of Tennessee

Agent Guide to Individual Products and Medicare Supplement Plans

Revised July 2009
This document contains confidential information

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Introduction & Important Contacts List

The Agent's Guide was developed to 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 Web site, bcbst.com, in the secure broker section.

Our Home Office Support Team and Field Agency Support 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 for under 65 products, please call the Field Agency Support Representative in your area:

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

North Central Tennessee
Laura Steere
1-800-515-2121 ext. 3745
(423) 535-3745

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

Knoxville/Tri-Cities Tennessee
Danielle Byers
1-800-515-2121 ext. 4645
(865) 588-4645

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

For questions about your commission account:

Jenene Bales
(423) 535-8003
Rhonda Ireland
(423) 535-8279
Errors & Omissions
(MGA Insurance Services)
1-800-593-7657

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

Alan Cooper
(423) 535-7123

For Membership and Billing Questions:

Under 65 and BlueCross65 Products
1-800-725-6849
(423) 535-6446 (Membership FAX)
(423) 535-6945 (Billing FAX)

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

For Sales Management:

Individual Sales (Under 65)
Charlie Goe, Business Segment Director
(423) 535-6237

Shirley Collier, Supervisor
(423) 535-6417
FAX (423) 535-6247

Medicare Sales
Sharon Dicorato, Senior Manager
(423) 535-3598

Sharon Bailey, Supervisor
(423) 535-3822
FAX (423) 535-7365 or (423) 296-4582

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 BlueCross BlueShield of Tennessee (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 an Agency Agreement, a copy of the Tennessee agent's license, the Producer Request for Appointment form, a W-9, evidence of Errors & Omissions coverage, and a Business Associate Agreement. These forms can be found on the Broker section of bcbst.com.

Agent Commission Information

For the Individual and Medicare supplement policies, all broker commissions 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.

First Year Commissions

For each individual 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.

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 mailed 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 Odd Effective Dates

If a policy is effective on any day of the month other than the 1st, (this is considered an odd effective date) your commissions will be paid as of the **next** month's billing due date, which would represent the first full month's billing, as stated above. For example, if the policy is effective on July 5, 2009, your commissions would become effective as of August 1, 2009. In this example, if premiums are processed prior to the date that commissions are paid for July, you will receive your commissions on your July statement. If, however, premiums are not processed prior to the commission run date, you will more than likely receive your commissions on your August statement.

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 insure 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?

Because your commissions are 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 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 BlueCross BlueShield of Tennessee 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

PremierBlue

PremierBlue offers the richest choice of benefits for underwritten individual plans. There are 10 different plan designs ranging from office visit copay plans to straight deductible and coinsurance plans. All plans include a choice of two different prescription drug plans. Both have copays of $10 for generic, $35 for preferred brand and $50 for non-preferred brand. One plan has a $200 deductible for brand name drugs. These plans also include wellness and preventive care. This plan uses providers in Blue Networks P and S and the RX04 pharmacy network. Optional Personal Dental Coverage and maternity coverage are also available for an additional monthly premium.

SimplyBlue & SimplyBlue*Plus*

SimplyBlue offers low-cost, underwritten coverage for basic medical services with four different deductible and coinsurance plan designs. SimplyBlue plans do not cover prescription drugs. Applicants have the option to buy enhanced coverage with SimplyBlue*Plus* plans. These *Plus* options feature the same four deductible and coinsurance plan designs but also include: well care for members age 6 and over, office visit copays for preventive care, two office visit copays per calendar year for illness or injury and limited, generic-only prescription drug coverage. The member pays a $15 copay for **generic drugs** and the plan covers up to $125 in **generic drugs** per calendar quarter (excluding the member's copay). **Brand-name drugs are not covered under the SimplyBlue*Plus* plan.**

This plan uses Blue Network S providers and the RX03 network pharmacy. It is important to explain to prospective customers that Blue Network S is a statewide network and they may be required to drive to another city to receive in-network benefits if a particular specialist is not in the network in their area. Optional Personal Dental Coverage and maternity coverage are available for an additional monthly premium on both SimplyBlue and SimplyBlue*Plus* plans. These plans do not provide any behavioral health benefits.

BluePartner

BluePartner is an HSA-qualified high-deductible health plan for the individual market. This plan offers four different deductible and coinsurance plans. BluePartner was designed to allow members to enjoy the tax savings of setting aside money in a Health Savings Account (HSA) to cover deductible and coinsurance expenses as well as non-covered medical expenses. BCBST does not administer HSA accounts, but we can provide information from our banking partners or you may direct your customer to another financial institution. Please visit bcbst.com for more information.

BluePartner plans include prescription drug coverage, subject to the medical deductible and coinsurance amount. The plan uses Blue Network P providers and the RX03 pharmacy network. Optional Personal Dental Coverage and maternity coverage are available for an additional monthly premium. BluePartner does not provide any behavioral health benefits.

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 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.

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 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.

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 are similar in plan design to the underwritten products and use the same provider and pharmacy networks. Personal Dental Coverage is 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 may also be purchased with both of these plans.

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 plans (BlueRx) require agents to go through an annual training, testing and credentialing process in order to sell these two product lines. For more information on this training and these products, please visit BlueAccess on bcbst.com. Medicare Supplement plans can be sold by any appointed agent, no special training required.

BlueCross65 includes nine standard Medicare Supplement plans, A through G, K and L. These plans do not offer any prescription drug coverage.

BlueCross65 *Select* offers premium savings of up to 15 percent in certain counties for our most popular plans, C and F. Members enrolled in these plans must agree to get their hospital care from specific BlueCross65 *Select* network hospitals. Members should also make sure their doctor has admitting privileges at a participating network hospital.

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*

Applicants may not be an expectant parent or in the process of adoption: BCBST will decline the application if a family member is pregnant or in the process of adoption. This also applies to the father of an unborn child. To be eligible for coverage, the mother must have had her post partum exam. Pregnant individuals can apply for Guaranteed Issue coverage, if eligible.

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: 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.

Newborn Eligibility: Newborn infants will be considered for coverage at 6 weeks of age. The infant must have had a well baby exam with any adverse findings disclosed on the application. The health questionnaire must be completed, signed and dated after the infant reaches six weeks of age. Applications with the health questionnaire completed, signed and dated before the infant reaches six weeks of age will be declined, even if the infant is six weeks of age at the time the application is received by BCBST. All underwriting guidelines apply in determining coverage. If an infant is born prior to 37 weeks gestation, please refer to prematurity underwriting guidelines.

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, colorectal cancer screening, cholesterol screening and blood pressure readings. Physical exam for males must include height/weight, colorectal cancer screening, 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 Part A (and Part B) 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) symptoms existed; (2) medical advice, diagnosis, care or treatment was recommended or received; or (3) 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.

Benefit Exclusion Riders

BCBST may deem it necessary to place a benefit exclusion rider on the policy for an applicant or covered dependent. Services, supplies, treatment, charges or medications may be excluded 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 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.

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 two qualifying events occurs:

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).**

The maternity rider may be requested on the original application or added or deleted by completing the APP-IHCC change application. The applicant or applicant's spouse 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. Do not submit a new application on a newborn if the parent(s) already has an individual policy. A new application will establish a pre-existing waiting period for this newborn.

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 application to BCBST within 31 days of the date that person first becomes eligible for coverage. The health questionnaire must be completed, and all underwriting guidelines will apply in determining eligibility for coverage.

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

Children Only Policies

BCBST accepts applications for minor dependent children who reside in Tennessee. The application should be signed by the parent or legal guardian who has knowledge of the health of the minor child. If applying for more than one child, each child should have a separate application. The application should list the minor child as the primary applicant.

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

Determining Plan Premiums: Plan premiums are based on the actual age of the applicant as of the policy's effective date. Plan premiums are rated by age bands. The rates are guaranteed for 12 months.
Initial Premium Payment: For all underwritten Individual Under 65 products, the first month's premium will be billed to the subscriber after the application is approved. Online applications require an initial premium payment.

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 or credit card. A credit card payment can be made over the telephone by calling the telephone number listed on the subscriber's billing statement.

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, automatic payments can be set up for bank draft or credit card payments. An automatic payment authorization form will be included

with the policy mailed to the subscriber. Accounts set up for a credit card or 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 or credit card company.

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.

Credit Card Payments: Recurring credit card payments are submitted to the credit card company on the 1st day of the month in which the premiums are due. We accept Master Card and Visa. If the credit card is rejected by the credit card company or it is past the expiration date and we have not been informed of the change in the expiration date, 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. A new credit card authorization form will be required to return to the credit card payment option.

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. (Bill must include postmarked envelope in which bill was mailed. 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)
- 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

BCBST uses its universal application (APP-IHCA) and a universal change application (APP-IHCC) for all our individual underwritten products.

The applicant must complete an application in black or blue ink. 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.
- For product changes, please refer to the Guidelines for Changing Products beginning on page 47 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.
- Faxed applications must be paid with automatic bank draft.

Health History Guidelines

Automatic Declines for Individuals Under 65

The following conditions are considered automatic declines. Applications on individuals with any of these conditions should not be submitted. This list is not all-inclusive.

Acromegaly
Addison's Disease
Adrenal Disorders
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
Angina
Angioplasty
Anticoagulant Therapy
Aortic Arch Arteritis
Aplastic Anemia
Arteritis, Necrotizing
Asbestosis
Ataxia Telangiectasia
Autonomic Neuropathy
Banti's Syndrome
Behcet's Syndrome
Bipolar Disorder
Cancer (within the last 10 yrs, see underwriting guidelines for exceptions)
Cancer - Thyroid Gland; Anaplastic Carcinoma
Cardiomegaly
Cardiomyopathy
Caroli's Disease
Charcot-Marie-Tooth Disease
Cirrhosis of the Liver
Coagulation Disorders/Deficiency
Congenital Familial Polyposis (Gardner's Syndrome) (Peutz-Jegher's Syndrome)
Congestive Heart Failure
Connective Tissue Disease
Coronary Artery Bypass Surgery, history
Coronary Artery Disease
Crohn's Disease
Cushing Syndrome
Cystic Fibrosis
Dementia
Dermatomyositis
Diabetes, Type I and II
Dialysis
Diamond Blackfan Anemia
Down's Syndrome
Ebstein's Malformation
Ehlers-Danlos Syndrome
Eisenmenger's Complex
Esophageal Varices
Factor IX Deficiency (Christmas Disease)
Factor VIII Deficiency (Hemophilia)
Hand-Schuller-Christian Disease
Heart Attack-Myocardial Infarction, history
Heart By-Pass Surgery, history
Heart Enlargement/hypertrophy
Hemiplegia
Hemochromotosis
Histocytosis X
Hodgkin's Disease
Huntington's Chorea
Hydrocephalus
Hypogammaglobulinemia
Hypoplastic Anemia
Klinefelter's Syndrome
Letterer-Siwe Disease
Lupus Erythematosus (Systemic Lupus)
Lymphoblastoma
Manic Depression
Marfan's Syndrome
Microcephaly
Mixed Connective Tissue Disorder
Multiple Myeloma
Multiple Sclerosis
Muscular Dystrophy
Myocardial Infarction
Narcolepsy
Nephrocalcinosis
Nephrosclerosis
Neurofibromatosis
Obesity Surgery
Osteogenesis Imperfecta
Pacemaker
Pancreatitis, Chronic
Paralysis (permanent)
Paraplegia
Parkinson's Disease
Peripheral Vascular Disease (Arteriosclerosis Obliterans, ASO)
Polycystic Kidney Disease
Polycythemia Vera
Porphyria
Portal Hypertension
Primary Pulmonary Hypertension
Pseudotumor Cerebri

Pulmonary Insufficiency
Quadriplegia
Reflex Sympathetic Dystrophy/Autonomic Neuropathy
Renal Failure (Chronic)
Schizophrenia
Sick Sinus Syndrome
Sickle Cell Anemia
Sjogren's Syndrome
Splenomegaly
Suicide Attempt (within last 5 yrs)
Systemic Lupus Erythematosis (SLE)
Tetrology of Fallot
Thalassemia Major
Thrombocytopenia
Transplant - Bone Marrow
Transplant – Organ
Tricuspid Atresia
Trisomy 21 Syndrome
Tuberous Sclerosis Complex
Ulcerative Colitis
Ulcerative Proctitis
Von Recklinghausen's Disease
Wegener's Granulomatosis
Wilson's Disease
Zollinger-Ellison Syndrome

Individuals with these conditions can apply for Guaranteed Issue coverage, if eligible.

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**	Standard Maximum	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:					
					Age 15-17	Age18-24	Age 25-29	Age 30-44	Age 45-49	Age 50+
4 Ft.	8″	(56″)	78	130	131-145	131-154	131-165	131-169	131-173	131-177
	9″	(57″)	81	135	136-151	136-160	136-172	136-175	131-180	131-184
	10″	(58″)	84	140	141-156	141-165	141-178	141-182	141-186	141-190
	11″	(59″)	87	145	146-162	146-171	146-184	146-188	146-193	146-197
5 Ft.	0″	(60″)	90	150	151-167	151-177	151-190	151-195	151-199	151-204
	1″	(61″)	93	155	156-173	156-183	156-197	156-202	156-206	156-211
	2″	(62″)	96	160	161-178	161-188	161-203	161-208	161-213	161-218
	3″	(63″)	99	166	167-185	167-195	167-210	167-215	167-220	167-225
	4″	(64″)	102	171	172-191	172-201	172-217	172-222	172-227	172-232
	5″	(65″)	105	176	177-196	177-207	177-223	177-228	177-234	177-239
	6″	(66″)	108	181	182-203	182-214	182-231	182-236	182-242	182-247
	7″	(67″)	112	187	188-209	188-221	188-237	188-243	188-248	188-254
	8″	(68″)	115	193	194-215	194-227	194-244	194-250	194-256	194-262
	9″	(69″)	119	198	199-221	199-234	199-252	199-258	199-264	199-270
	10″	(70″)	122	204	205-228	205-241	205-260	205-266	205-272	205-278
	11″	(71″)	125	210	211-235	211-248	211-267	211-273	211-280	211-286
6 Ft.	0″	(72″)	129	216	217-241	217-255	217-274	217-281	217-287	217-294
	1″	(73″)	133	223	224-248	224-262	224-282	224-289	224-295	224-302
	2″	(74″)	136	228	229-255	229-270	229-290	229-297	229-304	229-311
	3″	(75″)	140	234	235-262	235-277	235-298	235-305	235-312	235-319
	4″	(76″)	144	241	242-269	242-284	242-306	242-313	242-321	242-328
	5″	(77″)	148	247	248-276	248-291	248-314	248-321	248-329	248-336
	6″	(78″)	151	254	255-283	255-300	255-322	255-330	255-337	255-345
	7″	(79″)	155	260	261-291	261-308	261-331	261-339	261-346	261-354

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. In addition, applicants age 50 or over must submit the results of a DEXA scan.

Adult* Height & Weight - Male

Height			Minimum**	Standard Maximum	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:						
					Age 15-17	Age 18-24	Age 25-34	Age 35-39	Age 40-49	Age 50-54	Age 55+
4 Ft.	8″	(56″)	78	136	137-151	137-154	137-159	137-162	137-168	137-174	137-177
	9″	(57″)	81	141	142-157	142-159	142-165	142-168	142-175	142-181	142-184
	10″	(58″)	84	146	147-162	147-164	147-170	147-174	147-180	147-187	147-190
	11″	(59″)	87	151	152-168	152-170	152-176	152-180	152-187	152-194	152-197
5 Ft.	0″	(60″)	90	156	157-174	157-176	157-183	157-186	157-193	157-200	157-204
	1″	(61″)	93	161	162-180	162-183	162-189	162-192	162-200	162-207	162-211
	2″	(62″)	96	166	167-186	167-188	167-195	167-199	167-206	167-214	162-218
	3″	(63″)	99	172	173-192	173-195	173-202	173-206	173-213	173-221	173-225
	4″	(64″)	102	177	178-198	178-201	178-208	178-212	178-220	178-228	178-232
	5″	(65″)	105	184	185-204	185-208	185-214	185-218	185-227	185-235	185-239
	6″	(66″)	108	189	190-211	190-214	190-221	190-226	190-234	190-243	190-247
	7″	(67″)	112	195	196-217	196-220	196-227	196-232	196-241	196-250	196-254
	8″	(68″)	115	201	202-224	202-227	202-235	202-240	202-249	202-258	202-262
	9″	(69″)	119	206	207-231	207-234	207-243	207-247	207-256	207-265	207-270
	10″	(70″)	122	212	213-237	213-241	213-249	213-254	213-263	213-273	213-278
	11″	(71″)	125	218	219-244	219-248	219-256	219-261	219-271	219-281	219-286
6 Ft.	0″	(72″)	129	224	225-251	225-254	225-263	225-268	225-279	225-289	225-294
	1″	(73″)	133	232	233-258	233-262	233-270	233-276	233-286	233-297	233-302
	2″	(74″)	136	238	239-265	239-269	239-278	239-284	239-295	239-306	239-311
	3″	(75″)	140	244	245-273	245-277	245-286	245-292	245-303	245-314	245-319
	4″	(76″)	144	251	252-280	252-285	252-295	252-300	252-311	252-322	252-328
	5″	(77″)	148	257	258-287	258-291	258-302	258-307	258-319	258-330	258-336
	6″	(78″)	151	264	265-295	265-299	265-310	265-316	265-329	265-339	265-345
	7″	(79″)	155	270	271-302	271-307	271-317	271-323	271-336	271-348	271-354

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. In addition, applicants age 50 or over must submit the results of a DEXA scan..

Underwriting Guidelines for Brokers/Agents Effective 04/06/09

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.

Underwriting guidelines are subject to change without prior notice.

**Special guidelines for selected benefit exclusion riders have been added for SimplyBlue, SimplyBluePlus, and BluePartner high deductible plans. See the chart at the end of this section for specific criteria for each high deductible plan.*

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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 after testing is complete, and a definitive diagnosis has been established			
Acne	See Rider Guidelines	**Mild cases**, no prescription medication: No rate or rider **Mild cases**, prescription medication within the past year: Rider **Moderate or severe cases**, treatment within the past 2 years: Rider ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	**Mild cases,** no treatment within the past year; **Moderate or severe cases**, no treatment within the past 2 years	May require, based on case specifics
Acoustic Neuroma	Decline if unoperated or surgery to remove within the past two years	N/A	N/A	Required
Acromegaly	Decline	N/A	N/A	N/A
ADD/ADHD (Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder)	Rate up or decline based on severity, prescribed medications and/or receiving psychotherapy	Treatment within the past 2 years: Rider ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	Stable, no treatment for > 2 years	May require, based on case specifics
Addison's Disease	Decline	N/A	N/A	N/A
Adhesions	See rider guidelines	Unoperated: Rider	Operated, complete recovery, no recurrence for > 5 years following surgery	May require, based on case specifics
Adoption	Decline if the applicant(s) are in the process of adoption	N/A	N/A	N/A
Adrenal Disorder	Decline	N/A	N/A	N/A
AIDS/HIV infection	Decline	N/A	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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	N/A	Required; records for the past 5 years
ALS (Amyotrophic Lateral Sclerosis-Lou Gehrig's Disease)	Decline	N/A	N/A	N/A
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 BluePartner and SimplyBlue High Deductible Plans**	No immunotherapy or treatment with prescribed medications for > 5 years	May require for reconsideration of rider
Alzheimer's or Dementia	Decline	N/A	N/A	N/A
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 rating 4) ANA titer <1:40, no rating	N/A	N/A	Required
Androgen Insensitivity Syndrome	Decline	N/A	N/A	N/A
Anemia	Underwriting based on specific type of anemia and severity of condition (See Aplastic Anemia and Diamond Black Anemia)	N/A	N/A	May require, based on case specifics
Angina	Decline	N/A	N/A	N/A
Angioplasty	Decline	N/A	N/A	N/A
Ankle Disorder	See rider guidelines	Symptomatic, not recovered or current treatment: Rider	Complete recovery, asymptomatic	N/A
Ankle and Foot Disorder (unspecified derangement of ankle and foot joint)	See rider guidelines	Symptomatic, not recovered or current treatment: Rider	Complete recovery, asymptomatic	N/A
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 rating	N/A	N/A	Required; records for the past 5 years
Anticoagulant Therapy	Decline	N/A	N/A	N/A
Anxiety/Depression	See Behavioral Health Disorders			
Aortic Arch Arteritis	Decline	N/A	N/A	N/A
Aplastic Anemia	Decline	N/A	N/A	N/A
Arm Amputation	See rider guidelines	Rider	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Arnold Chiari Malformation	Decline if less than age 20 and unoperated; age 20 and older, operated (or no surgery anticipated), asymptomatic, no rating	N/A	N/A	Required
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	Required
Arthritis, Osteoarthritis	Severe, surgery contemplated, or continuous/ routine treatment with oral or injected steroids: Decline	Current treatment or taking prescription medications: Rider	N/A	May require, based on case specifics
Arthritis, Rheumatoid	Decline if: (1) chronic or severe extra-articular manifestation (2) chronic systemic treatment with steroids/immunosuppressant medications including methotrexate (3) joint replacement anticipated Individual consideration for mild cases with no deformities **(Offer of coverage will be determined by age of applicant and current treatment; some applicants with mild cases may still be declined)**	N/A	N/A	Required
Arthritis, Rheumatoid, Juvenile	Decline if symptomatic or treatment within the past year; No deformities, asymptomatic, no treatment for > one year: May approve with rating	N/A	N/A	Required
Asbestosis	Decline	N/A	N/A	N/A
Asperger's Syndrome	Decline if diagnosed < 2 years; diagnosed > 2 years, individual consideration	N/A	N/A	Required
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 ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	Asymptomatic, no treatment for > 2 years	May require, based on case specifics
Atrial Fibrillation – Chronic	Decline if diagnosed < 2 years; diagnosed > 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	N/A	Required
Ataxia Telangiectasia	Decline	N/A	N/A	N/A
Autism	Decline if diagnosed < 2 years; diagnosed > 2 years, individual consideration	N/A	N/A	Required
Autonomic Neuropathy	Decline	N/A	N/A	N/A
Back/Spine, Disk Disorder, Spinal Stenosis, Spondylolisthesis/ Spondylosis	See rider guidelines	Symptomatic or surgery within the past 2 years: Rider	Asymptomatic, no treatment for > 2 years	May require, based on case specifics
Back/Spine - Spinal Manipulation	See rider guidelines	Frequent (more than 2 visits per month) chiropractic visits: Rider	Complete recovery, no treatment for > one year	May require, based on case specifics
Back/Spine - Sprain or Strain	See rider guidelines	**Single episode,** non-disabling, recovered: No rate or rider **Multiple episodes** or chronic: Rider	N/A	May require, based on case specifics
Banti's Syndrome	Decline	N/A	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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: Rider *See special guidelines for BluePartner and SimplyBlue High Deductible Plans	**Mild** - stable, no treatment within the past 6 months; **Moderate to Severe,** stable, no counseling within the past 2 years, no treatment with prescribed medications within the past year	May require, based on case specifics
Behcet's Syndrome	Decline	N/A	N/A	N/A
Bipolar Disorder/ Manic Depressive	Decline	N/A	N/A	N/A
Bone Spur/Exostosis	See rider guidelines	Skull, unoperated or < 2 years since last treatment: Rider Other locations, symptomatic or surgery anticipated: Rider	Operated, complete recovery	N/A
Brachial Cleft Cyst	See rider guidelines	Unoperated: Rider	Operated, complete recovery	N/A
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)	Saline, > 2 years since placement, no complications (Note: rider not applied if implants placed after mastectomy due to cancer)	May require, based on case specifics
Breast, Fibrocystic Breast Disease	See rider guidelines	Severe, frequent biopsies, or surgery anticipated: Rider	N/A	May require, based on case specifics
Bronchitis – Chronic	Decline moderate to severe conditions; decline mild conditions if currently smoking or have smoked within the past 5 years; individual consideration for mild conditions if stopped smoking > 5 years ago or never smoked	N/A	N/A	Required
Bunion	See rider guidelines	Unoperated or symptomatic: Rider	Operated, complete recovery	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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)** **(All cancers with no guidelines for "local" will be declined if < 10 years since last treatment)**	N/A	N/A	See guidelines for individual cancer diagnoses
Cancer - Adrenal Gland	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer – Bone	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer – Brain	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Colon/Rectal	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Connective or Soft Tissue	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Corpus Uterus (endometrial carcinoma)	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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer – Esophagus	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Eye; Retinoblastoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Cancer - Hodgkin's Lymphoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Kidney; Renal Cell Carcinoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Kidney; Renal Pelvis and Ureter	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Leukemia, Monocytic	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Leukemia, Myeloid	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer – Liver	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document current state of health
Cancer – Melanoma	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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Multiple Myeloma	Always decline	N/A	N/A	N/A
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Non-Hodgkin's lymphoma	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Cancer – Pancreas	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer – Parathyroid	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment	N/A	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer – Peritoneum	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
Cancer - Pituitary gland	Local, decline if < 1 year since last treatment; regional and distant, decline if < 10 years since last treatment	N/A	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer – Sarcoma	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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Stomach, Small Intestine	Decline if < 10 years since last treatment (must be fully recovered to be considered for coverage)	N/A	N/A	Required, must document current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer - Thyroid Gland; Anaplastic Carcinoma	Decline	N/A	N/A	N/A
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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer, Urinary Bladder	Local, decline if < 4 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	N/A	Required, must document staging and treatment of cancer and current state of health
Cancer, Vagina, Labia, Clitoris	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	N/A	Required, must document staging and treatment of cancer and current state of health
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	N/A	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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	N/A	Required
Cardiomegaly	Decline	N/A	N/A	N/A
Cardiomyopathy	Decline	N/A	N/A	N/A
Caroli's Disease	Decline	N/A	N/A	N/A
Carpal Tunnel Syndrome	See rider guidelines	Unoperated or < one year since last treatment: Rider	Operated, complete recovery, no treatment for > one year	N/A
Cataract	See rider guidelines	**Unoperated:** Rider **Operated and recovered** for one eye: Rider **Operated and recovered** for both eyes < 2 years: Rider	Both eyes operated, recovered, > 2 years since surgery	N/A
Cerebral Palsy	Decline if 5 years of age or younger; decline for moderate or severe cases; otherwise, based on case specifics	N/A	N/A	Required
Cerebrovascular Accident (CVA)/Stroke	**Stroke with infarction or residual complications** (paralysis, aphasia, dysphagia, dysphasia, mental deficits, etc): Decline **Stroke without complications:** Decline if occurrence within the past year, individual consideration after one year of complete recovery	N/A	N/A	Required
Cervical Spine, Disk Disorder, Spinal Stenosis, Spondylolisthesis/ Spondylosis	See rider guidelines	Symptomatic or surgery within the past 2 years: Rider	Asymptomatic, no treatment for > 2 years	May require, based on case specifics
Cervical Dysplasia/ Abnormal Pap Smears	1) Reactive cellular changes, no rating or rider 2) ASCUS (abnormal squamous cells of unknown significance), HPV (human papilloma virus) negative, no rating 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"	Three subsequent normal pap smears and at least 18 months since abnormal pap	May require, based on case specifics
Charcot-Marie-Tooth-Disease	Decline	N/A	N/A	N/A
Chronic Fatigue Syndrome	Underwriting based on severity of condition and current treatment	N/A	N/A	Required
Cholesterol/Lipid Disorders	Decline if health history includes three of the following risk factors for cardiovascular disease: metabolic syndrome and/or pre-diabetes, lipid disorder, tobacco use (cigarettes), hypertension, or ratable build; Otherwise, underwriting based on risk assessment, current level of control, and medications used in treatment	Rider; excludes medications only ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	N/A	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Chronic Obstructive Pulmonary Disease (COPD)	Decline moderate or severe cases; decline mild cases if currently smoking or have smoked within the past 5 years; individual consideration for mild cases no smoking within the past 5 years (or never smoked)	N/A	N/A	Required
Cirrhosis of the Liver	Decline	N/A	N/A	N/A
Cleft Lip/Cleft Palate	Decline for pending surgery	**Unoperated:** Rider **Operated,** less than 19 years of age: Rider	Operated, complete recovery, over age 19	May require, based on case specifics
Club Foot	See rider guidelines	Unoperated, under age 18: Rider	Operated, complete recovery, over age 18	May require, based on case specifics
Coagulation Disorders/Deficiency	Decline	N/A	N/A	N/A
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	N/A	May require, based on case specifics
Congenital Abnormalities	Underwriting is based on the specific diagnosis and medical history	N/A	N/A	Required
Congenital Familial Polyposis (Gardner's Syndrome) (Peutz-Jegher's Syndrome)	Decline	N/A	N/A	N/A
Congestive Heart Failure	Decline	N/A	N/A	N/A
Connective Tissue Disease	Decline	N/A	N/A	N/A
Cornea Transplant	See rider guidelines	Less than one year since transplant: Rider	Complete recovery, > one year since transplant	May require, based on case specifics
Coronary Artery Disease (CAD)	Decline	N/A	N/A	N/A
Craniosynostosis	See rider guidelines	Unoperated: Rider	Operated, complete recovery, > 2 years since surgery	May require, based on case specifics
Crohn's Disease	Decline	N/A	N/A	N/A
Cushing Syndrome	Decline	N/A	N/A	N/A
Cystitis/Urinary Tract Infection	See rider guidelines	Rider for chronic cystitis	N/A	N/A
Cystic Fibrosis	Decline	N/A	N/A	N/A
Cystocele	See rider guidelines	Urinary or bowel incontinence present: Rider Symptomatic or < one year since surgical correction: Rider	Asymptomatic, surgery not contemplated, > 2 years since diagnosis; Operated, asymptomatic, > one year since surgery	May require, based on case specifics
Dementia	Decline	N/A	N/A	N/A
Dermatomyositis	Decline	N/A	N/A	N/A
Developmental Disorders	Underwriting based on case specifics	N/A	N/A	Required
Deviated Septum	See rider guidelines	Symptomatic or surgery anticipated: Rider	Asymptomatic, > one year since diagnosis, no surgery anticipated, or > one year since surgical correction	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Diabetes (includes, Type I and II; excludes gestational diabetes)	Decline	N/A	N/A	N/A
Dialysis	Decline	N/A	N/A	N/A
Diamond Blackfan Anemia	Decline	N/A	N/A	N/A
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	History of one episode, no recurrence one year following last episode; multiple episodes, no recurrence 3 years following last episode	May require, based on case specifics
Down's Syndrome	Decline	N/A	N/A	N/A
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	N/A	Required; medical records for the past 5 years
Drug Abuse or Illegal Drug Use – Amphetamine	Decline if current dependence/use or < 3 years since last use; 3 - 5 years since last use, rating; > 5 years since last use, no rating	N/A	N/A	Required; medical records for the past 5 years
Drug Abuse or Illegal Drug Use - Anabolic Steroids	Decline if current dependence/use or < 2 years since last use; 2-5 years since last use, rate up or decline, based on individual consideration; >5 years since last use, no rating	N/A	N/A	Required; medical records for the past 5 years
Drug Abuse or Illegal Drug Use – Barbiturates	Decline if current dependence/use or < 10 years since last use	N/A	N/A	Required; medical records for the past 5 years
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 rating	N/A	N/A	Required
Drug Abuse or Illegal Drug Use - Cocaine	Decline if current dependence/use or < 10 years since last use	N/A	N/A	Required; medical records for the past 5 years
Drug Abuse or Illegal Drug Use - Hallucinogens	Decline if current dependence/use or < 10 years since last use	N/A	N/A	Required; medical records for the past 5 years
Drug Abuse or Illegal Drug Use – Opioids	Decline if current dependence/illegal use or < 5 years since last use; 5 - 10 years since last use, rating or decline, based on individual consideration; > 10 years since last use, no rating	N/A	N/A	Required; medical records for the past 5 years
Dupuytrens Contracture (contracture of the palmer fascia)	See rider guidelines	Unoperated, symptomatic or < one year since surgery: Rider	Operated, asymptomatic, > one year since surgery	N/A
Ear (disorders of the middle and inner ear) - Chronic or Ear Tubes	See rider guidelines	Chronic: Rider	Surgically corrected, asymptomatic	N/A
Eating Disorders	See Anorexia/Bulimia			
Ebstein's Malformation	Decline	N/A	N/A	N/A
Eclampsia	Child bearing age, with two normal deliveries, no rating; less than two normal deliveries since episode, decline	N/A	N/A	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Elbow Disorder	See rider guidelines	Symptomatic or currently undergoing treatment: Rider	**Single episode,** complete recovery, asymptomatic; **Multiple episodes or recurrent,** no symptoms or treatment for > 3 years	May require, based on case specifics
Ehler's-Danlos Syndrome	Decline	N/A	N/A	N/A
Eisenmenger's Complex	Decline	N/A	N/A	N/A
Emphysema	See guidelines for "Chronic Obstructive Pulmonary Disease (COPD)"			
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,** operated, complete hysterectomy, or post menopausal **Mild**, diagnosed greater than 5 years	May require, based on case specifics
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	Resolved, no treatment for > 1 year	Required
Epilepsy/Seizures	Decline if seizure episode within the past 2 years or treated with 2 medications; otherwise, individual consideration **(Offer of coverage will be determined by age of applicant, time since last seizure episode and time since diagnosis; some applicants may still be declined, even if taking no medication and > 2 years since last seizure episode)**	N/A	N/A	Required
Erbs Palsy	Decline if less than 5 years of age or pending surgery; 5 years of age and older, underwriting based on case specifics; decline or rider based on severity of injury and current treatment	Rider	N/A	Required
Esophageal Varices	Decline	N/A	N/A	N/A
Facial Nerve Disorder	See rider guidelines	Surgery anticipated or residual symptoms: Rider	Complete recovery, no residual symptoms	N/A
Factor IX Deficiency (Christmas Disease)	Decline	N/A	N/A	N/A
Factor VIII Deficiency (Hemophilia)	Decline	N/A	N/A	N/A
Fibromyalgia	Rate up or decline based on medical history and treatment	N/A	N/A	Required
Fistula, Anal	See rider guidelines	Diagnosed < one year, or surgery anticipated: Rider	Operated, complete recovery, > one year since last treatment	May require, based on case specifics
Fistula, Female (rectovaginal, vesicovaginal or urinary fistula)	See rider guidelines	Unoperated or < 5 years since last treatment: Rider	Operated, complete recovery, > 5 years since last treatment	May require, based on case specifics
Foot Disorder	See rider guidelines	Symptomatic, not recovered, or current treatment: Rider	Complete recovery	N/A
Gallbladder	See rider guidelines	Gallstones present or symptomatic: Rider	Operated, complete recovery	May require, based on case specifics
Ganglion Cyst	See rider guidelines	Unoperated: Rider	Operated, complete recovery	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Gastric Polyps	See rider guidelines	Symptomatic, treatment or surgical removal anticipated: Rider	Asymptomatic, no further treatment anticipated	May require, based on case specifics
Gastritis	Underwriting based on underlying cause/ disorder	N/A	N/A	Required
Gastroesophageal Reflux Disease (GERD)	See rider guidelines	Treatment with prescribed medication within the past 2 years: Rider Testing in progress or planned, Barret's esophagus, strictures, or ulcerations: Rider Mild cases, resolved with over the counter medications only: No rate or rider ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	Resolved, no treatment within the past 2 years	May require, based on case specifics
Genital Prolapse	See rider guidelines	Surgery contemplated or diagnosed < 2 years: Rider	No surgery contemplated or operated, recovered > one year since surgery	May require, based on case specifics
Glaucoma	See rider guidelines	Rider	N/A	N/A
Goiter	Decline if thyroid function is abnormal	**Nodular goiter,** unoperated: Rider **Simple diffuse colloid goiter,** normal thyroid function: No rate or rider	Complete removal of thyroid; hormone levels within normal limits	Required
Gout	Decline for gout with renal failure/ insufficiency; otherwise, individual consideration	N/A	N/A	May require, based on case specifics
Hamartoma	See rider guidelines	Unoperated: Rider	Operated, complete recovery	N/A
Hand Disorder	See rider guidelines	Symptomatic, not recovered, or current treatment: Rider	Complete recovery	May require, based on case specifics
Hand-Schuller-Christian Disease	Decline	N/A	N/A	N/A
Headache, Severe, and/or Migraine	See rider guidelines	Greater than 6 attacks per year, multiple medications, ER visit within the past 2 years or severe/incapacitating: Rider	N/A	May require, based on case specifics
Hearing Loss	See rider guidelines	Surgery contemplated or diagnostic testing in progress: Rider	N/A	N/A
Heart Attack - Myocardial Infarction, history	Decline	N/A	N/A	N/A
Heart Bypass Surgery, history	Decline	N/A	N/A	N/A
Heart Enlargement	Decline	N/A	N/A	N/A
Heart Murmur	Underwriting based on case specifics	N/A	N/A	May require, based on case specifics

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Hemangioma	See rider guidelines	**Intracranial, retinal, or intraabdominal:** Rider **Excessively large,** located on face or surgery contemplated: Rider **Otherwise:** No rate or rider	Operated, complete recovery	May require, based on case specifics
Hemiplegia	Decline	N/A	N/A	N/A
Hemorrhoids	See rider guidelines	Chronic, severe, or surgery contemplated: Rider	Complete recovery, asymptomatic	May require, based on case specifics
Hemochromotosis	Decline	N/A	N/A	N/A
Hepatitis A or E	Present, decline; complete recovery with no residual health conditions, no rating	N/A	N/A	May require, based on case specifics
Hepatitis B	Acute (present) or chronic, decline; recovered, negative Hepatitis B surface antigen (HbsAg), normal liver function tests, individual consideration, may approve with rate up	N/A	N/A	Required, current hepatitis profile and liver function tests required
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	N/A	Required
Hepatitis, all other types	Decline	N/A	N/A	N/A
Hernia - Inquinal, umbilical, and femoral	See rider guidelines	Symptomatic or diagnosed < one year: Rider	Operated successfully, asymptomatic	May require, based on case specifics
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 BluePartner and SimplyBlue High Deductible Plans**	N/A	N/A
High Cholesterol	See Cholesterol/Lipid Disorder			
Hip or Hip Joint	See rider guidelines	Symptomatic, revision of hip joint anticipated or time since last treatment < 3 years: Rider	Asymptomatic, no further surgery anticipated, > 3 years since last treatment	May require, based on case specifics
Histocytosis X	Decline	N/A	N/A	N/A
HIV Infection	Decline	N/A	N/A	N/A
Hodgkin's Disease	Decline	N/A	N/A	N/A
Human Papilloma Virus (HPV), condyloma or genital warts	See rider guidelines (if associated with abnormal pap smears, see guidelines for "Abnormal pap smears")	**Anal or rectal,** occurrence within the past 2 years: Rider **Otherwise,** if present: Rider	Resolved, no recurrence	Required; current pap smears required for female applicants
Huntington's Chorea	Decline	N/A	N/A	N/A
Hydocephalus	Decline	N/A	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Hydrocele	See rider guidelines	Unoperated: Rider	Operated, complete recovery	N/A
Hypertension	Decline if uncontrolled or newly diagnosed (within the past 6 months); otherwise, rating is based on degree of control and current treatment; **Additional rating for tobacco users; Decline if health history includes three of the following risk factors for cardiovascular disease: metabolic syndrome and/or pre-diabetes, lipid disorder, tobacco use (cigarettes), hypertension, or ratable build.**	N/A	N/A	Required
Hyperthyroid	Decline if thyroid function is abnormal	Surgical or medical treatment within the past year: Rider	Treatment completed, thyroid hormone levels within normal limits	Required
Hypogammaglobulin-emia	Decline	N/A	N/A	N/A
Hypoplastic Anemia	Decline	N/A	N/A	N/A
Hypospadias	See rider guidelines	Unoperated: Rider	Operated, complete recovery	N/A
Interstitial Cystitis	Individual consideration **(Offer of coverage will be determined by age of applicant and current status, some applicants may be declined)**	N/A	N/A	Required
Irritable Bowel Syndrome	See rider guidelines	**Moderate or severe,** frequent attacks: Rider **Mild,** infrequent attacks: No rate or rider	N/A	May require, based on case specifics
Juvenile Arthritis	See "Arthritis, Juvenile"			
Keloid	See rider guidelines	Large, or on face, neck or ears, unoperated: Rider Operated, < one year since surgery: Rider	Operated, no recurrence, > one year since surgery	N/A
Keratosis, Actinic and Seborrheic	See rider guidelines	Multiple occurrences/ biopsies within the past year (2 or greater): Rider	Treated, complete recovery, no recurrence one year following removal	May require, based on case specifics
Kidney Failure (Chronic Renal Failure)	Decline	N/A	N/A	N/A
Kidney Stones	See rider guidelines	**One episode,** operated or passed spontaneously, < one year since episode: Rider **Two or more episodes,** passed spontaneously, <one year since episode: Rider **Two or more episodes,** lithotripsy or surgery required, < 5 years since last episode: Rider	No recurrence within specified time periods	May require, based on case specifics
Klinefelter's Syndrome	Decline	N/A	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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**	Complete recovery within specified time periods	May require, based on case specifics
Leg Amputation	See rider guidelines	Rider	N/A	N/A
Letterer-Siwe Disease	Decline	N/A	N/A	N/A
Leukemia	See "Cancer - Leukemia"			
Lipoma	See rider guidelines	**Skin or subcutaneous:** No rate or rider **Involving other organs:** Rider if unoperated	Operated, full recovery	N/A
Lupus Erythematosus, Discoid (skin-type)	Decline if diagnosed < one year (If albuminuria, hypertension, or arthritis are present, rate as "Systemic Lupus"); diagnosed > one year, no complications, may approve with rating **(Offer of coverage will be determined by age of applicant and time since diagnosis; some applicants will be declined even if > one year since diagnosis)**	N/A	N/A	Required
Lupus Erythematosus (Systemic Lupus)	Decline	N/A	N/A	N/A
Lymphedema	Decline if diagnosed < one year	Rider	N/A	Required
Lymphoblastoma	Decline	N/A	N/A	N/A
Macular Degeneration	See rider guidelines	**Exudative** (wet), cystoid, macular cyst or hole: Rider **Non-exudative,** Drusen (dry): No rate or rider	N/A	N/A
Mandible Hypoplasia	See rider guidelines	Unoperated: Rider	Operated, complete recovery, no further surgery planned	Required
Manic Depression	Decline	N/A	N/A	N/A
Marfan's Syndrome	Decline	N/A	N/A	N/A
Marijuana Abuse/Use	See "Drug Abuse - Cannabis"			
Meniere's Disease	See rider guidelines	Symptomatic: Rider	No symptoms within the past 2 years	May require, based on case specifics
Menstrual Disorder (menorrhagia, metrorrhagia, amenorrhea, abnormal uterine bleeding)	Decline if workup in progress or current/ recurrent abnormal bleeding, anemia present; workup complete, will rate or rider for underlying cause	Current/recurrent bleeding within the past 3 years: Rider	No recurrence for > 3 years	Required
Mental Retardation	Underwriting based on applicant's age and severity of condition	N/A	N/A	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Metabolic Syndrome (Syndrome X)	Decline if health history includes three of the following risk factors for cardiovascular disease: metabolic syndrome and/or pre-diabetes, lipid disorder, tobacco use (cigarettes), hypertension, or ratable build **(Note: rating will be in addition to rating for cholesterol, hypertension, and build, therefore some applicants will be declined related to cumulative ratings for these conditions)** 1) Elevated waist circumference: Men greater than or equal to 40 inches, Women: greater than or equal to 35 inches 2) Elevated triglycerides: Greater than or equal to 150mg/dl 3) Reduced HDL cholesterol: Men less than 40 mg/dL; Women less than 50 mg/dL 4) Elevated blood pressure: Greater than or equal to 130/85 mm Hg or treated hypertension 5) Elevated fasting glucose, 110mg/dL or higher	N/A	N/A	Required
Microcephaly	Decline	N/A	N/A	N/A
Mitral Valve Prolapse	Decline if symptomatic or evidence of greater than minimal mitral regurgitation; otherwise, no rating	N/A	N/A	May require, based on case specifics
Mitral Valve Regurgitation (insufficiency)	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rating 2) No cardiac studies available, decline 3) Symptomatic, decline	N/A	N/A	Required
Mixed Connective Tissue Disorder	Decline	N/A	N/A	N/A
MRSA (Methicillin-Resistant Staphylococcus Aureus) infection	Decline if active or current infection; decline if < one year since completion of treatment or residual complications	N/A	N/A	Required
Multiple Myeloma	Decline	N/A	N/A	N/A
Multiple Sclerosis	Decline	N/A	N/A	N/A
Muscular Dystrophy	Decline	N/A	N/A	N/A
Myocardial Infarction	Decline	N/A	N/A	N/A
Narcolepsy	Decline	N/A	N/A	N/A
Nasal Polyp	See rider guidelines	Unoperated: Rider	Operated, no recurrence	May require, based on case specifics
Nephrocalcinosis	Decline	N/A	N/A	N/A
Nephrosclerosis	Decline	N/A	N/A	N/A
Neurofibromatosis	Decline	N/A	N/A	N/A
Neurogenic Bladder	Decline if severe or paralysis present; otherwise, individual consideration	N/A	N/A	Required
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	N/A	May require, based on case specifics
Newborn	Will be considered for coverage at 6 weeks of age; infant must have had a well baby exam with any adverse findings disclosed on the application (if born at less than 37 weeks gestation, refer to prematurity guidelines) ****These guidelines do not apply to newborns added to an existing policy within 31 days after birth**	N/A	N/A	N/A

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Obesity surgery	Decline	N/A	N/A	N/A
Osteoarthritis	See "Arthritis, Osteoarthritis"			
Osteochondrosis	See rider guidelines	Symptomatic or < 2 years since last treatment: Rider	Asymptomatic, complete recovery, no deformities present, > 2 years since last treatment	Required
Osteogenesis Imperfecta	Decline	N/A	N/A	N/A
Osteomylitis	Underwriting based on case specifics; decline for chronic conditions	N/A	N/A	Required
Osteopenia	See rider guidelines	Treated with prescribed medication: Rider (rider excludes medication cost only) ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	N/A	May require, based on case specifics
Osteoporosis	Decline if severe (t-score below -2.5, history of fractures, frequent recurrent neck, back or other bone pain); otherwise, rating based on severity, risk factors, and age when diagnosed	Rider (excludes medication cost only) ***See special guidelines for BluePartner and SimplyBlue High Deductible Plans**	N/A	May require, based on case specifics
Otosclerosis	See rider guidelines	Surgery anticipated, or operated (unilateral only): Rider	Operated, bilateral, minimal hearing loss	May require, based on case specifics
Ovarian Cyst	See rider guidelines	Cyst present or < 3 years since last treatment: Rider	Spontaneously resolved or surgical removal with no recurrence within the past 3 years	May require, based on case specifics
Overactive Bladder	See rider guidelines	Rider if symptomatic or treatment within the past 2 years	Asymptomatic, no treatment for > 2 years	May require, based on case specifics
Pacemaker	Decline	N/A	N/A	N/A
Pancreatitis, Chronic	Decline	N/A	N/A	N/A
Paralysis	Decline if permanent	N/A	N/A	N/A
Paraplegia	Decline	N/A	N/A	N/A
Parkinson's Disease	Decline	N/A	N/A	N/A
Pectus Excavatum	Decline if cardiopulmonary defects or dysfunction present	Unoperated or < 5 years since surgical correction and treatment: Rider	Surgically corrected; complete recovery, > 5 years since surgery and treatment	Required
Penis, Disorders	See rider guidelines	Unoperated: Rider	Operated, complete recovery	May require, based on case specifics
Peripheral Vascular Disease (Arteriosclerosis Obliterans, ASO)	Decline	N/A	N/A	N/A
Pervasive Developmental Disorder	See guidelines for "Autism"	N/A	N/A	Required
Pilonidal Cyst	See rider guidelines	Infected (abscess): Rider	Resolved	N/A
Pituitary Dwarfism/ Growth Hormones	Decline if under age 20 and currently in treatment; otherwise, individual consideration	N/A	N/A	Required
Pityriasis rosacea	See guidelines for "Acne"			
Pneumonia	Decline if present; no rating if complete recovery, no underlying health conditions	N/A	N/A	Required, if multiple episodes or < 6 months since episode

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Polycystic Kidney Disease	Decline	N/A	N/A	N/A
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	N/A	Required
Polycythemia Vera	Decline	N/A	N/A	N/A
Portal Hypertension	Decline	N/A	N/A	N/A
Porphyria	Decline	N/A	N/A	N/A
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). **(Rating for pre-diabetes will be in addition to rating for other existing conditions such as build, hyperlipidemia or hypertension)**. Decline if treated with prescribed medication or diagnosed with 'diabetes'. Glucose levels above those specified as 'pre-diabetes' will be considered 'diabetes'.	N/A	N/A	Required
Pre-eclampsia	Decline if child bearing age and no normal delivery since pre-eclamptic episode	N/A	N/A	Required
Pregnancy – current	Decline if the applicant or any member of the family is pregnant at the time of application; this guideline also applies to the father of an unborn child	N/A	N/A	N/A
Premature Birth (born less than 37 weeks gestation)	1) Gestational age between 32-37 weeks (36 weeks, 6 days) and birth weight over 1750 grams (3 lbs, 14 ounces), decline for one year after birth. After one year of age, underwriting based on medical condition. 2) Gestational age less than 32 weeks or birth weight less than 1750 grams, decline for 2 years after birth. After 2 years of age, underwriting based on medical condition. Medical records required for underwriting 3) Applicants receiving immunization for RSV will be declined until 2 years of age 4) Gestational age more than 37 weeks will be considered full term	N/A	N/A	Required
Primary Pulmonary Hypertension	Decline	N/A	N/A	N/A
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	Operated, no symptoms or residual operative complications, > one year since surgery	Required
Prostate Specific Antigen Elevation	Decline if elevated (PSA 4.0 or greater)	N/A	N/A	N/A
Prostatitis – Chronic	Decline if elevated PSA (4.0 or greater)	Rider	N/A	May require, based on case specifics
Pseudotumor Cerebri	Decline	N/A	N/A	N/A
Psoriasis	Decline for severe conditions or chronic treatment with steroids/immunosuppressant medications including methotrexate	**Mild or moderate** conditions: Rider	N/A	May require, based on case specifics
Psoriatic Arthritis	Decline for severe conditions or chronic treatment with steroids/immunosuppressant medications including methotrexate; otherwise, rate up or decline based on individual consideration	N/A	N/A	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Pulmonary Insufficiency	Decline	N/A	N/A	N/A
Quadriplegia	Decline	N/A	N/A	N/A
Rectal Polyp	See "Colon Polyp"			
Rectocele	See rider guidelines	Urinary or bowel incontinence present: Rider Symptomatic or < one year since surgical correction: Rider	Asymptomatic, surgery not contemplated, > 2 years since diagnosis; Operated, asymptomatic, > one year since surgery	May require, based on case specifics
Reflex Sympathetic Dystrophy/Autonomic Neuropathy	Decline	N/A	N/A	N/A
Renal Failure (Chronic)	Decline	N/A	N/A	N/A
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	Required
Restless Leg Syndrome	See rider guidelines	Treatment with prescribed medications within the past 3 years: Rider	N/A	N/A
Retinal Hemorrhage	Underwriting based on underlying cause	N/A	N/A	Required
Retinopathy	Underwriting based on underlying cause	N/A	N/A	Required
Rheumatoid Arthritis	see "Arthritis, Rheumatoid"			
Rotator Cuff Syndromes	See rider guidelines	Unoperated or < 2 years last treatment: Rider	Operated, complete recovery, > 2 years since last treatment	May require, based on case specifics
RSV immunizations	Decline if currently receiving immunizations; if premature infant, see guidelines for "Premature Birth"	N/A	N/A	Required
RSV (viral infection)	Applicants with a viral infection caused by the RSV virus, completely recovered, no rating	N/A	N/A	N/A
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	N/A	Required
Schizophrenia	Decline	N/A	N/A	N/A
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	N/A	Required
Scoliosis	See "Back/Spine - Spinal Curvature"			
Sebaceous Cyst	See rider guidelines	Symptomatic or surgery planned: Rider	Operated, complete recovery	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	N/A	May be required for reconsideration of rider

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
Sick Sinus Syndrome	Decline	N/A	N/A	N/A
Sickle Cell Anemia	Decline	N/A	N/A	N/A
Sinusitis – Chronic	See rider guidelines	Surgery anticipated or diagnosed within the past year: Rider	N/A	May require, based on case specifics
Sjogren's Syndrome	Decline	N/A	N/A	N/A
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)	Time period for removal will be based on number of previous excisions	May require, based on case specifics
Sleep Apnea	Decline if poorly controlled; otherwise, individual consideration **(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	N/A	Required
Speech Disorder	See rider guidelines	Present or current treatment: Rider	Underlying condition resolved, no further treatment anticipated	May require, based on case specifics
Spermatocele	See rider guidelines	Symptomatic: Rider	Complete recovery	N/A
Spina Bifida Cystica	Decline if present or residual medical conditions or complications	N/A	N/A	Required
Spina Bifida Occulta	Decline if present and applicant < 20 years of age; otherwise based on case specifics	N/A	N/A	Required
Splenomegaly	Decline	N/A	N/A	N/A
Strabismus, Esotropia, Exotropia, Heterotropia and Heterophoria (binocular eye movement disorder)	See rider guidelines	**Congenital,** unoperated and under age 20: Rider **Due to injury,** unoperated and < 3 years since injury: Rider	N/A	N/A
Suicide Attempt	Decline if attempt within the last 5 years	N/A	N/A	N/A
Surgery - Inpatient or Outpatient	Decline for pending surgery	N/A	N/A	N/A
Syndactyly of fingers or toes	See rider guidelines	Unoperated or < 5 years since surgery: Rider	Operated, complete recovery, > five years since surgery	N/A
Synovitis and tenosynovitis	See rider guidelines	**Single episode,** symptomatic: Rider **Multiple episodes** or recurrent, symptomatic or treatment within the past 3 years: Rider	Complete recovery, no symptoms or treatment within the past 3 years	May require, based on case specifics
Systemic Lupus Erythematosus (SLE)	Decline	N/A	N/A	N/A
Temporomandibular Joint Syndrome (TMJ)	See rider guidelines	Surgery anticipated or residuals (facial pain or orthodontic treatment): Rider	N/A	N/A
Tetrology of Fallot	Decline	N/A	N/A	N/A
Thalassemia Major	Decline	N/A	N/A	N/A
Thrombocytopenia	Decline	N/A	N/A	N/A
TIA (Transient Ischemia Attack)	Rate as Cerebrovascular Accident, Stroke, without complications			
Tibia/Fibula Fracture	See rider guidelines	Symptomatic or continuing treatment: Rider	Complete recovery	May require, based on case specifics

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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, the applicant will be declined coverage; **Decline if health history includes three of the following risk factors for cardiovascular disease: metabolic syndrome and/or pre-diabetes, lipid disorder, tobacco use (cigarettes), hypertension, or ratable build**	N/A	N/A	Required for tobacco users age 45 or over; must submit current complete health assessment, blood pressure reading, height/weight, lipid panel, PSA (men), liver function tests, urinalysis, chest x-ray report and/or pulmonary function testing results, and EKG report; **Current subscribers** who request a change to a non-tobacco policy must submit the appropriate change form and include the results of a current negative **urine cotinine test**
Tobacco Use, within the past 5 years	Underwriting based on current health status	N/A	N/A	May require; requests will be made on an individual basis. Underwriting will take the following factors into consideration: age, current medical conditions, years of tobacco use, and time since cessation.
Tonsillitis – Chronic	See rider guidelines	Chronic or surgery anticipated: Rider	N/A	N/A
Transplant - Bone Marrow	Decline	N/A	N/A	N/A
Transplant – Organ	Decline	N/A	N/A	N/A
Transplant – Possible	Decline	N/A	N/A	N/A
Tremor	See rider guidelines	Essential tremor: Rider Physiologic: No rate or rider	N/A	N/A
Tricuspid Atresia	Decline	N/A	N/A	N/A
Tricuspid Valve Regurgitation (insufficiency)	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rating 2) No cardiac studies available, decline 3) Symptomatic or greater than mild regurgitation, decline	N/A	N/A	Required
Trigeminal Neuralgia	See rider guidelines	Unoperated, symptomatic, or surgery within the past 2 years: Rider	Asymptomatic, > 2 years since surgery	Required
Trisomy 21 Syndrome	Decline	N/A	N/A	N/A
Tuberculosis	Decline if active infection or symptomatic	N/A	N/A	Required
Tuberous Sclerosis Complex	Decline	N/A	N/A	N/A
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, asymptomatic, > 2 years since attack; multiple attacks, > 6 years since last attack	Required

Condition	Underwriting Action	Rider Criteria	Rider Removal	Medical Records Criteria
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	Recovered, > 4 years since last attack	Required
Ulcerative Colitis/ Ulcerative Proctitis	Decline	N/A	N/A	N/A
Urethral Stricture	See rider guidelines	Present, chronic or recurrent: Rider	N/A	May require, based on case specifics
Urinary Incontinence	See rider guidelines	Unresolved or current treatment: Rider	Resolved, no treatment for > one year	Required
Uterine Fibroid	See rider guidelines	Unoperated and premenopausal: Rider	Hysterectomy, myomectomy with no recurrence, or postmenopausal	May require, based on case specifics
Vaginal Polyp	See rider guidelines (work up must be complete to rule out malignant disease)	Symptomatic or treatment anticipated: Rider	N/A	May require, based on case specifics
Varicocele	See rider guidelines	Diagnosed < 2 years or treatment anticipated: Rider	Diagnosed > 2 years, no treatment anticipated or operated and recovery complete	May require, based on case specifics
Vertigo	Underwriting based on underlying cause, if workup complete and cause benign, see rider guidelines	Rider	N/A	Required
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	Unoperated, asymptomatic and no treatment for > 3 years; operated > one year, complete recovery	Required
Vitiligo	See rider guidelines	Treatment with prescribed medications within the past year: Rider	N/A	N/A
Vocal Cord Polyp	Underwriting based on underlying cause, if workup complete and cause benign, see rider guidelines	**Present:** Rider **Operated,** underlying cause uncorrected: Rider	Operated, underlying cause corrected, > 3 years since last treatment	Required
Von Recklinghausen's Disease	Decline	N/A	N/A	N/A
Wegener's Granulomatosis	Decline	N/A	N/A	N/A
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	N/A	Required
Wilson's Disease	Decline	N/A	N/A	N/A
Wrist Disorder	See rider guidelines	Symptomatic, not recovered or current treatment: Rider	Complete recovery	N/A
Zollinger - Ellison Syndrome	Decline	N/A	N/A	N/A

Special Guidelines for High-Deductible Plans

(Please Note: If an applicant has more than one of the medical conditions listed below, underwriting discretion will be used to decide which exclusion rider(s), if any, can be waived.)

Condition	Underwriting Action	SimplyBlue S3S & S3F	SimplyBlue S4S & S4F	SimplyBlue Plus S7S & S7F	SimplyBlue Plus S8S & S8S	BluePartner D2	BluePartner D3	BluePartner D4
Acne	See rider guidelines	No rider	No rider	No rider	No rider	Rider	Rider	No rider
ADD/ADHD (Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder)	Rate up or decline based on severity, prescribed medications and/or receiving psychotherapy	No rider	No rider	No rider	No rider	Rider	No rider	No rider
Allergies	See rider guidelines	Rider	No rider	Rider	No rider	Rider	Rider	No rider
Asthma	Decline for severe conditions	Rider	No rider	Rider	No rider	Rider	Rider	No rider
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 2 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 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	N/A	N/A	N/A	N/A	Rider	No rider	No rider

Special Guidelines for High-Deductible Plans *(continued)*

Condition	Underwriting Action	SimplyBlue S3S & S3F	SimplyBlue S4S & S4F	SimplyBlue Plus S7S & S7F	SimplyBlue Plus S8S & S8S	BluePartner D2	BluePartner D3	BluePartner D4
Cholesterol/Lipid Disorders	Decline if health history includes three of the following risk factors for cardiovascular disease: metabolic syndrome and/or pre-diabetes, lipid disorder, tobacco use (cigarettes), hypertension, or ratable build; Otherwise, underwriting based on risk assessment, current level of control, and medications used in treatment	N/A	N/A	N/A	N/A	Rider	No rider	No rider
Gastroesophageal Reflux Disease (GERD)/ Hiatal Hernia	See rider guidelines	Rider	No rider	Rider	No rider	Rider	Rider	No rider
Herpes simplex virus	See rider guidelines	No rider	No rider	No rider	No rider	Rider	No rider	No rider
Osteopenia	See rider guidelines	N/A	N/A	N/A	N/A	No rider	No rider	No rider
Osteoporosis	Decline if severe (t-score below -2.5, history of fractures, frequent recurrent neck, back or other bone pain); otherwise, rating based on severity, risk factors, and age when diagnosed	N/A	N/A	N/A	N/A	No rider	No rider	No rider

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 23, or to age 24. The dependent must be unmarried and dependent on the applicant or applicant's spouse for at least 50% of his/her support.

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 blue or 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.

Children Only Policies

BCBST accepts applications for minor dependent children who reside in Tennessee. The application should be signed by the parent or legal guardian of the minor child. If applying for more than one child, each child should have a separate application. The application should list the minor child as the primary applicant.

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.
- 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 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 23, or to age 24. The dependent must be unmarried and dependent on the applicant or applicant's spouse for at least 50 percent of his/her support.

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.
- The member will receive credit for the length of their enrollment with the BCBS plan toward the Guaranteed Issue Plan's waiting periods.

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 the Health Coverage Tax Credit

The Trade Adjustment Assistance (TAA) Reform 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. The tax credit is available only for "qualified" health insurance.

Any underwritten under 65 product is considered qualified as long as the TAA-eligible individual purchases it at least 30 days prior to the date their employer-sponsored coverage terminates.

Individuals may also be eligible for a state-based guaranteed issue coverage. The state of Tennessee has chosen to offer coverage through an arrangement between the state and a health insurance carrier. The state-based coverage option must include the following four provisions in order to meet the needs of individuals who have prior creditable health coverage:

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). To apply, applicants must submit their HCTC eligibility notification form and their Notice of Creditable Coverage from their prior employer. They must have had at least three months of continuous coverage, and the application must be received within 63 days of either:

1. The date they received their eligibility notice from HCTC; or
2. The date their employer-sponsored coverage terminated, whichever is later.

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 the monthly medical 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).

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 application to us within 31 days of the date that person first becomes eligible for coverage. We will determine if that person is eligible for coverage.

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

Children Only Policies

BCBST accepts applications for minor dependent children who reside in Tennessee. The application should be signed by the parent or legal guardian of the minor child. If applying for more than one child, each child should have a separate application. The application should list the minor child as the proposed insured.

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

Determining Plan Premiums: Plan premiums are based on the actual age of the applicant as of the policy date. Plan premiums are rated by age bands.

Initial Premium Payment: The first month's premium will be billed to the subscriber after the application is approved.

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 their 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, or credit card. A credit card payment can be made over the telephone by calling the telephone number listed on the subscriber's billing statement.

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, automatic payments can be set up for bank draft or credit card payments. An automatic payment authorization form will be included in the policy mailed to the customer. Accounts set up for a credit card or 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 or credit card company.

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.

Credit Card Payments: Recurring credit card payments are submitted to the credit card company on the 1st day of the month in which the premiums are due. We accept Master Card and Visa. If the credit card is rejected by the credit card company or it is past the expiration date and we have not been informed of the change in the expiration date, 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. A new credit card authorization form will be required to return to the credit card payment option.

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.
- Requests to upgrade coverage require medical underwriting. 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. The effective date of approved upgrades will be the first of the month following the 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. Upgrades in coverage always require re-underwriting. Select downgrades in coverage will not require re-underwriting. These include movement from PHC1, PHC2 or PremierBlue to several SimplyBlue or BluePartner plans as well as from BluePartner to select SimplyBlue plans. For specifics, or to confirm whether or not a change is considered an upgrade or a downgrade, please contact your field agency support representative. All requests to move from BluePreferred to a new product, or from PHC1 or PHC2 to PremierBlue, will require new underwriting. In the case of a downgrade, the transfer will receive commissions based on the renewal year percentage of the new product.

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.

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 Products Transfer Guidelines - Updated 8/21/08						
	Application Required	**Medical Underwriting Required?**	**Deductibles and Accumulators Carried Over?**	**Pre-ex Waiting Period**	**Maternity Rider**	**Dental Option**
BLUE PREFERRED						
BP to BP	App-73	Yes, for richer benefit plans	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	IHCC	Yes	No	Credit given for time under previous plan	Available	Available
BP to BluePartner	IHCC	Yes	No	Credit given for time under previous plan	Available	Available
BP to SimplyBlue	IHCC	Yes	No	Credit given for time under previous plan	Available	Available
BP Guaranteed Issue to BP Guaranteed Issue	Upgrade – Not Allowed Downgrade App-73	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	IHCC	Yes, for richer benefit plans	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	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 1 to BluePartner	IHCC	Yes, for richer benefit plans[2]	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available

Individual Products Transfer Guidelines - Updated 8/21/08						
	Application Required	Medical Underwriting Required?	Deductibles and Accumulators Carried Over?	Pre-ex Waiting Period	Maternity Rider	Dental Option
PHC 1 to SimplyBlue	IHCC	Yes, for richer benefit plans[2]	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	IHCC	Yes, for richer benefit plans	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2 to PremierBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2 to BluePartner	IHCC	Yes, for richer benefit plans[2]	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PHC 2 to SimplyBlue	IHCC	Yes, for richer benefit plans[2]	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
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					

Individual Products Transfer Guidelines - Updated 8/21/08						
	Application Required	Medical Underwriting Required?	Deductibles and Accumulators Carried Over?	Pre-ex Waiting Period	Maternity Rider	Dental Option
PremierBlue to PremierBlue	IHCC	Yes, for richer benefit plans	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PremierBlue to BluePartner	IHCC	Yes, for richer benefit plans[2]	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
PremierBlue to SimplyBlue	IHCC	Yes, for richer benefit plans[2]	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
BluePartner						
BluePartner to BP	Not Allowed					
BluePartner to PHC 1	Not Allowed					
BluePartner to PHC2	Not Allowed					
BluePartner to PremierBlue	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
BluePartner to SimplyBlue	IHCC	Yes, for richer benefit plans[2]	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
BluePartner to BluePartner	IHCC	Yes, for richer benefit plans	Yes	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	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
SimplyBlue to BluePartner	IHCC	Yes	No	Credit given for time under previous plan	May only add subject to a qualifying event	Available
SimplyBlue to SimplyBlue	IHCC	Yes, for richer benefit plans	Yes	Credit given for time under previous plan	May only add subject to a qualifying event	Available

Individual Products Transfer Guidelines - Updated 8/21/08						
	Application Required	**Medical Underwriting Required?**	**Deductibles and Accumulators Carried Over?**	**Pre-ex Waiting Period**	**Maternity Rider**	**Dental Option**
SimplyBlue Guaranteed Issue to SimplyBlue Guaranteed Issue	Upgrade – Not Allowed Downgrade App-140	No	Yes	N/A	Not available	Available
SimplyBlue Guaranteed Issue to BluePreferred Guaranteed Issue	Not Allowed					
SimplyBlue Guaranteed Issue to PHC2 Guaranteed Issue	Not Allowed					
SimplyBlue 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

Notes:

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

[2] Product Transfer/Downgrades allowed without underwriting on select products.

P1 – P30 are PHC1 plans
H1 – H30 are PHC2 plans
A1 – A58 are PremierBlue plans
D1 – D4 are BluePartner plans
S1 – S4 are SimplyBlue plans
S5 – S8 are SimplyBlue Plus plans

The chart below illustrates all the possible cross product downgrades available. X indicates that a transfer from the current plan to the proposed plan is considered a downgrade in coverage.

Current Plan - PremierBlue																				
Proposed Plan	A01	A02	A04	A12	A14	A18	A22	A24	A25	A28	A31	A32	A34	A42	A44	A48	A52	A54	A55	A58
D1																				
D2																				
D3									X										X	
D4	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
S1	X	X		X			X				X	X		X			X			
S2	X	X		X			X				X	X		X			X			
S3									X										X	
S4	X								X		X								X	
S5	X	X		X			X				X	X		X			X			
S6	X	X		X			X				X	X		X			X			
S7									X										X	
S8	X								X		X								X	

Current Plan - PHC2 (H Plans)														
Proposed Plan	H1	H2	H3	H5	H11	H13	H18	H20	H21	H25	H26	H28	H29	H30
D1	X	X	X		X			X	X				X	X
D2	X	X						X					X	X
D3	X	X	X		X			X	X	X			X	X
D4	X	X	X	X	X	X	X	X	X	X		X	X	X
S1	X	X	X		X			X	X				X	X
S2	X	X	X		X			X	X				X	X
S3	X	X	X		X			X	X	X			X	X
S4	X	X	X	X	X	X		X	X	X			X	X
S5	X	X	X		X			X	X				X	X
S6	X	X	X		X			X	X				X	X
S7	X	X	X		X			X	X	X			X	X
S8	X	X	X	X	X	X		X	X	X			X	X

Current Plan - BluePartner				
Proposed Plan	D1	D2	D3	D4
S1				
S2	X			
S3	X	X		
S4	X	X	X	
S5				
S6	X			
S7	X	X		
S8	X	X	X	

Current Plan - PHC (P Plans)															
Proposed Plan	P01	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12	P13	P14	P15
D1	X	X	X								X				
D2	X	X													
D3	X	X	X				X				X				X
D4	X	X	X	X	X	X	X			X	X	X	X	X	X
S1	X	X	X	X							X	X			
S2	X	X	X	X							X	X			
S3	X	X	X				X				X				X
S4	X	X	X	X	X		X				X	X	X		X
S5	X	X	X	X							X	X			
S6	X	X	X	X							X	X			
S7	X	X	X				X				X				X
S8	X	X	X	X	X		X				X	X	X		X

Current Plan - PHC (P Plans), continued															
Proposed Plan	P16	P17	P18	P19	P20	P21	P22	P23	P24	P25	P26	P27	P28	P29	P30
D1				X	X	X								X	X
D2				X	X									X	X
D3				X	X	X				X				X	X
D4			X	X	X	X	X	X	X	X			X	X	X
S1				X	X	X	X							X	X
S2				X	X	X	X							X	X
S3				X	X	X				X				X	X
S4				X	X	X	X	X		X				X	X
S5				X	X	X	X							X	X
S6				X	X	X	X							X	X
S7				X	X	X				X				X	X
S8				X	X	X	X	X		X				X	X

Medicare Supplement Product Guidelines

BlueCross65 Eligibility Requirements

To be eligible to enroll, the applicant:

- Must be a resident of Tennessee (must have a street address, post office boxes do not qualify)
- Must be age 65 or over
- 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 are eligible to enroll in any of our BlueAdvantage plans.

Health Qualifications
Initial Eligibility

You must be enrolled in Medicare Part A and Part B to be eligible to purchase a BC65 plan. If you enroll in BC65 after the attainment of age 65 and within the first six months of your enrollment in Medicare Part B, the policy is guaranteed issue, with no underwriting. Pre-existing condition limitations apply with creditable coverage offsets.

Applying from other coverage

Medigap Policy

- If you are transferring from a BCBST Medigap Plan and applying for equal or lesser benefits, the policy is guaranteed issue, with no underwriting or pre-existing condition limitations.
- If you are transferring from a BCBST Medigap Plan and applying for greater benefits, underwriting applies, and pre-existing condition limitations apply with creditable coverage offsets.
- If you are transferring from another Blues Medigap Plan, the policy is guaranteed issue, with no underwriting or pre-existing condition limitations. If the same level of certificate is not available for sale by BCBST, then the next alphabetically preceding standard product available for sale will be offered. For example, if the subscriber holds a certificate for Plan G, but BCBST does not sell Plan G, BCBST will offer Plan F. If BCBST does not sell Plan F, BCBST will offer Plan E, et cetera.
- If your Medigap insurance company goes bankrupt and you lose your coverage or your Medigap policy coverage otherwise ends through no fault of your own, you must apply within 63 calendar days from the date your coverage ends to obtain a Medigap Plan A, B, C, F, K, or L that is sold in Tennessee by any insurance company with no underwriting or pre-existing exclusion limitations.

Medicare Advantage Policy

- If you joined a Medicare Advantage Plan or PACE when you were first eligible for Medicare Part A at age 65 and within the first year of joining, you decide you want to switch to the original Medicare Plan, you have the right to buy any Medigap Policy that is sold in Tennessee with no underwriting or pre-existing exclusion limitation.
- If you dropped a Medigap policy to join a Medicare Advantage Plan for the first time, you have been in the plan less than a year, and you want to switch back to Medigap, you have the right to:
- Buy the Medigap policy you had with BCBST before you joined the Medicare Advantage Plan, if BCBST still sells it. If it included drug coverage, you can still get the same policy, but without the drug coverage.
- If your former Medigap policy is no longer available, you can also buy a Medigap Plan A, B, C, F, K, or L that is sold in Tennessee by any insurance company.
- If you leave a Medicare Advantage Plan because the company hasn't followed the rules, or it misled you, you must apply within 63 calendar days from the date your coverage ends to obtain a Medigap Plan A, B, C, F, K, or L that is sold in Tennessee by any insurance company with no underwriting or pre-existing exclusion limitations.
- If you voluntarily leave a Medicare Advantage Plan which you have had for more than 12 months, you must apply within 63 calendar days from the date your coverage ends to obtain a Medigap Plan that is sold in Tennessee by any insurance company subject to underwriting. Pre-existing exclusion limitations apply with creditable coverage offsets.

Other Coverage

- If you have lost group coverage through no fault of your own and if you apply within 63 days of the termination date, you are eligible for Plan A, B, C, F, K, or L with no underwriting or pre-existing exclusion limitations.
- If you are voluntarily replacing other individual or group coverage, underwriting applies, and pre-existing

condition limitations apply with creditable coverage offsets. However, if you are transferring from another Blues plan, we will offer standard Medicare supplemental insurance Plan A to transferring Medicare-eligible subscribers on a guaranteed issue basis, with no underwriting or pre-existing condition limitations.

6-Month Pre-existing Condition Waiting Period

A 6-month pre-existing condition waiting period is placed on all 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.

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: BlueCross65 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

BlueCross65 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.

Premiums, Billing and Payment Options

Determining Plan Premiums: The premium rate for BlueCross65 is based on the applicant's age as of January 1 of the year the coverage becomes effective. Once the subscriber starts paying premiums, it will stay the same for the remainder of the calendar year. Although the subscriber may have a birthday during the year, the premium rate will not increase until January 1 of the following year.

The premium rate can be increased otherwise only if the rate is increased for all other BC65 customers with the same plan and age.

Initial Premium Payment: BCBST does not require the first month's premium payment for BlueCross65. This will be billed to them.

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

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: An automatic payment authorization form will be included in the sales enrollment packet. Accounts set up for a credit card or 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 or credit card company.

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.

Credit Card Payments: Recurring credit card payments are submitted to the credit card company on the 1st day of the month in which the premiums are due. We accept Master Card and Visa. If the credit card is rejected by the credit card company or it is past the expiration date and we have not been informed of the change in the expiration date, 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. A new credit card authorization form will be required to return to the credit card payment option.

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 BlueCross65 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 APP-141 application for BlueCross65.
- 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 BlueCross65 policy, the Medicare Supplement Replacement Notice (APP-20-I) 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 PremierBlue, BluePartner, SimplyBlue and Short-Term Personal Health Coverage.

- Click on the Individual Products Rate Delivery System link.
- Select the product type from the pull down menu.
- Select the maternity or dental rider 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 Web site 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. Blue Perks 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:

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.
6. All General Restrictions apply.
7. Please provide the name of the book the ad will appear in.
8. You are responsible for all production and placement costs.
9. 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 Web site. 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 Web site, 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 Web site, provided you follow these guidelines and receive approval from the Marketing Communications Department. Requirements for approval:

1. Your Web site must represent your agency, not BCBST.
2. If your Web site 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 Web site, 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.

5. 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.
6. 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 Web site featuring the BCBST name or logo.
7. Your Web site must have a privacy policy posted that includes the requirements listed later in this guide.

Your Web site 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 Web Sites and Linking to bcbst.com

1. Your Web site 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 Web site.
3. You must use the phrase "an authorized agent (or agency) for" or "offering" with any use of the logo on the Web site.
4. The BCBST pages cannot be framed within your agency's site or otherwise implied to be a part of your Web site. A new browser window should open when the user goes to the BCBST Web site to help make a distinction between the two Web sites. This approach will also keep your Web site accessible to the user in the previous browser window.
5. You must use the full name and full logo on your Web site. 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 Web site 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 Web site 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 Web sites 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 Web site must have a privacy policy posted that meets the content requirement below.

Required Web Site 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 Web site.
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 Web site 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:

Alan Cooper
Communications Consultant,
Marketing Communications

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

Phone: (423) 535-7123
e-mail: alan_cooper@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.

of Tennessee
plans for better health. plans for a better life.™

bcbst.com

One Cameron Hill Circle
Chattanooga, TN 37402

M-141 (6/09)