covered, he/she may apply to add a dependent who becomes eligible after the initial enrollment, as follows:

1. A newborn child is covered from the moment of birth, and a legally adopted child, or a child for whom the member or the member's spouse has been appointed legal guardian by a court of competent jurisdiction, will be covered from the moment the child is placed in their physical custody. The subscriber must enroll the child within 31 days from when he or she has custody of the child by completing a change application.

   If the subscriber fails to submit the change application and an additional premium is required to cover the child, the policy will not cover the child after 31 days from when the subscriber gained custody of the child. If no additional premium is required to provide coverage to the child, the member's failure to enroll the child does not make the child ineligible for coverage. However, BCBST cannot add the child to the subscriber's coverage until notified of the child's birth. If the legally adopted (or placed) child has coverage for his/her medical expenses from a public or private agency or entity, the subscriber may not add him or her to the policy until that coverage ends.
2. Any other dependent may be added as a covered dependent if the subscriber completes and submits a signed change application to BCBST. The health questionnaire must be completed, and all underwriting guidelines will apply in determining eligibility for coverage. The earliest these dependents can be added to the policy is the 1st of the month following receipt of the change form, unless there is a qualifying event such as marriage. In the case of marriage, if the subscriber wishes to add the spouse as of the marriage date, the change application must be received within 31 days of the marriage date and a copy of the marriage certificate will be required.

The APP-IHCC change form should be used to add or remove dependents from a policy.

BlueCard PPO Program

With BCBST, subscribers carry an ID card that's recognized and accepted by doctors and hospitals throughout the United States. BlueCard® Worldwide is a special hospital network designed for our subscribers who need health care services when traveling outside of the BCBST service area. BCBST will help locate the nearest PPO doctor or hospital and the subscriber's medical bill will be handled through the BlueCard system.

REMEMBER: Subscribers are responsible for receiving prior authorization from BCBST. If prior authorization is not received, benefits may be reduced or denied. Subscribers can call the BlueCard PPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583) for prior authorization. In case of an emergency, subscribers should seek immediate care from the closest health care provider.

Premiums, Billing and Payment Options

Initial Premium Payment: For all underwritten Individual Under 65 products, paper applicants may choose to get billed the first month's premium or they may pay the first month's premium by eCheck. Online applications require an initial premium payment, which can be made by eCheck or credit card.

If the premium submitted is less than the amount due, the applicant will be billed for the additional premium. If the amount submitted is more than the amount due, the difference will be credited to the applicant and reflected on his or her next billing statement when their application is accepted and a policy is issued. If additional premium payment is required, we will bill the applicant for the additional amount.

Subsequent Premium Payments: The subscriber will be billed monthly. Payments can be made by eCheck by

calling the telephone number listed on the subscriber billing statement or online behind BlueAccess.

Subscribers will be billed approximately the 15th day of the month prior to the due date, if their previous payment was received timely. The subscriber will not be billed for the next billing period until payment for the previous billing period is received and processed. The due date is always the first day of the month for the period billed.

The entire premium amount due must be paid in full. Partial payments are not acceptable and will be returned to the subscriber. Any overpayments will be credited to the subscriber's account and reflected on their next billing statement.

If premium payment is not received within 31 days from the due date, the policy will be cancelled for non-payment and a termination letter will be sent to the subscriber.

Automatic Payment Options: Once a subscriber is approved and a policy is issued, he/she may make automatic electronic premium payments. The subscriber may pay online with eCheck by going to bcbst.com and registering for BlueAccess. In addition, an automatic payment authorization form will be included with the policy mailed to the subscriber.

Bank Drafts: Bank drafts are processed on the 4th day of the month for which the premium is due. The draft from the subscriber's account usually occurs between the 6th and 10th day of the month. If the bank draft is rejected by the subscriber's bank, the subscriber will be charged a $25 non-sufficient funds fee, the policy will be changed to a paper billing and the subscriber will be billed for premiums due. The subscriber must complete a new bank draft authorization form to return to the bank draft method of payment.

Note: Accounts set up for a bank draft arrangement will not receive a paper billing or receipt of the transaction. A record of these transactions should be available through the subscriber's bank.

Terminations due to non-payment: Claims processing and pre-certification will be suspended 15 days after the due date if premiums have not been applied to the subscriber's account. Policies will be terminated 31 days after the premium due date if premiums are not received.

Reinstatement eligibility: If a policy has been terminated for non-payment, it is eligible for reinstatement one time in a 12-month period. The request to reinstate must be in writing and must be received at BCBST within 60 days from the last day the policy was in effect. If reinstated, the effective date of the reinstatement will be retroactive to the termination date, without a lapse in coverage. The subscriber will be responsible for paying all premiums due at the time of reinstatement, including the premiums for the next billing cycle if it is time for that cycle to bill. In addition, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

A second reinstatement within a 12-month period due to extenuating circumstances can be granted with BCBST management approval. If approved, the subscriber would have to set up an automated payment method and pay all back premiums due. Once again, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

Residency Certification Processes

BCBST individual policies require that subscribers maintain Tennessee residency to continue eligibility for coverage. In order to monitor this requirement, two processes have been established.

Annual Process Performed by Membership:

- Annually, the membership area will perform a residency certification process.
- Any subscriber who has an out-of-state address in the BCBST system (Facets) will receive a letter requesting that the subscriber attest to the fact that he or she is a resident of Tennessee. The attestation form is attached to the letter.
- If the subscriber completes and returns the form within 30 days and the subscriber attests that he or she is a resident of Tennessee, coverage will continue.
- If the subscriber does not complete and return the form within 30 days or if the subscriber conveys that he or she is no longer a resident of Tennessee, Membership will help the subscriber obtain coverage with the BlueCross BlueShield Licensee that services the area in which he or she lives. The subscriber's BCBST policy will be terminated within 90 days.

Continuous Process performed in Underwriting (effective November 1, 2008):

- Based on the results of preliminary investigations

and/or claim patterns, Underwriting will request information from subscribers to validate their physical street address.

- Subscribers are required to complete the Validation of Residence Questionnaire and provide two documents from the List of Acceptable Residency Verification Documentation. Two forms of documentation will be required. Documents provided must be current and show the subscriber's name and physical street address. If the subscriber is a child under 5 years of age, documents with parent's name and physical street address will be accepted. (PO boxes not accepted.) For privacy concerns, financial data on any of the documents may be marked through. Please note that originals are not required and photocopied documents are preferred. Any two documents from the following list are acceptable:
  - Current utility bill (i.e. telephone, electric, water, gas, cable, etc.) Only one utility bill will be accepted. Initial deposit receipt is not acceptable.
  - Current bank statement (checking account only, not checks)
  - Current rental/mortgage contract fully signed and executed, or receipt including deed of sale for property
  - Current employer verification including paycheck/ check stub
  - Current automobile policy (not wallet cards) or current Tennessee motor vehicle registration
  - Current IRS tax reporting W-2 Form
  - Receipt for personal property or real estate taxes paid within the last year (Receipt should show subscriber's name and current address)
  - Current college tuition bill (Required for full-time students age 18 and over if attending an out-of-state college)
  - Most recent business tax return if you own a business headquartered in Tennessee (i.e. Form 1120, 1120A, 1120S/K1, 1040/Sch C, or 1065/ K1, etc.)
- If the subscriber is a child under 18 years of age, two documents with parent's name and physical street address will be accepted as above AND must include one of the following documents:
  - If the child is 5 years of age or older and IS NOT home schooled, please provide a copy of the child's most current school registration records.
  - If the child is 5 years of age or older and IS home schooled, please provide a copy of the state registration for home schooling.
- If the subscriber provides appropriate documents within 30 days of the request, and this documentation confirms that the subscriber is a resident, coverage will continue.
- If the subscriber does not provide appropriate documentation, indicates he or she is not a resident of Tennessee, or does not respond within 30 days, Underwriting will refer the case to Membership who will assist the subscriber in obtaining coverage with the BlueCross BlueShield Licensee that services the area in which he or she lives. The subscriber's BCBST policy will be terminated within 90 days.

Persons whose policies have been terminated through either process will have to provide proof of residency if they apply for individual coverage with BCBST in the future.

Completing Applications

Applicants may complete applications online at bcbst.com or use our universal paper application (APP-IHCA) for all individual underwritten products. The universal change application (APP-IHCC) should be used when changing product or plan benefits.

The application has medical questions and the applicant must answer for himself/herself and all eligible dependents he or she wants to cover. All medical questions must be answered as they relate to each applicant. Those questions answered "yes" require additional details. The application must be fully completed for the underwriting process to begin. **Incomplete applications may not only delay effective dates, but can also result in the termination of the underwriting process.**

The application must be signed and dated by the applicant and spouse, if applicable. Signatures of dependents age 18 and older are also required. The agent must sign the application if he or she assisted in completing the application.

Applicants will have 50 days to submit medical records, if requested. When medical records are not received within this time frame, the application will be rejected due to missing information and a policy will not be issued. The applicant will have to start the application process over.

Applications should be submitted as soon as possible after the applicant signs them. However, no initial submission of an application will be accepted if the

signature date is more than 30 days old when received at BCBST. Pending applications will be closed out after 50 days at BCBST if the requested information has not been received. The oldest possible signature date on an application pending for processing is 90 days.

If an application is returned due to missing signatures, inaccurate signature date and/or incomplete medical, tobacco use, height or weight information, it will be considered a new application when resubmitted. Health information must be reviewed and updated with any changes in health status documented. Sections 4 and 8 of the application must be resigned and redated by all persons applying for coverage where appropriate.

Once the applicant submits the application, BCBST will determine eligibility of coverage.

Tips for submitting applications:

- Use APP-IHCA for new applicants. This can be completed online at bcbst.com or by paper.
- For product changes, please refer to the Guidelines for Changing Products beginning on page 52 of this guide.
- Applications should be completed in blue or black ink.
- Applications can be submitted by mail, fax or online.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.

Health History Guidelines

Automatic declines for age 19 and older *(effective for applications received on or after 09-23-10)*
Applicants age 19 and older diagnosed with the following conditions should be automatically declined.

Acromegaly
AIDS/HIV infection
Alcohol Abuse or Dependency (within last 5 years)
ALS (Amyotrophic Lateral Sclerosis-Lou Gehrig's Disease)
Alzheimer's Disease
Androgen Insensitivity Syndrome
Angioplasty (coronary artery disease)
Aortic Arch Arteritis
Aplastic Anemia
Arteritis, Necrotizing
Asbestosis
Ataxia Telangiectasia
Banti's Syndrome
Behcet's Syndrome
Bipolar Disorder
Cancer (within the last 10 yrs, see underwriting guidelines for exceptions)
Cardiomyopathy
Caroli's Disease
Charcot-Marie-Tooth Disease
Cirrhosis of the Liver
Coagulation Defect (Hemophilia)
Congenital Familial Polyposis (Gardner's Syndrome)
(Peutz-Jegher's Syndrome)
Congestive Heart Failure
Coronary Artery Bypass Surgery, history
Coronary Artery Disease
Crohn's Disease
Cushing Syndrome
Cystic Fibrosis
Dermatomyositis
Diabetes Mellitus, Type I and II
Diamond Blackfan Anemia
Down's Syndrome
Ebstein's Malformation
Ehlers-Danlos Syndrome
Eisenmenger's Complex
Esophageal Varices
Hand-Schuller-Christian Disease
Heart Attack-Myocardial Infarction, history
Hemiplegia
Hemochromatosis
Histocytosis X
Huntington's Chorea
Hypoplastic Anemia
Kidney disease (Chronic)
Klinefelter's Syndrome
Letterer-Siwe Disease
Lupus Erythematosus (Systemic Lupus)
Lymphoblastoma
Manic Depression
Marfan's Syndrome
Microcephalus
Mixed Connective Tissue Disorder
Multiple Myeloma
Multiple Sclerosis
Muscular Dystrophy
Myocardial Infarction
Nephrocalcinosis
Neurofibromatosis
Obesity Surgery
Osteogenesis Imperfecta
Pancreatitis, Chronic
Paralysis (permanent)
Paraplegia
Parkinson's Disease
Polycystic Kidney Disease
Portal Hypertension
Pseudotumor Cerebri
Quadriplegia
Renal Failure (Chronic)
Schizophrenia
Senile Dementia
Sickle Cell Anemia
Sjogren's Syndrome
Systemic Lupus Erythematosis (SLE)
Tetralogy of Fallot
Thalassemia Major
Transplant - Bone Marrow
Transplant – Organ
Tricuspid Atresia
Tuberous Sclerosis Complex
Ulcerative Colitis
Ulcerative Proctitis
Von Recklinghausen's Disease
Wegener's Granulomatosis
Wilson's Disease
Zollinger-Ellison Syndrome

Adult Height and Weight

The build charts on the following pages were developed using Body Mass Index (BMI), a measurement of height and weight. BMI correlates with body fat.
The formula for calculating a person's BMI score is:

$$\text{BMI} = \frac{\text{Weight in Pounds}}{(\text{height in inches}) \times (\text{height in inches})} \times 703$$

The National Heart, Lung, and Blood Institute classifies adult BMI as follows:

Weight Class	BMI Score
Underweight	< 18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese, Class I	30.0 – 34.9
Obese, Class II	35.0 – 39.9
Extreme Obesity	40.0+

Adult* Height & Weight - Female

Height			Minimum**	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:					
				Age 15-18	Age 19-25	Age 26-44	Age 45-54	Age 55-59	Age 60-64
4 Ft.	8”	(56”)	78	131+	133-158	135-169	138-177	140-177	142-177
	9”	(57”)	81	136+	138-164	141-176	143-184	145-184	148-184
	10”	(58”)	84	141+	143-169	146-182	148-190	150-190	153-190
	11”	(59”)	87	146+	148-176	151-188	153-197	156-197	158-197
5 Ft.	0”	(60”)	90	151+	153-181	156-195	158-204	161-204	163-204
	1”	(61”)	93	156+	159-187	161-202	164-211	166-211	169-211
	2”	(62”)	96	161+	164-193	166-208	169-218	171-218	174-218
	3”	(63”)	99	167+	170-200	172-215	175-225	178-225	181-225
	4”	(64”)	102	172+	175-206	178-222	180-232	183-232	186-232
	5”	(65”)	105	177+	180-213	183-228	186-239	189-239	192-239
	6”	(66”)	108	182+	185-220	188-236	191-247	194-247	198-247
	7”	(67”)	112	188+	191-226	194-243	197-254	200-254	204-254
	8”	(68”)	115	194+	197-233	200-250	203-262	206-262	210-262
	9”	(69”)	119	199+	202-240	206-258	209-270	212-270	216-270
	10”	(70”)	122	205+	208-247	212-266	215-278	219-278	222-278
	11”	(71”)	125	211+	215-255	218-273	222-286	225-286	229-286
6 Ft.	0”	(72”)	129	217+	221-261	224-281	228-294	231-294	235-294
	1”	(73”)	133	224+	228-268	231-289	235-302	238-302	242-302
	2”	(74”)	136	229+	233-277	237-297	241-311	245-311	249-311
	3”	(75”)	140	235+	239-284	243-305	247-319	251-319	255-319
	4”	(76”)	144	242+	246-292	250-313	254-328	258-328	262-328
	5”	(77”)	148	248+	252-299	256-321	260-336	264-336	269-336
	6”	(78”)	151	255+	259-307	263-330	268-345	272-345	276-345
	7”	(79”)	155	261+	265-315	270-339	274-354	279-354	283-354

Note: Base rates are subject to increase depending on underwriting determination.

*Applicable for primary applicants and spouses age 15 or older.

** Any applicant who is below the minimum weight guideline may be considered if he/she submits a health statement from their physician indicating any current or prior medical conditions.

Adult* Height & Weight - Male

Height			Minimum**	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:								
				Age 15-18	Age 19-25	Age 26-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64
4 Ft.	8”	(56”)	78	137+	137-156	139-159	139-162	141-168	141-174	144-177	146-177	148-177
	9”	(57”)	81	142+	142-162	144-165	144-168	147-175	147-181	149-184	151-184	154-184
	10”	(58”)	84	147+	147-164	149-170	149-174	152-180	152-187	154-190	156-190	159-190
	11”	(59”)	87	152+	152-173	154-176	154-180	157-187	157-194	159-197	162-197	164-197
5 Ft.	0”	(60”)	90	157+	157-179	160-183	160-186	162-193	162-200	164-204	167-204	170-204
	1”	(61”)	93	162+	162-185	165-189	165-192	167-200	167-207	170-211	173-211	176-211
	2”	(62”)	96	167+	167-191	170-195	170-199	173-206	173-214	175-218	178-218	181-218
	3”	(63”)	99	173+	173-199	176-202	176-206	179-213	179-221	182-225	185-225	188-225
	4”	(64”)	102	178+	178-205	181-208	181-212	184-220	184-228	187-232	190-232	193-232
	5”	(65”)	105	185+	185-211	188-214	188-218	191-227	191-235	194-239	197-239	200-239
	6”	(66”)	108	190+	190-218	193-221	193-226	196-234	196-243	199-247	202-247	206-247
	7”	(67”)	112	196+	196-224	199-227	199-232	202-241	202-250	205-254	208-254	212-254
	8”	(68”)	115	202+	202-231	205-235	205-240	209-249	209-258	212-262	215-262	219-262
	9”	(69”)	119	207+	207-239	211-243	211-247	214-256	214-265	218-270	221-270	225-270
	10”	(70”)	122	213+	213-245	217-249	217-254	220-263	220-273	224-278	227-278	231-278
	11”	(71”)	125	219+	219-252	223-256	223-261	226-271	226-281	230-287	234-287	238-287
6 Ft.	0”	(72”)	129	225+	225-258	229-263	229-268	233-279	233-289	236-294	240-294	244-294
	1”	(73”)	133	233+	233-265	237-270	237-276	240-286	240-297	244-302	248-302	252-302
	2”	(74”)	136	239+	239-273	243-278	243-284	247-295	247-306	251-311	255-311	259-311
	3”	(75”)	140	245+	245-281	249-286	249-292	253-303	253-314	257-319	261-319	266-319
	4”	(76”)	144	252+	252-289	256-295	256-300	260-311	260-322	265-328	269-328	273-328
	5”	(77”)	148	258+	258-296	262-302	262-307	267-319	267-330	271-336	275-336	280-336
	6”	(78”)	151	265+	265-304	269-310	269-316	274-327	274-339	278-345	283-345	287-345
	7”	(79”)	155	271+	271-311	276-317	276-323	280-336	280-348	285-354	289-354	294-354

Note: Base rates are subject to increase depending on underwriting determination.

*Applicable for primary applicants and spouses age 15 or older.

** Any applicant who is below the minimum weight guideline may be considered if he/she submits a health statement from their physician indicating any current or prior medical conditions.

Underwriting Guidelines for Brokers/Agents

Effective for Applications with Effective Dates On or After 09-23-10

Note: These guidelines replace the guidelines that appear in earlier versions of the Individual Products Agent's Guide.

The following information provides possible underwriting decisions for the conditions listed. **If a benefit exclusion rider is placed on a policy, the rider will be in effect throughout the life of the policy.*** In all cases, the final underwriting decision will be based on the member's overall medical history.

We will consider removal of a benefit exclusion rider upon the member's written request and a current medical report regarding the condition. Exclusion rider guidelines are only applicable to individuals age 19 and older. Rating factors for individuals age 19 and older will range from 0% to 120% based on the risk assessment by underwriting. Rating factors for individuals under age 19 will range from 0% to 300% based on the risk assessment by underwriting.

Underwriting guidelines are subject to change without prior notice.

**Special guidelines for selected benefit exclusion riders have been added for some high-deductible plans. See the chart at the end of this section for specific criteria for each high-deductible plan.*

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Abnormal pap smears	See Cervical Dysplasia		
Abnormal test results	Anyone who has been recommended, advised, or scheduled for diagnostic testing, lab procedures or treatment will be declined until testing is complete, and a definitive diagnosis has been established		Anyone who has been recommended, advised, or scheduled for diagnostic testing, lab procedures or treatment will receive the maximum rate up until testing is complete, and a definitive diagnosis has been established
Acne	See Rider Guidelines	**Mild to moderate cases**, no prescription medication: No rate or rider **Mild to moderate cases**, current treatment: Rider **Moderate or severe cases (Accutane or equivalent, dermabrasion, cryotherapy, cosmetic surgery, intra-lesion injection)**, treatment within the past 2 years: Rider ***See special guidelines for High Deductible Plans**	**Mild to moderate cases**, no prescription medication: No rate up **Mild to moderate cases**, current treatment with prescription medication: Rate for medication **Moderate or severe cases** (Accutane or equivalent, dermabrasion, cryotherapy, cosmetic surgery, intra-lesion injection): Rate for condition and medication
Acoustic Neuroma	Decline if unoperated or surgery to remove within the past 6 months, otherwise, individual consideration based on time since complete recovery	N/A	Present, **unoperated**: Maximum rate up **Operated**, complete recovery, no residual complications, < 5 years: Rate based on time since recovery **Operated**, complete recovery, no residual complications, > 5 years: No rate up
Acromegaly	Decline	N/A	Maximum rate up
ADD/ADHD (Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder)	See rider guidelines	Treatment within the past 2 years: Rider ***See special guidelines for High Deductible Plans**	**Stable, infrequent physician visits** and/or medication adjustments: Rate for medication only **Frequent medication changes**, psychotherapy: Rate for condition and medication
Adhesions	See rider guidelines	Symptomatic: Rider Operated, < 5 years: Rider Unoperated, asymptomatic < 3 years: rider	**Unoperated, symptomatic:** Maximum rate up **Operated, asymptomatic,** complete recovery: No rate up
AIDS/HIV infection	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Alcohol Abuse or Dependency	Decline if < 5 years since abstinence; individual consideration following 5 years of abstinence, rate up or decline based on current condition; decline any applicant who consistently consumes greater than 4 drinks per day, or who has established a pattern of "binge" drinking, even if there is no diagnosis of alcohol abuse or dependence.	N/A	Maximum rate up if < 5 years since abstinence; individual consideration following 5 years of abstinence, rate based on current condition; Maximum rate up for any applicant who consistently consumes greater than 4 drinks per day, or who has established a pattern of "binge" drinking, even if there is no diagnosis of alcohol abuse or dependence.
ALS (Amyotrophic Lateral Sclerosis-Lou Gehrig's Disease)	Decline	N/A	Maximum rate up
Allergies	See rider guidelines	**Seasonal**, periodic treatment with over the counter or prescribed medications: No rate or rider **Chronic** (year round) treatment with immunotherapy or prescribed medications: Rider ***See special guidelines for High Deductible Plans**	**Seasonal**, periodic treatment with over the counter or prescribed medications: No rate up **Chronic** (year round) treatment with prescribed medication: Rate for medication **Chronic** (year round) treatment with immunotherapy and/or medication: Rate for condition and medication
Alzheimer's Disease or Dementia	Decline	N/A	Maximum rate up
ANA (anti-nuclear antibody) Positive tests	1) Decline if ANA titer 1:80 or above 2) Decline for ANA titer 1:40 or above, underlying disorder under investigation 3) ANA titer 1:40 or above (but not 1:80 or greater), asymptomatic, autoimmune disorder ruled out, no rate up 4) ANA titer <1:40, no rate up	N/A	1) Maximum rate up if ANA titer 1:80 or above 2) Maximum rate up for ANA titer 1:40 or above, underlying disorder under investigation 3) ANA titer 1:40 or above (but not 1:80 or greater), asymptomatic, autoimmune disorder ruled out, No rate up 4) ANA titer <1:40, No rate up
Androgen Insensitivity Syndrome	Decline	N/A	Maximum rating
Anemia	Underwriting based on specific type of anemia and severity of condition (See Aplastic Anemia and Diamond Black Anemia)	N/A	Underwriting based on specific type of anemia and severity of condition (See Aplastic Anemia and Diamond Black Anemia)
Angioplasty	Decline	N/A	Maximum rate up
Ankle Disorder	See rider guidelines	Symptomatic, not recovered or current treatment: Rider	**Surgery anticipated/recommended:** Maximum rate up **Symptomatic, not recovered, or current treatment:** Rate based on treatment and/or complications
Ankle and Foot Disorder (unspecified derangement of ankle and foot joint)	See rider guidelines	Symptomatic, not recovered or current treatment: Rider	**Surgery anticipated/recommended:** Maximum rate up **Symptomatic, not recovered, or current treatment:** Rate based on treatment and/or complications
Anorexia/Bulimia or Other Eating Disorder	Decline if < one year since complete recovery; complete recovery, no further treatment, 1 - 7 years, decline or rate up; > 7 years since complete recovery, no rate up	N/A	**Present:** Maximum rate up **Complete recovery, no further treatment:** < one year, Maximum rate up; 1 - 7 years, Rate up; > 7 years, No rate up
Anxiety/Depression	See Behavioral Health Disorders		See Behavioral Health Disorders
Aortic Arch Arteritis	Decline	N/A	Maximum rate up
Aplastic Anemia	Decline	N/A	Maximum rate up
Arm Amputation	See rider guidelines	Rider	Maximum rate up
Arnold Chiari Malformation	Decline if unoperated; operated (or no surgery anticipated), asymptomatic, no rate up	N/A	**Unoperated:** Maximum rate up **Operated**, asymptomatic: No rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Arteriosclerosis	Decline if diagnosed < one year; diagnosed > one year, individual consideration **(Offer of coverage will be determined by age of applicant and current status, some applicants may still be declined after one year)**	N/A	N/A
Arteritis, Necrotizing	Decline	N/A	Maximum rate up
Arthritis, Osteoarthritis	Severe, surgery contemplated, or continuous/routine treatment with oral or injected steroids: Decline	Current treatment or taking prescription medications: Rider	N/A
Arthritis, Rheumatoid	Decline if: (1) chronic or severe extra-articular manifestation (2) joint replacement anticipated Individual consideration for mild cases with no deformity **(Offer of coverage will be determined by age of applicant and current treatment; some applicants with mild cases may still be declined)**	N/A	**Diagnosed < 5 years:** Maximum rate up **Asymptomatic**, no deformities, no medication, diagnosed > 5 years: Rate up
Arthritis, Rheumatoid, Juvenile	Decline if symptomatic or treatment within the past year; No deformities, asymptomatic, no treatment for > one year: May approve with rate up	N/A	**Asymptomatic**, no deformities or medications, diagnosed < one year: Maximum rate up **Asymptomatic**, no deformities or medications, diagnosed > one year: Rate up **Otherwise:** Rate as Rheumatoid Arthritis
Asbestosis	Decline	N/A	Maximum rate up
Asperger Syndrome	Decline or rate up based on age and time since diagnosis	N/A	Maximum rate up
Asthma	Decline for severe conditions	**Mild exercise induced:** no rate or rider **Mild to moderate** conditions, symptomatic or treatment within the past 2 years: Rider	**Mild exercise induced:** No rate up **Mild, seasonal:** Rate for medication **Moderate conditions**, symptomatic or treatment within the past 2 years: Rate for condition and medication **Severe conditions:** Maximum rate up
Atrial Fibrillation – Chronic	Decline if persistent, paroxysmal, or unresolved < 2 years; resolved > 2 years, individual consideration **(Offer of coverage will be determined by age of applicant and current treatment, some applicants may still be declined after 2 years)**	N/A	**Persistent**, paroxysmal, or unresolved: Maximum rate up **Resolved < 4 years:** Rate based on time since last episode **Resolved > 4 years:** No rate up
Ataxia Telangiectasia	Decline	N/A	Maximum rate up
Autism	Decline or rate up based on age and time since diagnosis	N/A	Maximum rate up
Back/Spine, Disk Disorder	See rider guidelines	Symptomatic or surgery/treatment within the past 2 years: Rider ***See special guidelines for High Deductible Plans**	**Symptomatic or surgery contemplated:** Maximum rate up **Asymptomatic, no treatment < 2 years:** Rate up **Asymptomatic, no treatment > 2 years:** No rate up
Back/Spine - Spinal Curvature, Scoliosis	See rider guidelines	Operated or treated with brace, symptomatic: Rider Operated or treated with brace, asymptomatic > 2 years: No rate or rider ***See special guidelines for High Deductible Plans**	**Symptomatic:** Maximum rate up **Otherwise:** No rate up
Back/Spine, Spinal Manipulation	See rider guidelines	Frequent chiropractic visits: Rider ***See special guidelines for High Deductible Plans**	Rate for underlying condition

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Back/Spine, Spinal Stenosis	See rider guidelines	Rider ***See special guidelines for High Deductible Plans**	**Diagnosed < one year:** Maximum rate up **Diagnosed > one year:** Rate up
Back/Spine, Spondylolisthesis/ Spondylosis	See rider guidelines	Symptomatic: Rider Asymptomatic, no treatment for > one year: No rate or rider ***See special guidelines for High Deductible Plans**	**Symptomatic:** Maximum rate up **Asymptomatic:** Rate based on time since complete recovery
Back/Spine - Sprain or Strain	See rider guidelines	**Single episode**, non-disabling, recovered: No rate or rider **Multiple episodes or chronic:** Rider ***See special guidelines for High Deductible Plans**	**Present, symptomatic or chronic:** Maximum rate up **Single episode, non disabling, recovered:** No rate up **Single episode, disabling, recovered < one year:** Rate up **Single episode, disabling, recovered > one year:** No rate up **Multiple episodes, recovered < 2 years:** Maximum rate up **Multiple episodes, recovered > 2 years:** No rate up
Banti's Syndrome	Decline	N/A	Maximum rate up
Behavioral Health Disorders (phobias, obsessive-compulsive disorder, post traumatic stress, anxiety, and non-psychotic depression	1) Applicants currently taking, or within the last year have taken more than two medications concurrently for the treatment of behavioral health disorders will be declined 2) Applicants with chronic or recurrent neurotic disorders will be considered on an individual basis; rider or decline based on stability and severity of condition 3) Applicants taking benzodiazepines/ sedatives for the treatment of neurotic disorders must meet the following criteria to be considered for coverage: a) Must have had stable or near stable dosage of medication over a period of at least 2 years b) No mental health related inpatient admissions for a minimum of 5 years c) Evidence that the applicant has had little to no disruption of "activities of daily living" (e.g. if employed, then no work loss or job turnover during the past two years) d) No hospitalizations or emergency room visits for anxiety/panic related symptoms e) Must not have taken more than 2 medications concurrently within the past 12 months	**Mild** – Single episode, anxiety adjustment reactions or situational problems, treatment limited to one medication, no current or prior counseling, no prior hospitalization, treatment with prescribed medications within the past 6 months: Rider **Moderate to Severe**, treated with medication within the past year, currently in counseling, or have been in counseling in the past 2 years: Rider ***See special guidelines for High Deductible Plans**	Current treatment, no prior hospitalization: **Stable on medication, infrequent physician visits and/or medication adjustment:** Rate for medication only **Frequent physician visits and/or medication adjustment required:** Rate for condition and medication **(Additional rating if current psychotherapy)** **Condition unstable** (recent exacerbation of symptoms, frequent medication changes, recent hospitalization, disruption of activities of daily living): Maximum rate up **Treatment with more than 2 medications concurrently within the past 12 months:** Maximum rate up
Behcet's Syndrome	Decline	N/A	Maximum rate up
Bipolar Disorder/Manic Depressive	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Bone Spur/Exostosis	See rider guidelines	**Skull**, unoperated or further treatment planned: Rider Other locations, symptomatic or surgery anticipated: Rider **Other locations**, symptomatic or surgery anticipated: Maximum rate up	**Skull**, unoperated or further treatment planned: Maximum rate up **Other locations**, symptomatic or surgery anticipated: Maximum rate up **Complete recovery**, no further treatment planned: No rate up
Brachial Cleft Cyst	See rider guidelines	Unoperated: Rider	Symptomatic or surgery anticipated: Maximum rate up
Breast Implants	Decline for silicone implants with complications or pending removal	**Silicone** (no complications): Rider **Saline:** < 2 years since placement: Rider (rider does not exclude coverage for breast cancer)	**Complications:** Maximum rate up **No complications**, placed < 2 years: Rate up **No complications**, placed > 2 years: No rate up
Breast, Fibrocystic Breast Disease	See rider guidelines	Severe, frequent biopsies, or surgery anticipated: Rider	**Surgery anticipated:** Maximum rate up **Severe or frequent biopsies:** Rate up **Otherwise:** No rate up
Bronchitis – Chronic	Decline severe conditions or if currently smoking; individual consideration for mild or moderate conditions if stopped smoking or never smoked	N/A	N/A
Bunion	See rider guidelines	Unoperated or symptomatic: Rider	**Surgery anticipated:** Maximum rate up **Conservative treatment:** Rate up **Asymptomatic or operated with complete recovery:** No rate up
Cancer (see guidelines for individual cancer diagnoses)	Note: Cancer is considered localized if confined to the organ of origin with no lymph involvement **(Offer of coverage will be determined by age of applicant and time since last treatment, some applicants with history of local cancer may still be declined)**	N/A	Note: Cancer is considered localized if confined to the organ of origin with no lymph involvement **(Rate will be based on time since last treatment)**
Cancer - Adrenal Gland	Local, decline if less than 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Bone	Local, decline if less than 3 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Brain	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Breast	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Cervix/Uterus	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < one year since last treatment:** Maximum rate up **Local, 1 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Colon/Rectal	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Cancer - Connective or Soft Tissue	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Corpus Uterus (endometrial carcinoma)	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Esophagus	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Eye; Intraocular Melanoma and Lymphoma	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < one year since last treatment:** Maximum rate up **Local, 1 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Eye; Medulloepitheliomas	Local, decline if < 3 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 3 years since last treatment:** Maximum rate up **Local, 3 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Eye; Retinoblastoma	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Gallbladder	Local, decline if < 3 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 3 years since last treatment:** Maximum rate up **Local, 3 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Hodgkin's Lymphoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Kidney; Renal Pelvis and Ureter	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Larynx	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage) **(Applicants must have stopped using tobacco for more than 10 years to be considered for coverage)**	N/A	**Local, < 2 years since last treatment:** Maximum rate up **Local, 2 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Leukemia, Monocytic	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Leukemia, Myeloid	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Cancer – Liver	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Lung	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage) **(Applicants must have stopped using tobacco for more than 10 years to be considered for coverage)**	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Melanoma	Local*, decline or rate up based on age and time since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage) ***Melanoma in situ (stage 0) will be rated as squamous cell carcinoma**	N/A	**Local, < one year since last treatment:** Maximum rate up **Local, 1 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Multiple Myeloma	Always decline	N/A	Maximum rate up
Cancer - Nasal Sinus	Local, decline if < 3 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 3 years since last treatment:** Maximum rate up **Local, 3 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Non-hodgkin's lymphoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Oral Cavity, Pharynx	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage) **(Applicants must have stopped using tobacco for more than 10 years to be considered for coverage)**	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Oral Cavity, Lips Only	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage) **(Applicants must have stopped using tobacco for more than 10 years to be considered for coverage)**	N/A	**Local, < one year since last treatment:** Maximum rate up **Local, 1 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer – Ovary	Local, decline if < 3 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Pancreas	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Parathyroid	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Penis/Scrotum	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Peritoneum	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Cancer - Pituitary gland	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Prostate Gland	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Sarcoma	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 2 years since last treatment:** Maximum rate up **Local, 2 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer - Stomach, Small Intestine	Local, decline if < 5 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer – Testicular	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 3 years since last treatment:** Maximum rate up **Local, 3 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer – Thoracic	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Thyroid Gland; Anaplastic Carcinoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer - Thyroid Gland; Papillary, Follicular, and Lymphomas, Carcinomas	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 2 years since last treatment:** Maximum rate up **Local, 2 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cancer, Urinary Bladder	Local, decline if < 2 years since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	Less than 10 years since last treatment: Maximum rate up
Cancer, Vagina, Labia, Clitoris	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	**Local, < 2 years since last treatment:** Maximum rate up **Local, 2 – 10 years since last treatment:** Rate up based on time since last treatment **Regional and distant, < 10 years since last treatment:** Maximum rate up
Cardiac Arrhythmias, benign or palpitations	1) Underlying cardiac cause suspected, evaluation not complete, decline 2) Underlying cardiac cause not suspected or ruled out, symptomatic, decline 3) Asymptomatic and controlled with one medication, rate up	N/A	1) Underlying cardiac cause suspected, evaluation not complete: Maximum rate up 2) Underlying cardiac cause not suspected or ruled out, symptomatic: Maximum rate up 3) Asymptomatic and controlled with one medication: Rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Cardiac Arrhythmias, Paroxysmal Supraventricular Tachycardia (PSVT)	Diagnosed < 5 years: Individual consideration **(Offer of coverage will be determined by age of applicant and current status, some applicants may still be declined)** Stable, > 5 years since diagnosis: Std	N/A	Episodes of short duration, prompt response to treatment, 3 or less attacks per year, not increasing in frequency, no other cardiac impairment: **Diagnosed < one year:** Maximum rate up **Diagnosed < one year:** Maximum rate up **Diagnosed 1 – 5 years:** Rate up **Diagnosed > 5 years:** No rate up **Following ablation without recurrence:** > one year, Maximum rate up; 1 – 5 years, Rate up; > 5 years, No rate up
Cardiomyopathy	Decline	N/A	Maximum rate up
Caroli's Disease	Decline	N/A	Maximum rate up
Carpal Tunnel Syndrome	See rider guidelines	Unoperated, symptomatic: Rider	**Surgery contemplated:** Maximum rate up **Unoperated, < 2 years:** Maximum rate up **Unoperated, > 2 years:** Rate up **Operated, recovered:** No rate up
Cataract (per eye)	See rider guidelines	Unoperated: Rider Operated and recovered < 3 years: Rider	**Unoperated:** Maximum rate up **Operated, < one year:** Maximum rate up **Operated, 1-3 years:** Rate up **Operated, > 3 years:** No rate up
Cerebral Palsy	Decline for moderate or severe cases; otherwise, based on case specifics	N/A	**Under age 5:** Maximum rate up **Minimal** (no significant impairment, no therapy or assistive devices needed): Rate up **Other cases:** Maximum rate up
Cerebrovascular Accident (CVA)/Stroke	**Stroke with infarction or residual** complications (paralysis, aphasia, dysphagia, mental deficits, etc): Decline **Stroke without complications:** Decline if occurrence within the past year, individual consideration after one year of complete recovery	N/A	**Stroke without complications, < 2 years:** Maximum rate up **Stroke without complications, > 2 years:** Rate up **Stroke with permanent disability or residual complications:** Maximum rate up **Stroke with infarction:** Maximum rate up
Cervical Spine, Disk Disorder, Spinal Stenosis, Spondylolisthesis/ Spondylosis	See guidelines for back/spine		See guidelines for back/spine
Cervical Dysplasia/ Abnormal Pap Smears	1) Reactive cellular changes, no rate up or rider 2) ASCUS (abnormal squamous cells of unknown significance), HPV (human papilloma virus) negative, no rate up or rider 3) ASCUS, HPV positive, rider until 3 subsequent pap smears normal and at least 18 months since abnormal pap 4) Dysplasia of cervix, rider until at least 3 subsequent pap smears normal and at least 18 months since abnormal pap 5) Decline for abnormal pap without follow up	See "Underwriting Action"	1) Reactive cellular changes, No rate up 2) ASCUS (abnormal squamous cells of unknown significance), HPV (human papilloma virus) negative. No rate up 3) ASCUS, HPV positive, Rate up until 3 subsequent pap smears normal and at least 18 months since abnormal pap 4) Dysplasia of cervix, Rate up until at least 3 subsequent pap smears normal and at least 18 months since abnormal pap 5) Maximum rate up if abnormal pap without follow up
Charcot-Marie-Tooth Disease	Decline	N/A	Maximum rate up
Chronic Fatigue Syndrome	Underwriting based on severity of condition and current treatment	N/A	Rate up based on severity of condition and current treatment *No medications and asymptomatic > 5 years: No rate up*

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Cholesterol/Lipid Disorders	Underwriting based on risk assessment, current level of control, and medications used in treatment	Rider; excludes medications only ***See special guidelines High Deductible Plans**	N/A
Chronic Obstructive Pulmonary Disease (COPD)	Decline severe conditions or if currently smoking; individual consideration for mild or moderate conditions if stopped smoking or never smoked	N/A	N/A
Cirrhosis of the Liver	Decline	N/A	Maximum rate up
Cleft Lip/Cleft Palate	Decline for pending surgery	**Unoperated:** Rider **Operated**, no further surgery planned < 4 years: Rider; > 4 years: No rate up or rider	**Unoperated:** Maximum rate up **Operated**, complete recovery, no further surgery planned < 4 years: Maximum rate up; > 4 years: No rate
Club Foot	See rider guidelines	**Untreated:** Rider **Treated, recovered:** No rate or rider	**Surgery Pending:** Maximum rate up **Untreated:** Rate up **Treated, recovered, no further surgery planned:** No rate up
Coagulation Defect (Hemophilia)	Decline	N/A	Maximum rate up
Colon Polyps	Decline for Congenital Familial Polyposis (Gardner's Syndrome) (Peutz-Jegher's Syndrome)	**Multiple** (> 4) adenomatous polyps, multiple polyposis: Rider **Otherwise:** No rate or rider	**Multiple** (> 4) adenomatous polyps, multiple polyposis: Maximum rate up **Otherwise:** No rate up **Congenital Familial Polyposis** (Gardner's Syndrome) (Peutz-Jegher's Syndrome): Maximum rate up
Congenital Abnormalities	Underwriting is based on the specific diagnosis and medical history	N/A	Underwriting is based on the specific diagnosis and medical history
Congenital Familial Polyposis (Gardner's Syndrome) (Peutz-Jegher's Syndrome)	Decline	N/A	Maximum rate up
Congestive Heart Failure	Decline	N/A	Maximum rate up
Cornea Transplant	See rider guidelines	Less than one year since transplant: Rider	**Transplant pending:** Maximum rate up **Transplant completed, complete recovery, < one year:** Maximum rate up **Transplant completed, complete recovery, > one year:** No rate up
Coronary Artery Disease (CAD)	Decline	N/A	Maximum rate up
Craniosynostosis	See rider guidelines	Unoperated or time period since surgery < 2 years: Rider	**Unoperated or time period since surgery < 2 years:** Maximum rate up **Operated, complete recovery, > 2 years:** No rate up
Crohn's Disease	Decline	N/A	Maximum rate up
Cushing Syndrome	Decline	N/A	Maximum rate up
Cystitis/Urinary Tract Infection	See rider guidelines	Rider for frequent or chronic cystitis ***See special guidelines for High Deductible Plans**	**Frequent or chronic:** Maximum rate up **Acute, infrequent** (< 4 per year): No rate up
Cystic Fibrosis	Decline	N/A	Maximum rate up
Cystocele/Rectocele	See rider guidelines	Unoperated, urinary or bowel incontinence present: Rider Symptomatic or < one year since surgical correction: Rider	**Unoperated, urinary or bowel incontinence present:** Maximum rate up **Operated, complete recovery**, > one year: No rate up
Dermatomyositis	Decline	N/A	Maximum rate up
Developmental Disorders	Underwriting based on case specifics	N/A	Underwriting based on case specifics

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Deviated Septum	See rider guidelines	Symptomatic or surgery anticipated: Rider	**Surgery anticipated:** Maximum rate up **No surgery anticipated, symptomatic**, < 2 years, Rate up; > 2 years, No rate up **No surgery anticipated, asymptomatic:** < one year, Rate up; > one year, No rate up **Operated, complete recovery:** < one year, Rate up; > one year, No rate up
Diabetes (includes, Type I and II; excludes gestational diabetes)	Decline	N/A	Maximum rate up
Diamond Blackfan Anemia	Decline	N/A	Maximum rate up
Diverticulosis; Diverticulitis (Colon)	See rider guidelines	**Diverticulosis:** Rider if symptomatic **Diverticulitis,** history of **one episode**, rider if last episode within the past year; **multiple episodes**, rider if last **episode** within the past 3 years	**Diverticulosis, present, symptomatic:** Maximum rate up **Diverticulitis, symptomatic:** Maximum rate up **Diverticulitis, asymptomatic:** Rate based on time since last episode
Down's Syndrome	Decline	N/A	Maximum rate up
Driving under influence (DUI)/Driving while intoxicated (DWI)	Decline for 2 or more occurrences of DUI/DWI if last occurrence was within the past 5 years or < 5 years since abstinence from alcohol; decline if one occurrence of DUI/DWI within the past year	N/A	Maximum rate up if 2 or more occurrences of DUI/DWI if last occurrence was within the past 5 years or < 5 years since abstinence from alcohol; maximum rate up if one occurrence of DUI/DWI within the past year
Drug Abuse or Illegal Drug Use - Anabolic Steroids	Decline if current dependence/use; < 5 years since last use, individual consideration based on age and time since last use; > 5 years since last use, no rate up	N/A	Maximum rate up if current dependence/use or < 2 years since last use; Rate up if 2 – 5 years since last use; No rate up if > 5 years since last use
Drug Abuse or Illegal Drug Use – Barbiturates	Decline if current dependence/use; < 5 years since last use, individual consideration based on age and time since last use; > 5 years since last use, no rate up	N/A	Maximum rate up if current dependence/use or < 3 years since last use; Rate up if 3 – 5 years since last use; No rate up if > 5 years since last use
Drug Abuse or Illegal Drug Use - Cannabis (Marijuana)	Decline if current dependence/use; < 2 years since last use, rate up or decline, based on individual consideration; >2 years since last use, no rate up	N/A	Maximum rate up if current dependence/use; Rate up if < 2 years since last use; No rate up if > 2 years since last use
Drug Abuse or Illegal Drug Use - Cocaine	Decline if current dependence/use or < 10 years since last use	N/A	Maximum rate up if current dependenc/use or < 10 years since last use; No rate up if > 10 years since last use
Drug Abuse or Illegal Drug Use - Hallucinogens	Decline if current dependence/use; < 10 years since last use, individual consideration based on age and time since last use; > 10 years since last use, no rate up	N/A	Maximum rate up if current dependenc/use or < 10 years since last use; No rate up if > 10 years since last use
Drug Abuse or Illegal Drug Use – Opioids	Decline if current dependence/use; < 10 years since last use, individual consideration based on age and time since last use; > 10 years since last use, no rate up	N/A	Maximum rate up if current dependence/use or < 5 years since last use; Rate up if 5 - 10 years since last use; No rate up if > 10 years since last use
Dupuytrens Contracture (contracture of the palmer fascia)	See rider guidelines	Unoperated, symptomatic or < one year since surgery: Rider	**Unoperated or symptomatic:** Maximum rate up **Operated, complete recovery:** No rate up
Ear (disorders of the middle and inner ear) - Chronic or Ear Tubes	See rider guidelines	Chronic, unoperated or symptomatic: Rider	**Chronic** (4 or more episodes in the past 12 months): Rate up **Surgically corrected**, asymptomatic: No rate up
Eating Disorders	See Anorexia/Bulimia		See Anorexia/Bulimia

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Ebstein's Malformation	Decline	N/A	Maximum rate up
Eclampsia	Child bearing age, with two normal deliveries, no rate up; less than two normal deliveries since episode, individual consideration	N/A	Child bearing age, with two normal deliveries, No rate up; less than two normal deliveries since episode, Maximum rate up
Ehler's-Danlos Syndrome	Decline	N/A	Maximum rate up
Eisenmenger's Complex	Decline	N/A	Maximum rate up
Elbow disease, disorder, or injury	See rider guidelines	Symptomatic or currently undergoing treatment: Rider ***See special guidelines for High Deductible Plans**	**Present**, surgery anticipated or chronic: Maximum rate up **Resolved** or operated, asymptomatic: No rate up
Emphysema	See guidelines for "Chronic Obstructive Pulmonary Disease (COPD)"		N/A
Endometriosis	See rider guidelines	**Moderate or severe**, (disabling, treatment or surgery anticipated, treatment with narcotics): Rider **Mild**, treatment with NSAIDS only, diagnosed < 5 years: Rider	**Moderate or severe**, (disabling, treatment or surgery anticipated, treatment with narcotics): Maximum rate up **Mild**, treatment with NSAIDS only, diagnosed < 5 years: Rate up **Mild**, treatment with NSAIDS only, diagnosed > 5 years: No rate up
Enuresis (bed wetting)	Based on case specifics (age of applicant, number of episodes, and current treatment)	**Applicants over 6 years of age**, current treatment or treatment recommended: Rider ***See special guidelines for High Deductible Plans**	**Applicants over 6 years of age**, current treatment or treatment recommended: Rate for medication
Epilepsy/Seizures	Individual consideration, offer of coverage will be determined by age of applicant, time since last seizure episode and current treatment, some applicants may be declined	N/A	Individual consideration, rate will be determined by time since last seizure episode and current treatment
Erbs Palsy	Underwriting based on case specifics; decline or rider based on severity of injury and current treatment	Rider	Maximum rate up if less than 5 years of age or pending surgery; 5 years of age and older, rate based on case specifics (severity of injury and current treatment)
Esophageal Varices	Decline	N/A	Maximum rate up
Facial Nerve Disorder	See rider guidelines	Surgery anticipated or residual symptoms: Rider	**Surgery anticipated:** Maximum rate up **Residual symptoms**: Rate up
Fibromyalgia	Rate up or decline based on medical history and treatment	N/A	Rate for condition and medication
Fistula, Anal	See rider guidelines	Diagnosed < one year, or surgery anticipated: Rider	**Surgery anticipated:** Maximum rate up **Present**, no surgery anticipated, or < one year since complete recovery: Rate up
Fistula, Female (rectovaginal, vesicovaginal or urinary fistula)	See rider guidelines	Unoperated or < 1 year since last treatment: Rider	**Unoperated:** Maximum rate up **Operated**, complete recovery, time since last treatment < one year: Rate up
Foot disorder	See rider guidelines	Symptomatic, not recovered, or current treatment: Rider ***See special guidelines for High Deductible Plans**	**Surgery anticipated:** Maximum rate up **Symptomatic**, not recovered or current treatment: Rate up based on severity of condition and treatment plan
Gallbladder	See rider guidelines	Gallstones present or symptomatic: Rider	Gallstones present or symptomatic: Maximum rate up
Ganglion cyst	See rider guidelines	Unoperated: Rider ***See special guidelines for High Deductible Plans**	**Surgery recommended/anticipated:** Maximum rate up **No surgery recommended/anticipated:** Rate up
Gastritis	Underwriting based on underlying cause/disorder	N/A	Underwriting based on underlying cause/disorder

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Gastroesophageal Reflux Disease (GERD)	See rider guidelines	Treatment with prescribed medication within the past 2 years: Rider Testing in progress or planned, Barrett's esophagus, strictures, or ulcerations: Rider Mild cases, resolved with over the counter medications only: No rate or rider ***See special guidelines High Deductible Plans**	**Mild**, symptoms resolved with over the counter medication only: No rate up **Mild to moderate**, treatment with prescription medication: Rate for medication **Symptomatic**, testing in progress or planned: Maximum rate up **Barrett's esophagus, strictures, ulcerations:** Maximum rate up
Genital Prolapse	See rider guidelines	Surgery contemplated or diagnosed < 2 years: Rider	**Unoperated**, surgery not contemplated: rate based current status and time since diagnosis **Operated, recovered:** No rate up
Glaucoma	See rider guidelines	Rider ***See special guidelines for High Deductible Plans**	**Surgery or laser treatment anticipated:** Maximum rate up **Otherwise:** Rate for medication
Goiter	Decline if thyroid function is abnormal	**Nodular goiter**, unoperated: Rider **Simple diffuse colloid goiter,** normal thyroid function: No rate or rider	**Normal thyroid function**, simple diffuse colloid goiter, diagnosed < one year: Rate up **Nodular goiter**, surgery anticipated: Maximum rate up **Nodular goiter**, no surgery anticipated: Rate up based on time since diagnosis
Gout	Decline for gout with renal failure/ insufficiency; otherwise, individual consideration	N/A	N/A
Hamartoma	See rider guidelines	Unoperated: Rider	**Surgery anticipated:** Maximum rate up **Otherwise:** No rate up
Hand disease, disorder, or injury	See rider guidelines	Symptomatic, not recovered, or current treatment: Rider	**Surgery anticipated/recommended:** Maximum rate up **Symptomatic**, **not recovered or current treatment:** Rate based on severity of condition and treatment plan
Hand-Schuller-Christian Disease	Decline	N/A	Maximum rate up
Headache, Severe, and/or Migraine	See rider guidelines	Greater than 6 attacks per year, multiple medications, or severe, incapacitating: Rider	**Severe, incapacitating:** Maximum rate up **Otherwise:** Rate for medication
Hearing deficiency	See rider guidelines	Surgery contemplated or diagnostic testing in progress: Rider ***See special guidelines for High Deductible Plans**	**No surgery contemplated,** no treatment or treatment with hearing aids only: No rate up **Surgery contemplated** (Cochlear implant): Maximum rate up **Cochlear implant completed:** Rate up
Heart Attack - Myocardial Infarction, history	Decline	N/A	Maximum rate up
Heart Murmur	Underwriting based on case specifics	N/A	Underwriting based on case specifics
Hemangioma	See rider guidelines	**Intracranial, retinal, or intraabdominal:** Rider **Excessively large**, located on face or surgery contemplated: Rider **Otherwise**: No rate or rider	**Intracranial, retinal, or intraabdominal:** Maximum rate up **Excessively large**, located on face or surgery contemplated: Maximum rate up **Otherwise:** No rate up
Hemiplegia	Decline	N/A	Maximum rate up
Hemochromotosis	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Hemorrhoids	See rider guidelines	Chronic, severe, or surgery contemplated: Rider ***See special guidelines for High Deductible Plans**	**Chronic, severe, or surgery contemplated:** Rate up **Asymptomatic or mild**, treatment with topical medications only: No rate up
Hepatitis A or E	Present, decline; complete recovery with no residual health conditions, no rate up	N/A	**Present:** Maximum rate up **Complete recovery, no residual health conditions:** No rate up
Hepatitis B	Acute (present) or chronic, decline; recovered, negative Hepatitis B surface antigen (HbsAg), normal liver function tests, individual consideration based on age and time since complete recovery	N/A	**Acute (present) or chronic:** Maximum rate up **Recovered**, negative Hepatitis B surface antigen (HbsAg), normal liver function tests: Rate based on time since complete recovery **Recovered** > 5 years: No rate up
Hepatitis C	Acute (present) or chronic, decline; less than 4 years since completion of treatment, decline; recovered, normal liver function tests, negative HCV RNA in repeated testing, 4 years following completion of an appropriate treatment course, may approve with rate up, based on individual consideration	N/A	**Current active acute infection or chronic infection:** Maximum rate up **Recovered**, normal liver function tests, negative HCV RNA in repeated testing, 4 years following completion of an appropriate treatment course, < 4 years since completion of treatment: Maximum rate up **Recovered**, > 4 years since completion of treatment: Rate up
Hepatitis, all other types	Decline	N/A	Maximum rate up
Hernia - Inguinal, umbilical, and femoral	See rider guidelines	Symptomatic or diagnosed < one year: Rider	**Symptomatic:** Maximum rate up **Unoperated**, asymptomatic < one year: Rate up
Herpes simplex virus	See rider guidelines	**Genital infections**, active or treatment with prescribed medications within the past year: Rider **Oral infections only**, frequent treatment with prescribed medications: Rider ***See special guidelines for High Deductible Plans**	**Genital infections**, chronic (daily) treatment with prescribed medications: Rate for medication **Oral infections only**, frequent treatment with prescribed medications: Rate for medication
High Cholesterol	See Cholesterol/Lipid Disorder		N/A
Hip or Hip Joint	See rider guidelines	Symptomatic, revision of hip joint anticipated or time since last treatment < 3 years: Rider	Rate for specific hip condition
Histocytosis X	Decline	N/A	Maximum rate up
HIV Infection	Decline	N/A	Maximum rate up
Human Papilloma Virus (HPV), condyloma or genital warts	See rider guidelines (if associated with abnormal pap smears, see guidelines for "Abnormal pap smears")	**Present:** rider ***See special guidelines for High Deductible Plans**	**Present:** Rate for condition and medication **Resolved**, no recurrence: No rate up
Huntington's Chorea	Decline	N/A	Maximum rate up
Hydrocele	See rider guidelines	Unoperated: Rider	**Surgery anticipated** (large or symptomatic): Maximum rate up **Small, asymptomatic**, no treatment planned: No rate up
Hypertension	Decline if uncontrolled or newly diagnosed; otherwise, rate up is based on degree of control and current treatment; **Additional rating for tobacco users**	N/A	Rate based on degree of control and current treatment: **Additional rating for tobacco users**
Hypogammaglobulin-emia	Decline	N/A	Maximum rate up
Hypoplastic Anemia	Decline	N/A	Maximum rate up
Hypospadias	See rider guidelines	Unoperated: Rider	Unoperated: Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Interstitial Cystitis	Individual consideration **(Offer of coverage will be determined by age of applicant, time since diagnosis and current treatment, some applicants may be declined)**	N/A	**Diagnosed < 4 years:** Maximum rate up **Diagnosed > 4 years:** Rate based on gender and time since diagnosis
Irritable Bowel Syndrome	See rider guidelines	**Moderate or severe**, frequent attacks: Rider **Mild**, **infrequent attacks:** No rate or rider	**Mild, infrequent attacks:** No rate up **Moderate, frequent (> 4 per month and prescription medication required):** Rate for condition and medication **Severe attacks, prolonged periods:** Maximum rate up
Juvenile Arthritis	See "Arthritis, Juvenile"		See "Arthritis, Juvenile"
Keratosis, Actinic and Seborrheic	See rider guidelines	Multiple occurrences/biopsies (3 or more within the past year): Rider	Multiple occurrences/biopsies (3 or more within the past year): Rate up Treated, complete recovery, no recurrence: No rate up
Kidney disease, chronic	Decline	N/A	Maximum rate up
Kidney Stones	See rider guidelines	**One episode**, lithotripsy, surgery or passed spontaneously, < one year since episode: Rider **Two or more episodes**, lithotripsy, surgery or passed spontaneously, <3 years since episode: Rider **Four or more episodes**, lithotripsy, surgery or passed spontaneously, < 5 years since last episode: Rider	**Stones present**: Maximum rate up **One episode**, lithotripsy, surgery or passed spontaneously: < one year since episode, Maximum rate up; > one year since episode, No rate up **Two or more episodes**, lithotripsy, surgery or passed spontaneously: <one year since episode, Maximum rate up; 1 – 3 years since last episode, Rate up; > 3 years since last episode, No rate up **Four or more episodes**, lithotripsy, surgery or passed spontaneously: < 3 years since last episode, Maximum rate up; 3 – 5 years since last episode, Rate up; > 5 years since last episode, No rate up
Klinefelter's Syndrome	Decline	N/A	Maximum rate up
Knee Injury or Impairment	See rider guidelines	**Sprain or strain**, symptomatic or current treatment: Rider **Internal derangement**, symptomatic or operated within the past year: Rider **Joint replacement**, symptomatic, operated within the past 3 years, or additional surgery or revision anticipated: Rider **For all conditions, if chronic or recurrent: Rider**	**Sprain or strain**, symptomatic or current treatment: Maximum rate up **Internal derangement**, symptomatic or operated within the past year: Maximum rate up **Joint replacement**, symptomatic, operated within the past 3 years, or additional surgery or revision anticipated: Maximum rate up
Leg Amputation	See rider guidelines	Rider	Maximum rate up
Letterer-Siwe Disease	Decline	N/A	Maximum rate up
Lipoma	See rider guidelines	**Skin or subcutaneous:** No rate or rider **Involving other organs:** Rider if unoperated ***See special guidelines for High Deductible Plans**	**Skin or subcutaneous:** No rate up **Involving other organs, surgery anticipated/ recommended:** Maximum rate up
Lupus Erythematosus, Discoid (skin-type)	If albuminuria, hypertension, or arthritis are present, rate as "Systemic Lupus", otherwise, individual consideration based on age of applicant and time since diagnosis; some applicants will be declined	N/A	**Discoid**(skin-type), no complications: Rate up **Discoid** (skin-type), complications: Maximum rate up *If albuminuria, hypertension, or arthritis are present, rate as "Systemic Lupus"*
Lupus Erythematosus (Systemic Lupus)	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Lymphoblastoma	Decline	N/A	Maximum rate up
Macular Degeneration	See rider guidelines	**Exudative** (wet), cystoid, macular cyst or hole: Rider **Non-exudative**, Drusen (dry): No rate or rider	N/A
Mandible Hypoplasia	See rider guidelines	Unoperated: Rider	**Unoperated:** Maximum rate up **Operated, complete recovery, no further surgery planned:** No rate up
Manic Depression	Decline	N/A	Maximum rate up
Marfan's Syndrome	Decline	N/A	Maximum rate up
Marijuana Abuse/Use	See "Drug Abuse - Cannabis"		
Meniere's Disease	See rider guidelines	Symptomatic or resolved < 2 years: Rider ***See special guidelines for High Deductible Plans**	**Present, symptomatic:** Rate up **Asymptomatic, < 2 years:** Rate up **Asymptomatic, > 2 years:** No rate up
Menstruation Disorders (menorrhagia, metrorrhagia, amenorrhea, abnormal uterine bleeding)	Decline if workup in progress or current/ recurrent abnormal bleeding, anemia present; workup complete, will rate up or rider for underlying cause	Current/recurrent bleeding within the past 3 years: Rider ***See special guidelines for High Deductible Plans**	**Current/recurrent bleeding**, anemia: Maximum rate up **No recurrence:** < one year, Rate up; > one year, No rate up
Mental Retardation	Underwriting based on applicant's age and severity of condition	N/A	Underwriting based on applicant's age and severity of condition
Microcephalus	Decline	N/A	Maximum rate up
Mitral Valve Prolapse	Decline if symptomatic or evidence of greater than minimal mitral regurgitation; otherwise, no rate up	N/A	**Symptomatic:** Maximum rate up **Asymptomatic, no treatment (other than endocarditis prophylaxis):** No rate up
Mitral Valve Regurgitation (insufficiency)	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rate up 2) No cardiac studies available, decline 3) Symptomatic, decline	N/A	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities: No rate up 2) No cardiac studies available: Maximum rate up 3) Symptomatic: Maximum rate up
Mixed Connective Tissue Disorder	Decline	N/A	Maximum rate up
MRSA (Methicillin-Resistant Staphylococcus Aureus) infection	Decline if osteomyelitis, joint or internal organ involvement present, otherwise, individual consideration based on current status and time since recovery	N/A	**Skin infection only**, present: Rate up **Skin infection only**, complete recovery, no further treatment required, no residual complications: No rate up **Sepsis, osteomyelitis, joint or internal organ involvement**: Maximum rate up
Multiple Myeloma	Decline	N/A	Maximum rate up
Multiple Sclerosis	Decline	N/A	Maximum rate up
Muscular Dystrophy	Decline	N/A	Maximum rate up
Myocardial Infarction	Decline	N/A	Maximum rate up
Nasal Polyp	See rider guidelines	Unoperated or recurrent: Rider	Unoperated, symptomatic or recurrent: Maximum rate up
Nephrocalcinosis	Decline	N/A	Maximum rate up
Neurofibromatosis	Decline	N/A	Maximum rate up
Neurogenic Bladder	Decline if severe or paralysis present; otherwise, individual consideration	N/A	**Severe cases** (with or without paralysis): Maximum rate up **Mild cases:** Rate based on time since diagnosis
Nevus ("moles")	See rider guidelines (only apply if removed and pathology benign) Individual consideration for Melanocytic and Dysplastic nevus	History of multiple mole removals: Rider	**Nevi, acquired, not congenital, history of multiple removals:** Rate up **Melanocytic and Dysplastic nevi:** Rate based on size and recommended treatment
Obesity surgery	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Osteoarthritis	See "Arthritis, Osteoarthritis"		N/A
Osteochondrosis	See rider guidelines	Symptomatic, deformities present or < 2 years since last treatment: Rider ***See special guidelines for High Deductible Plans**	**Symptomatic**, deformities present **Upper or lower extremities:** Maximum rate up **Foot:** Rate up
Osteogenesis Imperfecta	Decline	N/A	Maximum rate up
Osteomyelitis	Underwriting based on case specifics; decline for chronic conditions	N/A	Acute or chronic: Maximum rate up
Osteopenia	See rider guidelines	Treated with prescribed medication: Rider (rider excludes medication cost only) *See special guidelines for High Deductible Plans	N/A
Osteoporosis	Rate based on severity, risk factors, and age when diagnosed	Rider (excludes medication cost only) *See special guidelines for High Deductible Plans	N/A
Otosclerosis	See rider guidelines	Surgery anticipated, or operated (unilateral only): Rider	**Surgery anticipated:** Maximum rate up **Operated, bilateral, minimal hearing loss:** No rate up **Operated, bilateral, moderate to severe hearing loss:** Rate up **Operated, unilateral:** Rate up
Ovarian Cyst	See rider guidelines	Cyst present **or** < 3 years since surgical removal: Rider	Present, symptomatic: Maximum rate up
Overactive Bladder	See rider guidelines	Symptomatic or treatment within the past 2 years: Rider	Symptomatic, current treatment: Rate for medication
Pancreatitis, Chronic	Decline	N/A	Maximum rate up
Paralysis	Decline if permanent	N/A	Maximum rate up
Paraplegia	Decline	N/A	Maximum rate up
Parkinson's Disease	Decline	N/A	N/A
Pectus Excavatum	Decline if cardiopulmonary defects or dysfunction present	Surgery anticipated: Rider	**Cardiopulmonary defect or dysfunction:** Rate for condition **Surgery anticipated:** Maximum rate up **Otherwise:** No rate up
Penis, Disorders	See rider guidelines	Unoperated: Rider	**Hypospadias**, unoperated: Maximum rate up **Peryronie's Disease**, unoperated: Rate up
Pervasive Developmental Disorder	See guidelines for "Autism"	N/A	See guidelines for "Autism"
Pilonidal Cyst	See rider guidelines	Infected (abcess): Rider	Infected (abcess): Rate up
Pituitary Dwarfism/Growth Hormones	Decline if currently in treatment; otherwise, individual consideration	N/A	**Currently in treatment:** Maximum rate up **No further treatment planned**: No rate up
Pityriasis rosacea	See guidelines for "Acne"		See guidelines for "Acne"
Pneumonia	Decline if present; no rate up if complete recovery, no underlying health conditions	N/A	**Multiple episodes, hospitalized (present, symptomatic, undergoing treatment):** Maximum rate up **Single episode, recovered**: No rate up
Polycystic Kidney Disease	Decline	N/A	Maximum rate up
Polycystic Ovarian Disease (PCOD)	Decline if surgery anticipated; otherwise, may approve with rate up **(Offer of coverage will be determined by age of applicant and time since diagnosis)**	N/A	**Surgery anticipated or < 3 years since diagnosis:** Maximum rate up **Greater than 3 years since diagnosis:** Rate up
Portal Hypertension	Decline	N/A	

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Pre-diabetes (impaired fasting glucose, impaired glucose tolerance)	Two or more consecutive abnormal glucose readings will constitute a diagnosis of pre-diabetes: fasting glucose (110 - 125) or glucose tolerance test results, 2 hour (140-199) Hemoglobin A1C (6% or greater). **(Rating for pre-diabetes will be in addition to rating for other existing conditions such as build, hyperlipidemia or hypertension)**. Decline if diagnosed with 'diabetes'. Glucose levels above those specified as 'pre-diabetes' will be considered 'diabetes'.	N/A	Meets criteria below: Rate up Two or more consecutive abnormal glucose readings will constitute a diagnosis of pre-diabetes: fasting glucose (110 - 125) or glucose tolerance test results, 2 hour (140-199) Hemoglobin A1C (6% or greater) **(Rating for pre-diabetes will be in addition to rating for other existing conditions such as build, hyperlipidemia or hypertension).**
Pre-eclampsia	Child bearing age and no normal delivery since pre-eclamptic episode, individual consideration	N/A	**No normal delivery since pre-eclamptic episode**: Rate up **One or more normal deliveries since pre-eclamptic episode:** No rate up
Pregnancy – current	Decline if applicant is currently pregnant	N/A	Currently pregnant: Maximum rate up
Premature Birth (born less than 37 weeks gestation)	N/A	N/A	Rate based on gestational age at birth, birth weight and current age *(Prematurity is defined as birth prior to 37 weeks gestation)*
Prostate Hypertrophy (enlargement)	Decline if PSA elevated, no ultrasound or biopsy done, or increasing PSA despite negative ultrasound and/or biopsy; decline for pending surgery, or PSA not available	Urinary retention and/or incontinence (PSA normal) or under current treatment: Rider	N/A
Prostate Specific Antigen Elevation	Decline if elevated (PSA 4.0 or greater)	N/A	N/A
Prostatitis – Chronic	Decline if elevated PSA (4.0 or greater)	Rider	N/A
Pseudotumor Cerebri	Decline	N/A	Maximum rate up
Psoriasis		All cases: Rider	Rate for medication
Psoriatic Arthritis	Individual consideration based on age of applicant, severity and current treatment; may receive rate up and/or exclusion rider	See 'Underwriting Action'	Rate for condition and medication
Quadraplegia	Decline	N/A	Maximum rate up
Rectal Polyp	See "Colon Polyp"		See "Colon Polyp"
Rectocele	See rider guidelines	Urinary or bowel incontinence present: Rider Symptomatic **or** < one year since surgical correction: Rider	**Unoperated, urinary or bowel incontinence present:** Maximum rate up **Operated**, complete recovery, > one year: No rate up
Renal Failure (Chronic)	Decline	N/A	Maximum rate up
Residence outside the United States within the past 12 months	Decline if < 6 months since legal residency established; decline if documentation of health status not submitted **(Must provide documentation of current health status, and age appropriate screenings. Depending on the prevalence of communicable disease in the country of origin, specific testing may be required by underwriting. All current underwriting guidelines apply when determining coverage)**	N/A	N/A

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Restless Leg Syndrome	See rider guidelines	Treatment with prescribed medications within the past 3 years: Rider ***See special guidelines for High Deductible Plans**	Treatment with prescribed medication: Rate for medication
Retinal Hemorrhage	Underwriting based on underlying cause	N/A	Underwriting based on underlying cause
Retinopathy	Underwriting based on underlying cause	N/A	Underwriting based on underlying cause
Rheumatoid Arthritis	See "Arthritis, Rheumatoid"		see "Arthritis, Rheumatoid"
Rotator Cuff Syndromes	See rider guidelines	Unoperated or < 2 years last treatment: Rider	Unoperated: Maximum rate up
RSV immunizations	N/A	N/A	Currently receiving immunizations: Maximum rate up
RSV (viral infection)	Applicants with a viral infection caused by the RSV virus, completely recovered, no rating	N/A	Applicants with a viral infection caused by the RSV virus, completely recovered, no rating
Sarcoidosis	Decline if pulmonary involvement; otherwise, individual consideration **(Offer of coverage will be determined by age of applicant and time since diagnosis; some applicants with no pulmonary involvement may still be declined)**	N/A	**Pulmonary involvement:** Maximum rate up **Stable with no pulmonary involvement:** diagnosed < one year, Maximum rate up; diagnosed > one year, Rate up
Schizophrenia	Decline	N/A	Maximum rate up
Scleroderma	Underwriting based on case specifics; applicants with minimal, localized and superficial involvement will be considered one year after diagnosis; **all other cases will be declined**	N/A	Maximum rate up
Scoliosis	See "Back/Spine - Spinal Curvature"		See "Back/Spine - Spinal Curvature"
Senile Dementia	Decline	N/A	N/A
Shoulder (any disease, disorder, derangement or injury of the shoulder)	See rider guidelines	**Single episode, present or treatment within the past year:** Rider **Recurrent episodes:** Rider ***See special guidelines for High Deductible Plans**	**Present:** Maximum rate up **Single episode, resolved, no symptoms nor medication:** No rate up **Recurrent episodes, surgery anticipated, undergoing treatment:** Maximum rate up
Sick Sinus Syndrome	Decline	N/A	Maximum rate up
Sickle Cell Anemia	Decline	N/A	Maximum rate up
Sinusitis – Chronic	See rider guidelines	Surgery anticipated or diagnosed within the past year: Rider	**Surgery anticipated:** Maximum rate up **Unoperated, no surgery anticipated:** < one year, Rate up; > one year, No rate up
Sjogren's Syndrome	Decline	N/A	Maximum rate up
Skin Cancer (basal cell and squamous cell carcinoma)	Decline for untreated squamous cell carcinoma	Previous excision: Rider (time period for placement will be based on number of previous excisions)	**Untreated:** Maximum rate up **Treated:** Rate based on treatment, number of previous excisions and time since last excision
Sleep Apnea	Decline if diagnosed with central or complex sleep apnea. Decline if obstructive sleep apnea is poorly controlled or evidence of non compliance; otherwise, individual consideration for well controlled obstructive sleep apnea **(Offer of coverage will be determined by age of applicant, current treatment and time since diagnosis; some applicants who are well controlled may still be declined)**	N/A	**Central or complex sleep apnea**: Maximum rate up **Obstructive sleep apnea, poorly controlled or non-compliant**: Maximum rate up **Obstructive sleep apnea, well controlled with CPAP/BiPAP:** Rate based on severity and time since diagnosis **Obstructive sleep apnea, well controlled or resolved without CPAP/BiPAP or operated and resolved:** No rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Speech Disorder	See rider guidelines	Present or current treatment: Rider ***See special guidelines for High Deductible Plans**	**Present**, current treatment (speech therapy): Rate up **Underlying condition resolved, no further treatment anticipated:** No rate up
Spermatocele	See rider guidelines	Symptomatic: Rider ***See special guidelines for High Deductible Plans**	**Symptomatic:** Maximum rate up **Asymptomatic or operated with complete recovery:** No rate up
Spina Bifida Cystica	Decline if present or residual medical conditions or complications	N/A	Maximum rate up
Spina Bifida Occulta	Underwriting based on age of applicant and current status	N/A	Maximum rate up
Strabismus, Esotropia, Exotropia, Heterotropia and Heterophoria (binocular eye movement disorder)	See rider guidelines	Congenital, unoperated: Rider Due to injury, unoperated and < 3 years since injury: Rider *See special guidelines for High Deductible Plans	**Congenital or due to injury, surgery anticipated:** Maximum rate up **Congenital, unoperated, no surgery anticipated:** Rate up **Due to injury, unoperated and < 3 years since injury**: Rate up **Opearted, complete recovery, no further surgery planned:** No rate up
Surgery - Inpatient or Outpatient	Decline for pending surgery	N/A	Pending surgery: Maximum rate up
Syndactyly of fingers or toes	See rider guidelines	Unoperated or < 5 years since surgery: Rider	Unoperated: Maximum rate up
Synovitis and tenosynovitis	See rider guidelines	**Single episode**, symptomatic: Rider **Multiple episodes or recurrent,** symptomatic or treatment within the past 3 years: Rider ***See special guidelines for High Deductible Plans**	**Single episode**, symptomatic: Rate up **Multiple episodes or recurrent,** symptomatic or treatment within the past 3 years: Rate up
Systemic Lupus Erythematosus (SLE)	Decline	N/A	Maximum rate up
Temporomandibular Joint Syndrome (TMJ)	See rider guidelines	Surgery anticipated or residuals (facial pain or orthodontic treatment): Rider	Surgery anticipated or residuals (facial pain or orthodontic treatment): Maximum rate up
Tetrology of Fallot	Decline	N/A	Maximum rate up
Thalassemia Major	Decline	N/A	Maximum rate up
Thyroid disease (Hyperthyroidism, Hypothyroidism)	See rider guidelines	Hyperthyroidism or Graves' Disease, present or symptomatic: Rider; Hypothyroidism, less than one year since diagnosis and treatment: Rider	**Hyperthyroidism or Graves' Disease**, present or symptomatic: Maximum rate up **Hyperthyroidism or Graves' Disease**, treated surgically or medically, asymptomatic, thyroid hormone levels within normal limits: < one year, Rate up; > one year, No rate up **Hypothyroidism**, less than one year since diagnosis and treatment: Rate up
TIA (Transient Ischemia Attack)	Rate as Cerebrovascular Accident, Stroke, without complications		Rate as Cerebrovascular Accident, Stroke, without complications
Tibia/Fibula Fracture	See rider guidelines	Symptomatic or continuing treatment: Rider	Symptomatic or continuing treatment: Maximum rate up
Tobacco Use, current or within the past year (Applicants who have used products containing nicotine within the past 12 consecutive months will be underwritten as current tobacco users)	If medical records and/or results of current full physical exam are not provided for tobacco users age 45 and older, the applicant will be declined coverage	N/A	N/A

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Tonsillitis – Chronic	Decline if surgery pending	Chronic (> 6 attacks per year): Rider	Surgery pending: Maximum rate up Chronic (> 6 attacks per year): Rate up
Transplant - Bone Marrow	Decline	N/A	Maximum rate up
Transplant – Organ	Decline	N/A	Maximum rate up
Tremor	See rider guidelines	**Essential tremor**, diagnosed < one year: Rider **Physiologic:** No rate or rider	**Essential tremor**, diagnosed < one year: Rate up **Physiologic:** No rate up
Tricuspid Atresia	N/A	N/A	Maximum rate up
Tricuspid Valve Regurgitation (insufficiency)	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rate up 2) No cardiac studies available, decline 3) Symptomatic or greater than mild regurgitation, decline	N/A	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities: No rate up 2) No cardiac studies available: Maximum rate up 3) Symptomatic or greater than mild regurgitation: Maximum rate up
Trigeminal Neuralgia	See rider guidelines	Unoperated, symptomatic, or surgery within the past 2 years: Rider	Unoperated or treated by injection, time period since diagnosis: < one year, Maximum rate up; 1-2 years, Rate up; > 2 years, No rate up
Tuberculosis	Decline if active infection, otherwise, individual consideration based on age and time since recovery	N/A	Maximum rate up if active infection, otherwise, individual consideration based on time since recovery
Tuberous Sclerosis Complex	Decline	N/A	Maximum rate up
Ulcer – Jejunal	See rider guidelines	**History of one attack**, symptomatic or < 2 years since attack: Rider **Multiple attacks**, symptomatic or < 6 years since last attack: Rider	**History of one attack**, symptomatic or < 2 years since attack: Maximum rate up **Multiple attacks,** symptomatic: < 3 years since last attack: Maximum rate up; 3 – 6 years since last attack: Rate up; > 6 years since last attack, No rate up
Ulcer – Peptic	Decline for one year following attack if associated with hemorrhage (bleeding) or perforation of the stomach	Rider if < 4 years since last attack	**Active, symptomatic:** Maximum rate up **Recovered, no recurrence**, with history of hemorrhage or perforation: < one year, Maximum rate up; 1-4 years, Rate up; > 4 years, No rate up
Ulcerative Colitis/ Ulcerative Proctitis	Decline	N/A	Maximum rate up
Urethral Stricture	See rider guidelines	Present, chronic or recurrent: Rider	**Present, chronic or recurrent:** Maximum rate up **Full recovery, asymptomatic:** < 6 mths, Maximum rate up; 6 mths – 1 year, Rate up; > one year, No rate up
Urinary Incontinence	See rider guidelines	Unresolved or current treatment: Rider	**Unresolved**, surgery contemplated: Maximum rate up **Unresolved**, surgery not contemplated: Rate up **Resolved, no treatment:** < one year, Rate up; > one year, No rate up
Uterine Fibroid	See rider guidelines	Unoperated and premenopausal: Rider	**Unoperated, symptomatic:** Maximum rate up **Unoperated, asymptomatic**: < 2 years, Maximum rate up; > 2 years, Rate up
Vaginal Polyp	See rider guidelines (work up must be complete to rule out malignant disease)	Symptomatic or treatment anticipated: Rider	Symptomatic or treatment anticipated: Rate up
Varicocele	See rider guidelines	Diagnosed < 2 years or treatment anticipated: Rider	Unoperated, treatment anticipated: < one year, Maximum rate up; 1-2 years, Rate up; > 2 years, No rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Vertigo	Underwriting based on underlying cause, if workup complete and cause benign, see rider guidelines	History of multiple attacks: Rider ***See special guidelines for High Deductible Plans**	**Cause unknown, work up in progress:** Maximum rate up **Cause unknown, multiple attacks**, work up complete, benign: Rate up
Vesicoureteral reflux	Decline if evidence of chronic renal disease	Evidence of renal impairment, residual of VUR, UTI or pyelonephritis: Rider Unoperated, asymptomatic, < 3 years since last treatment: Rider ***See special guidelines for High Deductible Plans**	**Evidence of chronic renal disease, UTI or renal impairment:** Maximum rate up **Unoperated**, no symptoms of VUR or pyelonephritis: < one year, Maximum rate up; 1-3 years, Rate up; > 3 years, No rate up **Operated**, no residuals of VUR: < one year, Maximum rate up; > one year, No rate up
Vitiligo	See rider guidelines	Treatment with prescribed medications within the past year: Rider ***See special guidelines for High Deductible Plans**	Rate for medication
Vocal Cord Polyp	Underwriting based on underlying cause, if workup complete and cause benign, see rider guidelines	**Present:** Rider **Operated**, underlying cause not corrected: Rider	**Present:** Maximum rate up **Operated**, underlying cause corrected: < one year, Maximum rate up; > one year, No rate up **Operated**, underlying cause uncorrected: Rate up
Von Recklinghausen's Disease	Decline	N/A	Maximum rate up
Wegener's Granulomatosis	Decline	N/A	Maximum rate up
Weight Loss	Decline for unintentional weight loss of more than 5% of normal body weight over the past 6-12 months or less; decline if weight not stabilized, work up not done or complete; weight stabilized, thorough work up complete, cause for weight loss established, underwriting determination will be based on underlying cause for weight loss	N/A	Unintentional **weight loss** of more than 5% of normal body weight over the past 6-12 months or less: Maximum rate up **Weight stabilized**, thorough work up complete, cause of weight loss established: Rate for cause **Otherwise:** Maximum rate up
Wilson's Disease	Decline	N/A	Maximum rate up

Condition	Underwriting Action (Age 19 and older)	Rider Criteria (Age 19 and older)	Underwriting Action (Under age 19)
Wrist Disorder	See rider guidelines	Symptomatic, not recovered or current treatment: Rider ***See special guidelines for High Deductible Plans**	**Surgery anticipated:** Maximum rate up **Symptomatic**, not recovered, or current treatment (no surgery anticipated): No rate up
Zollinger - Ellison Syndrome	Decline	N/A	Maximum rate up

Special Guidelines for High-Deductible Plans

Underwriting has determined that certain exclusion riders can be waived if an applicant selects one of the high-deductible options. See the following charts for guidelines specific to each product and plan option.

Please Note: If an applicant has more than one of the medical conditions listed in the following charts, underwriting discretion will be used to decide which exclusion rider(s), if any, can be waived. Decisions will be based on the medical and pharmacy cost associated with each condition and the deductible amount associated with the plan.

	PersonalBlue Plans (deductible amounts below refer to individual deductibles)					
Exclusion Rider	**HDHP $2500**	**HDHP $3500**	**HDHP $5000**	**PPO $3500**	**PPO $5000**	**PPO $7500**
Acne	X	X	No Rider	X	X	X
Allergies	X	X	No Rider	X	X	X
ADD/ADHD (Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder)	X	No Rider	No Rider	X	X	X
Back (curvature of the spine)	X	X	X	X	X	No Rider
Back disease, disorder or injury	X	X	X	X	X	No Rider
Behavioral health disorders	X	No Rider	No Rider	X	X	X
Cervical spine disorder	X	X	X	X	X	No Rider
Cystitis/Urinary Tract Infection	X	X	No Rider	X	No Rider	No Rider
Diverticulosis; Diverticulitis (Colon)	X	X	X	X	X	No Rider
Elbow disease, disorder or injury	X	X	X	X	X	No Rider
Enuresis	X	No Rider	No Rider	X	X	X
Foot disorder	X	X	X	X	X	No Rider
Ganglion cyst	X	X	X	X	X	No Rider
Gastroesophageal Reflux Disease (GERD)/Hiatal hernia	X	X	No Rider	X	No Rider*	No Rider*
Glaucoma	X	X	No Rider	X	No Rider	No Rider
Hearing deficiency	X	No Rider	No Rider	No Rider	No Rider	No Rider
Hemorrhoids	X	X	X	X	X	No Rider
Herpes simplex virus and herpes zoster	X	No Rider	No Rider	X	X	X
Human papillomavirus	X	X	No Rider	X	No Rider	No Rider
Lipoma	X	X	No Rider	X	No Rider	No Rider
Meniere's disease	X	X	X	X	X	No Rider
Menstruation disorders	X	X	X	X	X	No Rider
Osteochondrosis	X	X	X	X	X	No Rider
Osteoporosis/Osteopenia, prescribed medications	No Rider	No Rider	No Rider	X	X	X
Restless leg syndrome	X	X	No Rider	X	X	X
Shoulder disease, disorder or injury	X	X	X	X	X	No Rider
Skin neoplasm (benign) and other dermatoses	X	No Rider	No Rider	No Rider	No Rider	No Rider
Speech disorder	X	No Rider	No Rider	No Rider	No Rider	No Rider
Spermatocele	X	X	X	X	X	No Rider
Strabismus and other disorders of binocular eye movements	X	X	X	X	X	No Rider
Synovitis and tenosynovitis	X	X	No Rider	X	No Rider	No Rider
Vertigo	X	X	X	X	X	No Rider
Vesicoureteral reflux	X	X	X	X	X	No Rider

**Waive for applicants >age 18 related to limited formulary*

	PersonalBlue Plans (deductible amounts below refer to individual deductibles)					
Exclusion Rider	**HDHP $2500**	**HDHP $3500**	**HDHP $5000**	**PPO $3500**	**PPO $5000**	**PPO $7500**
Vitiligo	X	No Rider	No Rider	X	X	X
Wrist disease, disorder or injury	X	X	X	X	X	No Rider
HDHP $2500 - J3, J4	PPO $3500 - (K13 - K18) (L13 - L18) (M13 - M18)					
HDHP $3500 - J5, J6	PPO $5000 - (K19 - K24) (L19 - L24) (M19 - M24)					
HDHP $5000 - J7	PPO $7500 - (M26 - M30)					

**Waive for applicants >age 18 related to limited formulary*

	SimplyBlue & BluePartner Plans				
Exclusion Rider	**SimplyBlue (S3, S7)**	**SimplyBlue (S4, S8)**	**BluePartner (D2)**	**BluePartner (D3)**	**BluePartner (D4)**
Acne	X	X	X	X	No Rider
Allergies	X	No Rider	X	X	No Rider
ADD/ADHD (Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder)	No Rider	No Rider	X	No Rider	No Rider
Behavioral health disorders	No Rider	No Rider	X	No Rider	No Rider
Cystitis/Urinary Tract Infection	X	X	X	X	No Rider
Enuresis	No Rider	No Rider	X	No Rider	No Rider
Gastroesophageal Reflux Disease (GERD)/Hiatal hernia	X	No Rider	X	X	No Rider
Glaucoma	X	X	X	X	No Rider
Hearing deficiency	X	No Rider	X	X	No Rider
Herpes simplex virus and herpes zoster	No Rider	No Rider	X	No Rider	No Rider
Human papillomavirus	X	X	X	X	No Rider
Lipoma	X	X	X	X	No Rider
Osteoporosis/Osteopenia, prescribed medications	No Rider	No Rider	No Rider	No Rider	No Rider
Restless leg syndrome	X	X	X	X	No Rider
Skin neoplasm (benign) and other dermatoses	X	No Rider	X	No Rider	No Rider
Speech disorder	X	No Rider	X	No Rider	No Rider
Synovitis and tenosynovitis	X	X	X	X	No Rider
Vitiligo	X	No Rider	X	No Rider	No Rider

Misrepresentation Policy

BlueCross BlueShield of Tennessee relies upon the information provided on the application for coverage by the applicant in determining eligibility and insurability for participation in the Individual programs. The misrepresentation process is intended to identify members who potentially have omitted medical history on the application for coverage, investigate these leads, and pursue a valid resolution in the event it is determined that the members have in fact misrepresented medical history.

Brokers/Agents selling BlueCross BlueShield of Tennessee products and assisting in the completion of any application have a duty to provide accurate and complete information to BCBST and to the applicants.

Following the issuance of coverage, if information becomes available through any source indicating the information on the application may have been incomplete, a misrepresentation investigation will be conducted. If this investigation provides documented information that was not disclosed on the application that would have changed the original underwriting disposition, we have the ability to take the following action, including but not limited to:

- Rescind the policy retroactively. If coverage is rescinded, the person will not be allowed to reapply.
- Terminate the policy or exclude the member.

In lieu of terminating the policy, BlueCross BlueShield of Tennessee can:

- Add benefit exclusion rider(s) to the policy for certain conditions.
- Increase the rates on the policy.
- Add a combination of rider(s) and/or rate increases on the policy.

Case reviews

During the misrepresentation process, the following case reviews occur:

- Initial misrepresentation underwriter review.
- Individual underwriter review.
- Misrepresentation supervisor review.
- Misrepresentation Committee review.

The final case disposition and resolution will be decided by the Misrepresentation Committee. Members will be notified subsequently.

Residency and SIU handoffs

During the investigation process, an underwriter may determine there is a need for further investigation by the residency department or Special Investigations Unit. If there is a possible egregious misrepresentation, the case will be directed to the Special Investigations Unit. If the current address of the member appears to be out of state, the case will be referred to Residency.

Member Grievance

All inquiries concerning misrepresentation appeals will be directed to Member Grievance. Applicants agree that BlueCross BlueShield of Tennessee's Grievance process will govern any dispute with the Application or any Policy issued.

Reapplying for Coverage

If a member was previously terminated or excluded through the misrepresentation process, they may apply again for coverage at a later time.

Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine and denial of insurance benefits.

Confidentiality and Release of Information

It is the intent of BlueCross BlueShield of Tennessee to provide our members protection against financial loss due to unforeseen medical conditions. Therefore, any applicant whose current physical/mental condition or whose past medical history – that in the sole judgment of the individual underwriters – gives rise to conditions that are not unforeseen, must be either rejected for coverage or issued a policy with an increase in premium or benefit exclusion rider.

Medical information is protected by federal law and therefore, it is the policy of the Individual Underwriting Department not to release medical information received on applications, submitted medical records or medical records currently on file. Any information obtained is used solely for insurability determinations. If an applicant requires an explanation of the underwriting decision or requests reconsideration of a decision or rider, requests must be submitted in writing to:

Individual Underwriting
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
Fax: (423) 591-9348

Short-Term Coverage Product Guidelines

Eligibility Requirements

Applicants must meet the following criteria to purchase this type of plan:

- Must be a resident of Tennessee (must have a street address, post office boxes do not qualify)
- Must not be covered under any other individual, group or government-sponsored health policy plan or benefits
- Must not be pregnant or an expectant parent
- Must maintain a work/student visa and/or a valid green card and must have lived in the United States for a minimum of 6 months if not a United States citizen
- Must not be contemplating imminent or extended travel
- Must be under age 65

Eligible dependents: Applicants can apply to cover their dependents through age 25, or to age 26.

Dependents include the applicant's current spouse, as recognized under Tennessee law. Dependents also include the applicant's or the spouse's (1) natural children; (2) legally adopted children (including children placed with them for the purpose of adoption); (3) stepchild(ren); or (4) children for who the applicant or his or her spouse is the legal guardian.

Effective Dates

Short-Term coverage will be effective at 12:01 a.m. on the date after the postmark or on the requested effective date, whichever is later. This date may not be later than 60 days after the date of the application. The effective date of this coverage will not be backdated.

Note: if the envelope containing the application is not postmarked by the U.S. Post Office, or if the postmark is not legible, the policy date will be the later of:

- The date after BCBST receives the application, or
- The date requested on the application.

Length of Coverage

Applicants are limited to the purchase of four consecutive short-term policies, with combined coverage not to exceed 12 months. If additional coverage is needed the applicant must wait six months before submitting an application.

Short-Term Coverage may be considered creditable coverage for individual HIPAA coverage. However, it cannot be the last type of coverage the individual had. The last coverage must be employer-sponsored or government health coverage to meet HIPAA eligibility requirements.

The applicant must complete an application and send in the appropriate premium. All applications must be completed in black ink.

Pre-existing Conditions Excluded From Coverage

Short-Term policies do not cover pre-existing conditions. A pre-existing condition is defined as any physical or mental condition that was present prior to the effective date of the policy for which symptoms existed, medical advice, diagnosis, care or treatment was recommended, received or should reasonably been received from a provider of health care services. A condition does not have to be diagnosed or treated to be considered pre-existing.

If an applicant is applying for a second, third or fourth consecutive short-term policy, any condition that may have occurred during the terms of any previous policy is a pre-existing condition and is excluded from coverage under subsequent policies.

BlueCard PPO Program

With BCBST, subscribers carry an ID card that's recognized and accepted by doctors and hospitals throughout the United States. BlueCard® Worldwide is a special hospital network designed for our subscribers who need health care services when traveling outside of the BCBST service area. BCBST will help locate the nearest PPO doctor or hospital and the subscriber's medical bill will be handled through the BlueCard system.

REMEMBER: Subscribers are responsible for receiving prior authorization from BCBST. If prior authorization is not received, benefits may be reduced or denied. Subscribers can call the BlueCard PPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583) for prior authorization. In case of an emergency, subscribers should seek immediate care from the closest health care provider.

Premium Payment Options

BCBST requires the entire premium be submitted for the Short-Term Health Coverage plans. Separate premium payments should be submitted for family members submitting separate applications. Applications will be returned for separate premium payments.

Premium payments should be made through an automatic bank draft if submitting a paper application, or through an automatic bank draft or credit card if applying online.

Completing Applications

- Use the application included within the short-term brochure.
- Applications can be submitted by mail, fax or online at bcbst.com.
- Applications should be completed in black ink.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.
- Faxed applications must be paid with an automatic bank draft.

Guaranteed Issue Product Guidelines

Eligibility Requirements

These policies are sold to applicants who qualify under Interplan Transfer, Group Conversion, Health Coverage Tax Credit (HCTC) and HIPAA regulations. Additionally, applicants:

- Must be a resident of Tennessee (must have a street address, post office boxes do not qualify)
- Must not be covered under any other individual, group or government-sponsored health policy plan or benefits
- Must maintain a work/student visa and/or a valid green card and must have lived in the United States for a minimum of 6 months if not a United States citizen
- Must apply for coverage within 63 days of their loss of coverage

Eligible dependents: Applicants can apply to cover their dependents through age 25, or to age 26.

Dependents include the applicant's current spouse, as recognized under Tennessee law. Dependents also include the applicant's or the spouse's (1) natural children; (2) legally adopted children (including children placed with them for the purpose of adoption); (3) stepchild(ren); or (4) children for whom the applicant or his or her spouse is the legal guardian.

Guidelines for Interplan Transfers

If a member of another BlueCross BlueShield plan moves to Tennessee, and if the member has the premium bills sent to his or her new address, the member's coverage will be transferred to BCBST.

This policy will provide coverage without a medical exam or a health statement. If the member accepts the Interplan Transfer policy, the premium rates and benefits available from BCBST may vary from those offered by the other plan.

Guidelines for Group Conversion

A current BCBST group subscriber, under an insured policy, may convert from group coverage to Guaranteed Issue coverage. This policy will provide coverage without a medical exam or health statement. The subscriber must have had BCBST group coverage, and must have exercised and exhausted his or her COBRA coverage (if available) or state continuation coverage (if applicable), to be eligible for this policy. Persons whose group coverage was terminated for one of the following reasons are **not** eligible for Group Conversion:

- The member fails to pay a required premium contribution.
- The member becomes eligible for Medicare.
- The group agreement is replaced by similar group coverage within thirty-one (31) days.

These policies are to be effective the day after the prior group coverage ends, giving continuous coverage. The application must be received within 31 days from the time the group coverage is terminated or the subscriber is notified, whichever is later.

Guidelines for Health Coverage Tax Credit-Qualified Individuals

The Trade Act of 2002 created a tax credit for the purchase of private health insurance for certain individuals whose jobs have been moved overseas, or who are covered under the Pension Benefit Guaranty Corporation. This tax credit, usually referred to as the Health Coverage Tax Credit (HCTC), is available only for "qualified health coverage."

One type of HCTC-qualified health coverage is coverage that has been determined by a state's Department of Insurance to meet the requirements of the Trade Act of 2002 (State-Based Coverage). The Tennessee Department of Commerce and Insurance has approved BCBST's offering of its Personal Health Coverage as State-Based Coverage, and requires that the coverage satisfies the following criteria:

1. Coverage must be guaranteed issue;
2. Pre-existing condition limits are not permitted;
3. The premiums charged may not be greater than premiums charged to similarly situated individuals; and
4. The benefits must be the same as coverage offered to similarly situated individuals.

BCBST has agreed to make Personal Health Coverage guaranteed issue (HIPAA) H31, H32 and H37 plans, as well as SimplyBlue and SimplyBlue Plus options T1, T2, T3, T4, T5 and T6, available to applicants who qualify for the Health Coverage Tax Credit (HCTC). If the subscriber is eligible for Trade Adjustment Assistance, the applicant must:

1. Have at least three months of coverage with the group that went overseas (we need the Certificate of Creditable Coverage).
2. Provide an HCTC letter no more than 70 days old (63 plus 7 days for mailing) at the time the subscriber applies for coverage.
3. Not be in prison.
4. Currently be HCTC-eligible.

Guidelines for HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before the subscriber enrolls. If the subscriber or any person for whom he or she is applying had at least 18 consecutive months of group, COBRA, federal government, church coverage or other qualifying coverage, and the most recent qualifying coverage was through an employer, the applicant may qualify for a waiver of pre-existing condition exclusions. There must not be a gap of more than 63 days from the date the prior group coverage ended and the date we receive the application for coverage under this contract. In addition, the applicant must not be enrolled in other medical coverage and must have **exercised and exhausted** any COBRA or other State or Federal continuation coverage options.

Policies are to be effective the day after receipt of the application at BCBST if received after the termination date of the prior coverage, or effective the day after the current coverage ends if the application is received prior to the termination of the previous coverage. The application must be received within 63 days from the time the previous coverage is exhausted or the subscriber is notified, whichever is later.

If the applicant applies for an underwritten product with BCBST within the 63 days noted above, is approved for the underwritten product and declines the offer of coverage within the free look period, the applicant will still be allowed to exercise his/her HIPAA rights. The applicant will be required to submit a Guaranteed Issue application with a notification letter declining the offer of coverage for the underwritten product. The effective date of the Guaranteed Issue policy will be the effective date of the underwritten product the applicant declined. If the previous coverage is still active at the time of this request, the effective date will be the day after this coverage ends.

If BCBST declines the applicant for the underwritten product, the applicant will then be allowed to apply for a Guaranteed Issue Policy if requested within 31 days of the denial letter. If eligible, the effective date will be what would have been given for the underwritten product had it been approved.

The subscriber does not have to answer any health questions for these Guaranteed Issue Plans. All pre-existing waiting periods are waived for this plan.

Effective Dates

If the application is received within 63 days of the termination of prior coverage, the guaranteed issue coverage will begin the day after the application is received. If the application is received before their existing coverage terminates, the guaranteed issue coverage will begin the day after the current coverage ends.

Non-Tobacco Rates

To qualify for a non-tobacco rate, each eligible person must not have smoked cigarettes or used tobacco in any form within the past 12 consecutive months.

Personal Dental Coverage Guidelines

Personal Dental Coverage may be added at anytime. It can be deleted without terminating the medical policy. The APP-140 guaranteed issue change application must be used to add or remove dental.

When added, Personal Dental Coverage will apply to all individuals covered under the medical policy. Adult rates apply to anyone age 18 or over. Child rates apply to anyone age 2 through 17. The appropriate monthly dental premium for each individual will be added to the monthly medical premium.

Personal VisionBlue Guidelines

With Medical Coverage: Personal VisionBlue Coverage may be added to a guaranteed issue medical policy at initial enrollment or any time during the life of the policy. It can be deleted without terminating the medical policy. Once dropped, the vision coverage cannot be added back to the medical policy at a later date. The APP-140 guaranteed issue change application must be used to add or remove vision when a subscriber also has a guaranteed issue medical policy. When added to a medical policy, VisionBlue will apply to all individuals covered under the medical policy. The appropriate monthly vision premium for each individual will be added to the monthly medical premium.

With Personal Dental Coverage: Personal VisionBlue Coverage may be added to a stand-alone dental policy at initial enrollment or any time during the life of the policy. It can be deleted without terminating the personal dental policy. Once dropped, the vision coverage cannot be added back to the dental policy at a later date. The APP-144 Personal Dental Change Application must be used to add or remove vision when a subscriber also has a stand-alone dental policy. When added to the dental policy, VisionBlue will apply to all individuals covered under the dental policy. The appropriate monthly vision premium for each individual will be added to the monthly dental premium.

Maternity Rider Guidelines

(available on H32 and H37 only)

The maternity rider can be added at issue or with one of the following two qualifying events to the H32 and H37 Personal Health Coverage Guaranteed Issue plans:

1) Within 31 days of marriage (a copy of the marriage certificate must be provided); or
2) Within 31 days of a spouse's loss of employer sponsored coverage (a copy of the certificate of creditable coverage must be provided).
3) When a dependent reaches his/her age limit and splits from the parent's policy, they are permitted to add maternity coverage. A change form must be submitted within 31 days of the dependent's termination date.

The maternity rider may be requested on the original application or added or deleted by completing the APP-140 guaranteed issue change application. Once the maternity rider has been removed, the rider cannot be added back unless one of the qualifying events above occurs.

Maternity Benefits: Under the rider, all maternity benefits will be paid on the same basis as any other condition and subject to all policy provisions.

Adding Dependents

After the applicant is covered, he/she may apply to add a dependent, who becomes eligible after the initial enrollment, as follows:

1. A newborn child is covered from the moment of birth, and a legally adopted child, or a child for whom the member or the member's spouse has been appointed legal guardian by a court of competent jurisdiction, will be covered from the moment the child is placed in their physical custody. The subscriber must enroll the child within 31 days from when he or she has custody of the child by completing a change application. Do not submit a new application on a newborn if the parent(s) already has an individual policy.

   If the subscriber fails to submit the change application and an additional premium is required to cover the child, the policy will not cover the child after 31 days from when the subscriber gained custody of the child. If no additional premium is required to provide coverage to the child, the member's failure to enroll the child does not make the child ineligible for coverage. However, BCBST cannot add the child to the subscriber's coverage until notified of the child's birth. If the legally adopted (or placed) child has coverage for his/her medical expenses from a public or private agency or entity, the subscriber may not add him or her to the policy until that coverage ends.

2. Any other new family dependent (e.g. if the subscriber marries) may be added as a covered dependent if the subscriber completes and submits a signed change application to us within 31 days of the date that person first becomes eligible for coverage (e.g. the marriage date) and if he/she is eligible for guaranteed issue coverage. We will determine if that person is eligible for guaranteed issue coverage.

The APP-140 guaranteed issue change application should be used to add or remove dependents from a policy.

BlueCard PPO Program

With BCBST, subscribers carry an ID card that's recognized and accepted by doctors and hospitals throughout the United States. BlueCard® Worldwide is a special hospital network designed for our subscribers who need health care services when traveling outside of the BCBST service area. BCBST will help locate the nearest PPO doctor or hospital and the subscriber's medical bill will be handled through the BlueCard system.

REMEMBER: Subscribers are responsible for receiving prior authorization from BCBST. If prior authorization is not received, benefits may be reduced or denied. Subscribers can call the BlueCard PPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583) for prior authorization. In case of an emergency, subscribers should seek immediate care from the closest health care provider.

Premiums, Billing and Payment Options

Initial Premium Payment: For all underwritten Individual Under 65 products, paper applicants may choose to get billed the first month's premium or they may pay the first month's premium by eCheck. Online applications require an initial premium payment, which can be made by eCheck or credit card.

If the premium submitted is less than the amount due, the applicant will be billed for the additional premium. If the amount submitted is more than the amount due, the difference will be credited to the applicant and reflected on his or her next billing statement when their application is accepted and a policy is issued. If additional premium payment is required, we will bill the applicant for the additional amount.

Subsequent Premium Payments: The subscriber will be billed monthly. Payments can be made by eCheck by calling the telephone number listed on the subscriber billing statement or online behind BlueAccess.

Subscribers will be billed approximately the 15th day of the month prior to the due date, if their previous payment was received timely. The subscriber will not be billed for the next billing period until payment for the previous billing period is received and processed. The due date is always the first day of the month for the period billed.

The entire premium amount due must be paid in full. Partial payments are not acceptable and will be returned to the subscriber. Any overpayments will be credited to the subscriber's account and reflected on their next billing statement.

If premium payment is not received within 31 days from the due date, the policy will be cancelled for non-payment and a termination letter will be sent to the subscriber.

Automatic Payment Options: Once a subscriber is approved and a policy is issued, he/she may make automatic electronic premium payments. The subscriber may pay online with eCheck by going to bcbst.com and registering for BlueAccess. In addition, an automatic payment authorization form will be included with the policy mailed to the subscriber.

Bank Drafts: Bank drafts are processed on the 4th day of the month for which the premium is due. The draft from the subscriber's account usually occurs between the 6th and 10th day of the month. If the bank draft is rejected by the subscriber's bank, the subscriber will be charged a $25 non-sufficient funds fee, the policy will be changed to a paper billing and the subscriber will be billed for premiums due. The subscriber must complete a new bank draft authorization form to return to the bank draft method of payment.

Note: Accounts set up for a bank draft arrangement will not receive a paper billing or receipt of the transaction. A record of these transactions should be available through the subscriber's bank.

Terminations due to non-payment: Claims processing and pre-certification will be suspended 15 days after the due date if premiums have not been applied to the subscriber's account. Policies will be terminated 31 days after the premium due date if premiums are not received.

Reinstatement eligibility: If a policy has been terminated for non-payment, it is eligible for reinstatement one time in a 12-month period. The request to reinstate must be in writing and must be received at BCBST within 60 days from the last day the policy was in effect. If reinstated, the effective date of the reinstatement will be retroactive to the termination date, without a lapse in coverage. The subscriber will be responsible for paying all premiums due at the time of reinstatement, including the premiums for the next billing cycle if it is time for that cycle to bill. In addition, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

A second reinstatement within a 12-month period due to extenuating circumstances can be granted with BCBST management approval. If approved, the subscriber would have to set up an automated payment method and pay all back premiums due. Once again, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

Completing Applications

- Use the APP-102 application for new applicants and the APP-140 for changes to existing policies.
- Applications can be submitted by mail or fax.
- Applications should be completed in blue or black ink.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.
  - Faxed applications may be paid with an automatic bank draft.
  - Applicants may also select the "bill me" option.

Guidelines for Changing Products

This section contains information on how and when changes can be made.

Changes Within the Same Under 65 Product

Use the appropriate change application to request changes on existing coverage. These changes include:

- Adding a spouse or dependent. The health questionnaire must be completed. All medical questions must be answered. Those questions answered "yes" require additional details. The application must be fully completed for the underwriting process to begin. Incomplete applications may not only be delayed, but can also result in the termination of the underwriting process.
- Applying for removal of the tobacco rating.
- Applying for a change in plan or deductible.
- Requests to downgrade coverage do not require medical underwriting. The effective date of the change will be the first of the month following receipt of the application.
- Requesting a change in address. A change in address may be requested in writing with a change application (APP-IHCC) and must be signed by the insured or the parent or guardian if the insured is under age 18. The insured may also contact our Membership Service Department. BCBST subscribers must be residents of Tennessee. A move outside of Tennessee will require an interplan transfer. Additional information on Interplan Transfer can be located in the section titled Guaranteed Issue Plans.

Changes From One Under 65 Product to Another Under 65 Product

Underwritten Policies: Transfers from one product to another product require the completion of a change application, and the request will require new underwriting.

Guaranteed Issue Policies: Members may transfer from BluePreferred or PHC 2 guaranteed issue coverage to SimplyBlue guaranteed issue coverage. These transfers will not receive a first year commission as there is no underwriting involved. **We do not allow upgrades in guaranteed issue coverage.**

Additional Benefits:

Personal Dental Coverage is available on all medical products and can be added after the original medical effective date. When adding the dental policy, all members covered under the medical plan will be covered under the dental plan. Personal Dental Coverage can be removed without terminating the medical policy. It is also offered as a stand-alone plan.

Personal VisionBlue

With Medical Coverage: Personal VisionBlue Coverage may be added after the original medical effective date. When added to a medical policy, VisionBlue will apply to all individuals covered under the medical policy. The appropriate monthly vision premium for each individual will be added to the monthly medical premium. It can be deleted without terminating the medical policy. Once dropped, the vision coverage cannot be added back to the medical policy at a later date.

With Personal Dental Coverage: Personal VisionBlue Coverage may be added to a stand-alone dental policy after the original dental effective date. When added to the dental policy, VisionBlue will apply to all individuals covered under the dental policy. The appropriate monthly vision premium for each individual will be added to the monthly dental premium. It can be deleted without terminating the personal dental policy. Once dropped, the vision coverage cannot be added back to the dental policy at a later date.

The maternity rider may only be added at initial purchase or at a later date subject to a qualifying event of 1) marriage, or 2) spouse's loss of employer-sponsored coverage. The request to add this rider must be made within 31 days of the qualifying event. Please note that maternity coverage is not available on all Guaranteed Issue plans or any Short-Term Personal Health Coverage plan.

An "initial" purchase is defined as follows:

1) The first time an applicant purchases an individual product from BCBST.
2) A subsequent purchase of a BCBST individual product, as long as there has been at least six months between the termination of the first product and the effective date of the second product.

If you have any questions or problems with registration or with using this system, please contact the Host Unit at 1-800-351-9325.

Individual Product Transfer Guidelines

	Application Required	Medical Underwriting Required?	Deductibles and Accumulators Carried Over?	Pre-ex Waiting Period	Maternity Rider	Dental/Vision Option
BLUE PREFERRED						
BP to BP	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	Maternity is included and not a rider to BP.	Available
BP to PHC 1	Not Allowed					
BP to PHC 2	Not Allowed					
BP to PremierBlue	Not Allowed					
BP to BluePartner	Not Allowed					
BP to SimplyBlue	Not Allowed					
BP to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	Available	Available
BP Guaranteed Issue to BP Guaranteed Issue	Upgrade – Not Allowed Downgrade App-140	No	Yes	N/A	Maternity is included and not a rider to BP.	Available
BP Guaranteed Issue to PHC 2 Guaranteed Issue	Not Allowed					
BP Guaranteed Issue to SimplyBlue Guaranteed Issue	App-140	No	No	N/A	Not available	Available
BP Guaranteed Issue to any open underwritten product	IHCA	Yes	No	Credit given for time under previous plan	Available	Available
PHC 1						
PHC 1 to BP	Not Allowed					
PHC 1 to PHC 1	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 1 to PHC 2	Not Allowed					
PHC1 to PremierBlue	Not Allowed					
PHC 1 to BluePartner	Not Allowed					
PHC 1 to SimplyBlue	Not Allowed					
PHC 1 to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2						
PHC 2 to BP	Not Allowed					
PHC 2 to PHC 1	Not Allowed					
PHC 2 to PHC 2	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2 to PremierBlue	Not Allowed					
PHC 2 to BluePartner	Not Allowed					
PHC 2 to SimplyBlue	Not Allowed					
PHC 2 to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2 Guaranteed Issue to PHC 2 Guaranteed Issue	Upgrade – Not Allowed Downgrade App-140	No	Yes	N/A	May only add subject to a qualifying event	Available

	Application Required	Medical Underwriting Required?	Deductibles and Accumulators Carried Over?	Pre-ex Waiting Period	Maternity Rider	Dental/Vision Option
PHC 2 Guaranteed Issue to BP Guaranteed Issue	Not Allowed					
PHC 2 Guaranteed Issue to SimplyBlue Guaranteed Issue	App-140	No	No	N/A	Not available	Available
PHC 2 Guaranteed Issue to any open underwritten product	IHCA	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PremierBlue						
PremierBlue to BP	Not Allowed					
PremierBlue to PHC1	Not Allowed					
PremierBlue to PHC2	Not Allowed					
PremierBlue to PremierBlue	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PremierBlue to BluePartner	Not Allowed					
PremierBlue to SimplyBlue	Not Allowed					
PremierBlue to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
Blue Partner						
Blue Partner to BP	Not Allowed					
BluePartner to PHC 1	Not Allowed					
BluePartner to PHC2	Not Allowed					
BluePartner to PremierBlue	Not Allowed					
BluePartner to BluePartner	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
BluePartner to SimplyBlue	Not Allowed					
BluePartner to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
SimplyBlue						
SimplyBlue to BP	Not Allowed					
SimplyBlue to PHC 1	Not Allowed					
SimplyBlue to PHC 2	Not Allowed					
SimplyBlue to PremierBlue	Not Allowed					
SimplyBlue to BluePartner	Not Allowed					
SimplyBlue to SimplyBlue	Upgrade – Not Allowed Downgrade - IHCC	No	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
SimplyBlue to PersonalBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
SimplyBlue Guaranteed Issue to BluePreferred Guaranteed Issue	Not Allowed					
SimplyBlue Guaranteed Issue to PHC2 Guaranteed Issue	Not Allowed					
SimplyBlue Guaranteed Issue to SimplyBlue Guaranteed Issue	Upgrade – Not Allowed[2] Downgrade App-140	No	Yes	N/A	Not available	Available
SimplyBlue Guaranteed Issue to any open underwritten product	IHCA	Yes	No	Credit given for time under previous plan	Available	Available

	Application Required	Medical Underwriting Required?	Deductibles and Accumulators Carried Over?	Pre-ex Waiting Period	Maternity Rider	Dental/Vision Option
PersonalBlue						
PersonalBlue to BP	Not Allowed					
PersonalBlue to PHC1	Not Allowed					
PersonalBlue to PHC2	Not Allowed					
PersonalBlue to PremierBlue	Not Allowed					
PersonalBlue to BluePartner	Not Allowed					
PersonalBlue to SimplyBlue	Not Allowed					
PersonalBlue to PersonalBlue	IHCC	Yes, for richer benefit plans	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available

Notes:

[1] *A "Transfer" is defined as a move from one plan or product to another without a gap in coverage.*

[2] *Moving from a SimplyBlue GI to a SimplyBlue Plus GI is the only upgrade that is allowed. There are still limitations based on plan design, so refer to the Upgrade/Downgrade chart for confirmation of what is allowed. The new SimplyBlue Plus plan must be considered Non-grandfathered.*

Downgrading within a product does not impact grandfathered or non-grandfathered status. The status of the member in the current plan should be the same in the new plan. The only times status will change from grandfathered to non-grandfathered are in the case where someone moves to a new product. For example:

- *Grandfathered member in PHC2 GI moves to a SimplyBlue GI policy, they become non-grandfathered.*
- *Grandfathered member in any underwritten product (PHC, PremierBlue etc.) moves to PersonalBlue, they become non-grandfathered.*

Upgrading within a product is not allowed, with two exceptions:

- *PersonalBlue members may apply for an upgrade. This will require underwriting approval.*
- *SimplyBlue GI members may upgrade to select SimplyBlue Plus GI options. The new Plus option must be the non-grandfathered version.*

Effective May 7, 2009, policy splits will be allowed on all individual under 65 products, subject to the following guidelines.

Policy Splits:

A policy split occurs when the subscriber's coverage terminates and the remaining dependents want to continue their individual coverage under the same plan, or when a family policy is requested to be switched to multiple policies.

- *Effective 10/1/2010, child-only split off policies will not be allowed. If the adult(s) on the policy term, the entire family policy terms.*
- *The appropriate change application must be submitted.*
- *If the split includes an upgrade in coverage, those individuals will be required to go through medical underwriting. The agent listed on the change form will be the agent of record for the new policy, commissions will be at the new product's renewal level.*
- *If the split includes a downgrade or continuation of current benefits, medical underwriting will not be required. Exclusion riders on the original policy will be retained on the new policy. Commissions stay with the original agent at the renewal level.*
- *For policy forms with member level rating, the individuals will retain their member level rate up. For policy forms with contract level rating, if the original policy had a rate up, the premium will need to be reviewed by Underwriting to adjust for the members' new policies.*
- *Amounts already paid towards the deductible and out of pocket amounts will be credited to the new policies, if the new policies are within the same product. If the new policies are within a different product, deductibles and accumulators are not carried over.*
- *Credit towards any pre-existing waiting periods will be applied to the new policies, regardless of product.*
- *A policy split is not to be considered a qualifying event to add life coverage.*
- *A policy split is not to be considered a qualifying event to add maternity coverage, except in the case of a dependent splitting off due to aging off of the original policy, as defined by the dependent age-off guidelines.*

Grandfathered vs Non-Grandfathered Plans

The chart below provides a summary of which policies are grandfathered versus non-grandfathered. The term "initial enrollment" refers to the member's initial enrollment in that product, not plan design. As referenced above, downgrades in coverage within a particular product do not revoke grandfathered status.

Product	Grandfathered Policies	Non-Grandfathered Policies
BluePreferred Underwritten	All	None
BluePreferred Guarantee Issue	All	None
PHC1	All	None
PHC2 Underwritten	All	None
PHC2 Guarantee Issue	Initial enrollment < 3/23/10	Initial enrollment 3/23/10 and later
BluePartner	Initial enrollment < 3/23/10	Initial enrollment 3/23/10 and later
SimplyBlue Underwritten	Initial enrollment < 3/23/10	Initial enrollment 3/23/10 and later
SimplyBlue Guarantee Issue	Initial enrollment < 3/23/10	Initial enrollment 3/23/10 and later
PremierBlue	Initial enrollment < 3/23/10	Initial enrollment 3/23/10 and later
PersonalBlue – HSA Compatible	None	All
PersonalBlue – Standard PPO	None	All

Notes:

- *PersonalBlue plans were converted to non-grandfathered, effective 9/23/10*
- *New sales in PHC2 GI and SimplyBlue GI were non-grandfathered, effective 9/23/10*
- *All other existing policies were deemed grandfathered or non-grandfathered based on the chart above, effective 1/1/11*
- *Based on our current transfer guidelines, there are only three instances, after 1/1/11, where members will lose their grandfathered status. These are also noted in an earlier section of this document.*
  - *Grandfathered member in PHC2 GI moves to a SimplyBlue GI policy, they become non-grandfathered.*
  - *Grandfathered member in any underwritten or GI product (PHC, PremierBlue etc.) moves to PersonalBlue, they become non-grandfathered.*
  - *SimplyBlue GI members may upgrade to select SimplyBlue Plus GI options. The new Plus option must be the non-grandfathered version.*

BlueElite Eligibility Requirements

To be eligible to enroll, the applicant:

- Must be a resident of Tennessee (This must be a street address; post office boxes do not qualify.)
- Must be age 65 or over. Effective January 1, 2011, persons under age 65 who are eligible for Medicare by reason of disability or end stage renal disease are also eligible under certain conditions.
- Must be enrolled in Medicare Part A and B.
- Cannot have another federally regulated Medicare supplement policy

Beneficiaries who qualify for Medicare due to a disability or ESRD are eligible to enroll in any of our BlueAdvantage plans. Effective January 1, 2011, they may also be eligible to enroll in BlueElite under certain conditions.

Open Enrollment

1. If the application is submitted within six (6) months of the time when an individual is both 65 years of age or older and is enrolled for benefits in Medicare Part B, any currently available BlueElite policy is available to the applicant on a guaranteed issue basis. Preexisting condition limitations apply for six (6) months with creditable coverage offsets as of the enrollment date.

2. Effective January 1, 2011 persons under age 65 who are eligible for Medicare by reason of disability or end stage renal disease are also eligible for a six (6) month open enrollment period. Eligible individuals under age sixty-five (65) must be offered the same policies with the same standard benefits as the sixty-five (65) and older population. They will have a preexisting condition limitation apply for six (6) months with creditable coverage offsets as of the enrollment date. The following eligibility scenarios trigger a six (6) month open enrollment period:

   e. A person who has been enrolled in Medicare Part B since before January 1, 2011 will have six (6) months from that date to purchase a policy;

   f. A person who becomes enrolled in Medicare Part B after January 1, 2011 will have six (6) months from the date of enrollment to purchase a policy;

   g. A person who becomes retroactively enrolled in Medicare Part B due to a retroactive eligibility decision mad by the Social Security Administration will have six (6) months from the date of the notice of retroactive enrollment to purchase a policy;

   h. A person who loses access to alternative forms of health insurance coverage such as accident and sickness policies, employer-sponsored group health coverage or Medicare Advantage plans due to termination or cancellation of such coverage because of the individual's employment status, or due to an action by a health insurer or employer that is unrelated to the individual's status, conduct, or failure to pay premiums will have six (6) months from the date of loss of that coverage to purchase a policy; or

   i. A person who is involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act will have six (6) months from the date of disenrollment to purchase a policy.

Guaranteed Issue for Eligible Persons

1. Eligible persons as described below will have certain BlueElite plans available on a guaranteed issue basis with no pre-existing condition limitations.
2. An eligible person is an individual described as follows. If the applicant does not fit one of these categories, the policy is subject to underwriting and pre-existing condition limitations apply for six (6) months with creditable coverage offsets.

   a. The applicant has lost group health coverage through no fault of their own. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F.

   b. The applicant has a Medicare Advantage plan. The plan has been discontinued, the individual is no longer eligible, or the plan misled the individual. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F.

   c. The applicant is enrolled in a Section 1876 (Medicare cost) plan or Section 1833 (health care prepayment) plan that ceases. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F.

d. The individual has a Medicare Supplement policy, and enrollment ceases because the issuer goes bankrupt or misrepresented the policy. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F.

e. If the applicant dropped a Medicare Supplement policy to join a Medicare Advantage Plan for the first time, they have been in the plan less than a year, and they want to switch back to Medicare Supplement, they have the right to:

   1. Buy the Medicare Supplement policy they had with BCBST before they joined the Medicare Advantage Plan, if BCBST still sells it. If it included drug coverage, they can still get the same policy, but without the drug coverage.
   2. If their former Medicare Supplement policy is no longer available, they can also buy a BlueElite plan A or F.

   The guaranteed issue period ends sixty-three (63) days after termination.

f. The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan and disenrolls from the plan or program within the first year. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to any BlueElite plan currently issued – A, D, or F.

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers prescription drugs and the individual terminates enrollment in that policy. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F.

h. The individual is enrolled under Title XIX of the Social Security Act (Medicaid, or Tenncare) and the enrollment involuntarily ceases after the individual is 65 years of age or older and eligible for and enrolled in Medicare Part B. The guaranteed issue period ends sixty-three (63) days after termination. The applicant is entitled to BlueElite plans A and F. Note that special rules apply for individuals involuntarily disenrolled before March 2010.

For the members described in (e) and (f) above, the trial rights may extend for an extra twelve months under certain circumstances. If these members were involuntarily terminated within the first twelve months of their enrollment and, without an intervening enrollment, enrolled in another such plan, the subsequent enrollment shall be deemed to be an initial enrollment.

6-Month Pre-existing Condition Waiting Period

A 6-month pre-existing condition waiting period may be placed on new Medicare Supplement policies. This means that no benefits will be paid on conditions for which medical advice or treatment was given in the six months prior to the effective date of the policy. If an applicant has had creditable coverage, some or all of this waiting period may be waived. Creditable coverage for Medicare Supplement policies can be any of the following types of policies: a workplace health plan, COBRA, a federal government plan (including TRICARE, CHAMPUS, CHAMPVA), church plan coverage or an individual health plan or Medicare Supplement plan. A copy of proof of creditable coverage needs to be attached to the application to ensure proper credit is given. If their previous coverage was with BlueCross BlueShield of Tennessee, please make sure the policy number is noted in the questions in section five of the application.

Special Circumstances

1. Subscribers who move to Tennessee and transfer from another Blues Medicare supplement plan will be accepted on a guaranteed issue basis, with no underwriting or preexisting condition limitations. If the same level of plan is not available, BCBST will offer the next alphabetically preceding standard product available for sale. For example, if the subscriber holds a certificate for Plan G, but BCBST does not sell Plan G, we will offer Plan F. If we do not sell Plan F, we will offer Plan E, et cetera.

2. Note that no 1990 standardized Medicare Supplement benefit plan may be offered for sale on or after June 1, 2010. This also applies to internal transfers. Thus, there can be no movement between BC65 plans.

3. BlueElite members may move to Plan A at any time. There can be no movement from BC65 to BlueElite without underwriting.

Effective Dates

Medicare supplement policies will be made effective the first day of the month following receipt of the application, unless another effective date is requested on the application.

For new Medicare beneficiaries only: If the application is received by the 15th of the month in which the Medicare Part A and Part B become effective, the effective date will be back dated to the first of the month. Example:

Application received 7-15-07 and Medicare is effective 7-1-07, we would assign a 7-1-07 effective date unless subscriber requests otherwise.

Note: BlueElite applications are accepted up to 90 days from the requested effective date provided that the applicant's signature on the application is also dated within 90 days. If the signature is dated more than 90 days from the requested date, the application will be returned for an updated signature.

AirMed International Membership

BlueElite members receive a free membership in AirMed International. If the member is traveling more than 150 miles from home and becomes hospitalized, the member can receive the following assistance at no charge:

- Air ambulance transportation to a hospital close to the member's home.
- Transportation for a traveling companion.
- In the event of death, transportation of the member's remains to a funeral facility near the member's home.

The member will receive a detailed brochure explaining the services and limitations of this membership. Also included is a wallet card with the phone number to call to arrange services.

SilverSneakers® Fitness Program

BlueElite members receive a free membership in the SilverSneakers Fitness Program. This includes:

- A complimentary membership at a participating location near the member where he or she can use amenities included with a "basic" membership, such as steam and sauna rooms and exercise equipment.
- SilverSneakers classes, appropriate for members at all fitness levels.
- Opportunities to make new friends and participate in fun activities.
- Personalized, friendly service from an appointed fitness staff member, the Senior Advisor℠.

Premiums, Billing and Payment Options

Determining Plan Premiums: The premium rate for BlueElite is based on the applicant's age as of the June 1 before the coverage becomes effective. Once the subscriber is enrolled, rate increases will occur June 1st of each following year. The premium rate can be increased otherwise only if the subscriber moves out of state or the rate is increased for all other BlueElite customers with the same plan and age.

Initial Premium Payment: BCBST does not require the first month's premium payment for BlueElite. This will be billed to them.

Subsequent Premium Payments: The subscriber is billed monthly. Payments can be made by check, money order, bank draft, by phone or online. Payment can be made over the telephone by calling the telephone number listed on the subscriber's billing statement or online behind BlueAccess.

Subscribers will be billed approximately the 15th day of the month prior to the due date, if their previous payment was received timely. The subscriber will not be billed for the next billing period until payment for the previous billing period is received and processed. The due date is always the first day of the month for the period billed.

The entire premium amount due must be paid in full. Partial payments are not acceptable and will be returned to the subscriber. Any overpayments will be credited to the subscriber's account and reflected on their next billing statement.

If premium payment is not received within 31 days from the due date, the policy will be cancelled for non-payment and a termination letter will be sent to the subscriber.

Automatic Payment Options: Once a subscriber is approved and a policy is issued, he/she may make automatic electronic premium payments. The subscriber may pay online with eCheck by going to bcbst.com and registering for BlueAccess. In addition, an automatic payment authorization form will be included with the policy mailed to the subscriber.

Bank Drafts: Bank drafts are processed on the 4th day of the month for which the premium is due. The draft from the subscriber's account usually occurs between the 6th and 10th day of the month. If the bank draft is rejected by the subscriber's bank, the subscriber will be charged a $25 non-sufficient funds fee, the policy will be changed to a paper billing and the subscriber will be

billed for premiums due. The subscriber must complete a new bank draft authorization form to return to the bank draft method of payment.

Note: Accounts set up for a bank draft arrangement will not receive a paper billing or receipt of the transaction. A record of these transactions should be available through the subscriber's bank.

Terminations due to non-payment: Claims processing and pre-certification will be suspended 15 days after the due date if premiums have not been applied to the subscriber's account. Policies will be terminated 31 days after the premium due date if premiums are not received.

Reinstatement eligibility: If a policy has been terminated for non-payment, it is eligible for reinstatement one time in a 12-month period. The request to reinstate must be in writing and must be received at BCBST within 60 days from the last day the policy was in effect. If reinstated, the effective date of the reinstatement will be retroactive to the termination date, without a lapse in coverage. The subscriber will be responsible for paying all premiums due at the time of reinstatement, including the premiums for the next billing cycle if it is time for that cycle to bill. In addition, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

A second reinstatement within a 12-month period due to extenuating circumstances can be granted with BCBST management approval. If approved, the subscriber would have to set up an automated payment method and pay all back premiums due. Once again, the subscriber will be charged a $50 fee to reinstate any medical policy terminated for non-payment. Subscribers will be charged a $25 fee to reinstate dental-only policies terminated for non-payment.

30-Day Review

The new member has a full 30 days after receiving the BlueElite policy to examine it and make sure the coverage is right for him or her. If for any reason the member is not completely satisfied, he or she can return the policy to us within 30 days of receipt. BCBST will refund any premiums the member has paid, less any benefits we have paid.

Tips for Submitting Applications

- Use the 123776_BE_APP(02.10) application for BlueElite.
- Applications should be completed in blue or black ink.
- Applications can be submitted by mail or fax.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.

Replacing Other Medicare Supplement Coverage: If the applicant is terminating his or her existing Medicare supplement coverage and replacing it with a BlueElite policy, the Medicare Supplement Replacement Notice (APP-20-I (03.10)) must be signed and included with the application.

Broker Online Tools

The broker section of bcbst.com features useful information to help you sell BlueCross BlueShield of Tennessee individual products. By clicking on the broker link from the home page you can access:

- Broker licensing information
- Product information
- Application forms
- Individual Products marketing materials
- Online rate delivery system

Individual Products Marketing Materials

This link from the main (non-secure) broker section of bcbst.com takes you to our online catalog of marketing materials that should be included in each specific products sales package. To order these materials, please print a copy of the Literature Request Form from the main page of the catalog. **Please note that there are separate forms and fax numbers for Individual and Medicare literature requests.**

Online Rate Delivery System

Find quick quotes on individual health plans currently being sold.

- Click on the Individual Products Rate Delivery System link.
- Select the product type from the pull down menu.
- Select maternity, dental, and/or vision, if applicable. Not available on Short-Term.
- Enter your applicant's information.
- Select a low, middle or high rate (or combination).
- Click "Submit."

You will receive a monthly estimate of the premium based on information you submitted.

How to Register for BlueAccess

1. Go to bcbst.com
2. Click on the "Register Now" link within the BlueAccess section on the home page.
3. Select to register as a "Broker."
4. Enter your Tax ID (either the agency's Tax ID or your Social Security Number) and your e-mail address.
5. After selecting "Continue," verify your information on the next screen and enter the additional information requested. Select "Continue."
6. You will see a confirmation page verifying your BlueAccess account was created.

An e-mail will be sent to the e-mail address you provided. Click on the link provided in the confirmation e-mail and enter your license number to verify your account information. (If you do not receive this e-mail, please contact BCBST at 1-800-535-5600.)

Once you have a BlueAccess user ID and password, you can begin using even more secure online tools to help manage your business.

BlueConnections – Online Application & Quoting Tool

BlueConnections is an online sales and application tool that makes it easier for you to:

- Find plan options that best suit your client's needs;
- Compare plans side by side;
- Share quotes with your client;
- Share your client's online application;
- Keep track of your online cases and more.

BlueConnections is available after you log in to the secure BlueAccess section of bcbst.com and sign a Web Linking Agreement. It enables you to provide your clients with the convenience of applying online for BCBST coverage. You can even begin the application process on behalf of your client. Online applications apply toward your commission and applicable broker bonus programs.

To get set up on BlueConnections, contact the Field Agency Support Representative in your region. (Please refer to page 1 of this guide.)

For technical support, contact **Angela Lanier at 1-800-351-9325 and select option 3.**

Individual Application Status

If you need information during the application process click on the **"Individual Application Status."** To request access to this tool:

1. Logon to BlueAccess using your user ID and password.
2. Select "Individual Application Status."

3. A system-generated e-mail will pop up. Simply hit send. It is not necessary to add anything to the e-mail or create your own e-mail.
4. You will be notified by e-mail once your access has been granted. (This process takes 1 to 3 days.)

The most recent transactions since you last logged in will automatically be displayed. Other information and tools include:

- Application status – Approved, Pending, Approved with Rider(s) or Denied.
- View and print policy face pages, riders, information requested letters, and reconsideration letters.
- Access any applicant record that has been updated by BlueCross BlueShield of Tennessee in the last 90 days.
- Data can be sorted by selecting column headings such as name, application date, product, status, Social Security number, and effective date. When searching for a particular applicant, the easiest way is to enter the first letter of the last name in the last name field of the search engine. Your search will return all of your applicants with a last name beginning with that letter.

You are required to go to the Website to retrieve this information. BCBST is not able to fax it to you.

e-Health Services

For information after a customer's policy becomes effective, select **"e-Health Services."** For the first 30 days, you have access to the following information to provide the customer assistance with his or her new policy:

- Benefit, eligibility and coverage details.
- Medical and behavioral health claims (except prescription drug claims).
- Prior authorization status.
- Provider referrals.
- Order replacement ID cards

Federal Restrictions on Marketing Practices

HIPAA Restrictions When Using PHI

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) prevent the use of protected health information (PHI), collected in the process of selling and submitting applications for individual health products, for the purposes of marketing other insurance or financial products. PHI includes such data as name, address, age, gender, insurance status, and other contact information.

Simply put, HIPAA does not allow insurance companies or insurance agencies to use mailing lists, comprised of individuals who have purchased health insurance from the company or agency, for direct mail or telemarketing solicitation for non-health related products (e.g. property and casualty, life insurance and disability).

In order to market non-health related products and services to an existing health insurance customer, you must have a signed authorization form from that customer.

Situations That Require Authorization to Use PHI:

- Materials using the BlueCross BlueShield of Tennessee logo or name.
- Direct mail or telemarketing for non-health related (e.g. property and casualty, life insurance and disability) using a database of PHI collected during the sale of individual health insurance products.
- Newsletters that include articles about non-health related products.

Situations That Do Not Require Authorization to Use PHI:

- During face-to-face meetings with the customer.
- Items of nominal value.
- Communications that describe health-related products or services provided by the recipient's health insurer can be sent to the customer using PHI. Examples include:
  - Network Directories
  - Replacements or enhancements to a health plan (e.g. Medicare supplement plans)
  - Added-value products or services that are not part of the plan benefits but are available only to enrollees in the health plan (e.g. BluePerks℠ program)
  - Newsletters that are limited to non-marketing topics, such as wellness, value-added products or services, health-related products, legislative information and advocacy.

FCC Telemarketing Regulations

The Federal Communications Commission issued telemarketing regulations in July of 2003. These regulations incorporate the Federal Trade Commission's national do-not-call registry, clarify the scope of that registry and place additional restrictions on telephone and fax solicitations.

Updates have clarified the application of the joint Federal Communications Commission and Federal Trade Commission's Do Not Call telemarketing regulations to insurance agents and brokers. Specifically, all do not call regulations apply to insurance agents and brokers (see below for details). However, unlike an insurance company, an existing business relationship between customer and broker does not extend for the term of the insurance policy. Agents are not allowed to make telephone solicitations beyond the customary 18-month period allowed for existing business relationships without express written consent from the customer.

Here are other key telemarketing rules to keep in mind:

- It is against the law to make calls to any residential telephone phone number on the "Do Not Call" registry for the purpose of encouraging the purchase or rental of, or investment in property, goods or services.
- The same rules apply to pre-recorded telephone solicitations or facsimile messages.
- Agents engaged in telemarketing practices are required to check the national registry at least every 31 days and may not contact any telephone number listed without express written permission from the consumer or unless there is an established business relationship.
- An established business relationship is defined as a purchase from or transaction with the seller within the previous 18 months of the date of the call or an inquiry or application regarding products or services offered by the seller within the previous three months of the date of the call.

- Consumers have the right to opt out of telephone solicitations from any business, even if an established relationship exists. Entities must maintain these requests on a company specific do not call list for a minimum of five years.
- Calls before 8 a.m. and after 9 p.m. are prohibited regardless of the existence of a business relationship.
- Pre-recorded or automated unsolicited advertisements and solicitations are prohibited unless an established business relationship exists.
- Caller identification information must be transmitted. (Businesses cannot block caller ID on outgoing telemarketing calls.)
- Telemarketers must make sure that the abandonment rate of calls placed using a predictive dialer remains at no more than three percent. (A call is considered abandoned if it is not transferred to a live sales agent within two seconds of the recipient's greeting.)
- Unsolicited faxes are prohibited, unless the sender has written permission from the receiver, regardless of the existence of a business relationship.

An established business relationship is defined as a purchase or transaction within the last 18 months or an inquiry or application received within the last 3 months.

The above restrictions do not encompass all of the rules regarding telemarketing. Please see the full text version of the FCC regulation, 64 C.F.R. § 64.1200 for complete information or visit www.ftc.gov/bcp/menus/business/marketing.shtm.

This section includes general information HIPAA Administrative Simplification and FCC Regulations regarding telemarketing practices. It is not intended to replace or service as legal counsel. Seek advice from your legal counsel on compliance with these regulations.

Agent Guidelines for Advertising and Marketing

The BlueCross BlueShield logo is one of the most widely recognized symbols in the world. BCBST strives to maintain a high level of brand awareness through the proper use, placement and position of the company's name and logo.

To maintain brand positioning, BCBST requires responsible use of the company logo and name by its own employees and carefully evaluates each request for the use of the brand by people or organizations outside the company.

Agents, who have a signed agent agreement with BCBST, may use the company's name and logo in advertising and marketing materials. Please remember that we can only quote business in Tennessee. Logos for use in advertising and marketing materials are available upon request from the Marketing Communications Department.

Any materials that include the BCBST name or logo, must follow the specified guidelines below and must be approved prior to use by the Marketing Communications Department of BCBST. **BCBST will use all legal remedies to enforce compliance. Unapproved use of the BCBST name or logo by an agent can result in the immediate termination of the agent's agreement.**

General Restrictions for Advertising and Marketing Materials

1. You may not represent yourself or your agency as an employee or office of BCBST in any advertising and marketing materials. All materials produced by agents must be worded and designed so that the reader understands that the material is coming from the agent or agency and not BCBST.

2. You must use the phrase "an authorized agent (or agency) for" or "offering" before the name or the logo at least one time in the materials.

3. You must use the full name or full logo in your materials. The logo may be used only as provided. The logo cannot be distorted or used in a way not explicitly approved by BCBST or described in the brand regulations from the BlueCross BlueShield Association. See examples below for the correct name and logo:

   Correct Name:

   BlueCross® BlueShield® of Tennessee

Correct Logos:

Authorized Agent
BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

Authorized Agent
BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

Authorized Agent
BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

4. If you use the name only, you must include a register mark after BlueCross and a register mark after BlueShield on the first or most prominent use of the name. Example: BlueCross® BlueShield® of Tennessee

5. All materials using the logo must contain the following legal disclaimer somewhere. It can be in very small print (6 or 8 point type).

   BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

   ® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

6. The BCBST name or logo may not be used on your business cards.

7. Approval to use the BCBST name or logo on one particular type of material does not imply approval for any other use. Additional uses of the name or logo must also be submitted for approval.

8. BCBST will not allow its name or logo to be used on endorsements of any kind.

9 You may not use the logo in connection with any local sponsorships in which you choose to participate.

10. When used in conjunction with other insurance carriers, the BCBST logo must be displayed in a size no greater than that of any other carrier.

11. By using the BCBST logo, you are committed to channeling any prospective customer that BCBST cannot service to the BlueCross BlueShield Association.

12. All materials are subject to the approval of the BCBST Legal Division and must comply with BlueCross BlueShield Association brand regulations contained in these guidelines.

13. Use caution when listing other lines of non-BCBST products, such as life or auto insurance. You must not give the appearance that these products are also offered by BCBST.

14. Agents are not allowed to include Guaranteed Issue products in any advertising or sales solicitation materials.

Print Advertising

For pre-approved print ads, please see the Marketing Assistance Program section in this booklet. You can tag your own newspaper or magazine ads with the BCBST logo. Requirements for approval:

1. Submit a draft copy or proof of your ad to the Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.
2. If your ad is two color, the cross and shield symbols may not appear in any colors except blue or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
3. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
4. All General Restrictions apply.
5. You are responsible for all production and placement costs.
6. You must provide a list of publications the ad will appear in and the number of times the ad will run in each publication to the Marketing Communications Department.
7. Approvals are good for one year, and must be submitted for approval again each year.

An example of the correct usage of the logo in a print ad is shown below.

Yellow Page Advertising

BlueCross BlueShield of Tennessee now allows agents to list its name and logo in yellow page advertising. Requirements for approval:

1. Yellow and white page listings must be under your agency's name, not BCBST's name.
2. If your ad includes the name or logo of other insurance carriers, the BCBST name or logo may not be larger than the name or logo of any other carrier.
3. Submit a draft copy or proof of your ad to the Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.
4. If your ad is two color, the cross and shield symbols may not appear in any colors except blue or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
5. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.

1. All General Restrictions apply.
2. Please provide the name of the book the ad will appear in.
3. You are responsible for all production and placement costs.
4. Approvals are good for one year, and must be submitted for approval again each year.

Examples of the correct usage of the logo or name in a yellow page ad:

Outdoor Advertising

You can use the BCBST logo on outdoor advertising for your agency. Requirements for approval:

1. If your ad includes the name or logo of other insurance carriers, the BCBST name or logo may not be larger than the name or logo of any other carrier.
2. Submit a layout of your outdoor board to the Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.
3. The cross and shield symbols may not appear in any colors except blue (PMS 300) or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
4. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
5. All General Restrictions apply.
6. Please provide the location, size of the board and the length of the contract.
7. You are responsible for all production and placement costs, as well as maintenance of all outdoor advertising.
8. Approvals are good for one year, and must be submitted for approval again each year.

Examples of the correct usage of the logo on an outdoor advertising board:

or

Direct Mail

You can mention BCBST in direct mail campaigns, such as letters to prospective customers. Requirements for approval:

1. Submit a draft copy of your letter or direct mail piece to the Marketing Communications Department via fax, mail or e-mail.
2. All letters are subject to approval by the BCBST Legal Division.
3. Letters should be on your agency's letterhead. Do not create a letterhead look with the BCBST logo.

   If your direct mail piece is two color, the cross and shield symbols may not appear in any colors except blue (PMS 300) or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
4. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
5. All General Restrictions apply.
6. Please provide to what areas you plan to mail and identify your audience. (You can only mail to residents of Tennessee.)
7. You are responsible for all production and mailing costs.
8. Approvals are good for one year, and must be submitted for approval again each year.

Radio Advertising

Radio advertising using the BCBST name is permitted. Requirements for approval:

1. The radio advertising must be worded to come from your agency, not BCBST.
2. You must identify yourself or your agency as "an authorized agent (or agency) for BlueCross BlueShield of Tennessee."
3. Submit a draft copy to the Marketing Communications Department via fax, mail or e-mail for approval.
4. If changes are requested you will be required to submit corrected copy before approval will be given. Please allow time for this process.
5. All General Restrictions apply.
6. Please provide a list of stations and the dates the commercial will air.
7. You are responsible for all production and placement costs.
8. Approvals are good for one year, and must be submitted for approval again each year.

Television Advertising

You may use the BCBST logo in your television advertising. Requirements for approval:

1. The television advertising must be worded to come from your agency, not BCBST.
2. You must identify yourself or your agency as "an authorized agent (or agency) for BlueCross BlueShield of Tennessee" either visually on screen or in the voiceover.
3. Because of the expense involved in television production, please submit a draft copy to the Marketing Communications Department via fax, mail or e-mail for approval. This copy should indicate how the logo is to be used in the commercial.
4. The cross and shield symbols should be in blue and the "BlueCross BlueShield of Tennessee" should be in black.
5. The disclosures indicated in General Restriction No. 5 must appear on screen during the commercial.
6. Once production is complete, a VHS or DVD copy of the commercial must be submitted before airing for approval. Please be advised that if the General Restrictions are not followed, you will be required to correct the spot before airing and submit another copy for approval.
7. All General Restrictions apply.
8. Please provide a list of stations and the dates the commercial will air.
9. You are responsible for all production and placement costs.
10. Approvals are good for one year, and all materials must be submitted for approval again each year.

Agency Office Signage

You may include the BCBST logo on signage for your agency at your own expense. Requirements for approval:

1. Use the language "An Authorized Agent (or Agency) for" with the logo.
2. Submit your design to the Marketing Communications Department via fax, mail or e-mail for approval.
3. All General Restrictions apply.
4. Signage that includes the BCBST logo must be maintained in good condition.

Other Uses of the Logo or Name

Please contact BCBST's Marketing Communications Department for approval and guidance on any other uses of the name or logo not covered in this guide.

Marketing Assistance Program

BCBST offers agents pre-approved advertising materials, which can be purchased via our Marketing Assistance Program (MAP) in the broker section of bcbst.com using your Master Card or Visa. Materials offered include:

- Newspaper Ads
- Yellow Page Ads
- Direct Mail Brochures/Postcards

Materials are segmented by business line (individual, group, Medicare supplement and generic/all products). All materials will be customized for your agency. You can see a proof online and complete your transaction by entering your credit card information.

Direct mail services are also available for the postcard and direct mail brochures. You have the opportunity to order a one-time mailing list for businesses or consumers. **BCBST commercial customers are suppressed from any mailing lists you purchase.** You select your list criteria online based on age, geographic area, gender, income, etc. MAP will take care of the list rental, customizing the materials and your outbound postage for one inclusive price. Minimum order quantity is 500 on all pieces. Once you order a list, no other agent can purchase the exact same list of names for 30 days through this program.

Pricing for all products is available on the MAP Website. You must be a registered user of the BlueAccess secure area of bcbst.com.

Newspaper and yellow page ads are usually provided electronically to you within 2-3 business days. Printed pieces are usually delivered to you (or the post office if you are using the direct mail services) in 7 to 10 business days.

Resizing of ads or special printing requests are available for an additional charge. If you have special requests you should contact the Marketing Communications Department before you place your order.

To get started with MAP:

1. Log on to BlueAccess from the home page of bcbst.com.
2. Click on the Marketing Assistance Program.
3. First time visitors will be asked to fill out a profile. Your profile will be used to pre-populate some items on your order form.
4. Click on the Order Print Materials button.
5. Select the item you wish to purchase from the main menu.
6. Follow the instructions for completing your customization information.
7. If you are using the direct mail services, please follow the instructions to order your mailing list before you complete the customization portion of the form.
8. Review your proof carefully. If you need to make changes, select the back button at the bottom of the screen (don't use your browser's back button).
9. Once you are satisfied with your proof, enter your credit card information to complete your transaction.

If you need assistance at any time with MAP, please call the Marketing Communications Department. If you experience technical problems with the MAP Website, call the help line at 1-888-411-3111.

Internet Advertising

All of the General Restrictions apply to Internet advertising. You may not use the BCBST logo or name or any variation or abbreviation of the name as a link or a Web address in an Internet ad. Ads should represent your agency and only target Tennessee residents or businesses.

You may list that you are "an authorized agent for BlueCross BlueShield of Tennessee" or that you "offer BlueCross BlueShield of Tennessee" in descriptive copy in an Internet ad.

Linking to bcbst.com

You can use the BCBST logo on your agency Website, provided you follow these guidelines and receive approval from the Marketing Communications Department. Requirements for approval:

1. Your Website must represent your agency, not BCBST.
2. If your Website includes the logos of other carriers you represent, the BCBST logo cannot be larger than the other logos.
3. All Internet Advertising restrictions apply.
4. If you decide to include a link to the BCBST Website, you must provide a description of how the link is to be used on your site and sign a Linking Agreement that will be provided by Marketing Communications. Upon receipt of this agreement, instructions for linking to bcbst.com will be provided to you.

1. You must submit a link to your proposed site so that it may be viewed and approved by the Marketing Communications Department and the Legal Department prior to the site going live.

2. You are not allowed to generate and send SPAM e-mail using the BCBST name or logo nor can you include a link from any SPAM e-mail that directs recipients to your Website featuring the BCBST name or logo.

3. Your Website must have a privacy policy posted that includes the requirements listed later in this guide.

Your Website will be monitored by BCBST to ensure compliance with the general guidelines and linking agreement. If your site is not in compliance, your linking relationship will be terminated.

Restrictions for Use of BCBST Logo on Agency Websites and Linking to bcbst.com

1. Your Website must represent your agency, not BCBST or the BlueCross BlueShield Association.

2. You may only link directly to the BCBST home page. Special permission must be granted to link to other parts of the Website.

3. You must use the phrase "an authorized agent (or agency) for" or "offering" with any use of the logo on the Website.

4. The BCBST pages cannot be framed within your agency's site or otherwise implied to be a part of your Website. A new browser window should open when the user goes to the BCBST Website to help make a distinction between the two Websites. This approach will also keep your Website accessible to the user in the previous browser window.

5. You must use the full name and full logo on your Website. The logo may be used only as provided. The logo cannot be distorted or used in a way not explicitly approved by BCBST or described in the Brand Regulations from the BlueCross BlueShield Association. See examples below for the correct name and logo:

Correct Name:

BlueCross® BlueShield® of Tennessee

Correct Logos:

6. If your Website includes our logo, you must include the following legal disclaimer somewhere in close proximity to the logo. It can be in very small print (6 or 8 point type).

   BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

7. Approval to use the BCBST name or logo on your Website does not imply approval for any other use. Additional uses of the name or logo must also be submitted for approval.

8. BCBST will not allow its name or logo to be used on endorsements of any kind.

9. You may not use the logo in connection with any local sponsorships in which you choose to participate.

10. When used in conjunction with other insurance carriers, the BCBST logo must be displayed in a size no greater than that of any other carrier.

11. By using the BCBST logo, you are committed to channeling any prospective customer that BCBST cannot service to the BlueCross BlueShield Association.

12. All Websites are subject to the approval of the BCBST Legal Division and must comply with BlueCross BlueShield Association brand regulations contained in this booklet.

13. Your Website must have a privacy policy posted that meets the content requirement below.

Required Website Privacy Policy Content

1. Must contain a brief description of your organization and the activities that can be performed on your site. Describe public sections of your site and the information that your site may retain from each visitor (i.e. domain, date & time stamp, IP address, etc).

2. Identify secure sections that require login and password, if applicable. If you have a secure section, describe the activities that will be conducted on the secure section. Identify the information that is required to access the secure site for registration purposes. How will access be granted (i.e. immediately, mailed pin, etc).

3. Address child users under the age of 13 and what activities that they may perform on your site without parental consent. Also cover your secure sections, if applicable.

4. Address how e-mails forwarded to you from the site will be addressed, including how the e-mail address may be used in the future. Also include directions on how someone can remove their e-mail address from your database.

5. Address questionnaires or surveys if used by your site.

6. Disclosure of non-public personal information (GLB requirement). Address how your site protects non-public personal information. Include an opt-out statement if the information may be used for purposes outside the Website.

7. A section that identifies how long the information collected on your site will be retained before it is destroyed. Also include a way to correct personal information that is available on your site.

8. If your site uses cookies, you must describe how cookies will be used.

9. Add a section about linking to other sites. Include a statement about reviewing those privacy policies since they may be different from your site.

10. Include a section describing the security of your Website and how the information that is collected from your site will be protected from intrusion.

11. Include a reservation of rights in your policy that will allow you to change your policy without notice and advise visitors to review the policy frequently for any changes.

12. The contents of this site, such as text, graphics, images, and other material are for informational purposes only. The content is not intended to be a substitute for professional advice.

How to Contact the Marketing Communications Department

You may submit advertising and marketing materials for approval, requests for logos, requests for information on the Marketing Assistance Program and requests regarding linking to bcbst.com by mail, fax, or e-mail to the following contact in the Marketing Communications Department:

Ginger Pettway
Advertising Manager
Advertising Brand Strategy and New Media
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, CH 1.2, E55
Chattanooga, TN 37402

Phone: (423) 535-3384
Fax: (423) 591-9275
e-mail: ginger_pettway@bcbst.com

Please allow 5 business days for your request to be processed. Every effort is made to process requests as quickly as possible. However, requests that are product specific may require approval from the BCBST Legal Division.

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402
bcbst.com