



BlueCross
of California

Underwriting Guidelines

for Authorized Agents
Individual and Family Health Programs



OCTOBER **2004**

Important Addresses and Phone Numbers

Important Addresses and Phone Numbers

Individual Services Address

Blue Cross of California
P.O. Box 9041
Oxnard, CA 93031-9041

Individual Products Dedicated Customer Service Units

1-800-333-0912

Agent Sales Support

1-800-678-4466

Blue Cross of California Web Site

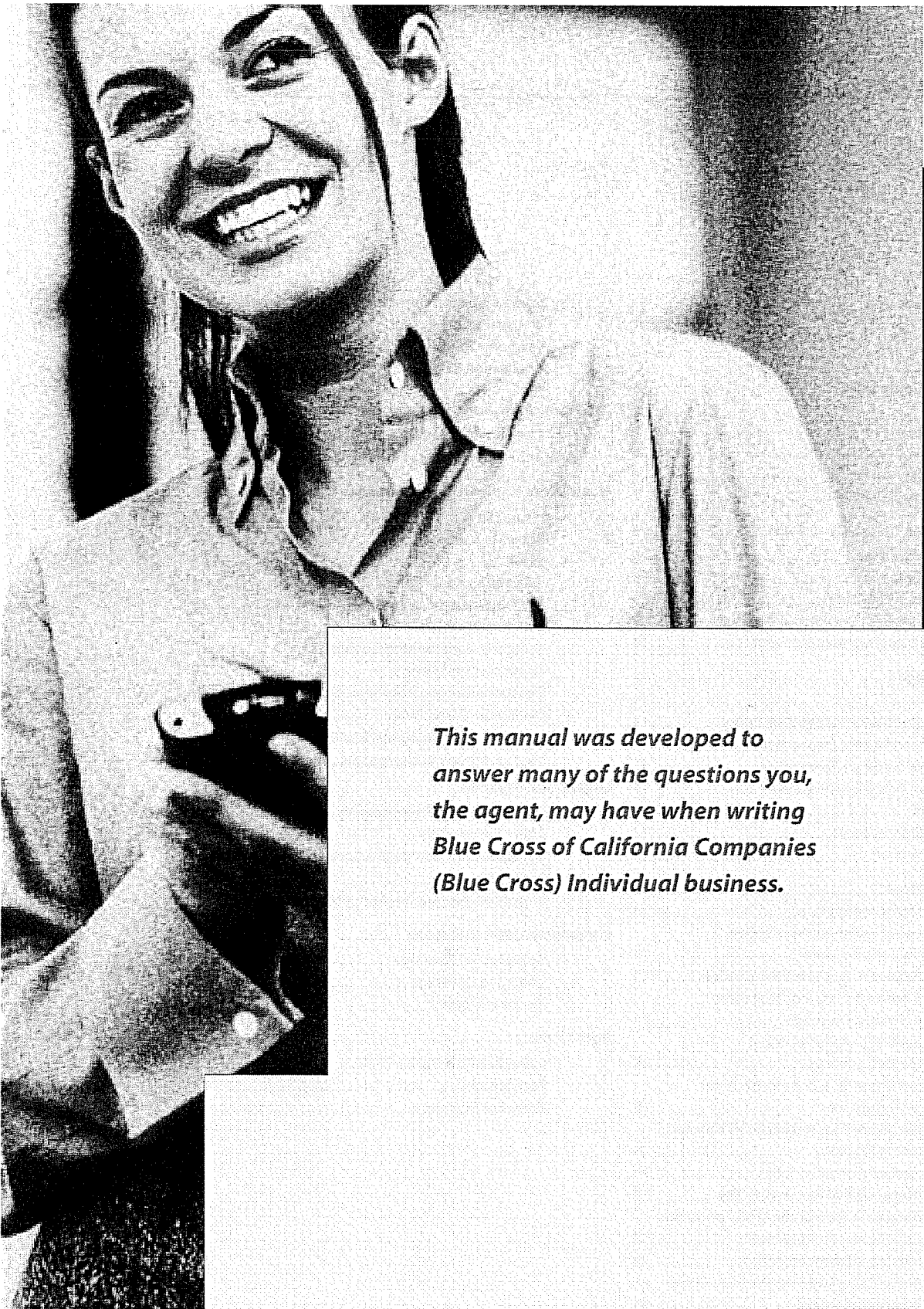
www.bluecrossca.com



Table of Contents

Table of Contents

Important Addresses and Phone Numbers	Inside front cover	Common Errors/Omissions That Delay Processing of Applications	19
Introduction	3	Payment Options	20
About Blue Cross Companies	5	Application Submission Options	21
Product Overview	6	The Application and Underwriting Process	22
PPO Plans	6	Tracking Applications	22
HMO Plans	7	Application Process Flowchart	23
HSA-Compatible Plans	7	Health Care Underwriting Guidelines	24
General Information	8	Insurability	24
Levels of Coverage	8	Body Mass Index (BMI)	24
Rate Guarantee	8	Smoking	24
Conditions of Eligibility	9	Prescription Medications	24
United States Residency Requirements	10	Full Disclosure of Medical History	25
California Residency Requirements	10	BMI Reference Chart	26
Short-Term Coverage	11	Using the Underwriting Guidelines	27
Overview	11	Common Conditions	28
Issuing a Short-Term Health Care Policy	11	Situations Causing Automatic Declination	43
Eligibility and Eligible Dependents	11	Declinable Conditions	44
Duration of the Short-Term Policy	11	Conditions Requiring Medical Records	46
Short-Term Policy Effective Date	11	Medical Record Authorization	46
Enrollment	11	Legal Requirements	47
Payment Discrepancies	12	Applicant/Client Responsibility	47
Adding Members	12	Agent Responsibility	47
Application Guidelines	13	Translations for Non-English Speaking Applicants... 47	
Key Points to Remember	13	Rescission	47
The Individual Enrollment Application	14	Important Information About Medicare	48
A Section-by-Section Guide	14	Frequently Asked Questions	49
Section 1: Applicant Information	14	Applying for Coverage	49
Section 2: Choice of Blue Cross	14	Changing Coverage	51
Individual Coverage	14	Payment Options	51
Section 3: Applicants for	15	Agent Tools	52
Medical Coverage	15	Individual Plan Option Table.....	52
Section 4: BC Life & Health Term	15	Technology	53
Life Insurance	15	Technical Support	53
Section 5: Prior Insurance History and	16		
HIPAA Eligibility	16		
Section 6: Health History	16		
Statement of Accountability	17		
Section 7: Application Understandings,	17		
Conditions and Agreement	17		
Section 8: Payment Method	18		
To Be Completed by the Blue Cross-	18		
Appointed Agent	18		
Situations That May Cause an Application To	19		
Be Returned	19		



*This manual was developed to
answer many of the questions you,
the agent, may have when writing
Blue Cross of California Companies
(Blue Cross) Individual business.*

Product Overview

PPO Plans

Key Features

- **Choice:** Direct access to a vast network of more than 42,000 doctors and 440 hospitals statewide.
- **Discounted Rates:** Discounts for in-network services apply even before the deductible is met on all plans except Basic PPO 2500 and Basic PPO 1000.
- **Lower Premiums:** Clients share more upfront costs (coinsurance and deductibles) in exchange for lower premiums.
- **\$5,000,000 of lifetime coverage**

Basic PPO and PPO Saver Plans* offer in-hospital and surgical coverage with low monthly premiums. Designed to protect against catastrophic financial losses due to unexpected illness or injury, these plans offer no maternity coverage and limited benefits for professional services and access to pharmacy discounts. Plans include

- Basic PPO 2500 (R418/R419)
- Basic PPO 1000 (7900/PE25)
- PPO Saver (NM31/PE27)

The **RightPlan PPO 40*** has no medical deductible and features a low office visit copay and three options for prescription drug coverage. Designed for specific life stages, this plan is written and priced on a single policyholder basis. A separate application for each applicant is preferred. Clients who are not seeking maternity coverage can save on premiums by choosing this plan. Options include

- RightPlan PPO 40 with No Rx Coverage (P958)
- RightPlan PPO 40 with Generic Only Rx Coverage (PE48)
- Right Plan PPO 40 with Comprehensive Rx Coverage (PE49)

The **3500 Deductible PPO Plan*** (R420) features 100 percent coverage on most in-network services after the annual \$3,500 deductible is met. No maternity coverage is provided.

*These plans are offered by BC Life & Health Insurance Company.

PPO Share Plans cover the same comprehensive package of health care services, differing in deductibles, coinsurance amounts and annual out-of-pocket maximums. First-dollar benefits for office visits (including Well Baby/Child) and generic drugs. Plans include

- PPO Share 5000 (H062)*
- PPO Share 2500 (7891)
- PPO Share 1500 (7889)
- PPO Share 1000 (1393/1930)
- PPO Share 500 (7895/1929)



HMO Plans

Key Features

- **Comprehensive health care coverage:** Within HMO network only, except for emergencies and prescription drugs
- **One primary care physician that coordinates all health care:** Self-referral for in-network OB/GYN (women's health specialists)
- **Low out-of-pocket costs:** minimal copays for office visits
- **Unlimited lifetime coverage**

HMO Plans provide extensive coverage with low out-of-pocket costs for covered health care services at HMO network providers only. Plans include

- Select HMO (no medical deductible) (PE43)
- HMO Saver (with deductibles and lower premiums) (7896)
- Individual HMO (no medical deductible) (7898)

HSA-Compatible Plans

Key Features

- **Lower Premiums:** High deductible cost sharing lowers monthly premium cost
- **Unlimited lifetime coverage**
- **Possible Tax Benefit:** When used in conjunction with an HSA account*

The PPO 3500 (HSA-Compatible) Plan† (T160) features lower premiums and 100 percent coverage on most in-network services after the annual \$3,500 combined deductible is met. No maternity coverage is provided. This high deductible health plan (HDHP) is compatible with a tax-advantaged Health Savings Account (HSA).

The EPO (HSA-Compatible) Plan (7892) provides partial coverage for most in-network services after the annual \$2,400 combined deductible is met. Out-of-network services are not covered, except in emergencies. This high deductible health plan may also be compatible with a Health Savings Account.

† This plan is offered by BC Life & Health Insurance Company.



*The PPO 3500 (HSA-Compatible) and the EPO (HSA-Compatible) plans are not HSA's and do not establish an HSA. An HSA is a savings account that allows individuals to save for qualified medical and retiree health expenses on a tax-free basis. To establish an HSA, an individual must be eligible under IRS regulations and must open an HSA that meets IRS requirements at a qualifying bank or financial institution. An HSA must be used in conjunction with a qualifying high deductible health plan. Individuals considering enrollment in the PPO 3500 or the EPO plans to use with an HSA should first consult their tax advisor.

General Information

Levels of Coverage

Blue Cross believes that the cost of covering the expenses of someone with minimal health care needs should not be unfairly offset by someone whose health can be predicted to require costly care. Blue Cross Individual plans offer a solution. These plans reduce the cost of coverage by making sure that a "risk balance" is maintained. We offer coverage to applicants by placing them in a level of coverage based upon underwriting guidelines.

Level 1 coverage is offered for all of our PPO (Prudent Buyer Plan®), EPO, Select HMO and HMO (CaliforniaCare®) plans. An applicant with no medical conditions or medical conditions of low underwriting risk, as determined by Blue Cross, may be placed in a Level 1 plan.

Level 1 +20 rate-up plans are offered for HMO plans only. These plans are the same as Level 1 plans, with rates that are 20 percent higher. An applicant with medical conditions of moderate underwriting risk, as determined by Blue Cross, and/or receiving medical treatment may be placed in a Level 1 +20 plan. In some areas, persons enrolling in the HMO for certain providers will be assigned this rate because of higher health care costs. PPO/EPO members whose original effective date is prior to March 1, 2004 may be on a Level 1 +20 plan. When these members request a plan downgrade, they may be downgraded to the requested plan at Level 1 +20 rates.

Level 1 +25 rate-up plans are offered for PPO plans only. These plans are the same as Level 1 plans, with rates that are 25 percent higher. An applicant with medical conditions of moderate underwriting risk, as determined by Blue Cross, may be placed in a Level 1 +25 plan.

Level 1 +50 rate-up plans are offered for PPO plans only, with rates that are 50 percent higher. An applicant with medical conditions determined by Blue Cross to be of moderately high underwriting risk will be placed in a Level 1 +50 plan.

Level 1 +75 and **Level 1 +100** rate-up plans are offered for PPO plans only, with rates that are 75 or 100 percent higher. An applicant with medical conditions, determined by Blue Cross to be a high underwriting risk, may be placed in a Level 1 +75 or Level 1 +100 plan.

IMPORTANT: Blue Cross Individual HMO or HMO Saver Plans DO NOT have Level 1 +25 or higher. To be enrolled in Level 1 +25 or higher, a PPO plan must be selected. Blue Cross also offers Individual BC Life & Health Short Term plans; see pages 11-12 for more information.

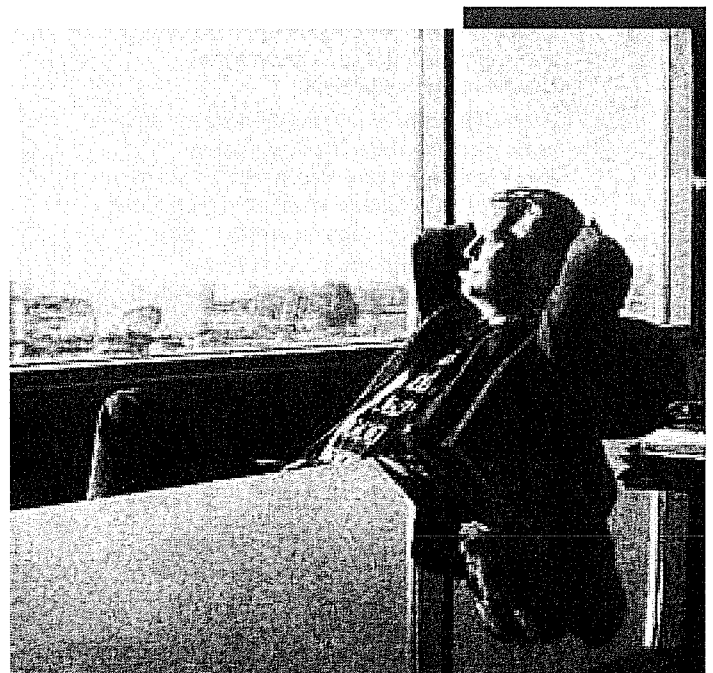
California Major Risk Medical Insurance Program (MRMIP) – Coverage may be declined for applicants that Blue Cross determines to have severe or significant health issues based on a medical condition or a combination of medical conditions. Applicants who are declined may apply for MRMIP coverage. A MRMIP application (form # ME 7208) is required.

HIPAA – Applicants may also be eligible for guaranteed-issue HIPAA coverage (see page 16).

Access for Infants and Mothers (AIM) – Applicants who are currently pregnant may qualify for AIM, a state-sponsored health plan. AIM is available to California residents who are not more than 30 weeks pregnant at the time they apply and who meet the remaining eligibility program criteria. For more information, call (800) 433-2611.

Rate Guarantee

Rates and benefits are guaranteed for six months from the original effective date of an Individual medical or dental policy. This applies to new business only.



Conditions of Eligibility

All applicants for Individual plans must meet the following requirements:

1. Must have resided in the United States for three months prior to applying for enrollment. (See United States Residency Requirements on page 10.)
2. Under age 64-3/4.
3. Not eligible for Medicare A or B.
4. **Applicants under age 18** – Applications must be signed and dated by the natural parent, adoptive parent or legal guardian.

Newborn to six months – Acceptable only after review of the Individual Enrollment Application by the Underwriting Department. *Medical records will be required.*

5. Dependents:

Newborns – A newborn child of the member, spouse or enrolled domestic partner may be added without proof of insurability within 60 days of birth. If an enrollment form is not submitted within 60 days of birth, eligibility will be contingent upon the review and approval of an application and any additionally required medical records by the Underwriting Department.

Adoptees – If the adopting parent is currently a member, spouse or enrolled domestic partner, the adoptee may be added without proof of insurability within 60 days of the date the child is placed in the home for the purpose of adoption (with adopting parents providing evidence of the right to control health care). If an enrollment form is not submitted within 60 days, eligibility will be contingent upon the review and approval of the application by the Underwriting Department.

Foster children – Foster children are not eligible as dependents under the foster parents' Blue Cross health care plan. A foster child may qualify as an underage member, provided that underage member requirements are met.

Foreign exchange students – Foreign exchange students who apply for Blue Cross Individual coverage must provide proof of enrollment in the Foreign Exchange Student Program. Appropriate documentation (e.g., papers from the American Field Service or student visa) must accompany the Individual Enrollment Application.

Spouse or Domestic Partner – Member's lawful spouse of the opposite sex or Domestic Partner* under age 64-3/4.

*Domestic Partner must provide a validated copy of the Declaration of Domestic Partnership issued by the State of California. For more information, visit www.ss.ca.gov/dpregistry.

Dependent children –

- Any unmarried child of the applicant, spouse or enrolled domestic partner who is under age 19.
- Any unmarried child of the applicant, spouse or enrolled domestic partner who is between ages 19 and 23, provided the child is dependent upon the parents for at least half of his/her support.
- Court-appointed guardianship children. (A copy of the court papers, signed by the judge, authorizing guardianship is required.)



General Information

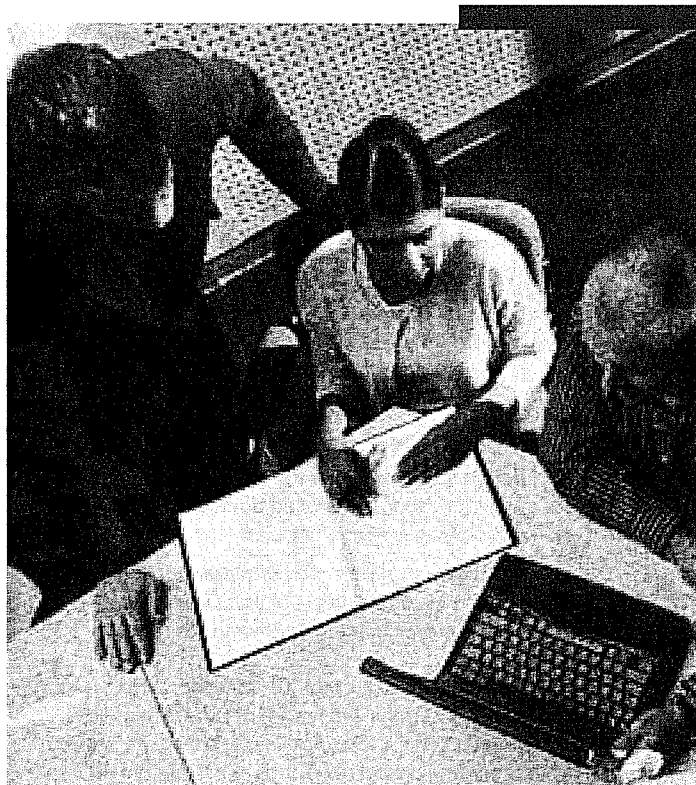
United States Residency Requirements

1. Any applicant applying as a member for an Individual plan who is not a citizen of the United States must provide proof that he/she has been a legal resident of the United States for the three consecutive months immediately prior to applying for Blue Cross coverage.
2. Blue Cross reserves the right to request proof of United States residency at any time during or after the underwriting process.
3. Only the following items may be accepted as proof of United States residency:
 - Verification of employment in the United States for the past three months (more than one employer is acceptable).
 - Rent or mortgage payment receipts in the United States for the past three months. These must be in the applicant's name.
 - Utility bill receipts in the United States for the past three months (e.g., telephone, electric, gas, water, etc.). These must be in the applicant's name.
 - Medical records documenting treatment and/or residency in the United States within the past three months.
 - Matricular Consular ID card with a minimum of three months from issuance date.
 - Immigrant visa.
 - Non-immigrant visa with a valid Form I-94.
4. Items that cannot be used as proof of United States residency are as follows:
 - Passports
 - Visas (Immigrant visas may be used as acceptable proof of United States residency, as they are issued to those who intend to permanently live and work in the United States.)
 - Social Security or ID numbers
 - Driver's licenses
 - California identification cards
 - Voter registration cards
 - Student IDs
 - Foreign certificates of birth

5. All members become ineligible for coverage when their California residency ceases for six consecutive months, regardless of their citizenship.

California Residency Requirements

1. Members become ineligible for coverage when their California residency ceases for six consecutive months, regardless of their citizenship.
2. Dependent children attending school outside of California that the member claims on his/her federal income tax are eligible for enrollment.



Overview

Short-Term coverage adheres to a different application review process than that outlined for other plans in this guide. The review process for Short-Term coverage is outlined below.

Issuing a Short-Term Health Care Policy

BC Life & Health Insurance Company (BCL&H) offers PPO coverage to qualifying residents of California on a short-term basis. Following is a list of plans for Short-Term health care coverage:

- BCL&H PPO 250 (NM04)
- BCL&H PPO 500 (NM05)
- BCL&H PPO 1000 (NM06)
- BCL&H PPO 2000 (NM07)

With a streamlined application review process, coverage can be issued quickly.

Eligibility and Eligible Dependents

An applicant must complete a simplified enrollment form. A qualified applicant is

- 15 days to 64 years of age
- A permanent legal resident of California AND
- A resident of the United States for at least 90 days

A qualified dependent is

- The legally married spouse or domestic partner* of the applicant
*Domestic partner must provide a validated copy of the Declaration of Domestic Partnership issued by the State of California.
- The applicant's child, or the child of the applicant's spouse/enrolled domestic partner, under 19 years of age OR
- The applicant's unmarried dependent child between 19 and 23 years of age ('Dependent' as defined by the Internal Revenue Service)

The application goes directly to Membership for processing. It is written for the length of time (start and end date) requested by the applicant. There are no effective date changes and no refunds of premium paid.

An enrollee has 10 days from the date of receipt to examine the Application Conditions and Agreement, in which he/she can decide to cancel for a full refund of premium paid.

Duration of the Short-Term Policy

NON RENEWABLE short-term health care coverage is purchased for 30 to 185 days. After the policy expires, the need for short-term coverage may continue. In this case, a client must apply for a new Short-Term plan.

Once a client has completed two consecutive elections of short-term coverage, he or she must wait six months to be eligible to apply for more short-term coverage.

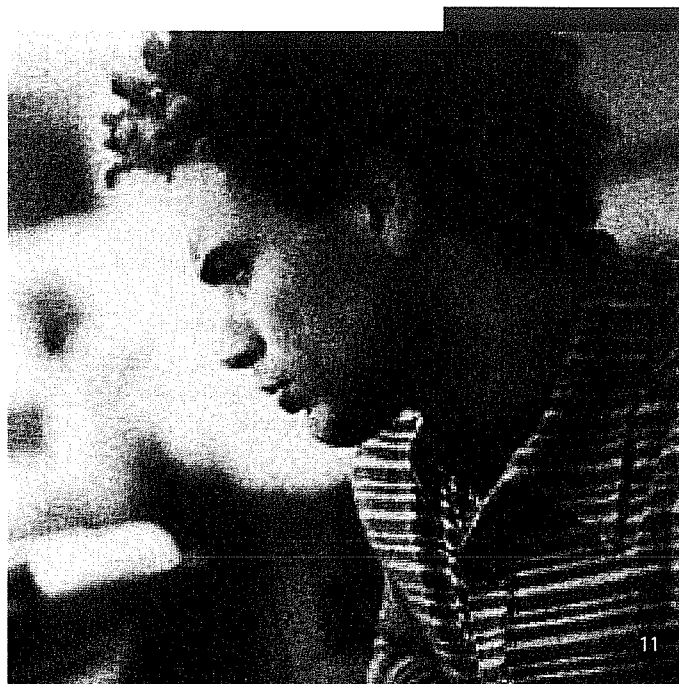
Short-Term Policy Effective Date

Applicants may request an effective date. If an effective date is NOT selected, coverage begins at 12:01 a.m. on the day following the postmark date stamped on the envelope by the post office or the day following the transmission for a faxed application.

Enrollment

The system automatically assigns a certificate number. Short-Term health care policy certificate numbers begin with "ST." Example: ST0000068.

The entire premium payment for the life of the policy is required and should accompany the application (check, money order, credit card information, etc.).



Short-Term Coverage

Payment Discrepancies

If there is a payment discrepancy for short-term coverage, the applicant is notified by letter or fax that he or she may submit a credit card payment immediately. If our Membership department does not hear from the client within three days of the receipt of the letter or fax, then the client must complete and submit a new application for coverage.

Adding Members

A Short-Term plan member may add his/her newborn or newly adopted child as a dependent.

- A newborn child – A written notification must be received within 60 days of the baby's date of birth. Coverage to begin on the newborn's date of birth.
- A legally adopted child – Proof of custody must be received within 60 days of physical custody. Coverage to begin the date of physical custody.

REMINDER: The full premium must accompany the request to add a newborn or newly adopted dependent.

If an applicant intends to apply for a regular plan while he/she is covered under a short-term plan, the applicant should request the effective date of the regular plan directly following the expiration date of the short-term plan.



Application Guidelines

Key Points to Remember

- **Acceptance** – Only Blue Cross Underwriting may determine whether an applicant will be accepted for coverage.
- **Effective Dates** – PPO applicants may request any effective date following the signature date but not greater than 75 days from the signature date on the application. HMO applicants may request any day of the month following approval.
- **Completion of Application** –
 - Applications must be completed in blue or black ink only.
 - Applications must be completed and signed by the applicant only. Applications completed and signed by an agent or broker will not be accepted.
 - Applications must be completed in full. Sections of the application that do not apply should be marked "N/A."
 - Any "yes" answers in the application's Health History section must include complete details, including diagnosis, date of onset, date treatment ended and all treatments rendered for each condition listed.
 - All prescription medications must be listed.
- **Enrollee Review Period** – An enrollee has 10 days from the date of receipt to examine the Application Conditions and Agreement, in which he/she can decide to cancel for a full refund of premium paid.



Application Guidelines

The Individual Enrollment Application – A Section-by-Section Guide

Section 1: Applicant Information

Application information must be completed by the applicant.

Social Security or ID Number – All applicants, except newborns require a Social Security or ID number or proof of U.S. residency.

Underage applicants: For a newborn (up to age 6 months), submit Social Security or ID number when received. Child Only applications must be submitted under the child's Social Security or ID number. Parents/guardians are required to obtain Social Security or ID numbers to claim dependents on federal income taxes.

If adding a dependent, list the existing member's information to ensure the eligible dependent is added to the correct contract.

Do not submit an application for immigrants until they have proof of U.S. residency. (Three months of continuous residency in the United States is required prior to enrollment.)

Home Address – Must be the applicant's actual physical address. A post office box is not acceptable. Applicant must be a permanent legal resident of California.

Mailing/Billing Address/E-mail Address – Post office box addresses may be used.

Home/Business Phone/Fax Number – Include both whenever possible to facilitate follow-up.

Maiden Name of Applicant and Spouse/Domestic Partner – This is very important in obtaining historical medical records. List any other names used by the applicant or spouse/domestic partner.

Language (optional) – Indicate language choice.

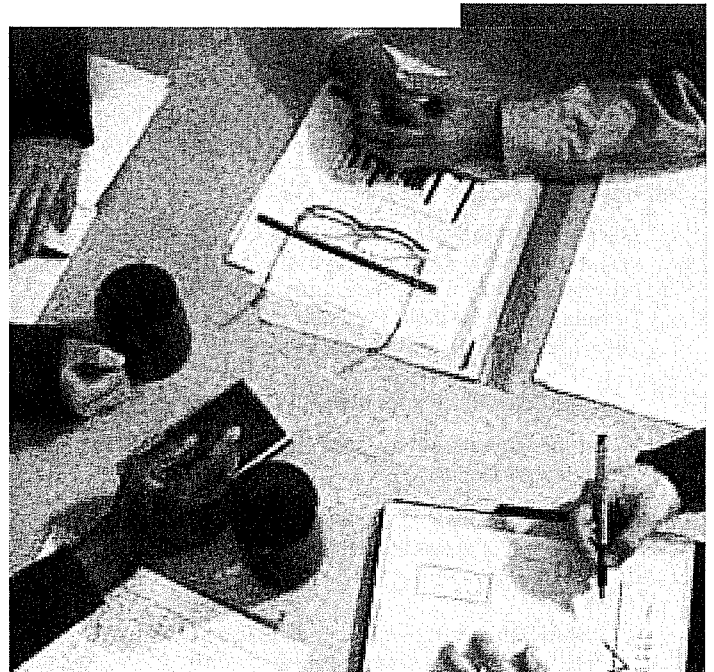
Reason for Application – If the application is for NEW ENROLLMENT or CHILD ONLY, send a check for the appropriate premium. If ADD DEPENDENTS or CHANGE EXISTING PLAN COVERAGE, a bill will be sent once approved.

Section 2: Choice of Blue Cross Individual Coverage

FamilyElect®

Each family member can choose a different health care plan. All accepted family members choosing FamilyElect will be assigned the same effective date of coverage.

- Must answer "yes" to the first question.
- Go to Section 3B and list a corresponding health care coverage plan code number from Section 2 (e.g., code 7889 for PPO Share 1500) next to a family member's name (e.g., John Smith).
- To calculate premium, choose the rate appropriate to the benefit choice, age and rating area. Add monthly rates together for all plans and submit one check.
- For the RightPlan PPO 40, separate checks should be submitted for each applicant.



Application Guidelines

Medical Coverage

PPO Coverage:

Basic PPO 1000 (7900)
 Basic PPO 1000 without Life (PE25)
 Basic PPO 2500 (R418)
 Basic PPO 2500 without Life (R419)
 PPO Saver (NM31)
 PPO Saver without Life (PE27)
 Share 5000 (H062)
 RightPlan PPO 40-No Rx (P958)
 RightPlan PPO 40-Generic Rx (PE48)
 RightPlan PPO 40-Comprehensive Rx (PE49)
 3500 Deductible PPO (R420)
 PPO Share 1000 (1930/1393)
 PPO Share 500 (1929/7895)
 PPO Share 2500 (7891)
 PPO Share 1500 (7889)
 PPO 3500 (HSA-Compatible) (T160)
 EPO (HSA-Compatible) (7892)

HMO Coverage:

Select HMO (PE43)
 HMO Saver (7896)
 Individual HMO (7898)

If applicant does not qualify for an HMO plan, indicate if he/she wishes to be considered for PPO coverage at a higher premium rate.

HIPAA Enrollment:

To determine eligibility, go to Section 5.

Dental Coverage

Check one of the plans offered by BCC or BCL&H. Then list the names and birth dates of the applicants to be covered. For any of the Blue Cross Dental SelectHMO coverages, a six-digit Provider Number from the Provider Directory must be indicated.

Section 3: Applicants for Medical Coverage

Must be completed by all applicants. Be sure to complete all sections.

New Enrollments – (including Child only) – List all applicants and all eligible dependents applying for coverage.

Add Dependents – List only eligible dependents to be added to existing contract.

Birthdate, Age, Height, Weight – All information must be complete and CURRENT for the applicant and all dependents in order to prevent delays in application processing. Applicants age 64-3/4 and over are not eligible.

3A. For HMO Use Only – Enter a three-digit PMG or IPA code AND a six-digit Primary Care Physician (PCP) code for each applicant choosing an HMO.

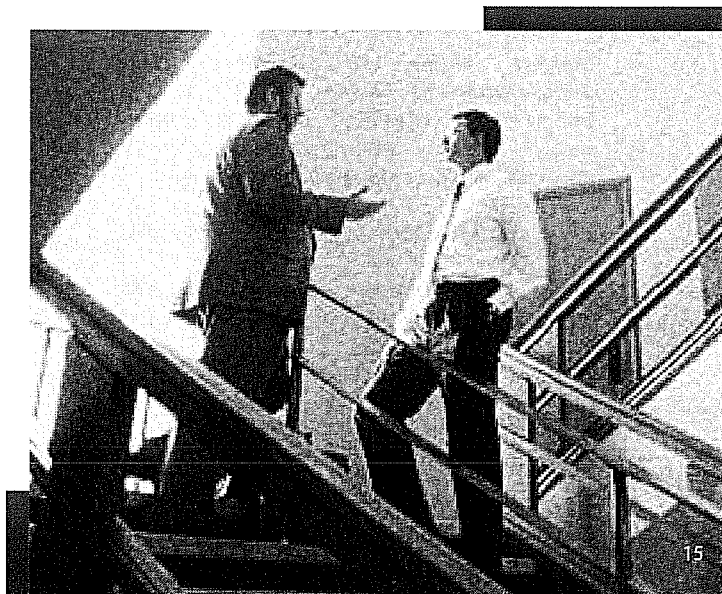
3B. FamilyElect Medical Coverage – Enter a four-digit code from Section 2 for each applicant's medical coverage choice.

3C. Dependent Information – This section must be completed for eligible dependents ages 19-23. These applicants must also read, sign and date Section 7, Application Understandings, Conditions and Agreement.

Section 4: BC Life & Health Term Life Coverage

Applicants and/or any dependents that are approved for coverage will also qualify for BCL&H Term Life coverage at an additional charge. Applicants under the age of one year are not eligible for Term Life coverage. DO NOT SUBMIT PREMIUM FOR TERM LIFE COVERAGE.

The \$50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under the age of 19, the selection will default to \$30,000. If beneficiary information is not listed and the policy is issued, death benefits will be paid in accordance with the Beneficiary Provision as stated in the policy.



Application Guidelines

Section 5: Prior Insurance History and HIPAA Eligibility

The applicant must list all previous health care coverage (Group or Individual) and include the name of the carrier, coverage dates (beginning and end), the name of the policyholder and the policy number.

The applicant must also list any benefits received under Medi-Cal, Medicare, Workers' Compensation, or any other disability health care coverage. A complete explanation for all of these coverages must also be included on the application. Attach an additional sheet if necessary.

The applicant will be given credit toward fulfillment of the six-month preexisting condition exclusion period if qualifying prior coverage has terminated within the last 63 days.

Failure to disclose current health care coverage information may be grounds for future retroactive action.

An individual who most recently was covered under a group plan may be eligible for benefits under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if he/she

- has had prior health care coverage for 18 consecutive months, with the most recent coverage being under an employer group plan.
- is ineligible for, or has exhausted, other coverage options, including COBRA, Cal-COBRA, Medicare, Medicaid or other group coverage, but not including eligibility for a conversion policy.
- does not have other coverage.
- has not lost prior coverage due to fraud or non-payment of premium.
- applies no later than 63 days after the loss of his/her last coverage.

Every applicant must answer questions A and D. Failure to complete this portion of the application will delay processing. A Certificate of Creditable Coverage and COBRA Expiration notice or an employer letter explaining why there is no COBRA must be submitted if a HIPAA plan is selected.

Section 6: Health History

Every applicant age 18 or over must review these questions and disclose ANY AND ALL history for these conditions.

For underage applicants/dependents who do not live with the member/payer, the custodial parent or guardian must complete and sign the health information section on behalf of the minor. The minor must be questioned regarding the use of alcohol and drugs, as the member will be held accountable for such omitted history in the event retroactive action becomes necessary.

Explanation for any "yes" answers must include the question number, applicant name, dates of service, name and address of each provider (indicate if any provider is deceased), names of specific conditions treated, plus any tests, treatment, surgery, etc. All past cosmetic/reconstructive surgery must be listed to prevent retroactive action based on an omission of this type. **THIS INFORMATION MUST BE COMPLETE** to avoid processing delays.

THE APPLICANT IS REQUIRED TO LIST THE LAST PHYSICIAN SEEN REGARDLESS OF THE DATE OR REASON, even if the responses to all health questions are "no." Lack of physician information for any family member on the application may delay processing. We must have this information regardless of the time that has lapsed since the last physician visit occurred.

NOTE: the health history information must cover the last 10 years.



Application Guidelines

Always instruct the applicant to list all health history information. Blue Cross Underwriting will determine the relevance of any given health information. This will help protect you, and it will allow us to properly and completely underwrite your business.

The more detailed the information provided in this section of the application, the quicker an underwriting decision can be made. Fewer Attending Physician Statements will be required if all information is available with the application.

Questions 7a through 7f must be answered by females only.

Additional Information – Use additional paper as necessary to include all health history information. (Also available is the Supplement to Individual Enrollment Application (form # 3955) on which additional health care information and/or applicants for health care and/or Term Life coverage can be listed.)

The section entitled *Other Health Questions* identifies applicants, including all adults and minor dependent children, with a history of substance abuse. Legal guardians are accountable for disclosing substance abuse information (including any counseling received) relating to minor children. This is the omission that most frequently results in claims being denied or the plan being voided from the beginning.

Statement of Accountability

For non-English speaking applicants, complete the Statement of Accountability or the Exception to Standard Enrollment form.

Section 7: Application Understandings, Conditions and Agreement

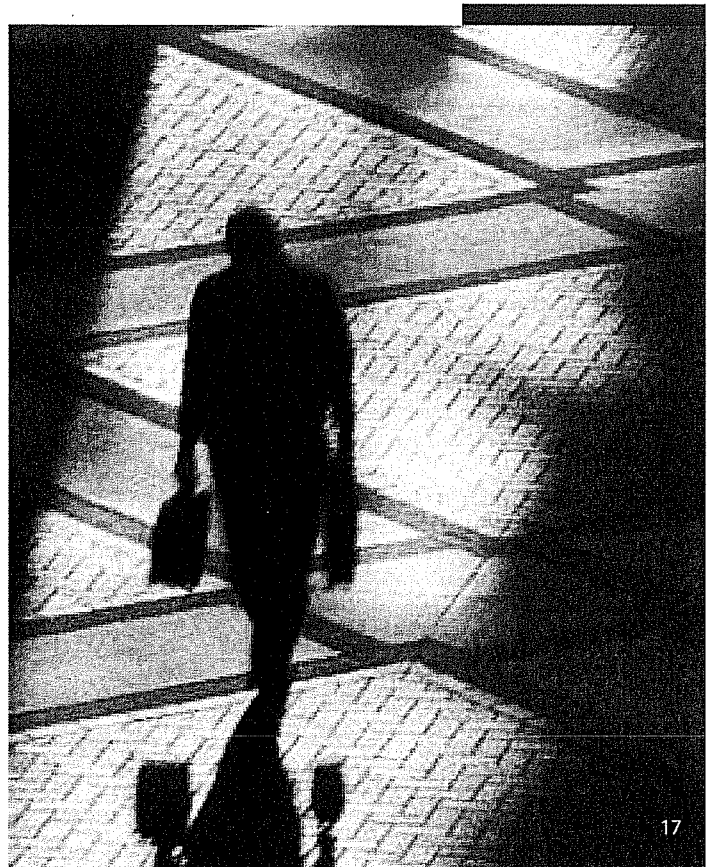
Applicant Responsibility – The legal age of accountability in this state is 18 years. All applicants age 18 and over must personally read, complete, sign and date this application.

PPO Plan Applicants Only – Applicants may request any effective date following the signature date but not greater than 75 days from the signature date on the application. If no effective date is requested, Blue Cross will assign the first day after underwriting approval.

HMO Applicants Only – Applicants may request any day of the month following approval. If no effective date is requested, Blue Cross will assign the first day after underwriting approval.

Effective Date – A requested effective date cannot be changed after submission. If the health history indicates the need for an Attending Physician Statement (APS), it is generally advisable to have Blue Cross assign the effective date due to the possible delay in receiving the APS.

NOTE: If the applicant is replacing other coverage, it is advisable for the applicant to request an effective date of at least 60 days from the signature date. This will allow adequate time for underwriting and will help avoid duplicate dues payment by the applicant. **Blue Cross strongly recommends that the applicant maintain current coverage until he/she is notified of acceptance.**



Application Guidelines

Eligible/Ineligible Applicants – Blue Cross will enroll all eligible family members unless otherwise instructed. If the applicant checks the box following the above statement on the application, Blue Cross will not enroll any eligible applicants unless all family members qualify.

Statement of Authorization and Agreement – Discuss each of the points contained in these sections with the applicant prior to submitting the application. It is very important for you to ensure that the applicant has read, understands and has signed the Authorization and Agreement.

To Be Completed by the Blue Cross-Appointed Agent

This section must be read carefully, understood, and completed by you, the agent. To insure prompt processing of your clients' applications, make sure you have completely covered all of the listed agent instructions and have answered the questions to the best of your knowledge.

As a further protection, you must complete this section after the applicant has completed the application and given it to you for submission to Blue Cross. It is essential in the event of any possible litigation that you answer all questions truthfully and sign this section.

Section 8: Payment Method

A PREMIUM PAYABLE TO BLUE CROSS OF CALIFORNIA MUST ACCOMPANY EACH APPLICATION. A payment representing *at least* one full month's premium must be submitted with the application. If the premium is missing or is incorrect, the application will be returned. Members may choose one of three payment methods:

8A. Monthly Checking Account Automatic Premium Payment

The enrollee completes the Payment Method form on the application and attaches a blank check marked "VOID" to the form. If the application is approved, the premiums for all products selected, including dental and/or Term Life, will automatically be deducted from the checking account on the first of the month.

8B. Payment by Credit Card

Available to new members to make initial or monthly health care coverage and dental premium payments.

8C. Other Billing Options (if payment by credit card or checking account automatic premium payment is not selected)

- **Bimonthly (two-month) Billing** – Applicant submits the premium for two months;
- **Quarterly (three-month) Billing** – Applicant submits the premium for three months.

NOTE: When applicants send a check to us, they authorize Blue Cross to convert the check into an electronic fund transfer. If an applicant is approved for coverage, the bank account will be debited for the amount indicated on the check. If an applicant does not qualify for coverage, the check will not be submitted for a fund transfer. The check will not be returned to the applicant.



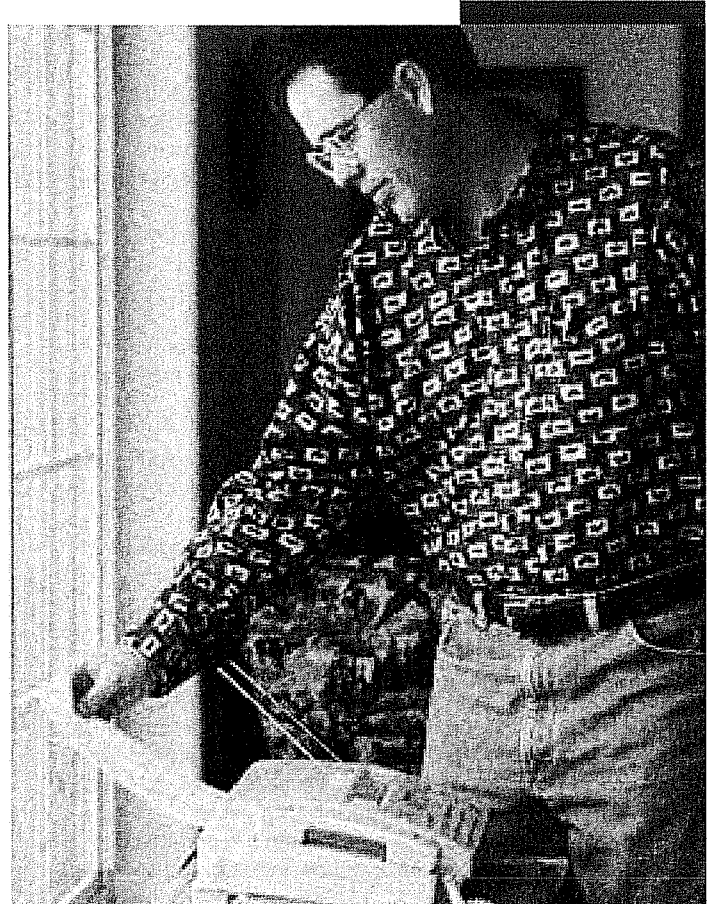
Application Guidelines

Situations That May Cause an Application to Be Returned

1. Applicant pregnant: Children may be enrolled on their own Blue Cross Agreement with the youngest child as the member. A newborn child will be subject to health care underwriting if the child is added to a sibling's agreement. Medical records will be required for newborns.
2. Signature missing for any applicant and/or dependent 18 years of age or over.
3. Date on application either missing, post-dated or over 30 days old.
4. Dues payment insufficient or missing; check is undated or over six months old.
5. Application completed in pencil.
6. Outdated application form.
7. Incomplete applications (sections not completed).

Common Errors/Omissions That Delay Processing of Applications

1. Broker certification not completed.
2. Dependent over the age of 18 did not sign/date application.
3. Spouse/domestic partner or dependent's Social Security or ID number omitted.
4. Responses changed without explanation or initials.
5. Health history questions missing or incomplete.
6. Current insurance/health care carrier information not answered, or name of current carrier missing.
7. Missing height, weight, age and/or birthday.
8. One check with multiple applications.
9. Agent number missing.
10. HMO selected but PMG/IPA not selected.
11. Incomplete address – missing ZIP code or P.O. Box listed, which is unacceptable as a residence address.
12. Agent signature missing.



Application Guidelines

Payment Options

Blue Cross offers a range of premium payment options for your clients' convenience.

Monthly Checking Account Automatic Premium Payment

– This option saves your clients postage, paperwork and gives them one less thing to worry about by having their premium paid automatically each month from their personal checking account. To select this option, new applicants should complete section 8A of the Individual Enrollment Application (form # IU2138). Existing members should complete and submit the Monthly Checking Account Automatic Premium Payment Authorization (form # IS7134). The applicant or member must also attach a blank, voided check.

Credit Card – This option is available to new applicants who wish to pay initial or monthly health care coverage or dental premiums with a VISA, MasterCard or Discover personal credit card. This option is not available to members making a change of coverage. Applicants should complete section 8B of the Individual Enrollment Application (form # IU2138).

Personal Check – New applicants may submit their first premium payment by personal check. Both applicants and existing members may pay their premium by personal check according to two billing options:

1. Bimonthly (every two-months)
2. Quarterly (every three-months)

Applicants should select one of the two options above in section 8C of the Individual Enrollment Application (form # IU2138).

Electronic Check Conversion

Blue Cross has joined other national institutions that have streamlined payment and servicing by moving from paper checks to electronic payments. If your client writes a paper check for initial or ongoing premium payment, Blue Cross will convert the check into an electronic payment, store a copy of the check and destroy the original paper check.*

The payment will appear on your client's bank account or credit union statement. The transaction will be listed as an Electronic Funds Transfer (EFT) and categorized under ATM withdrawals, as a direct or electronic payment, or under check listing.

Please note that Blue Cross will not transmit an EFT and no money will be debited from your client's account until the application for coverage has been approved.

***NOTE:** Not all checks qualify to be converted to Electronic Funds Transfer.



Application Guidelines

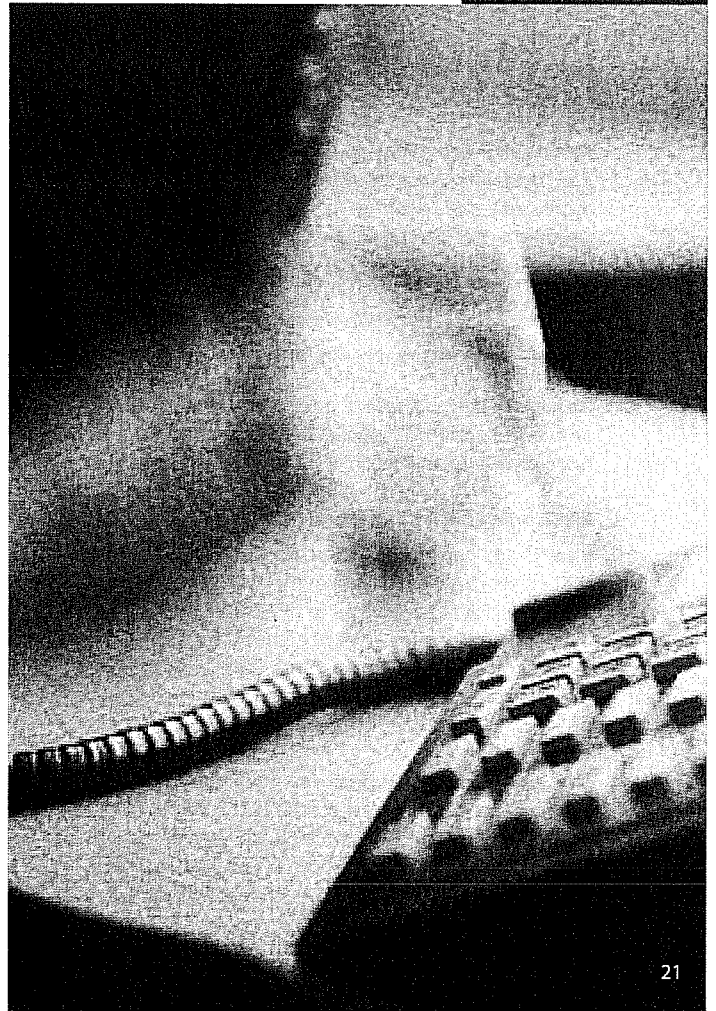
Application Submission Options

Blue Cross accepts application submission through any of the following methods:

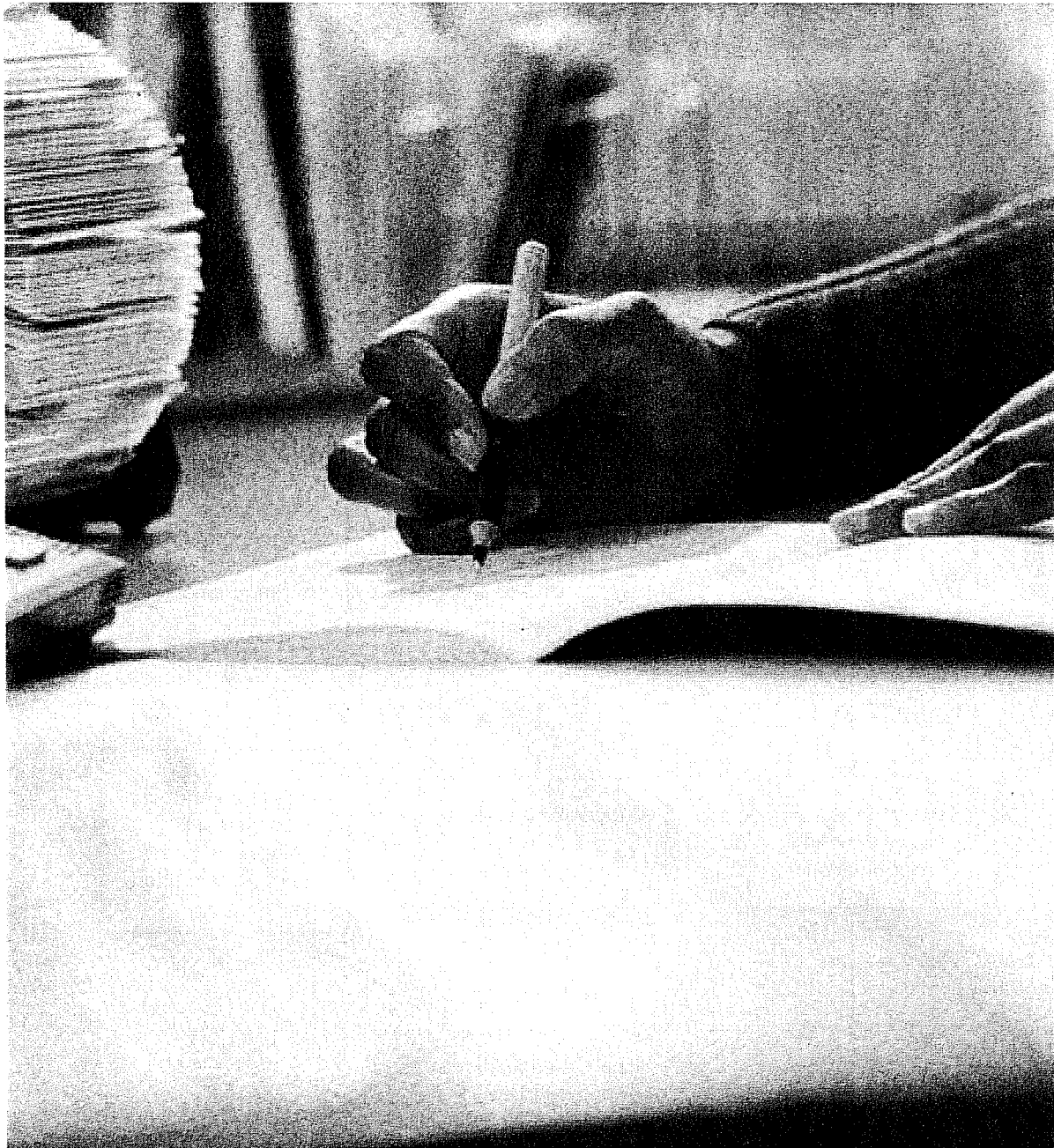
Online – Applications may be completed and submitted 24 hours a day, 7 days a week online at www.bluecrossca.com. Submission is instantaneous, providing the applicant with the fastest and most efficient method. To benefit from the expedited online submission process, the applicant should choose either the monthly checking account automatic premium payment or credit card option.

Fax – Completed applications may also be faxed to 805-480-8840 or 800-327-9255. To benefit from the expedited fax submission process, the applicant should choose either the monthly checking account automatic premium payment or credit card option.

Mail – Completed applications may be mailed to Blue Cross of California, P.O. Box 9041, Oxnard, CA 93031-9041. Applicants should ensure that one of the three payment options, monthly checking account automatic premium payment, credit card or billing is indicated on their application. If an applicant chooses to be billed, at least one month's premium in the form of a personal check must accompany the application.



The Application and Underwriting Process



The Application and Underwriting Process

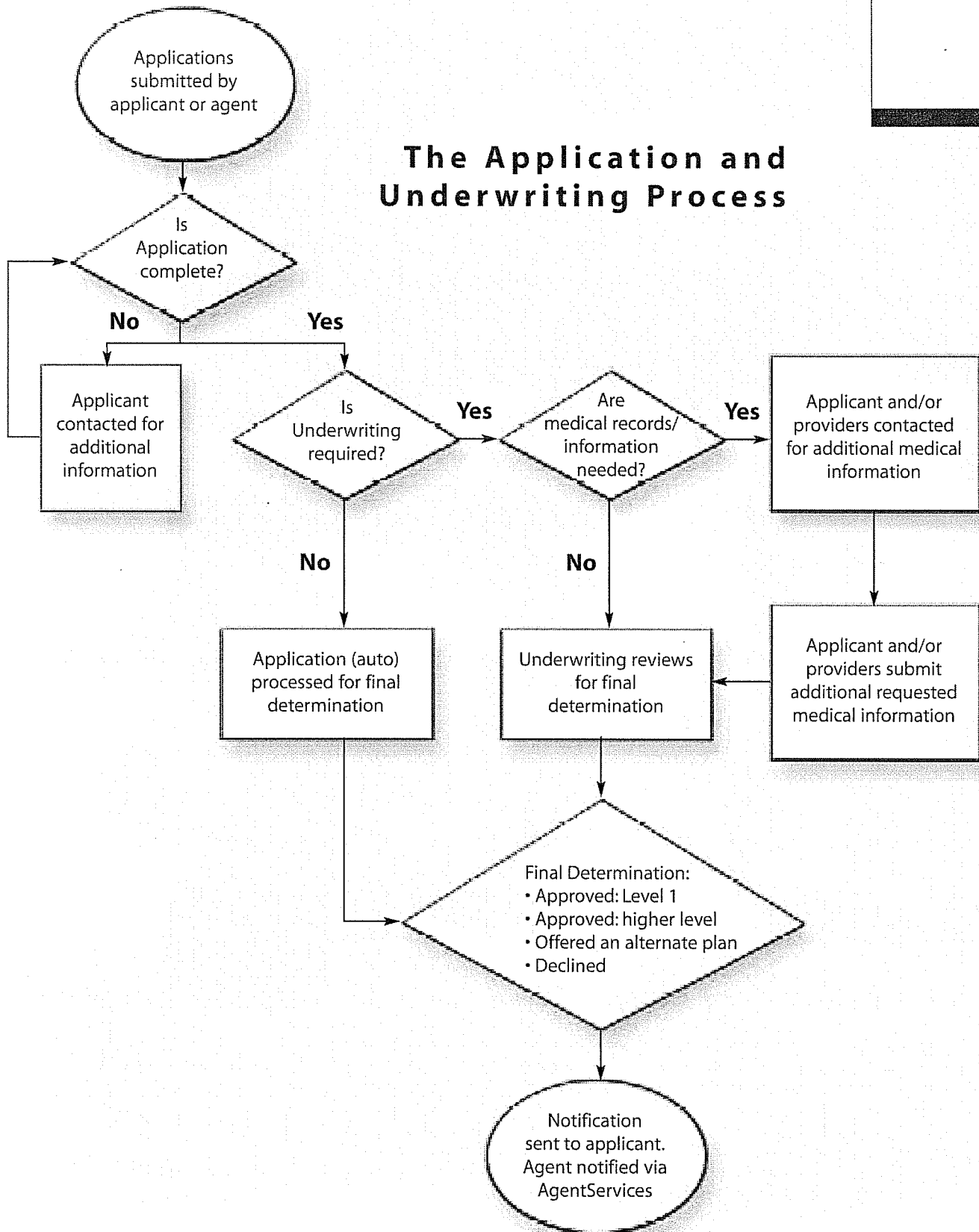
After you or your client have submitted an application, you may track the status of that application online (see information this page). A completed application with all necessary information allows us to reach a final determination within a quick turnaround time. In most cases, a final determination can be made within seven days. If additional information is needed from either the applicant or physicians to render a determination, processing time will be longer and will vary, depending on the length of time it takes to receive the requested information. The flowchart on the next page illustrates the application process.

Tracking Applications

Check application status online.

- Go to www.bluecrossca.com
- Click on Agents/Brokers
- Log on
- Click AgentServices
- Click Applicants

The Application and Underwriting Process



Health Care Underwriting Guidelines

Insurability

As discussed on page 8, Blue Cross believes that the cost of covering the expenses of someone with minimal health care needs should not be unfairly offset by someone whose health can be predicted to require costly care. Because of potential additional risk associated with certain medical conditions, Blue Cross may offer an applicant coverage at a higher premium level, offer an alternate plan, or decline an applicant for all coverages.

Body Mass Index

The Body Mass Index (BMI) in this manual (see page 26) is used to determine if an applicant is underweight or overweight. The BMI is the measurement of an individual's weight against height. By comparing the results against a set of reference values, one can determine if someone is underweight or overweight. This determination may result in a greater level of premium or a declination.

Applicants who have a BMI of 30 or greater may be offered an increased level of coverage (Level 1 +20 (HMO), 1 +25, 1 +50) or be declined. Overweight individuals who also have conditions such as diabetes, asthma, cardiac or eating disorders present an additional risk and will be underwritten accordingly.

Smoking

Studies show that individuals who smoke are at a greater risk for certain health conditions than non-smokers. Therefore, the smoking history of the applicant will be taken into consideration when underwriting certain medical conditions.

Prescription Medications

Sometimes the cost of certain medication(s) exceeds the cost of a member's monthly premium. When Blue Cross reviews an Individual Enrollment Application, we review the applicant's medications along with his/her medical history. Based on these factors, we may offer the applicant enrollment at a higher level of coverage than originally requested, offer an alternate plan, or decline coverage.

When determining risk for prescription medication(s), the following is taken into consideration:

1. Anticipated cost of the prescription medication(s) per month
2. Brand name or generic name medication
3. Plan applied for
4. Drug benefit of plan applied for

The following medications will not be used to determine the level of coverage:

- Non-sedating antihistamines (e.g., Claritin, Allegra, Zyrtec)
- Birth control pills
- Thyroid hormone replacements
- Female hormone replacements
- Short-term (up to 21 days supply) antibiotics

Applicants who are not eligible for a plan with a comprehensive pharmacy benefit, depending on their medical history, **may be** eligible for a plan without a pharmacy benefit or a plan with a "generic only" pharmacy benefit, such as:

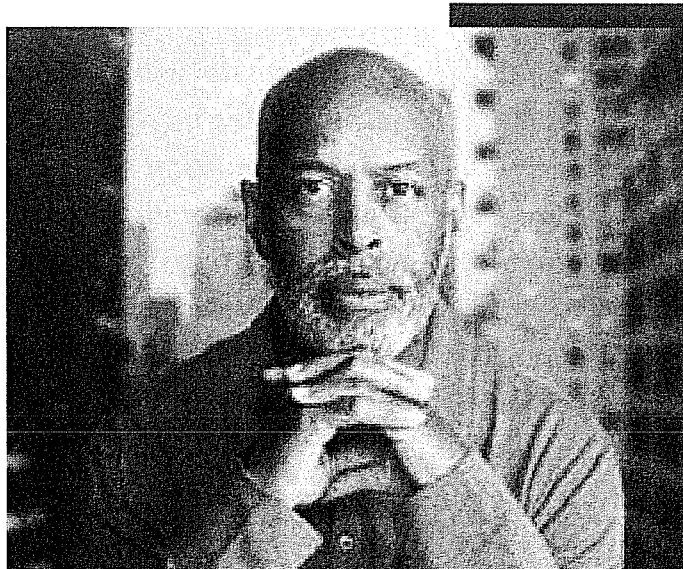
- Basic Plans* (R418/7900/R419)
- RightPlan PPO 40 with No Rx Coverage* (P958)
- RightPlan PPO 40 with Generic Only Rx Coverage* (PE48)

The following commonly prescribed medications are **EXAMPLES** of medications that when taken currently or within a specified timeframe **will result in a declination**.

- INH
- Clomid
- Femara
- Coumadin

NOTE: The medications above are an abbreviated list of examples and are not intended to represent an all-inclusive list.

*These plans are offered by BC Life & Health Insurance Company.



Health Care Underwriting Guidelines

Full Disclosure of Medical History

The application must be filled out accurately and completely. For Medical History, we will need the diagnosis, the date of onset, the date treatment ended, and all treatments rendered for each condition listed in order to underwrite accurately and make proper product placement decisions. Diagnostic work-ups must be completed prior to underwriting.

Blue Cross reserves the right to make decisions on some product placement and premium levels based on the applicant's medical history and our underwriting guidelines.



The Underwriting department will review an applicant's complete medical profile, including pharmacy use. Final determination of an applicant's coverage level or insurability can only be determined after a thorough evaluation by our Underwriting Department. Applicants who are declined coverage may apply for the California Major Risk Medical Insurance Program (MRMIP). (See MRMIP information on page 8.)

Health Care Underwriting Guidelines

BMI Reference Chart Male and Female Ages 18 – 64

Height	Level 1												Level 1 +25			Level 1 +50						Decline	
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39 >		
4'10" (58")	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186		
4'11" (59")	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193		
5'0" (60")	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199		
5'1" (61")	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206		
5'2" (62")	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	188	191	196	202	207	213		
5'3" (63")	107	113	118	124	130	135	141	146	152	158	163	169	175	180	185	191	197	203	208	214	220		
5'4" (64")	110	116	122	128	134	140	145	151	157	163	169	174	180	187	192	197	204	209	215	221	227		
5'5" (65")	114	120	128	132	138	144	150	158	162	168	174	180	188	192	198	204	210	216	222	228	234		
5'6" (66")	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241		
5'7" (67")	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249		
5'8" (68")	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256		
5'9" (69")	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263		
5'10" (70")	132	139	146	153	160	167	174	181	188	196	202	209	216	222	229	236	243	250	257	264	271		
5'11" (71")	136	143	150	157	165	172	179	186	193	200	208	215	222	229	235	243	250	257	265	272	279		
6'0" (72")	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287		
6'1" (73")	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295		
6'2" (74")	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303		
6'3" (75")	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311		
6'4" (76")	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	298	304	312	320		

National Heart, Lung and Blood Institute BMI Table

Pounds Have been rounded off .758

BMI based on height and weight listed on the application	APS	RATING TIER
BMI less than 19	Yes	Underwrite cause
BMI 19- 29.9	No	Level 1
BMI 30-32.9	No	Level 1 + 25
BMI 33-38.9 (non smoking)	Yes	Level 1 + 50
BMI 33-38.9 (smoking)	Yes	Level 1 + 75
BMI 39 or greater	No	Decline

Health Care Underwriting Guidelines

Using the Underwriting Guidelines

The guidelines presented in this section are only a brief overview of the Blue Cross of California Companies' underwriting practices. They are in no way definitive and are subject to change at any time without prior notice. These guidelines are intended to give you, the Blue Cross of California authorized agent, a general overview of our underwriting policies and to help you determine if Attending Physician Statements (APS) or medical records are required. Below are a few examples of how you might use the information in this section.

Scenario 1

A 42-year-old self-employed married man with two children is seeking health care coverage for his entire family. After the applicant determines the plan or plans for which the family will apply and completes an application, you review the application for completeness. While all other family members report no conditions, you notice that the applicant has been diagnosed with hypercholesterolemia (high cholesterol) and has been taking medication for two years. You check the Common Conditions list on the pages that follow and note that hypercholesterolemia requires full medical records. You ask the applicant to provide copies of his medical records, ensuring he has also disclosed exact medications he has taken. You then submit all information to Blue Cross, along with an Authorization for Use of Protected Health Information form (form # 9608), and wait for a final determination of coverage level offered or insurability.

Scenario 2

A 30-year-old divorced, single mother of two is seeking health care coverage for herself and one child. After the applicant determines the plan or plans for which she will apply and completes an application, you review the application for completeness. You notice that the child has a history of chronic bronchitis and the mother has had one instance of cervical dysplasia. You check the Common Conditions list on the pages that follow and note that chronic bronchitis requires full medical records. The instance of cervical dysplasia, however, occurred more than four years prior with no apparent recurring instances. You ask the applicant to provide copies of full medical records for the child and inform her that additional records may be required for her. You then submit all information to Blue Cross, along with an Authorization for Use of Protected Health Information form (form # 9608), and wait for a final determination of coverage level offered, insurability or if more medical records are required.



Health Care Underwriting Guidelines

Common Conditions

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
A					
Abnormal Pap smear	(see Cervical Dysplasia)				
Abnormal uterine bleeding	(see Female Disorders)				
Acne	Most cases treated within past 6 months	As needed		X	X
	Accutane use within 12 months				Decline
Alcohol Abuse (history of)	All cases, after 5 years	Always		X	X
Allergies (hay fever, rhinitis)	Most cases	As needed	X	X	
	Requires long term steroid use				X
Aneurysm	Operated, after 2 years	Always		X	X
Angina	(See Coronary Artery Disease)				
Anorexia Nervosa/Bulimia	All cases, after 8 years	Always		X	X
Apnea	Newborn apnea- resolved over 3 months ago	As needed	X	X	
	Sleep apnea- no treatment in 6 months (no CPAP)		X	X	
	CPAP, BMI greater than 30				Decline
Arthritis					
Osteoarthritis	Mild cases	As needed	X	X	
Psoriatic Arthritis	All cases				Decline
Rheumatoid Arthritis	All cases				Decline
Rheumatoid, Juvenile	All cases				Decline
Asthma	All cases depending on weight, medications and severity	As needed		X	X
	Hospital admit in 2 years, smoking within 6 months, BMI 29>				Decline
Atrial Fibrillation or flutter	(see Heart Conditions - Arrhythmias)				
Atrial Septal Defect (ASD)	No surgery, resolved by age 2 years	Always	X		
	Operated, after 2 years			X	X
Attention Deficit Hyperactive Disorder (ADHD, ADD)	All cases if treated within past 2 years	As needed		X	X
Autism	All cases, depending on severity and treatment	Always		X	X

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
B					
Back Pain					
Muscular	No treatment in past year	As needed	X		
	Treatment within past year			X	X
Disc Disease	Non operated or operated more than 3 months ago	As needed		X	X
	Symptoms or treatment within past 3 months				X
Bedwetting (Enuresis)	Testing complete	As needed		X	X
Bladder Infection	Single episode over 2 months ago	As needed	X		
	Single episode within 2 months, if resolved			X	
	Multiple episodes			X	X
Bone Spur (Exostosis)	Operated, after 12 months.	As needed	X	X	
	Most cases, after 3 months			X	
	Surgical candidate				X
Bradycardia	Normal EKG, after 6 months	Always	X		
Breast Disorder	Single benign excision, over 12 months	As needed (current mammogram)	X	X	
	Multiple episodes			X	X
Breast Implants	All cases after 6 months, no complications	As needed		X	
Breast Reduction	Surgery, after 6 months, no complications	As needed	X		
Bronchitis (Chronic)	All cases	As needed (records & pulmonary function test)		X	X
Bulimia	(See Anorexia)				
Bundle Branch Block (right)	No smoking, no symptoms for 12 months		X		
Bunions	Operated, after 6 months	As needed	X		
	Not operated, no symptoms after 6 months OR operated, after 3 months			X	
Burns	2nd-3rd degree, after 3 months	As needed		X	X
Bursitis	Most cases, after 6 months	As needed	X	X	

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
C					
Cancers	<i>Original Pathology report, complete records & other specific information (depending on the type of cancer) will usually be required,</i>				
Basal Cell	After 3 months depending on the pathology report	As needed		X	X
Other skin cancers	After 12 months depending on the pathology report	As needed		X	X
Breast cancer	Stage 1, after 2 years	Always		X	X
	Stage 2, after 10 years			X	X
	Node positive, after 15 years			X	X
Cervix	Stage 1, after 12 months, and a normal Pap	Always		X	X
	Other stages after 10 years			X	X
Eye (Retinoblastosis)	Depending on staging, after 10 years	Always		X	X
Hodgkin's/Lymphoma	Stage 1 or 2 after 10 years	Always		X	X
Non-Hodgkin's Lymphoma	After 10 years	Always		X	X
Internal cancers	After 10 years in most cases	Always		X	X
Leukemia	After 10 years	Always		X	X
Lung, bronchi	After 10 years	Always		X	X
Melanoma	Depending on staging and after 2 years	Always		X	X
Multiple Myeloma	After 10 years	Always		X	X
Prostate	Depending on staging & after 5 years	Always		X	X
Testicular	Operated, after 5 years	Always		X	X
Carotid Artery Disease	In all cases				Decline
Carpal Tunnel Syndrome	Operated, after 6 months	As needed	X		
	Operated within past 6 months			X	
	Not operated, splint only, stable 6 months			X	
Cataract	Operated, after 1 year	As needed	X		
	Operated, after 3 months			X	
	Not Operated				Decline
C-Section		None	X		
Cerebral Palsy	Under age 10 years				Decline
	Mild case not requiring treatment	Always		X	

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Cervical Dysplasia	Most cases when followed by 2 consecutive normal Paps (6 months apart)	As needed	X	X	
	Abnormal Pap				X
Chronic Fatigue Syndrome	Dependent on type and frequency of treatment	As needed		X	X
COPD (Chronic Obstructive Pulmonary Disease)	All cases				Decline
Cirrhosis of the Liver	All cases				Decline
Cleft Palate	Operated, treatment complete, after 2 years	As needed	X		
	Operated, after 1 year, or speech therapy required			X	X
Coarctation of aorta	Surgery, after 2 years	Always	X		X
Coccidioidomycosis	(see Valley Fever)				
Concussion	No loss of consciousness, recovered after 30 days	As needed	X	X	
Congestive Heart Failure (CHF)	All cases				Decline
Convulsive Disorder	(see Epilepsy)				
Condyloma	(see Genital Warts)				
Corneal Ulcer	After 12 months	As needed	X		
Coronary Artery Disease	All cases	Always		X	X
	Operated within 1 year, stent				Decline
Cosmetic Surgery					
Breast Implants	(see Breast Implants)				
Face Lift, Tummy Tuck	Operated and no complications after 60 days	As needed	X	X	
Craniosynostosis	Treatment completed, after 6 months & no complications	As needed	X	X	
Crohn's Disease	Most cases after 5 years	Always		X	X
Cystitis	(see Bladder Infection)				
Cystocele	Operated,after 3 months	As needed	X	X	
	Not operated - all cases			X	X
D					
Deafness	Work up complete, hearing aid	As needed	X		
	Surgical candidate, cochlear implant				Decline
Depression	(see Mental/Emotional Disorders)				

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Dermatitis	Single episode, after 3 months	As needed	x		
	Most other cases			x	
Detached Retina	Single surgery, after 1 year	As needed	x		
	2 episodes, after 1 year			x	x
	Multiple episodes; within 1 year				Decline
Deviated Septum	Not operated, after 6 months	As needed	x	x	
	Operated, after 3 months		x	x	
Diabetes	Requires records, current physical exam and blood tests				
Mellitus	Insulin dependant				Decline
	Non-insulin dependant, controlled, BMI 27 or less	Always requires records & current PE & blood studies		x	x
Gestational	Normal blood sugar		x		
Inspidus	Diagnosed more than 1 year ago			x	x
Disc Disease	(see Back Pain)				
Diverticulitis	Controlled by diet 3 years		x	x	
	Surgery after 3 years			x	
	All others				x
Down's Syndrome	Under age 3 years				Decline
	Over age 3, no treatment or other complications	Always	x		
Drug Abuse/Addiction (history of)					
Illegal	after 10 years	Always		x	
	IV drug use - all cases				x
Prescription	after 5 years	Always		x	
Marijuana only	No use in 2 years	Always	x		
Dupuytren's Contracture	Operated, after 6 months	As needed	x	x	
	Not operated			x	x
E					
Ear Infections (Otitis Media)	Infrequent episodes, without tubes	As needed	x	x	
	Frequent episodes, tubes			x	x
	Chronic				x
Eczema	(see Dermatitis)				
Endometriosis	(see Female Disorders)				
Enuresis	(see Bedwetting)				

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Epilepsy	All cases, no seizures in 12 months	As needed		X	X
Epstein Barr Syndrome	(see Chronic Fatigue Syndrome)				
Exostosis (bone spur)	(see Bone Spur)				
F					
Female Disorders					
Dysfunctional uterine bleeding (DUB)	Depending on underlying cause	As needed		X	X
Endometriosis	After menopause, or if ovaries removed, after 3 months	As needed	X	X	
	Before menopause- 3 months after successful treatment			X	X
Fibroids (Uterine)	Operated, after 3 months	As needed	X	X	
	Not-operated, depending on size, stability and symptoms			X	X
Ovarian Cyst	Operated, after 3 months	As needed	X		
	Not operated, resolved, after 3 months		X	X	
Salpingitis, PID (Pelvic Inflammatory Disease)	All cases	As needed		X	X
Fractures	Cast only - after 30 days		X		
	Operated- after 6 months, with or without permanent hardware	As needed		X	X
G					
Gallbladder (stones)	Operated, after 3 months & no complications	As needed	X		
	Not operated, after 1 year			X	X
Ganglion cyst	Operated, after 6 months	As needed	X		
	Not operated			X	
Gastric Ulcer	Operated, after 12 months	As needed	X	X	
	Not operated, after 12 months			X	X
Gender Reassignment	All cases - once all treatment completed	Always		X	X
Genital Warts	Single STD, after 5 years	As needed	X		
	No other STD, after 2 normals Paps (6 months apart)			X	X

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
GERD (Gastroesophageal Reflux Disease)	Work up complete, no treatment within 12 months	As needed	X		
	Most cases treated within past 6 months, BMI less than 33			X	
Gilbert's Disease	Over age 18 years, normal liver function blood tests	As needed	X		
Glaucoma	Most cases if controlled	Always		X	
	Uncontrolled, or surgical candidate				X
Glomerulonephritis, Nephritis	Acute, after 12 months	As needed	X		
	Chronic				X
Goiter	Surgery completed, controlled for 6 months	As needed		X	X
Gonorrhea	Single STD & after 1 year	As needed	X		
	1 other STD in 5 years			X	X
Gout	After 12 months, no hospital admission	As needed	X		
	Requires treatment including prophylactic			X	X
Guillain-Barre Syndrome	Mild case, recovered, after 12 months	Always	X		
	All other cases			X	X
Gynecomastia	Not operated, resolved	As needed	X		
	Operated, after 1 year		X	X	
H					
Hammer Toe	Operated, no hardware, after 6 months	As needed	X		
	All other cases			X	X
Hashimoto's Disease	All cases	As needed		X	X
	Stable less than 3 months				X
Headaches	(see Migraines)				
Hearing Loss	(see Deafness)				

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Heart Conditions	<i>Will require complete medical records & current cardiac exam & specific blood tests/echocardiogram</i>				
Angina	After 2 years, depending on the cardiac risk factors	Always		X	X
Arrhythmias	Depending on type, treatment, after 6 months	Always	X	X	
By pass surgery (cardiac)/ Angioplasty	After 2 years, depending on other risk factors, no stent	Always		X	X
Heart Attack (myocardial infarction)	After 2 years, BMI less than 28, depending on cardiac risk factors	Always		X	X
Heart Murmur	Depending on type, severity and treatment	Always		X	X
Mitral Valve Prolapse (MVP)	Best cases	Always	X		
	All others			X	X
Pacemaker	All cases				Decline
Valve Replacement	All cases				Decline
Hemorrhoids	Operated or no symptoms	As needed	X	X	
	Not operated, or severe			X	X
Hepatitis					
Any type	Current, chronic or persistent				Decline
Hepatitis A	After 3 months	Always	X	X	
Hepatitis B	Resolved, after 2 years			X	X
Other Hepatitis (C,D,E)					Decline
Hernia					
Femoral, umbilical, inguinal	Operated, after 3 months	As needed	X	X	
Hiatal	No treatment required	As needed	X		
	Treated less than 1 year ago			X	X
Herpes					
Genital	Within past 5 years	As needed		X	X
Zoster (Shingles)	1-2 episodes, after 6 months			X	X
Hodgkin's Disease	(see Cancer)				
Hydrocele	Operated, after 60 days	As needed	X		
	Not operated			X	X
Hypercholesterolemia (High Cholesterol)	Most cases controlled without medication	Always	X		
	Control with medication, BMI less than 34, no other risk factors			X	

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Hypertension (High Blood Pressure)	Controlled (140/90) without medication, BMI less than 26, no other risk factors	Always	X		
	Controlled 140/90 for 6 months, depending on other risk factors			X	X
	Uncontrolled (over 140/90), BMI greater 30				Decline
Hyperthyroidism	Most cases, after stable 3 months	As needed	X	X	
Hypothyroidism	Most cases	As needed	X	X	
I					
Impotence	Depending on cause and treatment			X	X
Infertility	Treated or evaluated within 5 years				X
	No evaluation or treatment in 5 years	As needed	X		
Irritable Bowel Syndrome (IBS)	Depending on episode frequency and treatment	As needed	X	X	X
Interstitial Cystitis	All cases	As needed		X	X
Ischemic Attack, Transient (TIA)	(see Stroke)				
J					
Jaw Disorders	All cases no symptoms or treatment in 2 years	As needed	X		
	Most cases, after 6 months			X	
	Surgical candidate				X
Joint Problems					
Dislocation	Operated, after 6-12 months & depending on retained hardware	As needed	X	X	
	Not-operated, resolved and after 12 months		X	X	
Replacement	After 12 months, depending on continued treatment				X
K					
Keloids	Operated or no surgery anticipated		X		
	Pending surgery				X
Keratosis	No treatment in 12 months	As needed	X		
	Most other cases, no treatment in 3 months			X	

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Kidney Conditions					
Stone (calculus)	Single episode, 12 months after passing stone	As needed	x		
	Most other cases			x	x
	Episode within past 3 months				Decline
Infection (pyelonephritis)	In most cases, single episode, after 6 months	As needed	x	x	
	All other cases			x	x
Single kidney	Depending on cause	Always	x		x
Cyst	Single, no treatment needed	As needed	x		
	Operated, after 3 months			x	
	Multiple cysts				x
Knee Injury	Operated, after 6 months	As needed	x	x	
	Not operated, after 2 years		x	x	
L					
Lactose Intolerance	Most cases, work up complete, treated with over the counter medication	As needed	x		
Leukemia	(see Cancers)				
Liver Disease					
Enlarged	All cases				Decline
Cirrhosis	All cases				Decline
Fatty Liver	All cases				x
Hepatitis	(see Hepatitis)				
Lupus					
Discoid	Normal blood studies, no joint involvement	Always		x	x
Systemic	all cases				Decline
Lyme Disease	Resolved 5 years ago	As needed	x		
	No symptoms for 18 months, normal physical exam (current)			x	
Lymphoma	(see Cancers)				
M					
Macular Degeneration	"Dry" type	As needed	x		
	"Wet" type				Decline
Medullary Sponge Kidney					Decline
Melanoma	(see Cancers)				
Meniere's Disease	All cases (no symptoms 3 months)	As needed		x	x

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Mental/Emotional Disorders					
Anxiety- Situational (divorce, death, sudden illness, etc.)	Treatment within 12 months depending on medication	As needed		X	X
Depression, mild, non psychotic	Treatment within 2 years, depending on stability	As needed		X	X
Depression - major; Bipolar, Manic disorders;	Stable for 5 years, depending on treatment	Always		X	X
Generalized Anxiety Disorder; Obsessive Compulsive Disorder; Panic Disorder	All cases	Always		X	X
Schizophrenia	Stable for 5 years, depending on treatment	Always		X	X
Suicide Attempt	Within past 5 years	Always			X
Migraines	Most cases, no narcotic medications	As needed		X	
Mitral Valve Disorder	(see Heart Conditions)				
Moles (Nevus)	Operated or stable without treatment	As needed	X		
Mononucleosis	Resolved, after 3 months	As needed	X	X	
Morton's Neuroma	Operated, after 6 months or symptomatic 1 year	As needed	X		
	All other cases			X	X
N					
Narcolepsy	All cases	Always		X	X
Nasal Polyp's	(see Polyps)				
Nevus	(see Moles)				
O					
Obesity with prior gastric surgery	All cases; after 2 years BMI stable at less than 27, asymptomatic, no complications, normal physical exam	Always		X	X
Osteoarthritis	(see Arthritis)				
Osteoporosis	All cases	As needed		X	X
Otosclerosis	Operated, normal hearing, after 3 months	As needed	X	X	
Ovarian Cyst	(see Female Disorders)				
P					
Pacemaker	(see Heart Conditions)				
Paget's Disease					X

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Pancreatitis	Single acute episode, after 5 years	Always	X		
	Episode after surgery, recovered 2-3 years		X	X	
	All other cases				X
Paralysis	All cases				Decline
PDA (Patent Ductus Arteriosis)	No surgery, resolved by age 2 years	Always	X		
	Operated, after 2 years			X	X
Pelvic Inflammatory Disease (PID)	(see Female Disorders)				
Pericarditis	Most cases after 2 years	As needed	X	X	
Peptic Ulcer	(see Ulcers)				
Peyronie's Disease	Most cases single episode resolved or operated	As needed	X	X	
Phlebitis	Most cases, after 6 months	As needed	X	X	
Pleurisy	Most cases single episode, after 6 months	As needed	X	X	
Pneumothorax	Most cases, after 12 months	As needed	X	X	
Pneumonia	Most cases, depending on age, severity, treatment, after 3 months	As needed	X	X	
	After 1 year, if recurrent or hospitalized			X	X
Poliomyelitis	acute- within past 5 years				Decline
Post Polio Syndrome	Most cases stable 1 year or more	Always	X	X	
Polyps					
Cervical	Operated, after 3 months	As needed	X	X	
	Not operated, all cases			X	X
Nasal	Operated, after 3 months	As needed	X	X	
	Not-operated, all cases			X	X
Pregnancy/Intent to adopt, process surrogot pregnancy	Currently pregnant, both applicant and spouse declined. Children may be enrolled under a "child only" policy. Male may be eligible for a "RightPlan" product.	None			X

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Prostatic Hypertrophy, Benign (enlarged prostate)	Operated, after 2 months, normal PSA	As needed	X	X	
	Most cases, not-operated, normal PSA, no symptoms or treatment in 6 months		X		
Prostatitis (prostate infection)	Single episode, normal PSA, after 6 months	As needed	X		
	All other cases			X	X
Prosthesis	Applicant must be over age 18 years				
Eye	All cases	Always		X	X
Limb	All cases	Always		X	X
Penile	All cases	Always		X	X
Psoriasis	Most cases	As needed		X	
	Not stable with treatment				X
Pyloric Stenosis	Most cases - adult-operated, after 6 months	As needed	X		
	Most cases child-operated, after 2 years		X		
R					
Raynaud's					
Disease	All cases	Always		X	X
Phenomenon	All cases				Decline
Syndrome	All cases				Decline
Rheumatic Fever	After 2 years no complications	As needed	X		
Ringworm	Most cases		X	X	
Rosacea	All cases	As needed		X	X
Rotator Cuff	Most cases after 6-12 months	As needed	X	X	
S					
Salpingitis	(see Female Disorders)				
Sarcoidosis	Normal physical exam and blood studies, after 3 years	As needed		X	X
Schizophrenic Disorders	(see Mental/Emotional Disorders)				
Scoliosis	(see Spinal Curvature)				
Seizures	(see Epilepsy)				
Shingles	(see Herpes Zoster)				
Sinusitis (Chronic)	Almost all cases, depending on severity	As needed		X	X
Sleep Apnea	(see Apnea)				

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Spinal Curvature (Scoliosis, Lordosis, Kyphosis)	Not operated- depending on degree of curvature, treatment	As needed	X		X
	Operated, after 6 months, no complications			X	
Strabismus	Treatment completed, after 6 months	As needed	X		
	Current treatment			X	X
Stroke (CVA)	After 2 years, depending on severity, no residual effects	Always		X	X
Substance Abuse	(see Alcohol or Drug Abuse)				
T					
Temporal Mandibular Joint Dysfunction (TMJ)	(see Jaw Disorders)				
Tennis Elbow	(see Bursitis)				
Tendonitis	Resolved, & after 6 months	As needed	X	X	
	Chronic			X	X
Tetrology of Fallot					Decline
Thalassemia (Minor)	Minor only & no treatment	None	X		
TIA (Transient Ischemic Attack)	(see Stroke)				
Tonsillitis	Operated, after 30 days	As needed	X		
	Non operated, depending on frequency of episodes		X	X	
	Chronic- after 6 months			X	X
Tuberculosis (TB)	Positive skin test & negative chest x-ray- no INH in 12 months	As needed physical exam, chest x-ray and liver function tests	X		
	Acute pulmonary- after 12 months from end of treatment			X	X
Tourette's Syndrome	Depending on stability	As needed		X	X
Trans-sexualism	(see Gender Reassignment)				
Transplants					
Corneal	Recovered, after 12 months	Always	X		
All others					Decline
U					
Ulcer, Peptic	Operated, after 2 years or not-operated, after 5 years	As needed	X		
	Most cases, no treatment in 12 months			X	
Ulcerative Colitis	Single episode, after 10 years	Always	X	X	
	No symptoms or treatment in 5 years			X	

Health Care Underwriting Guidelines

Health Care Underwriting Guidelines

Common Conditions (continued)

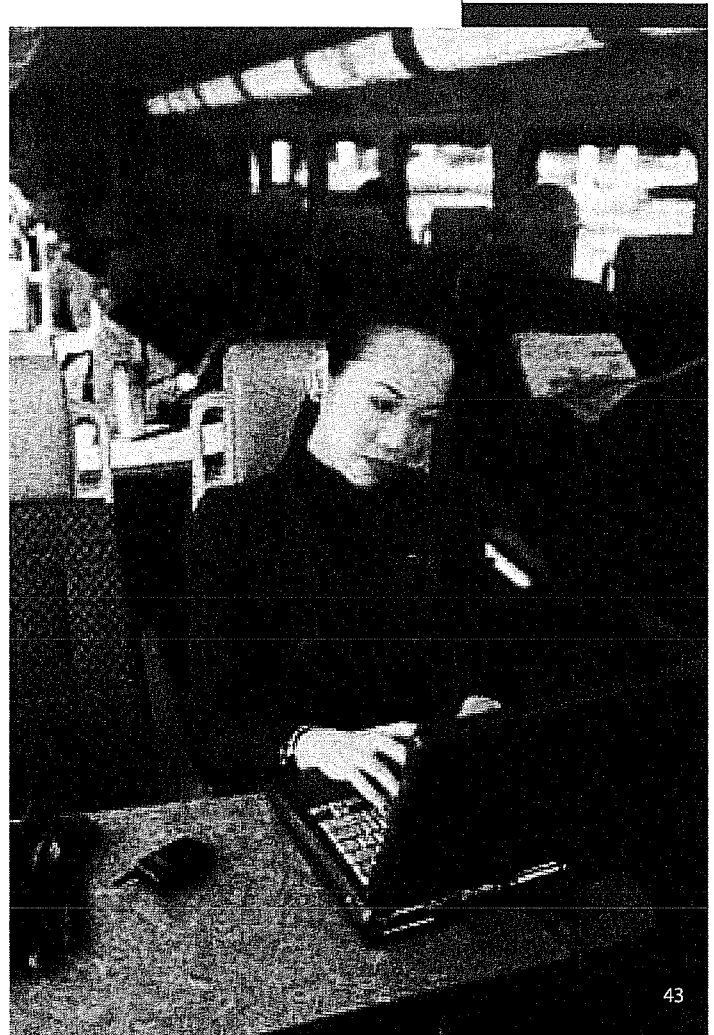
Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Undescended Testicle	Operated, after 6 months	As needed	X		
	Not operated & symptoms within 6 months			X	X
Uterine Fibroids (Tumors)	(see Female Disorders)				
V					
Valley Fever	After 12 months	As needed	X	X	
Valve replacement	All cases				Decline
Varicose Veins	Most cases	As needed	X	X	
	Surgical candidate				Decline
Ventricular Septal Defect (VSD)	Not operated, resolved by age 2 years, normal heart sounds	Always	X		
	Operated, after 2 years			X	X

Health Care Underwriting Guidelines

Situations Causing Automatic Declination

Depending on the plan, multiple conditions may meet the criteria for Level 1, Level 1 +20, Level 1 +25, Level 1 +50, Level 1 +75 or Level 1 +100 placement when considered individually. However, when reviewed in total, the following conditions may result in a decision to decline coverage:

- Based on "Declinable Conditions" list (see page 44)
- BMI of 39 or greater
- Infertility evaluated or treated within the past 5 years (male, female or spouse)
- Insulin dependent diabetic
- Intravenous drug use/abuse history
- Medical records requested incomplete or not current
- Medications use that does not meet the "Drug Underwriting" criteria
- Organ transplant history or awaiting an organ transplant
- Pregnant or in the process of adopting or surrogate pregnancy (applicant or spouse whether or not listed on the application)
 - Male applicant expecting a child within the next ten (10) months, by either natural or artificial means. (The mother may or may not be listed on the application, or he may or may not be legally married to the mother of their child.)
- Prosthesis replacement: Candidate or age 18 years or younger with a removable prosthesis
- Sexually transmitted diseases: 3 or more within the past 5 years
- Shunt or stent, or placement of a shunt required
- Signs, symptoms, and/or abnormal diagnostic test results for which a conclusive diagnosis has not been established
- Surgery candidate
- Suicide attempted within the past 5 years



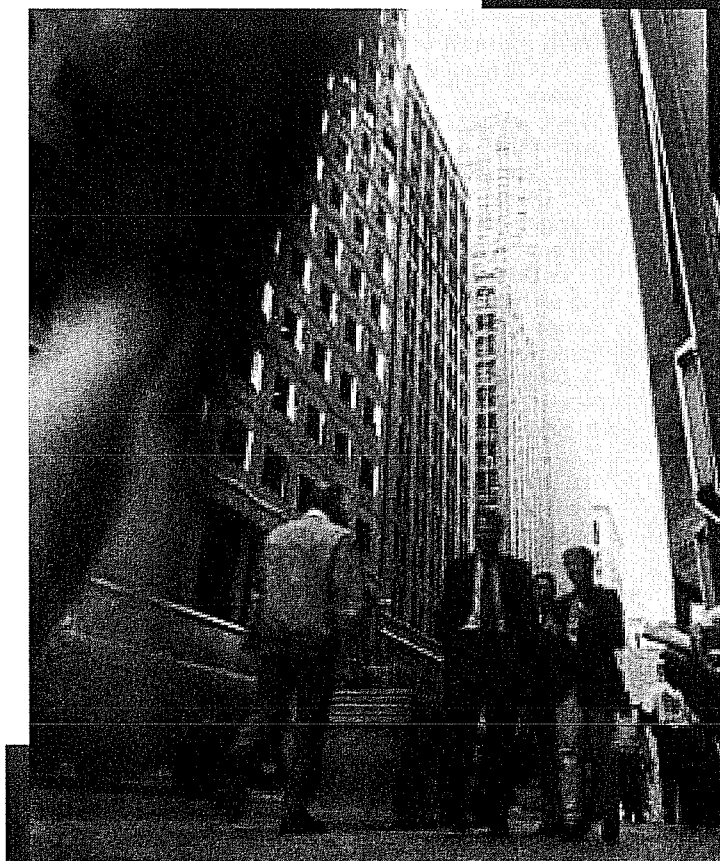
Health Care Underwriting Guidelines

Declinable Conditions

Certain serious conditions, once diagnosed, are considered a high underwriting risk and will result in a declination of coverage. Although every declinable condition is not listed below, here are examples of the more common declinable conditions.

- Achalasia, Cardiospasm
- Acromegaly
- Acquired Immune Deficiency Syndrome
- Acute Poliomyelitis
- Addison's Disease
- AIDS & AIDS Related Complex (ARC)
- Alcoholic Cirrhosis of Liver
- Psychosis
- Alzheimer's Disease
- Amyloidosis
- Amyotrophic Lateral Sclerosis (ALS)
- Anemia, Aplastic
- Cooley's
- Hemolytic
- Mediterranean (Thalassemia Major)
- Sickle Cell
- Ankylosing Spondylitis
- Ankylosis
- Arterial Embolism, Thrombosis
- Arteritis
- Arthritis, Rheumatoid
- Autism, Infantile
- Banti's Disease (Liver Disorder)
- Biliary Cirrhosis
- Blastomycosis
- Brain Damage (Organic)
- Bright's Disease (Glomerulonephritis)
- Bronchiectasis
- Buerger's Disease (Thromboangitis Obliterans)
- Burkett's Tumor (Malignant Lymphoma)
- Cachexia
- Cardiomyopathy
- Cardiospasm, Achalasia
- Cerebral Palsy (Infantile)
- Charcot-Marie Tooth Disease
- (Peroneal Peripheral Neuropathy)
- Chronic Glomerulonephritis
- Chronic Hepatitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Pulmonary Heart Disease
- Cirrhosis, Biliary
- Congestive Heart Failure
- Cooley's Anemia
- Cushing's Syndrome
- Cystic Fibrosis
- Cystic Kidney Disease
- Dermatomyositis
- Dentofacial Function Abnormalities (Crouzon's Disease)
- Disorders of Autonomic Nervous System
- Drug Psychosis

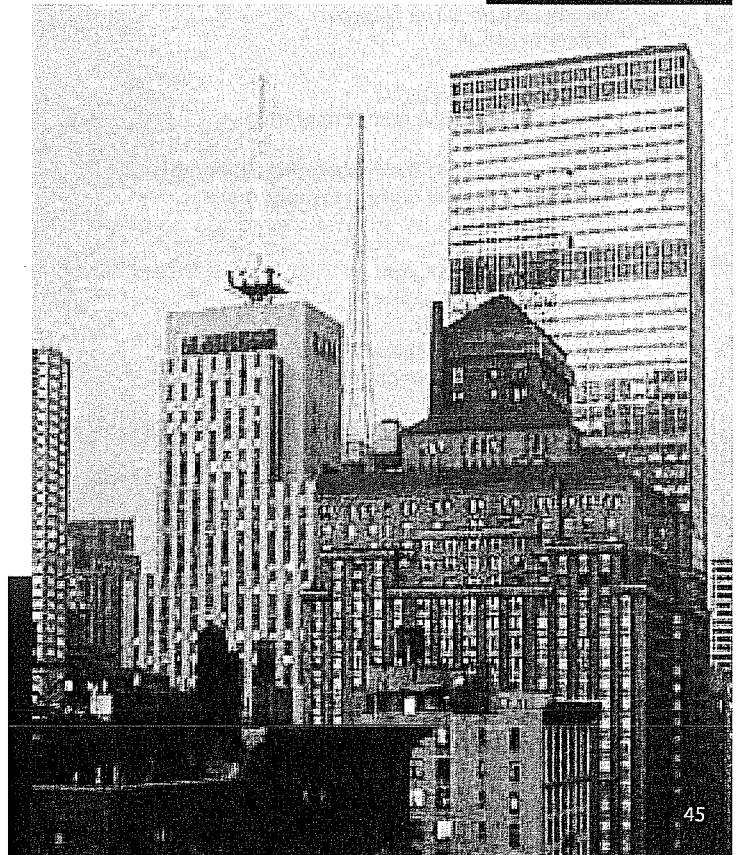
- Emphysema
- Glomerulonephritis, Chronic
- Hemiplegia
- Hemolytic Anemia
- Hemophilia, Von Willebrand's Disease
- Henoch's Purpura
- Hepatitis, Chronic
- Hepatomegaly
- Human T-Cell Leukemia Virus
- Human T-Cell Lymphotropic Virus
- Huntington's Chorea
- Hydrocephalus
- Hypersplenism
- Immunodeficiency Disorder
- Infantile Autism
- Kaposi's Sarcoma
- Klinefelter's Syndrome (Gonadal Dysgenesis)
- Legionella Pneumophilia
- Leukoencephalopathy
- Lipiosis (Neiman-Pick Disease)
- Lupus Erythematosus, Systemic
- Lymphadenitis
- Mediterranean Anemia (Thalassemia Major)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Myelopathy



Health Care Underwriting Guidelines

Declinable Conditions (continued)

Neiman Pick Disease (Lipidosis)
 Neurofibromatosis (Von Recklinghausen's Disease)
 Neuropathy, Inflammatory Toxic (Guillain Barre's Syndrome)
 Occlusion of Cerebral Arteries
 Osteitis Deformans (Paget's Disease)
 Paraplegia
 Paget's Disease (Osteitis Deformans)
 Parkinson's Disease
 Pemphigus
 Peroneal Peripheral Neuropathy
 Pneumoconiosis
 Poliomyelitis, Acute
 Polyarteritis Nodosa
 Polycythemia
 Polymyositis
 Polyneuropathy
 Porphyria
 Postinflammatory Pulmonary Fibrosis
 Psoriatic Arthropathy
 Psychosis Organic Brain Syndrome
 Pulmonary Alveolar Proteinosis
 Pulmonary Heart Disease, Chronic
 Purpura
 Quadriplegia
 Raynaud's, Phenomenon, Syndrome
 Renal Failure, Chronic, Uremic
 Sarcoma, Kaposi's
 Scleroderma
 Senile, Pre-senile Organic Syndromes
 Sickle Cell Anemia
 Silicosis
 Sjogren's Disease
 Spina Bifida
 Spinocerebellar Disease
 Spondylitis
 Syringobulbia, Syringomyelia
 Systemic Lupus Erythematosus
 Tabes Dorsalis
 Tay-Sach's Disease (Cerebral Lipidosis)
 Temporal Arteritis
 Testicular Dysfunction
 Tetralogy of Fallot
 Thalassemia, Anemia Major
 Thromboangitis
 Thrombotic Thrombocytopenia Purpura
 Transient Organic Psychotic Conditions
 Uremia
 Varices, Esophageal
 Von Recklinghausen's Disease (Neurofibromatosis)
 Von Willebrand's Disease (Hemophilia)
 Werlhof's Disease (Purpura, Thrombocytopenia)



Health Care Underwriting Guidelines

Conditions Requiring Medical Records

Following is a partial list of common conditions requiring an underwriting review of medical records. The Underwriting Department will determine the need for a review of medical records on an individual basis (please refer to pages 28-42).

- Alcohol abuse
- Aneurysm
- Anorexia Nervosa/Bulimia
- Atrial Septal Defect (ASD)
- Autism
- BMI of 33 or greater
- Bradycardia
- Cancer
- Cerebral Palsy
- Coarctation of aorta
- Coronary Artery Disease
- Crohn's Disease
- Diabetes (non-insulin dependent)
- Down's Syndrome
- Drug abuse
- Gender reassignment
- Glaucoma
- Guillain-Barre Syndrome
- Heart conditions
- Hepatitis (A & B)
- Hypercholesterolemia (high cholesterol)
- Hypertension (high blood pressure)
- Kidney conditions (single kidney)
- Lupus (Discoïd)
- Mental/Emotional Disorders
- Narcolepsy
- Obesity with prior surgery
- Pancreatitis
- PDA (patent ductus arteriosus)
- Post Polio Syndrome
- Prosthesis
- Raynaud's Disease/Syndrome
- Stroke (CVA)
- Ulcerative Colitis within past 5 years
- Ventricular Septal Defect (VSD)

Medical Record Authorization

A signed Authorization for Use of Protected Health Information (form # 9608) must accompany any request for medical records. If the authorization is not received within 10 days of request, the application will be withdrawn.

The authorization form is found on the Blue Cross Agent Web site, and may accompany your client's application.



Legal Requirements

Applicant/Client Responsibility

Blue Cross requires all applicants age 18 and over to personally read, complete and assume accountability for the Application Understandings, Conditions and Agreement by signing and dating the application. All applications should be completed by the applicant. Typed applications and/or applications printed from the Web site and submitted by mail must be completed and signed in blue or black ink by the applicant. E-signatures are acceptable for applications submitted online.

An enrollee has 10 days from the date of receipt to examine the Application Understandings, Conditions and Agreement, in which he/she can decide to cancel for a full refund of premium paid.

For underage applicants and dependents not residing with the member or payer, the health history must be signed and completed personally by the custodial parent or guardian. The member is held accountable for the accuracy of all health information, including omitted information regarding alcohol/drug use.

Agent Responsibility

We expect you to take these responsibilities seriously, and doing so can help protect you. If Blue Cross initiates a retroactive action due to omitted health information, you will want to be sure the member cannot claim that the omission was your fault. You must also advise the applicant to provide complete information and to omit absolutely nothing, even if it does not seem important to you or the applicant.

Translations for Non-English Speaking Applicants

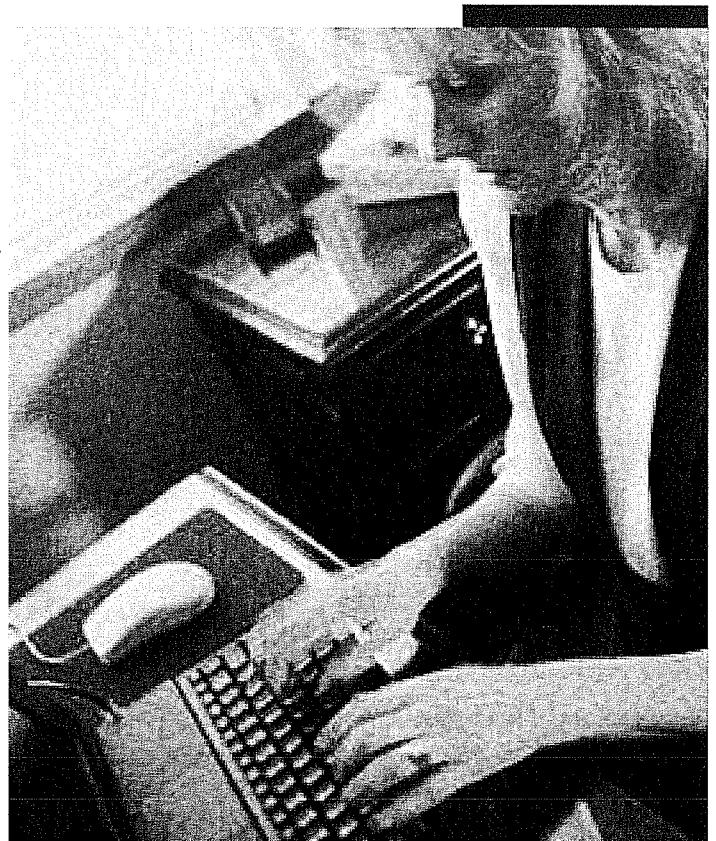
A qualified translator must translate questions, log the answers and submit a Statement of Accountability (Part C of the Exceptions to Standard Enrollment form or the Statement of Accountability section of the Individual Enrollment Application). Make sure the translator's daytime phone number is correct, as follow-up questions may be necessary. Individual Enrollment Applications are now available in Spanish (form #3963), Chinese (form #3964) and Korean (form #6262) translations.

Rescission

Blue Cross has 24 months to initiate retroactive action due to false or omitted health history information on the application. Claims submitted during that period are audited to ensure that preexisting conditions not listed on the application were not diagnosed, evaluated or treated prior to enrollment.

If a preexisting condition that should have been disclosed is discovered, the contract may be retroactively canceled, or it may be re-underwritten and placed into coverage that would have been offered based upon complete original information.

Your commission is adversely affected by any retroactive cancellations. If a contract is partially affected by retroactive cancellation (two-party to single), your commissions will be affected accordingly.



Legal Requirements

Important Information About Medicare

The Blue Cross Individual policy does not duplicate benefits paid by Medicare. If your client has Medicare, the Medicare coverage will not affect the services covered under your client's Blue Cross Individual coverage except as follows:

1. Your client's Medicare coverage will be applied first (primary) to any services covered by both Medicare and your client's Blue Cross coverage.
2. If your client received a service that is covered both by Medicare and Blue Cross, Blue Cross coverage will apply only to the Medicare deductibles, coinsurance and other charges for covered services that your client must pay over and above what is payable by your client's Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits that Blue Cross will provide for that claim will not be more than the allowed covered expense your client has incurred for the covered services your client received.

Blue Cross will apply any expenses paid by Medicare for services covered under your client's Individual Blue Cross plan towards your client's deductible (when applicable).

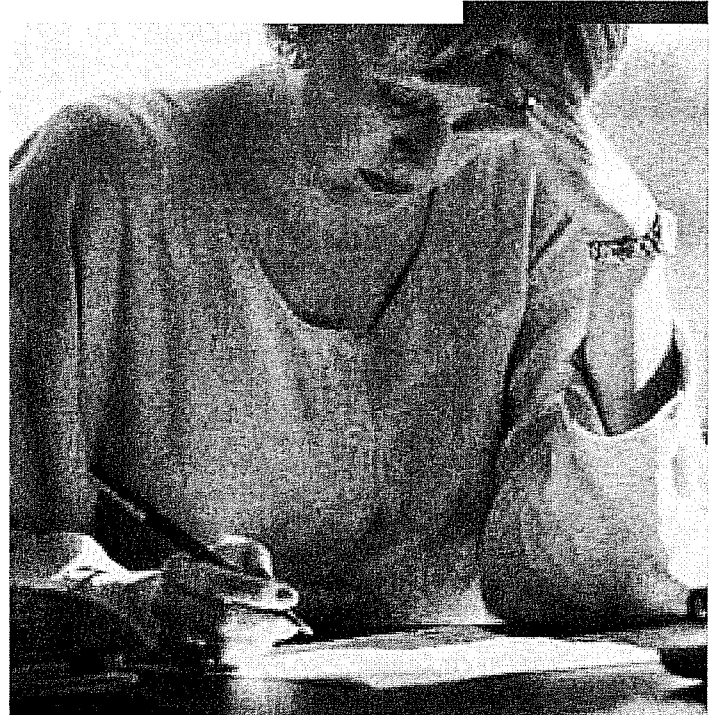
Questions your Medicare-eligible clients may have:

- Q:** Do I need both Medicare Part A (hospital coverage) and Part B (health care coverage including doctor visits and outpatient hospital care) coverage?
- A:** Please encourage your clients to apply for both.
- Q:** What options do my dependents have if I go on Medicare and drop my Individual coverage?
- A:** The dependents would be entitled to be covered under a separate Individual plan in their own names. The same plan may be continued without underwriting and we would only need an Individual Enrollment Application.

Blue Cross does offer Medicare Supplemental policies at affordable rates. The member has guaranteed issue with any supplemental plan, including those with prescription drug benefits, for the first six months after

obtaining Part B of Medicare. These policies are designed to cover deductible and copay amounts not covered by Medicare.

If you or your client would like information regarding our Medicare Supplemental policies, call (800) 333-3883.



Frequently Asked Questions

Frequently Asked Questions

Applying for Coverage

- Q:** What form should new Individual clients (applicant and dependents) complete to apply for health care and/or dental coverage?
- A:** The Individual Enrollment Application (form # IU2138).
- Q:** Where can my client list additional medical information and/or applicants for health care and/or Term Life coverage?
- A:** The additional information should be listed on a Supplement to Individual Enrollment Application (form # 3955) and submitted with the Individual Enrollment Application (form # IU2138).
- Q:** If my client completed and submitted an Individual Enrollment Application to Blue Cross in the past, may my client use this same application to apply or reapply for coverage?
- A:** Yes, if the date your client signed the Individual Enrollment Application is older than 30 days but under 75 days and there has been no change in health status. However, your client must also submit an Exceptions to Standard Enrollment Form (form # IU2071). Part A of this form must be completed, signed, dated and submitted within 30 days from the date the original application was withdrawn, cancelled or denied.
- Q:** How can my non-English speaking clients update information on an application that they have already submitted?
- A:** If the application has been submitted within the last 30 days, your clients may update the information on the Exceptions to Standard Enrollment Form (form # IU2071). If someone is completing the form in English on their behalf, that person must also sign and date Part C, the Statement of Accountability.
- Q:** May a person who is not a natural or adoptive parent of an applicant, but who is assuming financial and/or legal responsibility for that applicant, sign an Individual Enrollment Application for an applicant who is unable to do so?
- A:** No. The person assuming financial and/or legal responsibility must complete, sign and date Part B of an Exceptions to Standard Enrollment Form (form # IU2071). This form and court papers authorizing the legal guardianship must accompany the application. The responsible adult must be able to authorize access to medical, legal and psychiatric records.
- Q:** Since the RightPlan PPO 40 is for single policyholders, does each applicant within a family need to complete a separate Enrollment Application?
- A:** For ease of processing the applications, it's recommended that each applicant complete a separate application and submit a separate premium check for each RightPlan PPO 40 applicant.
- Q:** What are the U.S. residency requirements?
- A:** Refer to page 10 for a list of requirements an applicant must meet.
- Q:** What are the dependent limitations?
- A:** Refer to page 9 for information on dependent eligibility.
- Q:** Can there be a newborn/child only policy?
- A:** Yes. Refer to page 9 for information on dependent eligibility.
- Q:** If my client is submitting an application for two children, who would be the main applicant?
- A:** The youngest child would be the main applicant.
- Q:** Can my clients request any day of the month effective date?
- A:** Yes. For PPO plan applicants, the date requested can be any date following but not greater than 75 days after the signature date.
- Q:** What is the difference between the BC Life & Health products and the Blue Cross of California products?
- A:** The BC Life & Health products are regulated by the Department of Insurance. The Blue Cross products are regulated by the Department of Managed Health Care.



Frequently Asked Questions

Frequently Asked Questions

Q: What is an "APS"?

A: An APS is an Attending Physician Statement or a medical record. An APS or medical records may be required during the underwriting process to determine an applicant's insurability or premium level coverage. A letter from a physician is not a substitute for medical records.

Q: What are the Letter to Attending Physician and the Notice to Applicants Regarding Attending Physician Statement (APS)?

A: A Letter to Attending Physician is a form used by the Underwriting Department to obtain an APS, medical records or additional medical history from a provider due to information listed on the application or due to prior claims history with Blue Cross. If the physician from whom the additional information is required is listed on the application, the form letter is sent directly to the physician. An Authorization for Use of Protected Health Information form (form # 9608) signed by the client must accompany the request. The applicant then receives a notification letter (Notice to Applicants Regarding Attending Physician Statement) stating that this action has been taken.

If there is a diagnosis but no physician listed on the application, if the physician listed has not seen the applicant within 12 months of the signature date on the application, or if the physician's address is not complete, then the applicant will receive both the notification letter and the letter to the physician requesting medical information.

The cost of any necessary examination is not reimbursed by Blue Cross.

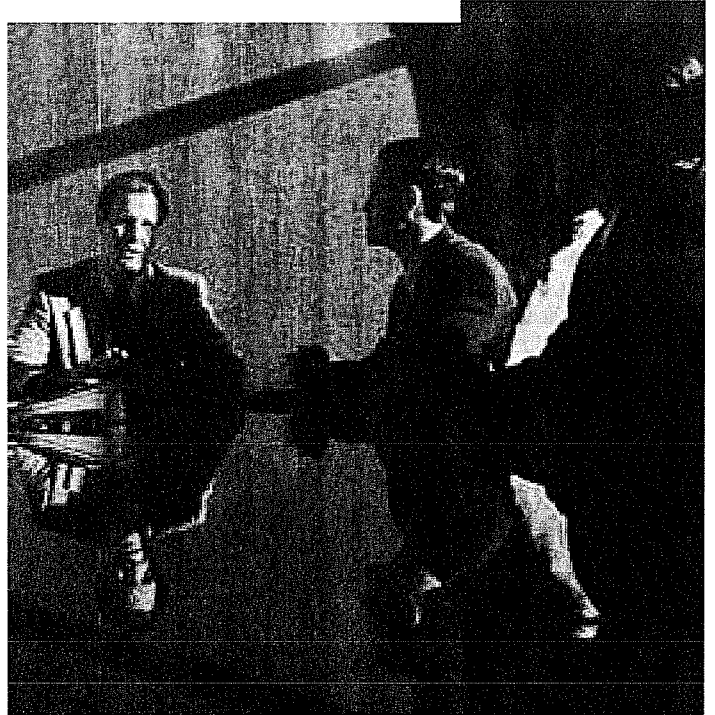
Some APS requests ask for "current" medical information. Blue Cross defines "current" medical information as physician evaluations (medical records) that have occurred within the last 12 months.

Q: What happens when a provider does not respond to a request for medical records?

A: If medical records are not received within 15 days, a second request is sent to providers. Notice is also sent to the applicant as notification of the delay in processing. Blue Cross will pend the application and hold the applicant's check for a maximum of 45 days.

Q: How can my client apply for coverage under HIPAA?

A: You should first determine if your client is eligible for HIPAA coverage (see page 16 for information on HIPAA eligibility). Your client may then complete and submit the Enrollment Form for Coverage Under HIPAA (form # IS8043).



Frequently Asked Questions

Frequently Asked Questions

Changing Coverage

Q: How can my existing clients upgrade or downgrade their coverage or switch to or from an HMO plan?

A: Depending on the plans, existing members must do one of the following:

- Complete a new Individual Enrollment Application (form # IU2138).
- Complete a Change of Coverage Application (form # 3953).
- Submit a written request to the address listed on the inside front cover of this guide.

Refer to the Individual Plan Option Table on page 52.

Q: How can my clients add a newborn to their existing policy?

A: When a child is born either to an existing member, or the member's non-enrolled spouse/domestic partner, the newborn is automatically covered only for a 31-day period from birth for illness or injury. However, within 60 days of the date of birth, a written request must be submitted by the member to enroll the child onto the existing policy. If this procedure is followed, the newborn will be enrolled onto the existing policy without underwriting. The same procedures apply for newly legally adopted children.

NOTE: The written request for newborn enrollment must be received within the 60-day time frame. Without a family enrollment, coverage for the newborn automatically terminates at the end of the 31-day period. Any Blue Cross payment of claims for the newborn during the 31-day automatic coverage period DOES NOT imply enrollment onto the existing policy.

Payment Options

Q: What premium payment options do my clients have?

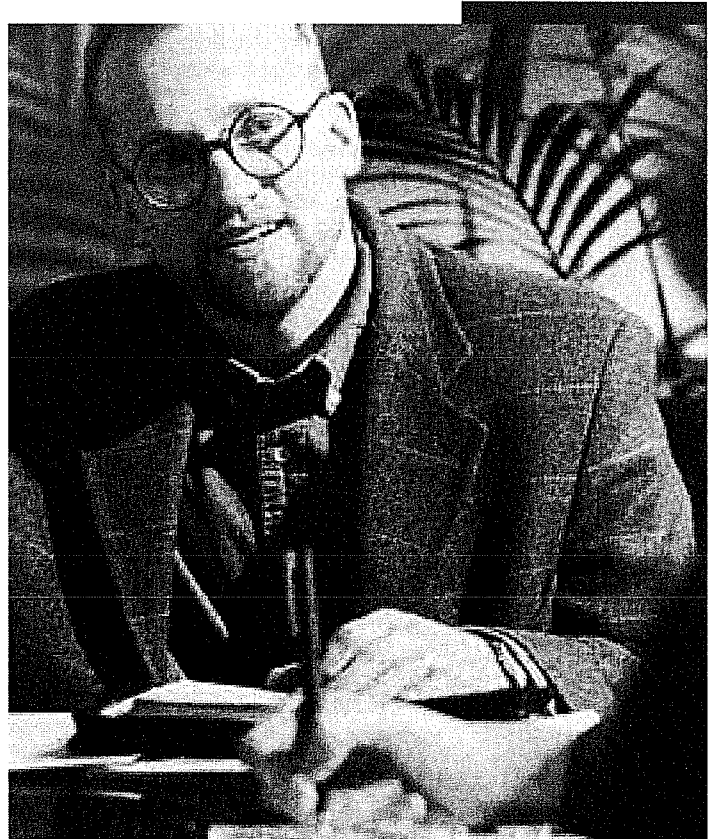
A: Your clients have three options:

1. Monthly checking account automatic premium payment
2. Payment by credit card
3. Personal check bimonthly or quarterly

For more information, see the Payment Options section on page 20.

Q: What must my clients do to have their premiums paid automatically every month from a checking account?

A: New applicants and existing members who are changing coverage and must complete a new Individual Enrollment Application (form # IU2138) can complete Section 8A of the form and attach a blank, voided check. Existing members can complete and submit the Monthly Checking Account Automatic Premium Payment Authorization Form (form # IS7134) with a blank, voided check attached to the address indicated on the form. Your clients should note that authorization received after the 15th of the month may not be activated the 1st of the following month. Their premiums should be current to avoid cancellation.



Individual Plan Option Table

Effective 10-01-04



PPO and HMO Plan Options

Effective 10-1-04

From: Level 1

To: Level 1

	R418 = BC Life Basic PPO 2500	7900 = BC Life Basic PPO 1000	T160 = PPO 3500 (HSA-Compatible)	R420 = 3500 Deductible PPO	H062 = BC Life PPO Share 5000	NM31 = BC Life PPO Saver	7891 = PPO Share 2500	7892 = EPO (HSA-Compatible)	7893 = PPO Share 1000	7895 = PPO Share 500	1930 = BC Life PPO Share 1000	7899 = BC Life PPO Share 500	PE48 = Select HMO	7898 = HMO Saver	7898 = Individual HMO	PE48 = RightPlan PPO 40 (Generic Rx)	PE49 = RightPlan PPO 40 (Comprehensive Rx)	P958 = RightPlan PPO 40 (No Rx)
R418 = BC Life Basic PPO 2500	A																	
7900 = BC Life Basic PPO 1000	W	A																
T160 = PPO 3500 (HSA-Compatible)	W	W	W													W	W	W
R420 = 3500 Deductible PPO	W	W	W													W	W	W
H062 = BC Life PPO Share 5000	W	W																
NM31 = BC Life PPO Saver	W	W																
7891 = PPO Share 2500	W	W																
7892 = EPO (HSA-Compatible)	W	W	W															
7889 = PPO Share 500	W	W																
1393 = PPO Share 1000	W	W																
7895 = PPO Share 500	W	W																
1930 = BC Life PPO Share 1000	W	W																
7899 = BC Life PPO Share 500	W	W																
PE48 = Select HMO	W	W																
7898 = HMO Saver	W	W																
7898 = Individual HMO	W	W																
PE48 = RightPlan PPO 40 (Generic Rx)	W	W	W	W	W	W	C	C	C	C	C	C	C	C	C		C	W
PE49 = RightPlan PPO 40 (Comprehensive Rx)	W	W	W	W	W	W	C	C	C	C	C	C	C	C	C	W		W
P958 = RightPlan PPO 40 (No Rx)	W	W	C	C	W	C	C	C	C	C	C	C	C	C	C	C		

A = Full Application C = Change of Coverage Application W = Written Request

- Downgrades in coverage are not allowed once the member's out-of-pocket maximum has been met.
- A change in plan or rating tier may only be requested 6 months or more after the original effective date.
- A Change of Coverage Application must be submitted when a rate tier change is requested.

Any change from a HIPAA plan to any other product requires a full application.

The following plans are offered by Blue Cross of California (BCC): PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO. The following plans are offered by BC Life & Health Insurance Company (BCL&H): Basic PPO 2500/1000, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), Short-Term PPO Plan and PPO Dental and Term Life products. BCC and BCL&H are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

10/04

Technology

Go to the Blue Cross Agent Web site 24 hours a day, 7 days a week to find helpful resources, up-to-date information and custom sales tools you need to help your business succeed.

At www.bluecrossca.com in the Agents/Brokers area, you can:

- find out What's New
- obtain product and rate information
- instantly access and print out forms and sales presentations
- create proposals
- order supplies
- locate network providers

The Web site is also your exclusive portal to:

- AgentServices – where you can review real time status of your book of business and submissions
- AgentConnect – where you can link your clients to our online application and other helpful sales tools

Technical Support

Trained Technical Support Specialists are standing by to help you put all of the Blue Cross technical tools to work for your agency – call on them if you need any help using Blue Cross technology.

(800) 678 - 4466



These underwriting guidelines are subject to change at any time without notice to you.

Introduction

Introduction

This Application/Underwriting Guidelines manual was developed to answer many of the questions you, the agent, may have when writing Blue Cross of California Companies (Blue Cross) Individual business.

This manual will help you in advising your clients of the likely outcome of their applications when discussing potential placement into one of the available levels of coverage. It can help save valued time and money by taking some of the guesswork out of health care underwriting. The manual also provides information regarding the accurate completion of the application.

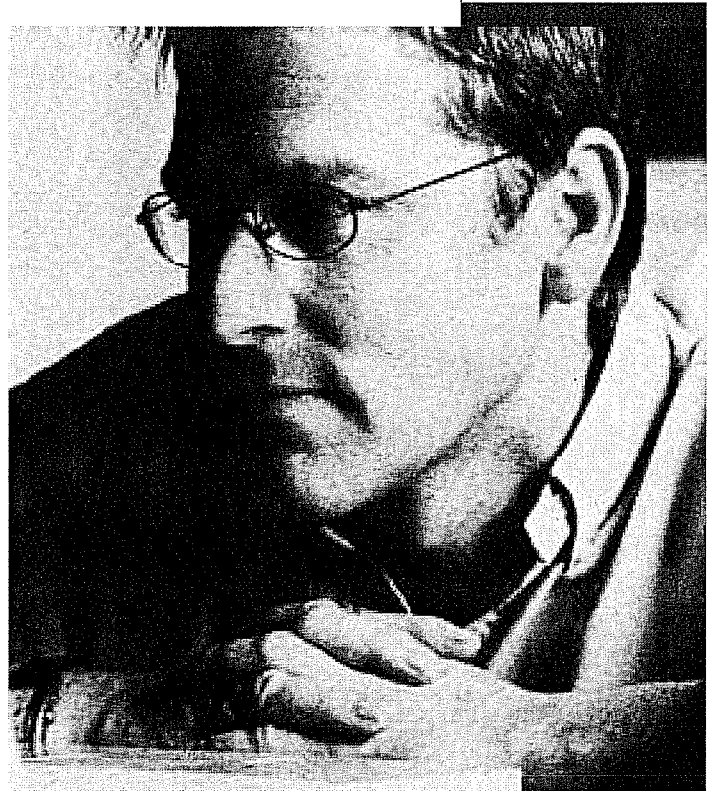
Please be aware that the underwriting portion of this manual is meant to provide a brief overview of Blue Cross Companies' underwriting practices. It is not definitive, and is subject to change at any time.

Based upon the applicant's health history, our underwriting requirements and our health care underwriting guidelines, Blue Cross reserves the right to place the applicant in any level of coverage, offer an alternate plan at any level of coverage, or to decline coverage. **Agents and brokers are expressly NOT authorized to make any promises or representations about whether, or what type of, coverage may be offered.**

You may view, download and print these underwriting guidelines from the Agents/Brokers section of our Web site. To access the online version of this document, visit www.bluecrossca.com and click *Agents/Brokers*. Log in and then click *Agent Supplies, Forms & Documents, Individuals and Families Forms & Documents* and *Individual Underwriting Guidelines*.

The **Agents/Brokers** section of our Web site also provides

- Important news and updates on Blue Cross products and services
- Agent Services linking you to applicant, member and billing information for your clients
- Agent Supplies: order or print forms and sales materials directly from the Internet
- Plan rates, a Provider Finder and Blue Cross pharmacy formularies
- Your commission and account maintenance
- Information and downloads for agent sales technology, (AgentConnect and AgentOnline)
- Other general information including a services directory and available discounts especially for Blue Cross agents



This manual will help you in advising your clients of the likely outcome of their applications when discussing potential placement into one of the available levels of coverage.

This manual is Blue Cross **CONFIDENTIAL**. Please do not copy or disclose its contents without the express written permission of an officer of Blue Cross.



The following plans are offered by Blue Cross of California (BCC): PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO, and DentalSelect HMO plans. The following plans are offered by BC Life & Health Insurance Company (BCL&H): Basic PPO 2500/1000, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), Short-Term PPO Plan, Dental PPO, and Term Life products. BCC and BCL&H are independent licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

Blue Cross of California
2000 Corporate Center Drive
Newbury Park, California 91320

www.bluecrossca.com

IS 8009 10/04

Plan Option Table



Effective 3-1-06

To: Level 1

From: Level 1

	R418 = BCL&H Basic PPO 2500	7900 = BCL&H Basic PPO 1000	T160 = PPO 3500 (HSA-Compatible)	R420 = 3500 Deductible PPO	H062 = BCL&H PPO Share 5000	NM31 = BCL&H PPO Saver	7891 = PPO Share 2500	7892 = EPO	7889 = PPO Share 1500	1393 = PPO Share 1000	7895 = PPO Share 500	1930 = BCL&H PPO Share 1000	1929 = BCL&H PPO Share 500	PE43 = Select HMO	7896 = HMO Saver	7898 = Individual HMO	PE 48 = RightPlan PPO 40 (Generic Rx)	PE 49 = RightPlan PPO 40 (Comprehensive Rx)	P958 = RightPlan PPO 40 (No Rx)
R418 = BCL&H Basic PPO 2500		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
7900 = BCL&H Basic PPO 1000	W		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
T160 = PPO 3500 (HSA-Compatible)	W	W		W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C
R420 = 3500 Deductible PPO	W	W	W		C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
H062 = BCL&H PPO Share 5000	W	W	C	C		C	C	C	C	C	C	C	C	C	C	C	C	C	C
NM31 = BCL&H PPO Saver	W	W	W	W	W		C	C	C	C	C	C	C	C	C	C	C	C	C
7891 = PPO Share 2500	W	W	C	C	W	W		C	C	C	C	C	C	C	C	C	C	C	C
7892 = EPO	W	W	W	W	W	W	C		C	C	C	C	C	C	C	C	C	C	C
7889 = PPO Share 1500	W	W	C	C	W	W	W	W		C	C	C	C	C	C	C	C	C	C
1393 = PPO Share 1000	W	W	C	C	W	W	W	W	W		C	W	C	C	C	C	C	C	C
7895 = PPO Share 500	W	W	C	C	W	W	W	W	W	W		W	W	C	C	C	C	C	C
1930 = BCL&H PPO Share 1000	W	W	C	C	W	W	W	W	W	W	C		C	C	C	C	C	C	C
1929 = BCL&H PPO Share 500	W	W	C	C	W	W	W	W	W	W	W	W		C	C	C	C	C	C
PE43 = Select HMO	W	W	A	A	A	A	A	A	A	A	A	A	A		A	W	A	A	A
7896 = HMO Saver	W	W	A	A	A	A	A	A	A	A	A	A	A	W		W	A	A	A
7898 = Individual HMO	W	W	A	A	A	A	A	A	A	A	A	A	A	W	W		A	A	A
PE48 = RightPlan PPO 40 (Generic Rx)	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C		C	W
PE49 = RightPlan PPO 40 (Comprehensive Rx)	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	W		W
P958 = RightPlan PPO 40 (No Rx)	W	W	C	C	W	C	C	C	C	C	C	C	C	C	C	C	C	C	

A= Full Application (Underwriting required) **C**= Change of Coverage Application (Underwriting required) **W**=Written Request (Underwriting not required)

Members can determine if another Blue Cross plan will better fit their needs by going to www.bccplanoptions.com to use the Explore Coverage Options online tool. In addition to exploring their options, existing members can also use this tool to change to another plan **without completing a new Enrollment Application**.

- Downgrades in coverage are not allowed once the member's out-of-pocket maximum has been met.
- A change in plan or rating tier may only be requested six months or more after the original effective date.
- A Change of Coverage Application must be submitted when a rate tier change is requested.
- Tonik members can change to another Tonik plan with a Written Request. To change to another Blue Cross plan, they need to complete an Individual Enrollment Application that will be reviewed by Underwriting.
- Any change from a HIPAA plan to any other product requires a Full Application.

The following plans are offered by Blue Cross of California (BCC): PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO. The following plans are offered by BC Life & Health Insurance Company (BCL&H): Basic PPO 1000/2500, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), Tonik, Short-Term PPO, PPO Dental and Term Life products. BCC and BCL&H are Independent Licensees of the Blue Cross Association (BCA). The Power of Blue is a service mark and the Blue Cross name and symbol are registered service marks of the BCA.

