application and underwriting process guide

For Individual and Family Plans and Medicare Supplement plans

What you'll find inside:

- Application processing information
- Underwriting tips
- Probable action guide
- Height and weight guidelines
- Broker resources

Effective August 1, 2011

Table of contents

Speed dial
For fast answers to application/underwriting questions, contact:

Producer Services
(800) 559-5905
ProducerServices@blueshieldca.com

Introduction

We are pleased to present the latest edition of the Blue Shield *Application and Underwriting Process Guide* – one of the many tools we provide each year in an effort to make it easier for you to sell Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) products.

Blue Shield's underwriting philosophy

The guidelines detailed here represent our application processing procedures and general approach to underwriting new and existing business.

We use the Milliman Inc. *Health Cost Guidelines for Individual Medical Underwriting*, a guide developed cooperatively by actuarial and clinical consultants representing a combination of research, experience, and judgment. These guidelines provide Blue Shield underwriters with a consistent basis for determining the relative risks associated with an individual's medical characteristics.

Underwriting decisions are based on underwriting guidelines, an applicant's medical history, and the overall underwriting risk the applicant poses; lifestyle and/or behavioral preferences are not considered unless related to an applicant's medical history. Depending on the information provided on each application, as well as any additional information acquired by the initial telephone interview and prescription drug use history, the underwriter might request and consider additional medical information during the underwriting process.

Blue Shield may use any medical information in reviewing an individual's application, including any medical condition that occurs after the signature and submission of the application, and before an underwriting decision is made (or before the effective date of coverage).

Only a Blue Shield underwriter can make the final decision to accept or decline an application, or to determine the rate level or effective date of coverage. Brokers are **not** authorized to bind or guarantee coverage, or establish a specific rate or effective date. Please advise all prospective members to maintain their current coverage until Blue Shield notifies them in writing of our decision regarding their coverage.

Blue Shield will not refuse to enter into any contract, cancel, or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, genetic history, marital status, sexual orientation, or age of any individual applicant or member. Blue Shield also will not modify the benefits or coverage of any contract because of race, color, national origin, ancestry, religion, sex, genetic history, marital status, sexual orientation, or age, except for premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data.

This booklet provides a general description of Blue Shield's individual underwriting process and probable underwriting outcomes for the most common medical conditions. It is meant for information purposes only, and is not intended to be all-inclusive. Other underwriting criteria and guidelines not contained in this booklet may apply.

The guidelines provided in this booklet are the proprietary business information of Blue Shield. No part of this document may be copied, reproduced, or redistributed in any form or by any means without the express prior written permission of a Blue Shield officer or a Blue Shield sales director. If you have any questions, contact Producer Services at **(800) 559-5905**.

Updates

In general, the information provided in this *Application and Underwriting Process Guide* booklet is updated and published annually. We make every effort to keep you updated on any interim changes to this information; however, policies and/or procedures may change without advance written notice. In this version, we have included updates based on the Patient Protection and Affordable Care Act (PPACA).

Thank you for your support in making Blue Shield a popular choice among Californians.

Application process

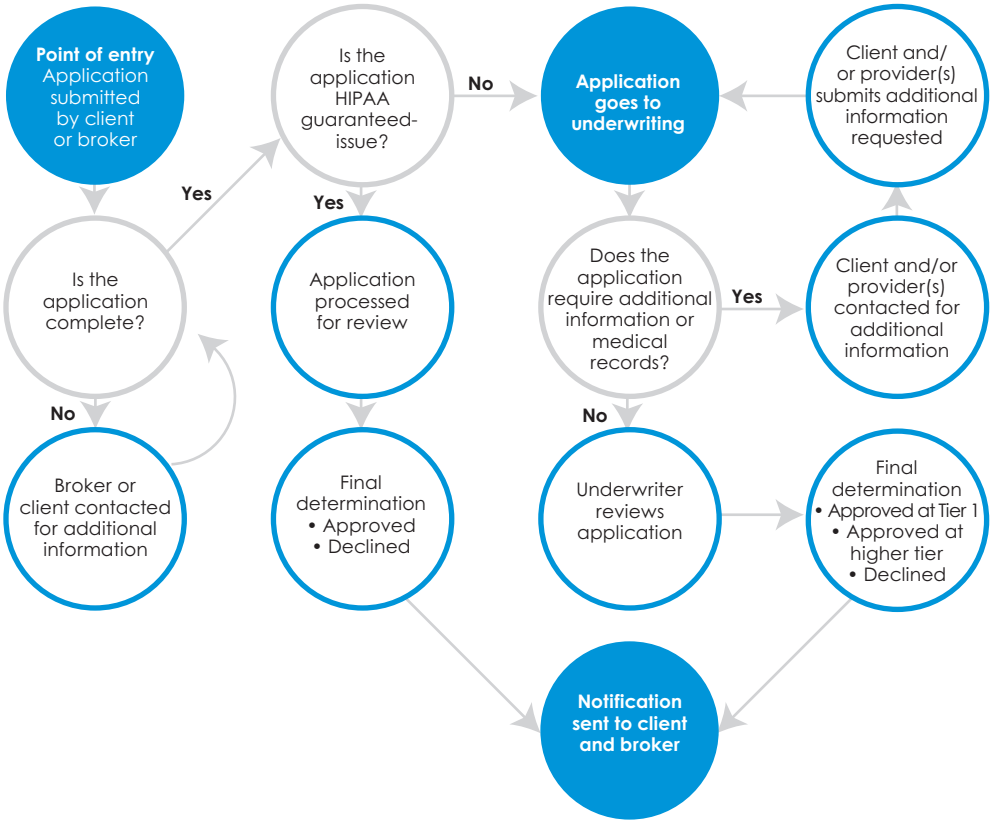
The basics

Our internal tracking system monitors applications at each stage of the underwriting process – from receipt to determination. We notify you and your client in writing when a final determination is made on the application. In most cases, you and your client should receive notice of our final determination within 10 days of submission of a **complete** application.

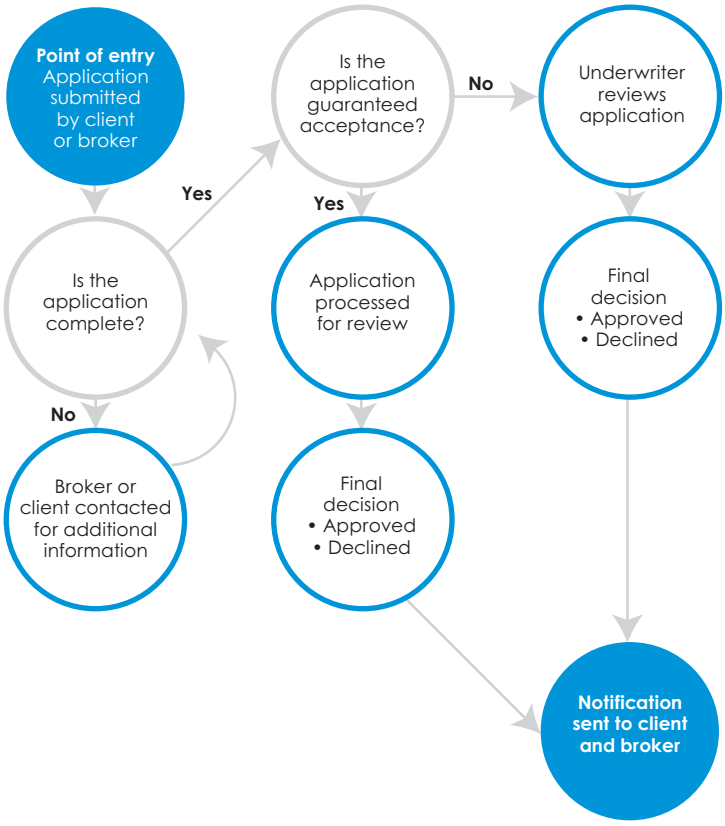
Delays may occur when we need to request additional medical information from the applicant, medical records (an attending physician statement – APS), or database information regarding the applicant. In such cases, we can't estimate the length of time necessary to complete the application process as it depends on several factors, including how long it takes for us to receive the requested information.

Important for replacement of other coverage: If your clients are replacing other health plan coverage, please advise them not to cancel their existing coverage until they receive written notification that they have been accepted for coverage.

What to expect after the IFP application is submitted



What to expect after the Medicare Supplement plan application is submitted



Payment options

Blue Shield requires payment of the first month's dues/premiums with all application submissions. Payments will only be processed if an application is approved. If payment is received via check, and the application is not approved, the check will be destroyed.

Note: Acceptance of payment by Blue Shield does not constitute an approval or a declaration of coverage.

Once coverage is approved, we offer three convenient payment options:

1. Easy$Pay

This option lets your clients have their IFP or Medicare Supplement plan dues/premiums automatically deducted from their Visa, MasterCard, checking, or savings account.

Medicare Supplement plan members who choose Easy$Pay℠ using a checking or savings account will save $2 per month on their Medicare Supplement plan dues if they are enrolled in Plan A, C, D, or F.* This savings does not apply to Plan K, or to IFP plans.

Simply have your clients complete and submit the automatic payment form that applies to their plan type (IFP or Medicare Supplement plan). You can download or order a supply of the forms from **blueshieldca.com/producer**.

- IFP Automatic Payment Options, A17018-A (1/11)
- Medicare Supplement Automatic Payment Options, A10578-MS-LO (11/10)

Clients can also make a payment over the phone using their Visa, MasterCard, or bank account by calling Customer Service at **(800) 431-2809**.

2. Online payment

Clients enrolling in an IFP or Medicare Supplement plan can choose to make a one-time payment, or set up recurring payments with a credit card (Visa or MasterCard) or bank account using Easy$Pay Online. They can even view their billing statements and payment history.

To use this tool, they need to register as a member at **blueshieldca.com**. Then, under the *I've Got Care* section, click on *Pay Monthly Premium*, fill out the *Register IFP Subscriber* section, and select the payment type of their choice.

3. Direct bill

For clients who prefer monthly or quarterly billing by mail, the payment due date will be included on each bill they receive. All monthly and quarterly payments made after the initial application payment should be sent to:

Blue Shield of California
P.O. Box 51827
Los Angeles, CA 90051-6127

* Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber.

Policies

Cancellation/reinstatement of the *Evidence of Coverage* and Health Service Agreement or Policy (IFP only)

Blue Shield's ability to cancel or reinstate an *Evidence of Coverage* and Health Service Agreement (EOC) or Policy is governed by applicable law and the terms of the specific contract in question. The following is only an overview; the information contained in the EOC or Policy is the governing process. Please refer to the EOC or Policy for complete information.

Blue Shield may terminate the EOC/Policy, together with all like EOCs/Policies, by giving 90 days' written notice. Members or insureds who want to terminate the EOC/Policy shall give Blue Shield 30 days' written notice.

Blue Shield may cancel an EOC/Policy immediately upon written notice for the following reasons:

1. Fraud or deception in obtaining, or attempting to obtain, benefits under the EOC/Policy.
2. Knowingly permitting fraud or deception by another person in connection with the EOC/Policy, such as, without limitation, permitting someone else to seek benefits under the EOC/Policy, or improperly seeking payment from Blue Shield for benefits provided.
3. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield personnel and providers of services; or (2) substantially impairs the ability of Blue Shield to arrange for services to the person; or (3) substantially impairs the ability of providers of services to furnish services to the person or to other patients.

Cancellation of the EOC/Policy will terminate the EOC/Policy effective as of the date that written notice of termination is mailed to the subscriber. It is not retroactive to the original effective date of the EOC/Policy.

Rescission

Blue Shield may, in accordance with state and federal law, be entitled to rescind coverage if the member or anyone acting on his or her behalf commits fraud or makes an intentional misrepresentation of material fact in the application for coverage or in other communications with Blue Shield prior to the issuance of the coverage. Rescission voids the coverage as if it never existed and, therefore, will be retroactive to the original effective date of coverage.

If the member/insured is under age 19, Blue Shield may assign the highest tier rate allowed under law, if an intentional misrepresentation has taken place. This action may replace rescission for this population, and is retroactive to the original effective date of coverage.

If Blue Shield rescinds coverage due to fraud or intentional misrepresentation of a material fact made by an applicant during the enrollment process, Blue Shield will take back the commissions paid to you.

Blue Shield expects that applicants will be provided a copy of the full application to carefully review. If you are assisting an applicant in completing the application, Blue Shield requires that the applicant review each question as it appears on the application. Do not skip questions, summarize them, or paraphrase them in any way. Never advise your client not to disclose facts requested on the application, even if you or your client think the information is insignificant. All information requested on the application must be disclosed.

In addition to English, Blue Shield offers the IFP application in several threshold languages: Spanish, Chinese, and Vietnamese. Please make certain that your client is provided with an application written in their preferred language.

Never have your client sign a blank application. The applicant may only sign the application after it has been fully completed and the client has carefully reviewed the answers.

Broker information changes

Effective January 2009, California law requires that the broker provide information regarding his or her involvement in assisting the applicant in completion of the application. The applicant will be queried during the underwriting process regarding the completion and review of the application. The applicant will be contacted and asked "who assisted?" in the completion of the application, and "did you review?" the application responses prior to submission.

Please carefully review and complete the questions in the Broker Information section of the IFP Application. Discrepancies and/or incomplete information will delay the processing of your client's application. If you have questions regarding this change, please contact your Broker Development Specialist, Regional Sales Manager, or Producer Services at **(800) 559-5905**.

Cancellation of the EOC/Policy for nonpayment of dues/premiums

Blue Shield requires prepayment for the plan billing period. If dues/premiums have not been received by the due date, Blue Shield will send a Prospective Notice of Cancellation that states:

a. Dues/premiums have not been paid, and that the EOC/Policy will be cancelled if the required dues/premiums are not paid within 15 days from the date the Prospective Notice of Cancellation is mailed;
b. The specific date coverage will end if dues/premiums are not paid; and
c. Information regarding the consequences of any failure to pay the dues/premiums within 15 days.

Within five business days of canceling or not renewing the EOC/Policy, Blue Shield will mail a Notice Confirming Termination of Coverage, which will inform the subscriber of the following:

a. That the EOC/Policy has been cancelled, and the reasons for cancellation;
b. The specific date coverage ends; and
c. Information regarding the availability of reinstatement of coverage under the EOC/Policy.

If the EOC/Policy is cancelled due to nonpayment of the required dues/premiums when due, then coverage will end on the "paid to" date for which dues/premiums are paid. This prospective cancellation period will not exceed 60 days from the date we mail the Notice Confirming Termination of Coverage.

Grace period for payment of premium of Blue Shield Life plans

After payment of the first premium, the subscriber receives a 30-day grace period for payment of any premium due. During the grace period, the Policy remains in force. However, the subscriber is responsible for payment of all premiums that accrue during the period the Policy continues in force. If the due bill is not paid by the end of the 30-day grace period, coverage is cancelled effective at the end of the grace period.

Reinstatement of the EOC/Policy after cancellation

If the EOC/Policy is cancelled for nonpayment of dues/premiums, Blue Shield will permit reinstatement of the EOC/Policy twice during any rolling 12-month period without a change in dues/premiums, and without consideration of the medical condition of the subscriber or any dependent, if the amounts owed are paid within 15 days of the Notice Confirming Termination of Coverage mail date. If request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the EOC/Policy is cancelled for nonpayment of dues/premiums more than twice during the preceding 12-month period, then Blue Shield is not required to reinstate, and the subscriber will need to re-apply for coverage. In this case, Blue Shield may impose different dues/premiums and consider the medical condition(s) of the subscriber and any dependents in deciding whether to offer coverage.

Blue Shield may cancel the EOC/Policy for failure to pay the required dues/premiums, when due. If the contract is being cancelled because your client failed to pay the required dues/premiums on time, coverage will end 30 days after the date for which payment was due. Your client will be liable for all dues/premiums accrued while the EOC/Policy continues in-force, including those accrued during the 30-day grace period outlined above. Within five business days of canceling or not renewing the EOC/Policy, Blue Shield will mail your client a Notice Confirming Termination of Coverage, which will provide the following information:

a. That the EOC/Policy has been cancelled, and the reasons for cancellation; and

b. The specific date and time when coverage ended.

Utilization review process

State law requires that health plans disclose to plan members and providers the process used to authorize or deny healthcare services under the plan. Blue Shield has documented this process ("Utilization Review"). Please call the appropriate IFP customer service department toll-free at the number listed below to request a copy of this document:

Blue Shield of California Healthy Families plans:
(800) 237-3654

Blue Shield IFP PPO and HMO plans:
(800) 431-2809

Blue Shield of California Medicare Supplement plans:
(800) 248-2341

IFP applications

Eligibility

Conditions of eligibility

To be eligible for a Blue Shield Individual and Family Plan, your clients must be:

- California residents
- Younger than age 65

Dependent coverage is available for:

- Spouses younger than age 65
- Domestic partners younger than age 65
- Dependent children who are younger than age 26

Note: If your client has other coverage, it will need to be cancelled if their application for Blue Shield coverage is approved.

Additional coverage considerations for applicants under age 19

Effective January 2011, in accordance with federal and state law, Blue Shield introduced guaranteed-issue health coverage for applicants and dependents under age 19. Blue Shield may not decline these individuals; however, a rating tier may still be applied to the contract, as applicable. A fully completed application for coverage is required for applicants under age 19.

For additional information concerning eligibility, please contact your sales representative or Blue Shield at **(800) 559-5905**.

Service area requirements

Clients and their eligible dependents applying for an Access+ HMO® package, Access+ Value℠ HMO, and/or a Dental HMO plan must each live or work in our HMO plan service areas. Each family member covered by the plan will need to select a Personal Physician and/or dental provider located sufficiently close to home or work to ensure reasonable access to care, as determined by Blue Shield.

To determine the service area, or to find a Personal Physician and/or dental provider, you or your clients can:

- Go to **blueshieldca.com** and search for a provider using their home ZIP code
- Call Member Services or Producer Services
- Review the consumer rate book – page 4 lists the HMO-eligible counties

HIPAA guaranteed-issue plans

California residents who are age 19 or older and not eligible for other coverage (including Medicare), but who meet certain other conditions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), may be eligible for our Shield Spectrum PPO℠ 5500, Shield Spectrum PPO 5000,* Shield Savings℠ 4000/8000,* Access+ HMO package, and Access+ Value HMO HIPAA guaranteed-issue plans. Our HIPAA guaranteed-issue plans are an alternative for those applicants age 19 and older who are ineligible for underwritten plans because of a pre-existing condition.

Note: Children under age 19 are only eligible for a HIPAA guaranteed-issue plan if applying as a dependent for family coverage.

* Underwritten by Blue Shield of California Life & Health Insurance Company.

Qualifying for HIPAA guaranteed-issue plans

Generally, people apply for HIPAA guaranteed-issue plans if they know or suspect they're not eligible for an underwritten plan. Clients applying only for a HIPAA guaranteed-issue plan should complete the following sections:

a. Applicant information

b. Supplemental plan choices (if applicable)

c. Dependent information (if applicable)

d. Prior medical coverage

e. Authorization for release of information

f. Authorization, terms, and conditions

g. Statement of HIPAA guaranteed-issue eligibility

If you are not sure whether your client is eligible for an underwritten plan, you can recommend that they apply for both a HIPAA guaranteed-issue and underwritten plan simultaneously by completing the entire IFP application. We will examine the entire application to see if he or she (and any applying dependents) are eligible for either plan. We will notify you and your clients of the plan(s) and rates for which they qualify. Completing the entire IFP application will not affect your client's eligibility for a HIPAA guaranteed-issue plan.

Applying for HIPAA guaranteed-issue plans

Step 1: Clients use the IFP application [Form C12900-AE-A] to apply for a HIPAA guaranteed-issue plan, selecting from these plan options:

- Shield Spectrum PPO 5500 HIPAA Guaranteed Issue
- Shield Spectrum PPO 5000 HIPAA Guaranteed Issue
- Shield Savings 4000/8000 HIPAA Guaranteed Issue
- Access+ HMO HIPAA Guaranteed Issue
- Access+ Value HMO HIPAA Guaranteed Issue

Step 2: Applicants complete a Statement of HIPAA Guaranteed-Issue Eligibility for themselves, as well as for each dependent applying for a HIPAA guaranteed-issue plan.

HIPAA guaranteed-issue plan rates may be higher than a rate for a Blue Shield underwritten plan. If your clients also wish to be considered for an underwritten plan at the time of their application, they should complete the entire application.

Step 3: Certificate(s) of Creditable Coverage is/are required from all HIPAA guaranteed-issue applicants. The certificate from their previous health plan(s) must indicate that they were covered for 18 months or more. This time frame can include the number of months they were covered under COBRA or Cal-COBRA continuation coverage as part of their most recent group coverage.

Before Blue Shield will consider an application for a HIPAA guaranteed-issue plan, all required eligibility materials must be provided at the time of application, including the HIPAA Certificate (certificate of prior creditable coverage) and any COBRA/Cal-COBRA or prior employer or prior carrier letters, as appropriate. Refer to the HIPAA application eligibility checklist in the *Application for Blue Shield Individual and Family Health Plans*. If an application for a HIPAA guaranteed-issue plan is received without verification of eligibility, processing of the application will stop and the applicant will be notified.

Step 4: Include payment for the first month's dues/premiums for the HIPAA guaranteed-issue plan of choice.

Please note that individual term life insurance and/or dental coverage is not available with HIPAA guaranteed-issue plans. If you would like more information about eligibility for HIPAA guaranteed-issue plans, please call Producer Services at **(800) 559-5905**.

Guaranteed-issue for kids (children under age 19)

To be eligible for the 2:1 rating tier maximum under the Patient Protection and Affordable Care Act (PPACA), applicants under age 19 must apply for coverage during their annual open enrollment period, which is defined as the birthday month. For example, if an applicant under age 19 has a birthday November 15, we must receive the application for coverage between November 1 and November 30. The effective date of coverage will be assigned per the rules outlined on page 15.

Continuous coverage and surcharge

A legislated mandate designed to encourage continuous coverage for applicants under age 19 requires that applicants under age 19 applying on their own – who have not had continuous coverage for at least 90 days prior, and up to the signature date of the application – be charged a 20% surcharge to their final rate that will remain in effect for 12 months. The surcharge applies irrespective of the health status of the applicant or when the application is submitted (during one's birth month or outside of one's birth month). To avoid the surcharge, acceptable documentation demonstrating proof of continuous coverage must be provided during the application process.

Qualifying event period

A qualifying event period (QEP) or special enrollment period (SEP) is also known as a "life event change" and is considered a personal modification or change in status. A qualifying event generally allows enrollment in the health plan outside of the normal open enrollment period. Under PPACA, underwriting applies; if acceptable documentation demonstrating proof of a qualifying event can be provided during the application process, the maximum rate assigned to a guaranteed-issue child is limited to the 2:1 rating tier maximum. If acceptable qualifying event documentation cannot be provided during the application process, coverage is still available but the application will be fully underwritten and rated accordingly. This rate may be higher than Tier 6.

Applicants under age 19 applying outside of their open enrollment period, but within 63 days of one of the following, may have met the definition of a qualifying event as defined under PPACA:

- Under-age-19 applicant lost dependent coverage due to the termination or change in employment status of the person through whom the child was covered
- Newborn or child(ren) placed for adoption within 63 days of applying for IFP coverage, *and are not* an addition to an existing contract
- Under-age-19 applicant lost coverage due to a change in employment status
- Discontinuation of an employer's contribution to an employee's or dependent's group health coverage plan
- Death of the person under which the under-age-19 applicant was covered as a dependent
- Legal separation or divorce of the parents under whom the under-age-19 dependent was covered as a dependent
- Loss of healthcare coverage under the Healthy Families Program, the Access for Infants and Mother's Program, or the Medi-cal Program
- The under-age-19 applicant became a resident of California during a month that is not the open enrollment period (birth month)
- The under-age-19 applicant is a child dependent, and coverage is mandated pursuant to a valid state or federal court order

Documentation supporting the validity of a qualifying event will be required at the time of application submission. These may include (but are not limited to) a copy of the birth certificate, court documents supporting the placement for adoption, the HIPAA certificate, and/or a letter from the employer indicating reduction or cancellation of coverage from the group plan. Please contact your Regional Sales Representative or Blue Shield for additional information concerning qualifying event verification requirements.

If an application is received outside of a supportable qualifying event, the under-age-19 applicant is eligible for coverage, but will be underwritten and approved at an actuarially sound rate, which may exceed the 2:1 ratio. Furthermore, if the under-age-19 applicant does not have continuous health coverage for at least 90 days prior to the application signature date, the 20% surcharge will apply, and will be applied in addition to the actuarially sound rate. At the end of the 12-month period, the 20% surcharge will be automatically discontinued.

Medical underwriting and rating tiers for applicants under age 19

The Patient Protection and Affordable Care Act (PPACA) stipulates a maximum tier rate of 2:1 for applicants under age 19 who qualify for guaranteed-issue coverage. This tier rating has been called "Tier 6" by Blue Shield. Tier 6 rates are lower than Tier 5 rates, and higher than Tier 4 rates. To be eligible for Tier 6, applicants under age 19 must submit an application for enrollment during their annual open enrollment period (OEP), which is defined as their birth month. For example, if an applicant under age 19 has a birthday October 9, the application must be received by Blue Shield in the month of October.

Applicants under age 19 who enroll outside of their birthday month, and are not eligible based on a qualifying event, may be rated at the appropriate actuarial level. This means the applicant may be assigned the highest tier available (higher than the Tier 6 rate).

Other factors affecting the final underwriting rating tier are as follows:

- Missing or incomplete application information
- No response from the applicant to a request for additional information
- Health status/history
- Not a resident of California for at least six months, and no recent physical exam by a California physician
- A child under age 5 has not had routine well-child examinations

The above scenarios *may* result in the highest allowable tier rating based on the date of enrollment. For example, an *incomplete* application for an applicant age 16 who is applying during the birth month would be rated at Tier 6; the same child outside of his/her birth month, would be rated at the highest actuarial tier available at the time of underwriting.

The health history of applicants under age 19 continues to be evaluated as it was prior to the enactment of health care reform. Children meeting the health and enrollment eligibility requirements will be considered for all tier rates at the time of underwriting. If the child exceeds Blue Shield's defined health risk parameters, instead of declining the under-age-19 applicant, the highest allowable tier rate will be assigned, based on the time of enrollment (OEP or outside of the OEP). Underwriting may continue to decline coverage if the request is to add to an existing contract under a grandfathered plan.

Dependent coverage

Adding dependents

If your clients want to add dependents to their existing coverage, they should:

1. Fill out the IFP application (Form C12900-AE-A)
2. Mark the box, "Add family member to existing coverage"
3. Submit it to the Underwriting Department

Members may add a dependent child to their contract without underwriting if Blue Shield receives the request to add the dependent within 31 days of birth,* or for a dependent child placed for adoption, within 31 days of the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document – including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form granting the subscriber, spouse, or domestic partner the right to control the health care for the adoptive child. An enrollment request must accompany one of these forms to process the request appropriately. Coverage will be effective the date of birth, or in the case of adoption, the date on which the right to control the health care of the adoptive child is awarded. Absent written documentation regarding the right to control the health care of an adoptive child, coverage will become effective on the date there exists evidence of the subscriber's, spouse's, or domestic partner's right to control the health care of the child placed for adoption.

Tell your clients their rates may be adjusted to reflect the changes made to their plan contract or policy. If higher monthly dues/premiums are assessed, Blue Shield will bill your clients for the difference, deduct it from their checking/savings account, or charge it to their credit card (if your client has elected an automatic payment option).

Dependent coverage is not available for the following subscriber-only plans underwritten by Blue Shield of California Life & Health Insurance Company: Active Start℠ Plan 25, Active Start Plan 25 Generic Rx,† Active Start Plan 35, Active Start Plan 35 Generic Rx,† Vital Shield℠ 900,† Vital Shield 2900,† Essential℠ 1750,† Essential 3000, and Essential 4500.

Grandfathered IFP health plans

An applicant under age 19 who is applying as a dependent addition to a grandfathered plan is not subject to the guaranteed-issue underwriting criteria under the Patient Protection and Affordable Care Act (health care reform). This means the dependent addition may result in a new contract rate at a tier rating higher than the 2:1 maximum allowed under health care reform, or the dependent application may be declined for coverage as a dependent under the grandfathered plan.

Grandfathered health plans are those plans that were in effect on or before the date of health care reform enactment (March 23, 2010). Grandfathered plans do not need to comply with all reform provisions; however, grandfathered plans are still required to comply with some of the health reform requirements (e.g., the elimination of the lifetime maximum, and additional costs for preventive services).

Deleting dependents

Requests to cancel dependents from a family plan or from an application that is in process may be made by calling Producer Services at **(800) 559-5905**.

* See additional information regarding qualifying events under "Qualifying Event Period" on pages 11-12 of this guide.

† Pending regulatory approval.

Bundling/unbundling policy

If a dependent currently covered under a separate plan wants to be bundled under the parent's current Blue Shield plan, or if there is a request to unbundle a dependent from the parent's plan to his or her own plan, a completed Subscriber IFP Plan Change Request Form (Form C12278) must be submitted for medical review.

Exception: family members who each has coverage under the same plan and tier may be bundled with the same plan and tier without underwriting review. These requests can be made by phone or mail (see the contact section in the back of this booklet).

Occasionally, after a family application is approved, Blue Shield may receive a request to unbundle one or more family members to their own coverage(s), usually to reduce the overall monthly dues/premiums amount. This request to unbundle from a family contract to individual contracts can represent an underwriting risk, so an underwriting review is required to make this type of change to the contract for coverage.

If a family with dependent(s) under age 19 enrolls, then later decides to unbundle one or more of their children to a separate contract, each child will be subject to the maximum allowable actuarially sound rating tier if the unbundle occurs outside of the applicable birth month or open enrollment period (OEP). A new tier may also be assigned to the original family contract.

Note: If a family with dependent(s) under age 19 wishes to unbundle any who are under 19 years old within 90 days of the original application signature date, the application of a surcharge may apply. See the "Continuous Coverage and Surcharge" section.

To make an unbundling request, you or the member must submit a Subscriber IFP Plan Change Request Form, clearly describing the unbundling details.

Rate guarantee

Blue Shield offers an initial 6-month rate guarantee based on the member's original effective date. Rate guarantee ensures that your clients will not have their dues/premiums increased for their first six consecutive months of coverage. Exceptions include:

- HIPAA guaranteed-issue, guaranteed-issue for children under age 19, individual conversion, MRMIP, and Post-MRMIP Graduate plans
- Rate changes due to a change in age
- Plan transfers within the rate guarantee period
- Changes in residence resulting in a rating region change

Example: Blue Shield's IFP rates change January 1, 2012. If your client applied for PPO coverage in November 2011 and is approved with a December 1, 2011 effective date, they would be guaranteed coverage at the previous rates until June 1, 2012, six months from the original effective date. Blue Shield will notify your clients 60 days in advance that their rate guarantee is expiring, and what their new rate will be (if applicable).

Please be aware that plan designs may be modified to ensure compliance with state and federal requirements. IFP members who transfer plans will lose the rate guarantee associated with the original plan, and will get the most current rate available under the new plan.

IFP effective dates

Blue Shield IFP plan effective dates are dependent on several factors including the date we receive the application, the date we approve the application, and the type of coverage being requested. The effective date will always be at least 15 days following the receipt date of an application for medically underwritten coverage. Please refer to effective date rules below.

PPO

Clients applying for a PPO plan – with or without dental – can receive an effective date as early as 15 days following the receipt date of their application.

Examples:

- Coverage for an application received on October 9 and approved on October 11 will become effective October 24.
- Coverage for an application received on October 1 and approved on October 20 will become effective October 21.

PPO plan applicants can choose a later effective date if they prefer, which helps with coordination of any current health coverage expiration. For example, PPO plan applicants can choose an effective date to coordinate with the termination of a Blue Shield group plan, or coverage with another health insurance carrier. However, the requested effective date cannot be later than 90 days from the applicant's signature date on the application.

The bill date for new clients is the first day of the month, so if your client is approved for an effective date other than the first of the month, the bill for the first month will be prorated.

HMO

The earliest effective date for coverage under an HMO medical plan is the first day of the month following approval, so long as that date is at least 15 days after the receipt date of the application. If the first day of the month following approval is less than 15 days from the receipt date of the application, the effective date will be the first day of the following month.

Examples:

- Coverage for an application received on September 9 and approved on September 11 will become effective October 1.
- Coverage for an application received on September 14 and approved on October 5 will become effective November 1.
- Coverage for an application received on September 18 and approved on September 20 will become effective November 1.

HIPAA guaranteed-issue plan effective dates

The effective date for HIPAA guaranteed-issue coverage is based on the receipt date of the application.

Application receipt date	Effective date
1st through the 15th day of month 1	1st day of month 2
16th through the last day of month 1	1st day of month 3

Examples:

- A HIPAA guaranteed-issue application received July 7 will become effective August 1.
- A HIPAA guaranteed-issue application received July 25 will become effective September 1.

IFP transfer policy

Existing Blue Shield of California and Blue Shield Life IFP members may choose to apply for a plan transfer at any time. Some plan transfer requests require medical underwriting, while others do not. See the "Transfer Guidelines" section and the IFP Plan Transfer Matrix on pages 17-18 for non-underwritten plan transfer eligibility requirements.

New information regarding *underwritten* transfers

Members requesting a medically underwritten plan transfer will be subject to the new rating requirements established by PPACA. To be eligible for the 2:1 rate (Tier 6) under the new plan, the under-age-19 member must apply for the transfer during their birthday month (annual open enrollment period). Medically underwritten plan transfer requests received during any other time of the year may be subject to the highest actuarially sound tier rating.

How to transfer

1. Complete the appropriate form:

- If your client is a HIPAA guaranteed-issue, group, or individual conversion plan member, have him or her complete the Application for Blue Shield Individual and Family Health Plans (Form C12900-AE-A), available for download at **blueshieldca.com/producer/ifp**. Then submit it to underwriting for review.
- All other subscribers should complete a transfer application: Subscriber IFP Plan Change Request Form (Form C12278). See the IFP Plan Transfer Matrix on page 18 to determine underwritten and non-underwritten plan transfer options (those applying for a non-underwritten plan transfer can omit the health history information).

2. Submit the completed form to the appropriate location:

Transfer applications

Blue Shield of California
Attn: IFP Plan Transfer Team
P.O. Box 629013
El Dorado Hills, CA 95762-9013
Fax: (916) 350-7500

New applications – *Application for Blue Shield Individual and Family Health Plans*

Blue Shield of California
Attn: I&M – Applications
P.O. Box 3008
Lodi, CA 95241-9969
Fax: (888) 386-3420
E-mail: **IFPapplications@blueshieldca.com**

Eligible non-underwritten plan transfer requests will be approved upon receipt of a Subscriber IFP Plan Change Request Form (Form C12278), **signed by the subscriber and any dependent 18 years of age or older**. All other plan transfer requests will require medical underwriting review, and are subject to approval. You and your clients will receive a confirmation letter after the transfer request has been processed.

Remember, requests for non-underwritten plan transfers can be submitted over the phone. Over-the-phone transfer rules are identical to the transfer rules in the IFP Plan Transfer Matrix guidelines.

Blue Shield members can request a transfer by calling **(800) 431-2809**. To request a non-underwritten transfer on your client's behalf, call Producer Services at **(800) 559-5905**.

Transfer guidelines

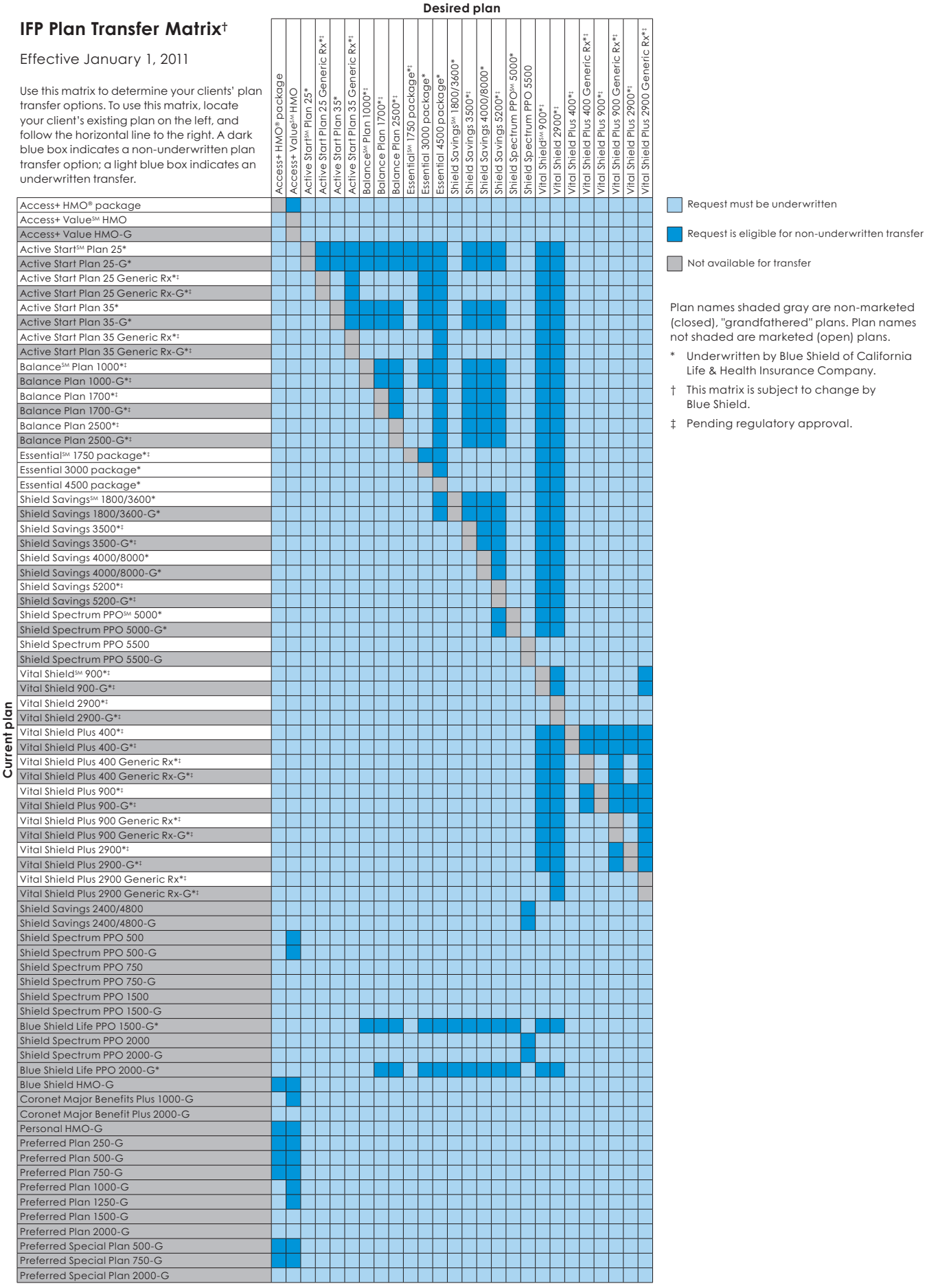
- All approved transfers will be to a non-grandfathered health plan.
- Non-underwritten (free) transfers are always to the same rating tier. Tier reconsideration requests are subject to underwriting.
- Non-underwritten transfers are subject to an initial enrollment waiting period. A member must be enrolled continuously for 12 consecutive months in an underwritten Individual and Family Plan to be eligible for a non-underwritten transfer to another plan.*
- Members are allowed one non-underwritten transfer each calendar year.
- Non-underwritten transfers apply to all members covered under the existing plan contract or policy. For example, under a family plan the entire family will be transferred to the new plan.
- Families covered under a family plan must request a transfer to another eligible family plan to be eligible for a non-underwritten plan transfer. If a family covered under a family plan requests a plan transfer to individual-only plans, the family must be unbundled to separate contracts, which requires medical underwriting.
- Subscribers in non-marketed (closed) plans are allowed the same non-underwritten (free) transfer options available to subscribers in marketed (open) plans.
- Members in non-marketed/grandfathered plans will not be allowed to transfer back to their original plan once they have transferred out of the non-marketed/grandfathered plan to the plan requested.
- The most current published version of the non-underwritten IFP Plan Transfer Matrix will apply to a request for a non-underwritten transfer. The matrix is subject to change by Blue Shield at any time.
- There is no age restriction for non-underwritten transfers. Members age 65 and older are eligible

* Members in non-underwritten Individual and Family Plans – including HIPAA guaranteed-issue, individual conversion, Medicare Supplement, and Healthy Families plans – are not eligible for a non-underwritten (free) transfer and must be underwritten.

IFP Plan Transfer Matrix†

Effective January 1, 2011

Use this matrix to determine your clients' plan transfer options. To use this matrix, locate your client's existing plan on the left, and follow the horizontal line to the right. A dark blue box indicates a non-underwritten plan transfer option; a light blue box indicates an underwritten transfer.



Request must be underwritten

Request is eligible for non-underwritten transfer

Not available for transfer

Plan names shaded gray are non-marketed (closed), "grandfathered" plans. Plan names not shaded are marketed (open) plans.

* Underwritten by Blue Shield of California Life & Health Insurance Company.

† This matrix is subject to change by Blue Shield.

‡ Pending regulatory approval.

IFP applications

Final determination client conversations

When your clients and their dependents receive a final underwriting determination from Blue Shield, you may need to communicate some or all of the following information depending on the circumstances:

Accepted at a higher tier

If your clients are accepted into a Blue Shield plan in a higher tier than originally quoted, they will need to submit payment for the difference in monthly dues/premiums as explained in their letter of acceptance. Example: If your client was originally quoted a Tier 1 rate of $91 a month, but was approved for the plan at a Tier 2 monthly rate of $114, your client will need to submit payment for the $23 difference. Please advise your client to remit any additional payment due as soon as possible. Full payment for the first month of coverage must be received before your client can access coverage.

Denied coverage

On family applications, if any of the applicant's family members are not accepted for Blue Shield coverage, the applicable portion of the initial payment will be applied toward future monthly dues/premiums for the approved member(s) on the application. If your client prefers to receive a refund of these dues/premiums, he or she must request it by calling Blue Shield Customer Service at **(800) 431-2809**.

Right to return policy

If your client finds that they're not satisfied with their contract, they may return it to:

Blue Shield of California
P.O. Box 272560
Chico, CA 95927-2560

If your client sends the contract back to us within 10 days of receiving it, we will treat the contract as if it had never been issued and return all of your client's payments.

Appeal of an underwriting decision

Your clients can appeal an underwriting decision by sending a written request to the Applicant Appeals and Grievance Department. The request needs to include information pertinent to the appeal. Mail or fax the request to Blue Shield at:

Blue Shield of California
Attention: Applicant Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011
Fax: **(916) 350-7585**

Your clients may write to us directly. Or they can provide you with the information to submit to us on their behalf.

If your clients have questions about appealing an underwriting decision, they may call us at **(800) 431-2809**.

Medicare Supplement plan applications

Eligibility

Clients may apply to enroll in any of Blue Shield's Medicare Supplement plans if they are:

- 65 years of age or older
- A resident of California
- Enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time of application

Two-party contracts are available for all Medicare Supplement plans (except Plan K), and may result in additional monthly savings* when the following conditions are met:

- Spouses/domestic partners are both 65 years of age or older
- Both the subscriber and spouse/domestic partner enroll in the same plan type

New members age 65 or older receive a $20 savings* each month for their first 12 months of coverage when we receive their application within six months of the date they first enrolled for benefits under Medicare Part B.

* Savings are due to increased efficiencies from administering Medicare Supplement plans under this program, and are passed on to the subscriber.

Clients who are 64 years of age or younger may be able to enroll in a Blue Shield Medicare Supplement plan under the following conditions:

- They are a resident of California
- They are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time of application
- They qualify for guaranteed acceptance in a Blue Shield Medicare Supplement plan according to Blue Shield's guidelines
- They have not been diagnosed with end-stage renal disease

If your client qualifies for guaranteed acceptance, completion of the Health Statement is neither required nor requested.

Guaranteed acceptance (GA) plans

To qualify for guaranteed acceptance, your client must meet specific criteria as outlined in Blue Shield's *Guaranteed Acceptance Guide*. For additional information about qualifying for guaranteed acceptance in a Blue Shield Medicare Supplement plan, please refer to the *Guaranteed Acceptance Guide* (Form MSP17149). You'll find a copy at Producer Connection on **blueshieldca.com/producer**. Or contact Producer Services at **(800) 559-5905**.

Rate guarantee policy

Medicare Supplement plan rates may change from time to time in response to the rising cost of health care. However, new members are given a six-month rate guarantee to shield them from these changes for at least six months. Please note, any changes requested by the member to their coverage will affect their eligibility for a rate guarantee.

Effective date of coverage

Medicare Supplement plan applicants can select an effective date for the 1st or 15th of the month. However, the effective date can't be earlier than the date the client becomes entitled to Medicare Part B.

For those who enrolled in Medicare Part B within six months prior to submitting an application for one of our Medicare Supplement plans, we will coordinate the effective date of their Medicare Supplement plan with the effective date of their Medicare Part B unless a later effective date is requested. *Example*: A Medicare Supplement plan applicant enrolled in Medicare Part B effective August 1, 2011. The application is submitted July 27, and approved August 6. This applicant will be given an August 1 effective date, unless a later date is requested.

For those who have been enrolled in Medicare Part B for more than six months prior to submitting an application for one of our Medicare Supplement plans, the effective date of coverage will be the 1st or 15th of the month (whichever comes next)

following the date the application is approved by Underwriting, unless a later effective date is requested. *Example*: A Medicare Supplement plan application approved on May 16 will have a June 1 effective date, unless a later date is requested.

Exceptions:

- Medicare Supplement plan applicants can choose a later effective date if they prefer, which helps with coordination of any current health coverage expiration. However, the requested effective date cannot be later than 90 days after the applicant's signature date on the application.
- All effective dates will be later than the application receipt date, except for applicants eligible under Guaranteed Acceptance scenario one.

The bill date is always the first day of the month. If clients select a mid-month effective date, the bill for the first month will be prorated.

Switching from another plan to a Blue Shield Medicare Supplement plan

Applicants should never disenroll from current coverage until coverage with Blue Shield has been approved.

If your client has a Medicare Advantage plan or Medicare Advantage-Prescription Drug Plan

An individual may not be enrolled in a Medicare Supplement plan if they are currently enrolled in a Medicare Advantage plan, unless the effective date of coverage is after the termination date of the individual's coverage under Medicare Advantage.

For clients who are members of a Medicare Advantage plan, and would like to enroll in a Medicare Prescription Drug Plan and/or a Blue Shield Medicare Supplement plan, it is in their best interest to choose one of the options listed below to disenroll from the Medicare Advantage plan. This will help ensure that the current Medicare Advantage coverage is terminated, and the client's Original Medicare coverage – which works in conjunction with Medicare Supplement coverage – is in place. For that reason, we will work with your clients to coordinate the effective date of any Medicare Supplement coverage we approve with the date they disenroll from their current Medicare Advantage plan.

Options for disenrollment in Medicare Advantage

If your client also plans to enroll in a Medicare Prescription Drug Plan, make sure they enroll in a Medicare Prescription Drug Plan *before* disenrolling from their Medicare Advantage plan. During the annual election period, disenrolling from a Medicare Advantage plan will count as their election, and your client may have to wait until the next annual election period to be able to enroll in a Medicare Prescription Drug Plan. Enrolling in a Medicare Prescription Drug Plan will automatically disenroll your client from their Medicare Advantage plan.

If your client is only interested in applying for a Medicare Supplement plan without a Medicare Prescription Drug Plan, they may choose one of the options below to disenroll from their Medicare Advantage plan.

Option 1

Your client can go directly to their Social Security office and disenroll there. If your client chooses this option, please advise them to get a copy of the disenrollment form, including the date stamp from the Social Security office, for their records. Please fax or mail a copy of the form with the Social Security date stamp to Blue Shield (see page 22).

Option 2

Your client can call the Centers for Medicare & Medicaid Services (CMS, the federal agency that administers Medicare) at 1-800-MEDICARE and ask to be disenrolled from their current Medicare Advantage plan. CMS will either mail or fax your client a confirmation of termination from the Medicare Advantage plan. Please mail or fax a copy of the termination confirmation to Blue Shield (see below).

Option 3

Your client can make a request to his or her current Medicare Advantage plan to be disenrolled. This request can be made in one of two ways:

- By calling their current Medicare Advantage plan and asking for a disenrollment form to be sent to them – then complete and return the form to the Medicare Advantage plan. (Advise your client to keep a copy for their records.)
- By sending their current Medicare Advantage plan a letter, which includes their name and member ID number, requesting disenrollment. (Advise your client to keep a photocopy of the letter for his or her records.)

Your client's disenrollment request will be processed the same month it's received, effective for the first of the following month. The applicant must submit a termination letter to Blue Shield, or ask their current Medicare Advantage plan to call Blue Shield and provide us with a verbal confirmation that the applicant has been disenrolled from their plan.

Phone: **(800) 248-2341**
TTY: (800) 241-1823
Fax: (209) 367-6391

Mailing address:

Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912

If your client has other health coverage

Blue Shield may not enroll clients in a Medicare Supplement plan if they already have coverage (such as an existing Medicare Supplement or employer group plan) that the Blue Shield Medicare Supplement plan would duplicate. To help ensure that this doesn't happen, we will coordinate your client's effective date of coverage under his or her new Blue Shield Medicare Supplement plan to coincide with disenrollment from his or her previous health plan. First, we will notify your client by letter of his or her acceptance in a Blue Shield Medicare Supplement plan pending verification that his or her other health coverage has been terminated. Once your client has terminated his or her previous coverage, please submit proof of termination so we can finalize your client's acceptance.

Important: Your client should not disenroll from current coverage until coverage with Blue Shield has been approved.

Retroactive coverage

Clients may request that their effective date coincides with the date they received Medicare Part B if they have applied and been approved for coverage under Blue Shield's guaranteed-acceptance guidelines, and are either (1) 65 years of age or older and have received Medicare Part B within the previous six months, or (2) eligible by reason of disability and have received – or were notified of eligibility to receive – Medicare Part B within the previous six months. Once your client pays plan dues/premiums for the period elapsed since the month of his or her entitlement to Medicare Part B, he or she will receive retroactive coverage.

Suspension

If a subscriber becomes entitled to Medi-Cal assistance, the benefits of this agreement will be suspended for up to 24 months. The subscriber must make a request for suspension of coverage within 90 days of Medi-Cal entitlement. Blue Shield shall return to the subscriber the amount of prepaid dues, if any, minus any monies paid by Blue Shield for claims after the effective date of suspension. If the subscriber loses entitlement to Medi-Cal, the benefits of this agreement will be automatically reinstated as of the date of the loss of entitlement, provided the subscriber gives notice within 90 days of that date and pays the dues amount attributable to the retroactive period.

Blue Shield shall suspend the benefits and dues of this agreement for a subscriber when that subscriber:

- Is totally disabled as defined herein and entitled to Medicare benefits by reason of that disability;
- Is covered under a group health plan as defined in section 42 U.S.C. 1395y(b)(1)(A)(v); and
- Submits a request to Blue Shield for such suspension.

After all of the above criteria have been satisfied, benefits and dues of this agreement for the totally disabled subscriber will be suspended for any period that may be provided by federal law. For subscribers who have suspended their benefits under this agreement as specified above, and who subsequently lose coverage under their group health plan, the benefits and dues of this agreement will be reinstated only when the subscriber:

- Has notified Blue Shield of such loss of group coverage within 90 days after the date of such loss; and
- Pays the dues attributable to the period, effective as of the date of loss of group coverage.

If the above criteria have been satisfied, the effective date of the reinstatement will be the date of the loss of group coverage.

Blue Shield shall:

- Provide coverage substantially equivalent to coverage in effect before the date of suspension;
- Provide dues classification terms no less favorable than those which would have been applied had coverage not been suspended; and
- Not impose any waiting period with respect to treatment of pre-existing conditions.

Medicare Supplement applications

Transfer policy

Switching from one Blue Shield Medicare Supplement plan to a different Blue Shield Medicare Supplement plan

- *Applicants should never disenroll from current coverage until coverage on the new plan has been approved.* Members can always apply to transfer plans with one exception: transfers from open plans to closed plans are not available.
- If it is during their annual open enrollment period (birthday month), members can transfer to an open plan of equal or lesser value without going through underwriting. Clients fill out a Medicare Supplement Plan Guaranteed Acceptance Application (Form MSP15571) and send it to Blue Shield by mail or fax.
- If it is not during their annual open enrollment period, members must go through underwriting to transfer to an open plan. Clients must fill out an *Application for Blue Shield of California Medicare Supplement Plans* (Form C12687-LO), and submit it to Blue Shield by mail or fax.

Members enrolled in Blue Shield 65 Plus℠ may apply for a Medicare Supplement plan. Please refer to the *Guaranteed Acceptance Guide* for specifics about transfers, applications, etc.

See page 25 for a complete list of plan transfer options.

Final determination client conversations

When your clients receive a final determination from Blue Shield, you may need to communicate some or all of the following information, depending on the circumstances:

Right to return policy

If your client finds that he or she is not satisfied with his or her contract, he or she may return it to:

Blue Shield of California
P.O. Box 272560
Chico, CA 95927-2560

When clients send the contract back to us within 30 days of receipt, we will treat the contract as if it had never been issued and return all of your client's payments.

Denied coverage

If your client is denied coverage for a Medicare Supplement plan, we will automatically refund any payment submitted with the application. Refunds will be mailed within 7 to 10 business days.

Appeal of an underwriting decision

If your clients would like to appeal an underwriting decision, they may write to:

Medicare Supplement Plan Member Customer Service Department
P.O. Box 3008
Lodi, CA 95241-1912
(800) 248-2341

Transfer rules matrix and key

Free – Members can transfer between these open plans without underwriting approval during the annual open enrollment guaranteed-acceptance period.

Apply – Member's application must be approved by underwriting for transfer between these plans.

Transfer options for subscribers in 2010 standardized plans (effective 6/1/2010)

Subscriber's current 2010 standardized plan	2010 standardized plans				
	Plan K	**Plan A**	**Plan D**	**Plan C**	**Plan F**
Plan F High-Deductible	Apply	Apply	Apply	Apply	Apply
Plan K	N/A	Free*	Apply	Apply	Apply
Plan A	Free	N/A	Apply	Apply	Apply
Plan L	Free	Free	Apply	Apply	Apply
Plan N	Free	Free	Apply	Apply	Apply
Plan M	Free	Free	Apply	Apply	Apply
Plan B	Free	Free	Apply	Apply	Apply
Plan D	Free	Free	N/A	Apply	Apply
Plan G	Free	Free	Free	Apply	Apply
Plan C	Free	Free	Free	N/A	Apply
Plan F	Free	Free	Free	Free	N/A

Transfer options for subscribers in 1990 standardized or pre-standardized closed plans† (effective 6/1/2010)

Subscriber's current 1990 standardized or pre-standardized closed plan	2010 standardized plans				
	Plan K	**Plan A**	**Plan D**	**Plan C**	**Plan F**
Plan F High-Deductible	Apply	Apply	Apply	Apply	Apply
Plan J High-Deductible	Apply	Apply	Apply	Apply	Apply
Plan K	Free	Free*	Apply	Apply	Apply
Plan A	Free	Free	Apply	Apply	Apply
Plan L	Free	Free	Apply	Apply	Apply
Plan B	Free	Free	Apply	Apply	Apply
Plan H (no Rx)	Free	Free	Free	Apply	Apply
Plan D	Free	Free	Free	Apply	Apply
Plan G	Free	Free	Free	Apply	Apply
Plan E	Free	Free	Free	Apply	Apply
Plan I (no Rx)	Free	Free	Free	Apply	Apply
Plan C	Free	Free	Free	Free	Apply
Plan F	Free	Free	Free	Free	Free
Plan J	Free	Free	Free	Free	Free
Plan H (with Rx)	Free	Free	Free	Free	Free
Plan I (with Rx)	Free	Free	Free	Free	Free
Pre-standardized plans	Free	Free	Free	Free	Free

* For Medicare Supplement Plan K, there is no plan that is of equal or lesser value. As a result, we are not required to allow members guaranteed acceptance into any of the other Medicare Supplement plans during the annual open enrollment period (the period starting with member's birthday). **However, we will allow Plan K members guaranteed acceptance into Plan A during the annual open enrollment period.**

† Pre-standardized plans include Blue Shield's pre-standardized plans, as well as other carriers' pre-standardized plans.

Individual term life insurance*

Submitting an application

New health plan applicants do not need to complete a separate application for life insurance.

While completing their health plan application, they can simply check a box to indicate the amount of life insurance coverage they want and list their beneficiary. The application for health and life insurance will be considered concurrently and, if approved, coverage effective dates will be the same for both.

If your client has already signed and submitted a medical plan application within the last 90 days, and now wants to add individual term life insurance (ITL), simply have your client complete the term life insurance portion of the application and resubmit it for underwriting consideration.

Or

If your client has already been enrolled in a Blue Shield health plan for more than 90 days from the medical application's signature date, and would like to apply for individual term life insurance, an Evidence of Insurability Form (also referred to as the "Evidence of Good Health Form") is required. You can download the form from **blueshieldca.com/producer/ifp/helpclients**, or request a copy by calling Producer Services at **(800) 559-5905**.

Your client simply completes the form indicating the amount of coverage and returns it to:

Blue Shield of California Life & Health
Insurance Company
Attn: Underwriting
4203 Town Center Blvd.
El Dorado Hills, CA 95762

If coverage is approved, the effective coverage date will be the first day of the month following approval.

Important: Your client must fill out an ITL Replacement Form (*Acknowledgement of Life Insurance Replacement Coverage*). You can download the form from **blueshieldca.com/producer/ifp/products/life.jhtml**. If he or she is replacing an existing Life policy, this form needs to be signed and dated by both you and your client.

Eligibility

Coverage is available to the primary applicant (ages 1 to 64) of any Blue Shield Individual and Family health plan except for HIPAA guaranteed-issue and Kids Guaranteed-Issue plans. Applicants rating higher than an underwritten Tier 4 are not eligible for enrollment in an ITL product. Applicants under the age of 19 may not apply for amounts over $30,000, and applicants over 50 years of age may not apply for amounts in excess of $60,000.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Dental coverage

Submitting an application for Individual and Family dental plans

Dental coverage with medical coverage

New health plan applicants do not need to complete a separate application for dental coverage. When completing their health plan application, they can simply check the box for the dental coverage they want. The application for health coverage and dental coverage will be considered concurrently and, if approved, coverage effective dates will be the same for both.

If a member has already been enrolled in a Blue Shield individual and family health plan and would like to add dental coverage, the member can either submit a completed dental plan enrollment application (A16166) or apply online at **blueshieldca.com/dental**.

Dental coverage without a medical plan

If your client is not enrolled in a Blue Shield health plan, but would like to enroll in either the Smile℠ PPO* or Value Smile℠ PPO* dental plans, a Blue Shield Life Dental Plan Application (C36143) must be completed.

Eligibility for all Individual and Family dental plans

To be eligible for coverage, your client must reside in California and be under the age of 65.

If coverage is approved, the coverage effective date will be the date requested by the applicant. If that date can not be honored, coverage will begin as soon as possible.

You can download dental brochures with applications at **blueshieldca.com/dental**, or request a copy by calling Producer Services at **(800) 559-5905**.

Medicare Supplement plan member dental plans

New Medicare Supplement plan applicants do not need to complete a separate application for dental coverage. When completing their Medicare Supplement plan application, they can simply check the box for the dental coverage they want. The application for Medicare Supplement coverage and dental coverage will be considered concurrently and, if approved, coverage effective dates will be the same for both.

If a member has already been enrolled in a Blue Shield Medicare Supplement plan and would like to add dental coverage, the member can submit a completed dental plan enrollment application (Form A17739) for Medicare Supplement plan members. This application is available for download at **blueshieldca.com/producer/medeligible/products/dental.jhtml**.

Eligibility for Medicare Supplement plan member dental plans

If coverage is approved, it will become effective on the date requested by the applicant whenever possible. If that date can not be honored, coverage will begin as soon as possible.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Medical underwriting guidelines

Overview

In this section, we give you four resources that will help you assess your clients' eligibility for our health plans:

1. Height and weight tables
2. Declinable conditions
3. Probable action guideline
4. IFP Probable Underwriting Decision Request

How to use this section

We recommend that you cross-reference the four resources in this section as needed to compile a complete picture for your clients. For example, while some forms of aneurysm are listed in the declinable conditions table, there are two scenarios that qualify for possible eligibility at the Tier 1 rate or at a higher tier rate.

1. Height and weight tables

The height and weight guidelines are for IFP only, and apply to applicants who do not qualify for HIPAA guaranteed-issue coverage.

2. Declinable conditions

IFP applicants age 19 or older and Medicare Supplement applicants with any of the conditions listed in this table may be automatically declined. In this case, clients may qualify for acceptance in a HIPAA guaranteed-issue IFP or Medicare Supplement plan. Find out more by referring to:

- *Application for Blue Shield Individual and Family Health Plans;* or
- *Guaranteed Acceptance Guide* for Medicare Supplement plans.

3. Probable action guideline

This section applies only to IFP (HIPAA non-guaranteed-issue) applicants. It lists Blue Shield's probable actions guideline for a single applicant who has a listed condition as the only health condition. The guideline identifies medical conditions and the three possible underwriting determinations:

- Possible eligibility for coverage at the Tier 1 rate
- Possible eligibility for coverage at a higher tier rate
- Possible or probable decline (for applicants age 19 or older)

Remember, approval to add a dependent to an existing contract in a grandfathered plan is not guaranteed. Applicants under age 19 may be declined.

4. IFP Probable Underwriting Decision Request form

If you want to know how Blue Shield might underwrite your client in advance of submitting an actual application, complete a Probable Underwriting Decision Request form (available on page 55) and fax it to Underwriting. We can tell you if your client is likely to be covered, and at what tier rating. Underwriting provides this service as a courtesy to help you understand possible eligibility. Blue Shield's response is based on the information provided on the form. *Please note: Blue Shield only makes final decisions for coverage based on a signed, complete application.*

Multiple conditions, treatment type (including medication), and multiple family members with health conditions may affect the probable action and final determination for an applicant.

Guideline scope

This guideline covers the more common disorders. Of course, not all conditions in existence can be captured in this type of list. Any conditions not on this list would require underwriting, and some conditions on this list might require underwriting upon further review of an individual's application.

This chart is not a guarantee of a specific medical underwriting decision.

- *Only Blue Shield underwriters may make the final decision to accept or decline an application, or determine the rate level or an effective date.*
- Decisions are based on an applicant's medical history, the overall risk the applicant poses, and current underwriting guidelines (which may change throughout the year).
- Blue Shield may use any medical information in reviewing an application, including any medical condition that occurs after the signature and submission of the application and before an underwriting decision is made (or before the effective date of coverage).
- Brokers are not authorized to bind or guarantee coverage for a specific rate or an effective date.

To help you assess probable underwriting decisions, we offer the IFP Probable Underwriting Decision Request. See the "Broker Resources" section for details.

Condition time frames

- Any time frames specified refer to a continuous time period before applicants applied for coverage, during which they were symptom-free and did not require any treatment for the condition.
- If no timeframes are indicated, the applicant must be fully recovered without further treatment anticipated or recommended to qualify for possible eligibility.

Coverage consideration cannot be made if:

- Symptoms are undiagnosed or untreated.
- Recovery from recent treatment or procedures is not complete.
- Further evaluation or treatment for symptoms or conditions is recommended, anticipated, or pending.

Surrogate pregnancies and coverage

Coverage will be declined until after the delivery of a child, or for two years after the surrogacy process has been discontinued, for applicants who:

- Plan to serve as a surrogate for a pregnancy; or
- Have applied to a surrogate agency; or
- Have begun surrogacy workup or treatment; or
- Intend to contract or have contracted for a surrogate pregnancy; or
- Plan to adopt a baby or babies resulting from a surrogate pregnancy.

1. Height and weight table

General: These height and weight guidelines apply to all IFP applicants who do not qualify for HIPAA guaranteed-issue coverage. These guidelines do **not** apply to Medicare Supplement plan applicants.

Overweight: All IFP applicants whose weight falls between the maximum and overweight categories require underwriting review, and must provide results of a physical examination performed within the past 12 months. However, applicants age 19 and older, whose weight equals and/or exceeds the values in the overweight column, will be declined.

Underweight: All IFP applicants whose weight is at or below the minimum weight category require underwriting review.

IFP adult height and weight table

Male			Height		Female		
Overweight	Maximum	Minimum	Ft.	In.	Minimum	Maximum	Overweight
181	164	95	4	8	94	160	180
185	167	99	4	9	96	163	184
190	170	103	4	10	98	167	188
194	173	107	4	11	99	171	192
199	177	111	5	0	102	175	197
203	181	114	5	1	105	179	202
208	185	116	5	2	107	183	207
213	190	120	5	3	110	187	212
218	195	123	5	4	112	192	217
224	199	127	5	5	115	196	222
230	205	130	5	6	118	201	227
236	210	133	5	7	121	206	232
243	216	137	5	8	124	211	238
249	222	140	5	9	128	217	244
255	228	144	5	10	131	224	251
262	232	148	5	11	135	230	259
269	240	152	6	0	139	238	268
276	248	156	6	1	143	246	275
283	256	160	6	2	147	251	281
290	264	164	6	3	151	258	288
298	272	169	6	4	153	265	296
306	280	173	6	5	156	272	304
314	288	178	6	6	160	279	312
322	296	182	6	7	164	286	320
330	304	186	6	8	171	294	328

Child height and weight tables

While weight is a consideration when evaluating a child's application for coverage, more than weight is considered. All children applicants are encouraged to apply regardless of their weight.

2. Declinable conditions (applies to applicants age 19 and older)

IFP and Medicare Supplement plan applicants who have any of the conditions listed below may be declined without medical record review.

- Acromegaly
- Adoption in progress
- AIDS
- AIDS-related complex (ARC)
- Alzheimer's
- ALS, Lou Gehrig's disease
- Amputation, single or bilateral foot or leg
- Anaplastic carcinoma
- Anemia, aplastic
- Anemia, Cooley's/ Mediterranean/major thalessemia
- Anemia, Cooley's/ Mediterranean/minor thalessemia with symptoms
- Anemia, hemolytic, auto-immune
- Aneurysm – aortic, abdominal, thoracic
- Aneurysm, cerebral artery (brain) with stent/shunt
- Angina
- Angioplasty
- Aortic obstruction
- Aortic valve stenosis
- Apnea (see sleep apnea)
- Arnold-Chiari syndrome
- Arteriosclerosis
- Arteriovenous malformation, unoperated
- Arteriovenous malformation, operated but shunt in place or with residuals
- Arteritis, necrotizing
- Arthritis, osteoarthritis severe
- Arthritis, psoriatic
- Arthritis, rheumatoid: chronic, severe, or under treatment
- Atrial fibrillation on blood thinners
- Atrial tachycardia
- Asbestosis
- Back sprain/strain, chronic
- Banti's disease
- Barrett's esophageal ulceration
- Basal cell skin cancer, multiple removals in one site
- Behcet's syndrome
- Bicuspid aortic valve
- Bipolar disease
- Bladder stones, present
- Bradycardia with pacemaker
- Breast microcalcifications – severe after biopsy or present without biopsy
- Bypass surgery – all cases
- Cancer, all non-localized
- Cancer, liver, all cases
- Cancer, ovarian, all cases
- Cancer, pancreas, all cases
- Cardiomyopathy
- Carotid artery disease
- Carotid endarterectomy
- Carotid bruit
- Cellulitis, chronic
- Chorea, Huntington's
- Chronic obstructive pulmonary disease (COPD): moderate to severe or smoking
- Christmas disease
- Cirrhosis
- Coagulation defects
- Colitis, ulcerative: unoperated or with colectomy
- Colitis, ulcerative with or Ileostomy or colostomy
- Congestive heart disease
- Connective tissue disease
- Cor pulmonale
- Corneal degeneration
- Corneal ulcer: chronic and unoperated
- Coronary artery/heart disease
- Cretinism
- Cystic fibrosis
- Cytomegalovirus
- Dandy Walker Syndrome (see hydrocephalus)
- Delirium tremens
- Demyelinating disease
- Dermatomyositis
- Diabetes with hypertension or weight exceeds the normal range or on insulin pump
- Diabetic neuropathy
- Diabetic retinopathy
- Dialysis
- Dysplastic nevus syndrome
- Endometriosis: symptomatic before or after surgical or natural menopause
- Esophageal ulcerations or varicosities
- Factor VIII, IX, or XI disorders/deficiencies
- Fanconi's syndrome
- Fasciitis: chronic or recurrent
- Fatty liver
- Fibromyalgia
- Flexion contracture
- Friedrich's ataxia
- Gallstones, unoperated
- Gangrene, diabetic/ arteriosclerotic
- Glomerulonephritis: nephritis, chronic
- Glomerulosclerosis
- Goodpasture's syndrome
- Gout: tophaceous or with renal involvement
- Guillain-Barre syndrome: present or with residuals
- Hamman-Rich disease
- Hansen's disease (leprosy)
- Heart attack, myocardial infarction
- Heart enlargement
- Heart pacemaker
- Heart valve replacement
- Heart valve stenosis
- Hemangioendothelioma
- Hemochromatosis
- Hemoglobinuria
- Hemophilia
- Hepatitis: all those other than A, B, or E
- Hepatitis: any type – present, chronic or persistent
- Herpes Zoster: eye or ear Involvement
- Hirschsprung's, unoperated
- Hodgkin's lymphoma
- Huntington's chorea
- Hydrocephalus
- Hyperprolactinemia with tumor
- Hypertension with diabetes or renal disease or history of stroke
- Hypertension and exceeds the normal weight guidelines or uncontrolled or hospitalized within 1 year
- Hypogammaglobulinemia
- Immunodeficiency disorder, except HIV infection
- Infertility treatment within past 2 years
- Interstitial cystitis
- Ischemic attack, transient (TIA)
- Ischemic heart disease
- Joint replacements: both knees or hips
- Joint replacements: multiple surgeries or shoulder, elbow, wrist, ankle
- Kaposi's sarcoma
- Kidney dialysis
- Kidney stones, present
- Kimmelstiel-Wilson syndrome
- Kleinfelter's syndrome
- Leprosy (Hansen's disease)
- Leriche syndrome
- Leukemia
- Lou Gehrig's disease

Lupus erythematous: discoid – chronic

Lupus erythematous: systemic

Lyme's disease: chronic or symptomatic

Lymphedema

Lymphoma (Hodgkin's and non-Hodgkin's)

Macular degeneration: exudative

Major depression

Manic depression

Marfan's syndrome

Mitral valve prolapse: more than trace regurgitation or not on prophylactic antibiotics

Mitral valve stenosis

Multiple myeloma

Multiple sclerosis

Muscular dystrophy

Myasthenia gravis

Myocardial infarction

Nephrectomy: persistent renal or cardiovascular abnormalities

Neuroblastoma

Neurofibromatosis

Nevus: dysplastic syndrome or giant melanocytic

Non-Hodgkin's lymphoma

Obesity with prior surgery

Osler-Weber-Rendu disease

Otosclerosis, unoperated

Pacemaker

Pancreatitis: recurrent or chronic or secondary to alcoholism

Paralysis: quadraplegia, paraplegia

Parkinson's disease

Pelvic inflammatory disease (PID): present

Pemphigus

Pericarditis: constrictive

Peripheral vascular disease

Phlebitis, deep vein: present or on anti-coagulants

Pleurisy, unresolved

Pneumocystis Carinii

Polio with bladder or bowel residuals

Polycystic kidney

Polycystic ovaries (Stein Levinthal syndrome) without removal of ovaries

Polycythemia vera

Polymyositis

Polyp, anal or rectal: more than 4 and/or unoperated

Polyp, bladder: present or recurrent

Polyp, gastrointestinal: unoperated

Pott's disease

Pregnancy of self, spouse, or significant other (excludes males applying for individual-only plans)

Progeria

Prostate stones with prostatitis

Psoriasis, severe

Psoriatic arthritis

Psychopathic personalities

Psychotic disorders

Pulmonary embolism: present

Pulmonary fibrosis

Pulmonary hypertension

Pulmonary osteoarthropathy

Pulmonic stenosis

Quadriplegic paralysis

Reiter's syndrome: symptomatic

Renal failure: chronic or end stage

Retinoblastoma

Rett's syndrome

Rheumatic heart disease

Rotator cuff: unoperated, symptomatic

Sarcoidosis

Schizophrenia

Scleroderma: recurrent, extensive or diagnosed within 1 year

Sezary's syndrome

Shingles: eye or ear involvement

Shunts or stents

Sick sinus syndrome

Sickle cell anemia

Sjogrens syndrome

Sleep apnea: obstructive or poorly controlled or requiring CPAP (continuous positive airway pressure)

Spina bifida, cystica: unoperated or operated with residuals

Spinal curvature: kyphosis, scoliosis or kyphoscoliosis, unoperated

Stein-Leventhal syndrome (polycystic ovaries)

Stroke within 10 years

Subdural hematoma: unoperated

Superior vena cava syndrome

Surrogacy planned within 2 years with surrogate mother or applicant as surrogate

Syphilis: tertiary

Syringomyelia

Systemic lupus erythematosus

Tabes dorsalis

Tay-Sachs disease

Temporal arteritis

Temporomandibular joint syndrome (TMJ): operated with residuals

Thalessemia major

Thrombocytosis

Tonsillitis: chronic, recurrent (5 or more attacks per year)

Toxoplasmosis

Tracheotomy: present

Transient ischemic attack (TIA)

Transplants: all except corneal

Transposition of the great vessels: unoperated

Treatment with AZT, HIVID, or pentamidine

Trigeminal pulse

Tuberculosis, epididymus

Turner's syndrome

Ulcer, peptic: active within 2 years or H. pylori positive

Upper airway resistance syndrome

Urethral stricture: chronic, recurrent

Uterine fibroid tumor: unoperated, multiple, and/or moderate-to-large size

Valve disease, valve replacement

Varicose veins: moderate to severe

Ventricular fibrillation

Ventricular tachycardia

Von Recklinghausen's disease

Von Willebrand's disease

Wegener's granulomatosis

Wolff-Parkinson-White syndrome: without cardiac ablation

3. Probable action guideline for IFP plan applicants ("Possible or probable decline" applies to applicants age 19 and older)

Important note: A request to add a dependent under age 19 to an existing contract in a grandfathered plan is not guaranteed, and may be declined based on health risk.

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
A				
Abnormal Pap test	See cervical dysplasia			
Abnormal uterine bleeding	Postmenopausal after 1 year, resolved	X	X	
Abscess				
Brain	After 2 years, fully recovered		X	
Liver	Fully recovered		X	
Lung	After 1 year, fully recovered		X	
Peritonsillar	Unoperated, fully recovered		X	
	Operated	X		
Pilonidal	Fully recovered	X	X	
Acid indigestion	See esophagitis			
Acid reflux	See esophagitis			
Acne	Dependent on severity and treatment	X	X	X
Acoustic neuroma	Operated, after 2 years, fully recovered		X	
Addison's	Within 5 years or chronic			X
	After 5 years, fully recovered		X	X
Agoraphobia	No episodes or medications	X	X	
Alcoholism	After 2 years of abstinence		X	X
Allergies	Testing in progress		X	X
	Most cases	X	X	
Anemia				
Aplastic	All cases			Auto decline
Iron deficiency	Most cases	X		
Hemolytic				
Auto-immune	Without splenectomy			Auto decline
	After splenectomy, asymptomatic, fully recovered	X	X	
Cooley's (Thalassemia, Mediterranean)	Major or minor with symptoms			Auto decline
	Minor, asymptomatic	X		
Macrocytic	After 1 year, recovered, no treatment	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Anemia *(continued)*				
Pernicious	Normal blood count and hemoglobin after treatment	X	X	X
Sickle	Sickle cell trait only	X		
	Sickle cell anemia			Auto decline
Aneurysm	Unoperated			Auto decline
Cerebral	Operated, fully recovered, after 2 years		X	X
Peripheral artery	Operated, fully recovered, after 1 year		X	
Anorexia nervosa	Recovered, no further treatment, after 1 year	X	X	
Aortic coarctation	See congenital heart defects			
Apnea				
Apnea of the newborn	All cases	X	X	
Sleep apnea	Obstructive, poorly controlled, or requiring CPAP			Auto decline
	Operated, after 6 months, asymptomatic, fully recovered, no CPAP, without tracheotomy		X	
	Tracheotomy present			Auto decline
Arteriovenous malformation				
All cases	Unoperated			Auto decline
Brain	Operated, with shunt			Auto decline
	Operated, no shunt, but residuals			Auto decline
	Operated, no shunt, no residuals, after 1 year	X	X	
Extremity	Operated, no residuals, after 6 months	X	X	
Lung, aorta, gastrointestinal	Operated, no residuals, after 6 months		X	X
Arthritis				
Osteoarthritis	Mild to moderate	X	X	
	Severe			Auto decline
Rheumatoid, juvenile	All cases		X	X
Rheumatoid	After 2 years, no medication, asymptomatic		X	X
	Chronic, severe or under treatment			Auto decline
ASD (atrial septal defect)	See congenital heart defects			
Asthma	Mild, occasional episodes, never in emergency room or hospital	X	X	
	Moderate to severe, frequent episodes, history of emergency room visits and hospitalizations		X	X

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Atrial fibrillation or flutter	Resolved, after 4 years		X	X
Atrial septal defect (ASD)	See congenital heart defects			
Attention deficit hyperactive disorder	Counseling and/or medication treatment		X	X
	Controlled, asymptomatic, no meds, no psychotherapy	X		
Autism	Testing complete, depending on treatment		X	
B				
Back sprain/strain	Single episode, no restrictions, fully recovered	X	X	
	Multiple episodes, fully recovered, no restrictions, after 6 months		X	X
	Chronic or present			Auto decline
Bell's palsy	If severe residuals		X	
Bladder infection	Single episode, fully recovered	X	X	
	Multiple episodes, fully recovered, within 1 year		X	X
	Chronic, within 2 years		X	X
	Interstitial			X
Bladder, neurogenic	Fully recovered, Within 2 years		X	X
Bladder stones	See kidney stones			
Bradycardia	No cardiac disease, normal EKG	X		
	Due to complete heart block, resolved, no pacemaker, after 1 year		X	
	Due to sick sinus syndrome			X
	With pacemaker			Auto decline
Brain concussion	Severe or with residuals			X
	Mild without residuals, fully recovered	X	X	
Breast implants				
Saline	Fully recovered from surgery and released from care with no complications	X	X	
Silicone	Fully recovered from surgery and released from care with no complications	X	X	
Breast reduction	After 6 months, fully recovered	X	X	
Breast microcalcifications	Mild to moderate after benign biopsy		X	
	Severe after benign biopsy or present without biopsy			X
Bulimia	Recovered, no further treatment, after 1 year	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Burns	1st or 2nd degree, treatment concluded	X	X	
	3rd degree, treatment concluded		X	X
Bursitis	Asymptomatic, resolved, no residuals	X	X	
	Chronic, recurrent, after 2 years		X	
C				
Cancer	Localized or Stage 0 or 1 can be considered			
Bladder, urinary	Recovered, no further treatment, after 2 years		X	X
Bone	Recovered, no further treatment, after 3 years		X	X
Brain/nervous	Recovered, no further treatment, after 3 years		X	X
Breast	Recovered, no further treatment, after 5 years		X	X
Cervix	Recovered, no further treatment, after 3 years		X	X
Colon/rectum	Recovered, no further treatment, after 3 years		X	X
Esophagus	Recovered, no further treatment, after 4 years		X	X
Eye (retinoblastosis)	Recovered, no further treatment, after 3 years		X	
Gallbladder	Recovered, no further treatment, after 3 years		X	X
Kidney	Recovered, no further treatment, after 3 years		X	X
Larynx	Recovered, no further treatment, after 2 years		X	X
Liver	All cases			Auto decline
Lung, bronchi	Recovered, no further treatment, after 3 years		X	X
Melanoma	Recovered, no further treatment, after 1 year		X	X
Nasal sinus	Recovered, no further treatment, after 3 years		X	X
Oral cavity, pharynx	Recovered, no further treatment, after 2 years		X	X
Ovary	All cases			Auto decline
Pancreas	All cases			Auto decline
Peritoneum	Recovered, no further treatment, after 4 years		X	X
Prostate	Recovered, no further treatment, after 2 years		X	X
Skin	Basal, treated	X	X	
	Squamous, treated, after 2 years		X	
Cancer *(continued)*				
Stomach	Recovered, no further treatment, after 4 years		X	X
Testicular	Recovered, no further treatment, after 3 years		X	X
Thyroid	Recovered, no further treatment, after 1 year		X	X

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Uterine	Recovered, no further treatment, after 1 year		X	X
Cardiac arrhythmia	Present or on long-term blood thinners			X
Carpal tunnel syndrome	Unoperated		X	X
	Operated, recovered, no further treatment	X	X	
Cataracts	Unoperated		X	X
	Operated, recovered, no further treatment	X	X	
Cerebral palsy	Mild only	X	X	
Cervical dysplasia	Abnormal Pap smear			X
	Two (2) normal Pap tests 6 months apart following the abnormal Pap		X	X
Chiropractic treatment or physical therapy	Rating dependent on medical diagnosis and frequency of therapy			
Cholesterol	See hypercholesterolemia			
Chronic fatigue syndrome	Fully functional without restrictions, no symptoms or medications, after 2 years	X	X	
Chronic obstructive pulmonary disease (COPD)	Consider pulmonary function tests, smoking history			
	Mild, after 5 years smoking cessation, no treatment		X	
	Moderate to severe or smoking			Auto decline
Chronic pain	Within 1 year			X
	No further treatment/medications, no symptoms	X	X	
Cleft lip/palate	Operated, within 2 years		X	X
	Operated, correction complete, after 2 years	X	X	
	Unoperated, over age 19		X	X
Club foot	No treatment anticipated/recommended	X	X	X
Coarctation of the aorta	See congenital heart defects			
Coccidioidomycosis	See Valley fever			
Colitis				
Ulcerative	Total colectomy			Auto decline
	Partial colectomy or ileostomy or colostomy			Auto decline
	Unoperated			Auto decline
Colitis *(continued)*				
Non-ulcerative	Mild or moderate, fully recovered	X	X	
	Severe after 5 years, fully recovered		X	
Congenital familial polyposis	Operated, after 5 years		X	X

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Congenital heart defects ASD – atrial septal defect PDA – patent ductus arteriosis VSD – ventricular septal defect	All cases		X	X
Coarctation of aorta	All cases	X	X	X
Dextrocardia	No symptoms or abnormalities	X	X	
Convulsive disorder				
Febrile	After 1 year, seizure free		X	X
Others	After 2 years, seizure free		X	X
Corneal ulcer	Acute	X	X	
	Chronic and unoperated			Auto decline
	Operated, fully recovered	X	X	
Craniosynostosis (infant)	Operated, fully recovered, after 2 years		X	
Crohn's disease	No symptoms, after 3 years		X	X
	Operated, after 12 months, no ileostomy or colostomy		X	X
Cystocele	Operated, fully recovered	X	X	
D				
Depression	See mental/emotional disorders			
De Quervain's disease (stenosing tenosynovitis)	Successful surgery or medical treatment, released from care	X	X	
Detached retina	Operated, fully recovered, after 1 year		X	X
Deviated septum	Unoperated		X	X
	Operated, fully recovered, asymptomatic	X	X	
Diabetes				
Gestational	Normal GTT, after delivery	X	X	
Insipidus	Before 30 years of age, after 2 years from onset		X	X
	After 30 years of age, after 5 years from onset		X	X
Mellitus • Type 2 – treated with oral medications • Type 1 – insulin dependent	Controlled, no complications, within weight guidelines, normal lab work		X	X
	Other than above (with hypertension, neuropathy, retinopathy, abnormal lab work, overweight guidelines, etc.)			Auto decline
	Requiring insulin pump			Auto decline

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Diaphragmatic hernia	Unoperated: See esophagitis			
	Operated, fully recovered	X	X	
Disc disease, herniated	Unoperated, asymptomatic, after 1 year		X	
	Unoperated, symptomatic			X
	Operated, asymptomatic, no treatment, after 6 months		X	
Dislocation – shoulder, elbow, wrist, ankle	Single episode, symptom/treatment-free	X	X	
	Multiple episodes, after 3 years, no residuals	X	X	
Diverticulitis	Resolved, responsive to treatment	X	X	
	Operated, recovered	X	X	
	All others			X
Down's Syndrome	No cardiac or other complications		X	
	Cardiac involvement, operated, asymptomatic, after 1 year		X	X
Drug addiction, history of	After 2 years of abstinence, no residuals		X	X
Dumping syndrome	Most cases		X	X
Dupuytren's contracture	Operated, after 1 year	X		
	Unoperated, no surgery anticipated		X	X
Dwarfism				
Achondroplastic	Over age 25, no significant physical or mental impairment		X	
Pituitary	Over age 20, max growth achieved, no further treatment	X	X	
Dysfunctional uterine bleeding	Asymptomatic, after 1 year, no surgery recommended	X	X	
Dyspepsia	See esophagitis			
E				
Ear infections	Infrequent episodes, responsive to medication, even after surgery	X	X	
	Frequent or recurrent episodes, within 6 months, even after surgery		X	X
	After 6 months, asymptomatic, no recurrence, even after surgery	X		
	Chronic		X	X
Emphysema, pulmonary	See Chronic obstructive pulmonary disease (COPD)			

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Endocarditis	Complete recovery, without residuals, after 3 years	X	X	
Endometriosis	Before menopause, minimal symptoms, within 5 years, only on NSAIDS		X	X
	Before menopause, moderate to severe symptoms			Auto decline
	After hysterectomy or menopause, asymptomatic	X	X	
	After menopause, symptomatic			Auto decline
Enuresis	Testing complete, consider medications	X	X	
Epicondylitis	No therapy, no cortisone shots	X	X	
Epilepsy	See convulsive disorder			
Epstein-Barr virus	See chronic fatigue syndrome or mononucleosis			
Erectile dysfunction	Testing complete, consider medications, possible further treatment/surgery		X	X
Erythema multiforme	Single attack, recovered	X		
	Recurrent, severe or chronic	X	X	X
Esophageal stricture	No symptoms or treatment, after 12 months	X	X	X
	Severe symptoms			X
Esophagitis	Infrequent episodes, occasional short course of meds		X	
	Frequent episodes or those requiring long-term or ongoing drug therapy		X	X
Exostosis	Ear involvement, symptomatic			X
	Ear involvement but asymptomatic	X	X	
	Otherwise, recovered	X	X	
F				
Familial polyposis	See congenital familial polyposis			
Fasciitis	Acute, no steroid injections, within 1 year		X	
	Recovered, symptom-/treatment-free, after 1 year	X		
	Chronic/recurrent or steroid injections, within 3 years			Auto decline
	History chronic/recurrent, fully recovered, symptom/treatment free, after 3 years	X		
Fasciitis, necrotizing	Fully recovered, after 2 years		X	X
Fetal alcohol syndrome	Testing complete, no complications or residuals	X	X	
Fibrocystic breast disease	Current, no biopsy		X	X
	Operated, benign biopsy	X	X	
	Asymptomatic, no treatment required	X	X	
Fissure, anal	Recovered, no residuals or further treatment	X	X	
	Chronic			X

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Fistula – anal, rectal, vaginal, tracheoesophageal	Unoperated, all cases			X
	Operated, recovered, no residuals	X	X	
Fractures				
Spine	Minor – without spinal cord damage, after 1 year	X	X	
	Compression – asymptomatic, no treatment	X	X	
	Symptomatic, recovered, after 2 years		X	X
Hip	Recovered, no limitations or residuals, after 3 years		X	
Simple	No hardware	X	X	
	Hardware after 1 year		X	
G				
Gall stones	Present			Auto decline
	After surgery, no complications	X		
Ganglion cyst	All cases unless surgery anticipated/recommended	X	X	
Gastric bypass				Auto decline
Gastritis	Single attack	X	X	
	All others		X	X
Genital warts	Most cases, resolved, normal Pap test	X	X	
GERD (gastroesophageal reflux disease)	See esophagitis			
Glaucoma	Most cases	X	X	
Glomerulonephritis, Nephritis	Single attack after 1 year	X	X	
	Chronic			Auto decline
Gonorrhea	Single attack, treated	X	X	
	Multiple attacks, treated		X	X
Gout	Mild, occasional attacks	X	X	
	Tophaceous or with renal involvement			Auto decline
Guillain-Barre syndrome	Present or with residuals			Auto decline
	After recovery, no residuals	X	X	
H				
Hammer toe	Unoperated		X	X
	Operated, released from care, asymptomatic	X	X	
Hashimoto's Disease	Most cases, asymptomatic	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Headaches	Migraines – see separate guideline			
	Otherwise	X	X	
Hearing loss	Traumatic, no treatment, released from care	X		
	Otherwise	X	X	
Heart attack	All cases			Auto decline
Heart murmur	Functional, no heart disease	X		
	Otherwise, consider cause of murmur		X	X
Hemorrhoids	Unoperated or severe		X	X
	Asymptomatic or mild/moderate	X	X	
Hepatitis				
Any type	Present, chronic, or persistent			Auto decline
A, B, E, or alcohol-related	Recovered after 6 months	X	X	
C and all other types	All cases			Auto decline
Hernia				
Femoral, inguinal, umbilical	Unoperated		X	X
	Operated	X		
Hiatal or diaphragmatic	Unoperated: See esophagitis			
	Operated, asymptomatic, no medication	X	X	
Herpes	Genital	X	X	
	Ocular (keratitis)			
	– Recovered, normal vision, no residuals	X	X	
	– Recovered with residuals or active, in treatment			X
	Oral	X	X	
	Zoster (shingles)			
	– Skin, single attack, no residuals	X		
	– Skin, multiple attacks, after 3 years	X	X	
	– Eye or ear involvement			Auto decline
Hip dysplasia	Of the newborn, underwritten based on severity and treatment type	X	X	
	Otherwise, see Legg-Calve-Perthes disease			
Hirschsprung's	Unoperated, or operated with symptoms		X	Auto decline
	Operated, asymptomatic	X	X	
HPV (Human Papillomavirus)	See cervical dysplasia and genital warts			

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Huntington's chorea	All cases			Auto decline
Hyaline membrane disease	All cases	X	X	
Hydrocele	Unoperated		X	X
Hydronephrosis	Recovered	X	X	
Hypercholesterol-emia	Controlled, within normal range	X	X	
Hypertension	Controlled, no medication	X	X	
	Controlled on medication		X	
	Uncontrolled or hospital within 1 year			Auto decline
	Complications (diabetes, overweight, etc.)			Auto decline
Hyperthyroidism	See thyroid diseases			
Hypoglycemia	Infrequent, mild attacks, no diabetes	X	X	
Hypospadias	Operated, within 2 years	X	X	
Hypotension	Underwritten based on cause	X	X	X
Hypothyroid	See thyroid diseases			
I				
Impotence	Testing complete, consider medications, possible further treatment/surgery		X	X
Incontinence, stress	Underwritten based on cause or pending surgery	X	X	X
Infertility	Current treatment and/or within 2 years			Auto decline
	No further tests, attempts, meds, etc., after 2 years	X		
Intestinal obstruction	Single attack, unoperated, after 1 year	X	X	
	Multiple attacks after 5 years		X	X
Intussusception	Operated, recovered	X	X	
Iritis	Single occurrence, after 6 months, no residuals	X	X	
	Multiple occurrences, after 1 year, no residuals	X	X	
Irritable bowel syndrome	Mild, infrequent attacks, OTC meds	X		
	Moderate, more frequent attacks, occasional prescription meds		X	X
	Frequent or prolonged attacks, after 5 years, prescription meds		X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
J				
Joint replacement	Single surgery, minimal mobility impairment, asymptomatic			
Hip	One hip, after 1 year		X	X
	Both hips			Auto decline
Knee	One knee, after 5 years		X	X
	Both knees			Auto decline
Shoulder, elbow, wrist, or ankle	All cases			Auto decline
All types of replacement	More than one surgery or persistent pain or significant mobility impairment			Auto decline
Juvenile rheumatoid arthritis	All cases		X	X
K				
Keloids	Most cases	X	X	
Keratosis	Most cases	X		
Kidney cyst	Simple, operated or no surgery anticipated, asymptomatic	X	X	
	Polycystic			X
Kidney infection	Single episode, recovered	X		
	Multiple attacks, after 5 years	X	X	
	Multiple attacks, within 5 years or chronic			X
Kidney stones	Present			Auto decline
	Single attack or single stone passed	X	X	
	Multiple attacks or multiple stones passed		X	X
Knee injury	Symptomatic			X
	Asymptomatic, mobility not impaired, operated or unoperated, after 1 year		X	
	Multiple surgeries, same site, asymptomatic, mobility not impaired, after 2 years		X	
	Sprains, strains	X	X	
L				
Legg-Calve-Perthes disease	Unoperated, see Osteoarthritis			
	Operated, see Joint Replacement			
Ligament injuries	Recovered/repaired, no pain, swelling, or instability	X	X	
Lupus erythematosus	Systemic			Auto decline
	Discoid, after 2 years	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Lyme disease	Asymptomatic, no residuals	X	X	
	Chronic			X
M				
Meniere's disease	Asymptomatic	X	X	
Meningitis	Recovered, no residuals			
	Single attack	X	X	
	Multiple attacks after 1 year		X	
Mental/emotional disorders	Category 1: Single episode			
Neurotic disorders or non-psychotic depression (phobias, obsessive-compulsive disorders, post-traumatic stress syndrome) or anxiety adjustments, reactions, or situational problems	**Mild to moderate** No medication, no counseling, no hospitalization	X	X	
	With counseling		X	
	Medication and counseling		X	X
	Severe Prior hospitalization and/or treatment episode, recovered, no current medication, counseling or psychotherapy, after 1 year	X	X	
	With psychotherapy or counseling		X	X
Psychotic disorders – schizophrenia, bipolar (manic depression), etc.	Category 2: Multiple episodes			X
	All cases			Auto decline
Suicide attempt	Within 3 years or multiple attempts			Auto decline
Migraines	Mild, infrequent, no emergency room visits	X	X	
	Severe or frequent or seen in ER within 2 years		X	X
Miscarriage	Final rate is dependent on number of miscarriages within 2 years		X	X
Mitral valve prolapse	Diagnosed by echocardiogram, normal or non-classic thickness/displacement	X		
	Classic, trace regurgitation or less, uses antibiotics prophylactically		X	
	More than trace regurgitation or not using antibiotics prophylactically			Auto decline
Moles	Benign pathology report	X		
Mononucleosis	No symptoms	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Myofibrositis, myositis	Single attack, mild case, recovered		X	
	Severe or multiple attacks		X	X
N				
Narcolepsy	All cases		X	X
Nephrectomy (non-malignant cause)	No residuals, normal kidney function, after 6 months	X	X	
	Persistent renal or cardiovascular abnormalities			Auto decline
Nephritis, nephrotic syndrome	See glomerulonephritis			
Nevus				
Single dysplastic nevus	All cases	X	X	
Congenital melanocytic	Small to medium, removed, benign	X	X	
	Giant			Auto decline
Dysplastic syndrome	All cases			Auto decline
O				
Osgood-Schlatter disease	See osteochondrosis			
Osteoarthritis	See arthritis			
Osteochondrosis	Recovered		X	X
Osteopenia	Mild		X	
Osteoporosis	Mild		X	
	Moderate to severe			Auto decline
Otitis Media	See ear infections			
Otosclerosis	Unoperated			Auto decline
	Operated	X	X	
Ovarian cyst	Spontaneously resolved	X		
	Operated or controlled by birth control pills	X	X	
	Polycystic ovary disease, after ovaries removed	X	X	
	Polycystic ovary disease, before ovaries removed			Auto decline
P				
Pancreatitis	Acute, single attack, unoperated gall stones			X
	Acute, single attack, gall stones removed	X	X	
	Recurrent/chronic, or secondary to alcoholism			Auto decline

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Pap tests, abnormal	See cervical dysplasia			
PDA (patent ductus arteriosis)	See congenital heart defects			
Pelvic inflammatory disease	Present			Auto decline
	Single episode or operated after tube removal	X	X	
	Multiple episodes within 2 years		X	X
Pericarditis	Non-constrictive, no residuals			
	Due to viral infection or unknown cause, after 3 years	X	X	
	Due to bacterial infection, after 1 year	X		
Peyronie's disease	All cases	X	X	
Phlebitis	Superficial	X	X	
	Deep vein, present, or on anticoagulants			Auto decline
	Deep vein, resolved – single attack		X	X
	Deep vein, resolved – multiple attacks, after 2 years		X	X
Pleurisy	Unresolved			Auto decline
	Resolved, without effusion	X	X	
	Resolved, with effusion after 5 years	X	X	
Pneumothorax	Most cases	X	X	
Poliomyelitis	With bladder or sphincter function involvement			Auto decline
	With limb weakness		X	
Polymyositis	After 1 year		X	
Polyp				
Anal or rectal	Unoperated, more than 4 polyps			Auto decline
	Unoperated, less than 4 polyps		X	X
	Operated, benign, less than 4 polyps		X	
	Operated, benign, multiple polyposis or adenomatosis, after 5 years		X	X
Bladder	Single, benign, after 12 months	X	X	
	Multiple, after 5 years	X	X	
	Present or recurrences within 5 years			Auto decline
Polyp				
Cervical	Pathology negative, no symptoms or recurrence	X	X	
Endometrial	Pathology negative, no symptoms or recurrence after 6 months	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Gastrointestinal	Unoperated			Auto decline
	Operated, benign, less than 4 polyps		X	
	Operated, benign, multiple polyposis or adenomatosis, after 5 years		X	X
Nasal or vocal cord	Benign, single	X	X	
	Benign, two or more recurrences, after 3 years		X	
Premature birth				
Good weight gain, normal development, no residuals or complications	33-37 weeks gestation	X	X	
	29-32 weeks gestation, after 2 years	X	X	
Proctitis	Single episode	X	X	
	Multiple or recurrent, after 1 year	X	X	
Prostate stones	Most cases	X	X	
	With prostatitis			Auto decline
Prostatic hypertrophy, benign	Unoperated, PSA normal • Asymptomatic or minimal symptoms, no medications, recent ultrasound/biopsy negative		X	
	Unoperated, PSA elevated but stable for 2 years • Asymptomatic or minimal symptoms, no medications, recent ultrasound/biopsy negative		X	X
	Operated • Asymptomatic, no residual operative complications	X	X	
	Otherwise			X
Prostatitis	Single episode, resolved	X	X	
	Chronic, recurrent after 6 months		X	X
Prosthesis				
Eye	Substitution complete, after 3 months	X	X	
Penile	All cases		X	X
Limb	Due to traumatic amputation, after age 18		X	X
Psoriasis	Mild to moderate	X	X	
	Severe			Auto decline
Psychosis	See mental/emotional disorders			
Pulmonary embolism	No residuals, after 3 months	X	X	
Purpura	See thrombocytopenia, purpura			

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
End-stage pyloric stenosis	Operated	X	X	
R				
Raynaud's disease	Operated or unoperated, mild, non-progressive, no complications, asymptomatic	X	X	
	Otherwise			X
Rectocele	Operated	X	X	
Reiter's syndrome	Occasional mild symptoms		X	
	Within 6 months of diagnosis			Auto decline
Renal failure/ insufficiency	Complete recovery, normal kidney function, after 1 year	X	X	
	End-stage renal failure or dialysis			Auto decline
Retinitis pigmentosa	All cases	X	X	
Rheumatic fever	Single attack, recovered, no complications	X	X	
	Multiple attacks, after 1 year, no complications	X	X	
Rotator cuff	Operated, recovered, released from care	X	X	
	Unoperated, asymptomatic		X	
	Unoperated, symptomatic			X
S				
Sarcoidosis (Boeck's)	Stable, non-progressive, no pulmonary impairment		X	X
Scarlet fever	Recovered without residuals	X	X	
Schizophrenia	See mental/emotional disorders			
Scleroderma	Minimal, localized, superficial, after 1 year		X	
	Recurrent, extensive or within 1 year			Auto decline
Seizures	See convulsive disorder			
Shingles	See herpes: zoster			
Sinusitis				
Smoker	Within 6 months, acute, no ENT abnormality, less than 3 episodes	X	X	
	Chronic		X	X
	Operated within 1 year		X	
Non-smoker	Acute, no ENT abnormality	X		
	Recurrent within 12 months		X	
Sleep apnea	See apnea			
Spermatocele	All cases	X	X	

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Spina bifida				
Cystica	Unoperated or operated with residuals			Auto decline
	Operated, asymptomatic	X	X	
Occulta	Unoperated under age 20		X	X
	Operated or over age 20 years	X	X	
Spinal curvature				
All cases	Operated, recovered after 1 year	X		
Lordosis	Asymptomatic	X		
Kyphosis	Unoperated			Auto decline
Scoliosis/ Kyphoscoliosis	Unoperated, more than 30 degree curvature			Auto decline
Spondylolisthesis or Spondylosis	Best cases after 1 year		X	
Sponge kidney	No history of infections, stones, or renal insufficiencies		X	
Sprains – knee, shoulder	See back sprain/strain			
Stasis dermatitis	No history of ulcerations/cellulites: mild, non-progressive		X	
	History of ulcerations/cellulitis			
	– Single episode, fully recovered		X	
	– Present or recurrent, after 3 years		X	
Strabismus	Unoperated, congenital or traumatic, within 6 months		X	X
	Operated, recovered, after 6 months	X	X	
Stroke	Acute, no residuals, no underlying disease, fully recovered, after 10 years		X	
Subdural hematoma	Unoperated			Auto decline
	Operated after 1 year, no residuals	X	X	
Substance abuse	See alcoholism or drug addiction			
Surrogacy	2 years with no planned surrogate or applicant as surrogate	X		
Synovitis	Single attack	X	X	
	Multiple attacks		X	X
T				
Temporomandibular joint syndrome (TMJ)	Unoperated, asymptomatic, no treatment	X	X	
	Operated	X	X	
	Surgery anticipated or operated with residuals			Auto decline
Tennis elbow	See epicondylitis			
Tetrology of fallot	See congenital heart defects			

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Thoracic outlet syndrome	Best cases	X	X	
Thrombocytopenia, purpura	After 6 months, without splenectomy	X	X	
	After 3 years, with splenectomy	X	X	
Thymoma	Benign, after 5 years		X	
	Malignant, after 10 years		X	
Thyroid diseases				
Hypothyroidism	All cases	X	X	
Hyperthyroidism, Grave's disease	Surgically or medically controlled, after 6 months	X	X	
Thyroiditis	Recovered	X	X	
Tic douloureux	Unoperated, or treated with injections after 1 year		X	
	Operated	X	X	
Tonsillitis	4 acute attacks per year, recovered	X		
	Chronic, recurrent, 5 or more attacks per year			Auto decline
Tourette's syndrome	Best cases	X	X	
Tracheo-esophageal fistula	See fistula			
Transplants	All except corneal			Auto decline
	Corneal, recovered, no residuals	X	X	
Transposition of the great vessels	See congenital heart defects			
Tuberculosis				
Positive skin test, negative chest X-ray	After release from drug therapy	X	X	
Pulmonary	Arrested, after 2 years		X	
Skin	After 2 years	X	X	
Epidydimus	All cases			Auto decline
U				
Ulcer, peptic	Currently active or unoperated, single attack within 2 years			Auto decline
	Recovered without surgery, single attack, after 2 years	X	X	
	Operated, no recurrence	X	X	
	Unoperated, multiple attacks after 2 years		X	
	Recurrent ulcer, H Pylori positive			Auto decline

Probable action guideline

Condition	Specifics	Possible eligibility at Tier 1 rate	Possible eligibility at higher tier rate	Possible or probable decline
Undescended testicle	Operated	X	X	
Ureteral stricture	Recovered or operated after 2 years	X	X	
Urethral stricture	Full recovery, after 6 months	X	X	
	Chronic, recurrent			Auto decline
Uterine fibroid tumor	Unoperated, moderate to large or multiple tumors			Auto decline
	Unoperated, single, small, no size change, after 1 year		X	
	Operated by myomectomy		X	X
	Operated by hysterectomy	X	X	
Urinary tract reflux (VUR: vesico-ureteral reflux)	Unoperated, after 1 year, no symptoms/medication, or evidence of infection or renal impairment	X	X	
	Operated, no symptoms/medication, normal renal function	X	X	
V				
Valley fever	Treated and recovered	X	X	
Varicocele	Unoperated after 2 years	X	X	
	Operated, recovered	X	X	
Varicose veins	Operated	X	X	
	Unoperated – Mild	X		
	– Moderate to severe			Auto decline
Ventricular septal defect (VSD)	See congenital heart defects			
Volvulus	Operated, no complications or residuals		X	X
W				
Wolff-Parkinson-White syndrome	With cardiac ablation, asymptomatic, after 1 year		X	
	Without cardiac ablation			Auto decline

Broker resources

The 2011 edition of our *Application and Underwriting Process Guide* makes selling Blue Shield easier than ever with these handy tools:

1. Application how-to tips
2. IFP Probable Underwriting Decision Request form
3. Key contacts and resources

Application how-to tips

Forms to use

- Individual and Family Plan general application – Form C12900-AE-A
- Medicare Supplement plan application – Form C12687 (included in pre-sale kit, MedSupp-LO/PDP4)

Checklist for completeness

You can help speed client applications through processing by doing a quick check to make sure each application is complete before you send it in. This checklist makes completed applications easy:

- ☐ Print clearly in blue or black ink. Do not use pencil.
- ☐ List the younger spouse as the applicant if applying as a married couple or domestic partners. Doing so may result in lower monthly dues/premiums for your clients.
- ☐ Select a plan type.
- ☐ Provide all medical information. Gender-specific questions need only be answered as applicable.
- ☐ Complete height, weight, and date of birth.
- ☐ Include information for all family members to be covered.
- ☐ Fill in all address information.
- ☐ Answer all information requested for last physician visit.
- ☐ Sign the application. All applicants age 18 or older must sign the application.
- ☐ Write the date next to the signature.
- ☐ Submit applications within 30 days of the applicant's signature date.

Once completed, have your clients submit the application to Blue Shield along with a personal check or money order, payable to Blue Shield, equal to one month's dues/premiums.

IFP-specific tips

Individual subscriber plans

- Only one application is needed even for multiple applicants within a family.
- We'll split the applicants out during processing.

Save time with online applications and fillable PDFs

- Try our IFP Quote and Apply Online system and see how much easier it is to close sales fast and smoothly.
- Enjoy our time-saving fillable PDF IFP application. It's easy to use. Get a copy at **blueshieldca.com/producer**.

Where to submit

New IFP applications

Blue Shield of California
Attn: I&M – Applications
P.O. Box 3008
Lodi, CA 95241-9969

Fax: **(888) 386-3420**

E-mail: **IFPapplications@blueshieldca.com**

IFP transfer applications

Blue Shield of California
Attn: IFP Plan Transfer Team
P.O. Box 629013
El Dorado Hills, CA 95762-9989

Fax: **(916) 350-7500**

Medicare Supplement plan-specific tips

These tips apply to applications for any of the following plans: A, C, D, F, and K.

Advice to clients

Please advise your clients to truthfully and completely answer all questions about their medical and health history. They should carefully review their completed applications before signing to be certain that each section has been properly recorded.

In addition to the general tips provided in this section, be sure to have clients who are applying for a Medicare Supplement plan do the following:

- Read all the instructions carefully.
- Print clearly in blue or black ink – do not use pencil.
- Retain the yellow copy of each page of the application for their files.

Completeness check

Additional items to check for Medicare Supplement plan applications:

- ☐ Health coverage information
- ☐ Subscriber number and prior healthcare company name
- ☐ Replacement form for applicants with current Medicare Supplement plan coverage
- ☐ Statement of health (except if guaranteed acceptance)

Where to submit

Submit new enrollment and transfer Medicare Supplement plan applications to:

Blue Shield of California
Attn: Medicare – Applications
P.O. Box 3008
Lodi, CA 95241-1912

Fax: **(209) 367-6391**

E-mail: **msinstall@blueshieldca.com**

IFP probable underwriting decision request

Blue Shield can help you evaluate applicant eligibility for IFP coverage.

1. Complete this form. Probable underwriting decisions require a complete health picture for each person listed on the application. If you need more room to provide details on conditions and/or medications, please attach an additional sheet of paper.
2. Fax the form with any additional pages to Blue Shield Underwriting at **(209) 371-5831**.
3. Expect a response by fax:
   - Requests received before 12 p.m., Monday through Friday, will have a response by end of the same day.
   - Requests received after 12 p.m., Monday through Friday, will have a response by 12 p.m. of the next business day.

Required information

Applicant initials	No. of applying family members	County of residence

Individual subscriber plans
- ☐ Active Start℠ Plan 35*
- ☐ Active Start Plan 35 Generic Rx*
- ☐ Active Start Plan 25*
- ☐ Active Start Plan 25 Generic Rx*
- ☐ Essential℠ 1750* package
- ☐ Essential 3000* package
- ☐ Essential 4500* package

Shield Spectrum PPO℠ plans
- ☐ PPO 5000*
- ☐ PPO 5500

Vital Shield℠ plans
- ☐ 900*
- ☐ 2900*

Shield Savings℠ plans
- ☐ 1800/3600*
- ☐ 3500*
- ☐ 4000/8000*
- ☐ 5200*

Blue Shield HMO plans
- ☐ Access+ HMO® package
- ☐ Access+ Value℠ HMO

Balance℠ plans
- ☐ 1000*
- ☐ 1700*
- ☐ 2500*

Vital Shield℠ Plus plans
- ☐ 400*
- ☐ 400 Generic Rx*
- ☐ 900*
- ☐ 900 Generic Rx*
- ☐ 2900*
- ☐ 2900 Generic Rx*

Medical conditions

Applicant data					**Dependent No.1 data**				
☐ Male ☐ Female	Age	Height	Weight	Smoker? ☐ Yes ☐ No	☐ Male ☐ Female	Age	Height	Weight	Smoker? ☐ Yes ☐ No
Specific diagnosis			Hospitalized ☐ Yes ☐ No		Specific diagnosis			Hospitalized ☐ Yes ☐ No	
Complete details of condition, including current status					Complete details of condition, including current status				
Treatment date(s) Start: ___/___/___ End: ___/___/___		Recovery date(s) if applicable			Treatment date(s) Start: ___/___/___ End: ___/___/___		Recovery date(s) if applicable		
Current medications/dosages					Current medications/dosages				

General concerns/questions (Please attach additional pages as needed)

Producer information

Producer name	Producer ID	Phone	Fax	E-mail

For underwriting use only – underwriting response

- ☐ Possible Tier 1
- ☐ Possible Tier 2
- ☐ Possible Tier 3
- ☐ Possible Tier 4
- ☐ Possible Tier 5
- ☐ Possible Tier 6†
- ☐ Possible Maximum Tier
- ☐ Decline

Notes

Underwriter | Date

This is not a final underwriting decision or acceptance of coverage. Underwriting provides this service as a courtesy to help you understand how Blue Shield might underwrite your client in advance of submitting an application. The probable underwriting decision we provide to you is based on the information you provide in the form, and does not constitute a final decision for coverage. Final decisions for coverage are based only on a signed, complete application.

* Underwritten by Blue Shield of California Life & Health Insurance Company

† Applies to child applicants under age 19. Must be in birthday month or meet the qualifying event criteria.

An Independent Member of the Blue Shield Association A17463 (7/11)

Key contacts and resources

On these pages you'll find all the ways you can contact us, and whom to ask for what. For fast service, use the phone or fax number, address, or e-mail address specific to your question.

Individual and family plans

	E-mail	Phone	Fax
New applications – submissions	IFPapplications@blueshieldca.com		(888) 386-3420
Pend information – submissions	Pend.Updates@blueshieldca.com	(800) 559-5905	(209) 367-6395
Transfer applications – submissions			(916) 350-7500
Transfer applications – pends			(916) 350-8695
Application status	ProducerServices@blueshieldca.com	(800) 559-5905 Mon – Thurs: 8 a.m. – 6 p.m. Friday: 9 a.m. – 5 p.m. Automated information available after business hours	(209) 371-5830
Information Sources Dues/premiums payment information Delinquent report fax-back requests Underwriting guidelines Commissions information/issues Product information Supply orders Broker correspondence	ProducerServices@blueshieldca.com	(800) 559-5905	(209) 371-5830
Electronic claims submission help desk		(800) 480-1221	
Dental member services		(888) 679-8928	
IFP addresses			
IFP applications – New submissions Application updates Transfer requests Medical records Underwriting requests Letters from members/subscribers	Blue Shield of California Attn: I&M – Applications P.O. Box 3008 Lodi, CA 95241-9969		
IFP transfer applications	Blue Shield of California Attn: IFP Plan Transfer Team P.O. Box 629013 El Dorado Hills, CA 95762-9989		

Medicare Supplement plans

	E-mail	Phone	Fax
New applications – submissions	msinstall@blueshieldca.com	(800) 559-5905	(209) 367-6391
Pend information – submissions	msinstall@blueshieldca.com	(800) 559-5905	(209) 367-6391
Transfer applications – submissions			(209) 367-6391
Application status	ProducerServices@blueshieldca.com	(800) 559-5905 Mon – Thurs: 8 a.m. – 6 p.m. Friday: 9 a.m. – 5 p.m. Automated information available after business hours	(209) 371-5830
Information Sources Dues/premiums payment information Underwriting guidelines Commissions information/issues Product information Supply orders Broker correspondence	ProducerServices@blueshieldca.com	(800) 559-5905	(209) 371-5830
Electronic Claims Submission Help Desk		(800) 480-1221	

Addresses	
Medicare Supplement plan applications Correspondence about Medicare Supplement plans	Medicare Supplement Department P.O. Box 3008 Lodi, CA 95241-1912

General addresses

License updates Errors and Omissions updates New appointment paperwork Broker of record changes Commissions issues New group quotes Broker information updates	Blue Shield of California Producer Services P.O. Box 2630 Lodi, CA 95241-9918

Online resources

Plans and rates • Product information including plan summaries • Underwriting guidelines • Applications and other forms Tools • Quoting • Online application • Supply ordering system • Advertising resources to help promote your business Rewards • Commission structures • Bonus programs • MVP News • Product and company information • Policy announcements • Press releases	**blueshieldca.com/producer**

For members

Blue Shield of California Network Provider Directory	**blueshieldca.com**
Blue Shield Life Network Provider Directory	**bscalife.com**
Health Insurance Counseling and Advocacy Program (HICAP): provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number for a referral to the local HICAP office. HICAP is a service provided free of charge by the state of California.	(800) 434-0222
Medicare Supplement plan member customer service	(800) 248-2341 TTY (800) 241-1823
IFP and Medicare Supplement member premium/dues payment address	Blue Shield of California P.O. Box 51827 Los Angeles, CA 90051-6127
Dental Member Services	(888) 679-8928
Dental HMO claims address	Blue Shield of California Attention: Claims Unit P.O. Box 272540 Chico, CA 95927-2540
Dental PPO claims address	Blue Shield of California P.O. Box 272590 Chico, CA 95927-2590
Enhanced dental services for pregnant women	Blue Shield of California Periodontal Coverage for Women During Pregnancy 425 Market Street, 12th Floor San Francisco, CA 94105

Statewide sales support

Northern California

Fresno

Phone: **(888) 734-4263**
Fax: (818) 228-5020
Broker development specialists provide service for this area

Sacramento

11249 Gold Country Blvd., Suite 160
Gold River, CA 95670
Phone: **(916) 851-3400**
Fax: (916) 851-3450

San Francisco

Phone: **(408) 452-6900**
Fax: (408) 452-6910
IFP regional sales manager is located in the San Jose office

San Jose

1735 Technology Dr., Bldg. 4, Suite 100
San Jose, CA 95110-1058
Phone: **(408) 452-6900**
Fax: (408) 452-6910

Walnut Creek

2175 N. California Blvd., Suite 250
Walnut Creek, CA 94596
Phone: **(925) 927-7400**
Fax: (925) 927-7410

Southern California

Los Angeles

100 N. Sepulveda Blvd.
El Segundo, CA 90245
Phone: **(310) 744-2580**
Fax: (310) 744-2894

Ontario

3401 Centrelake Drive, Suite 400
Ontario, CA 91761
Phone: **(909) 974-5200**
Fax: (909) 974-5220

Orange

555 Anton Blvd., 8th Floor
Costa Mesa, CA 92626
Phone: **(714) 428-8200**
Fax: (714) 428-4949

San Diego

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