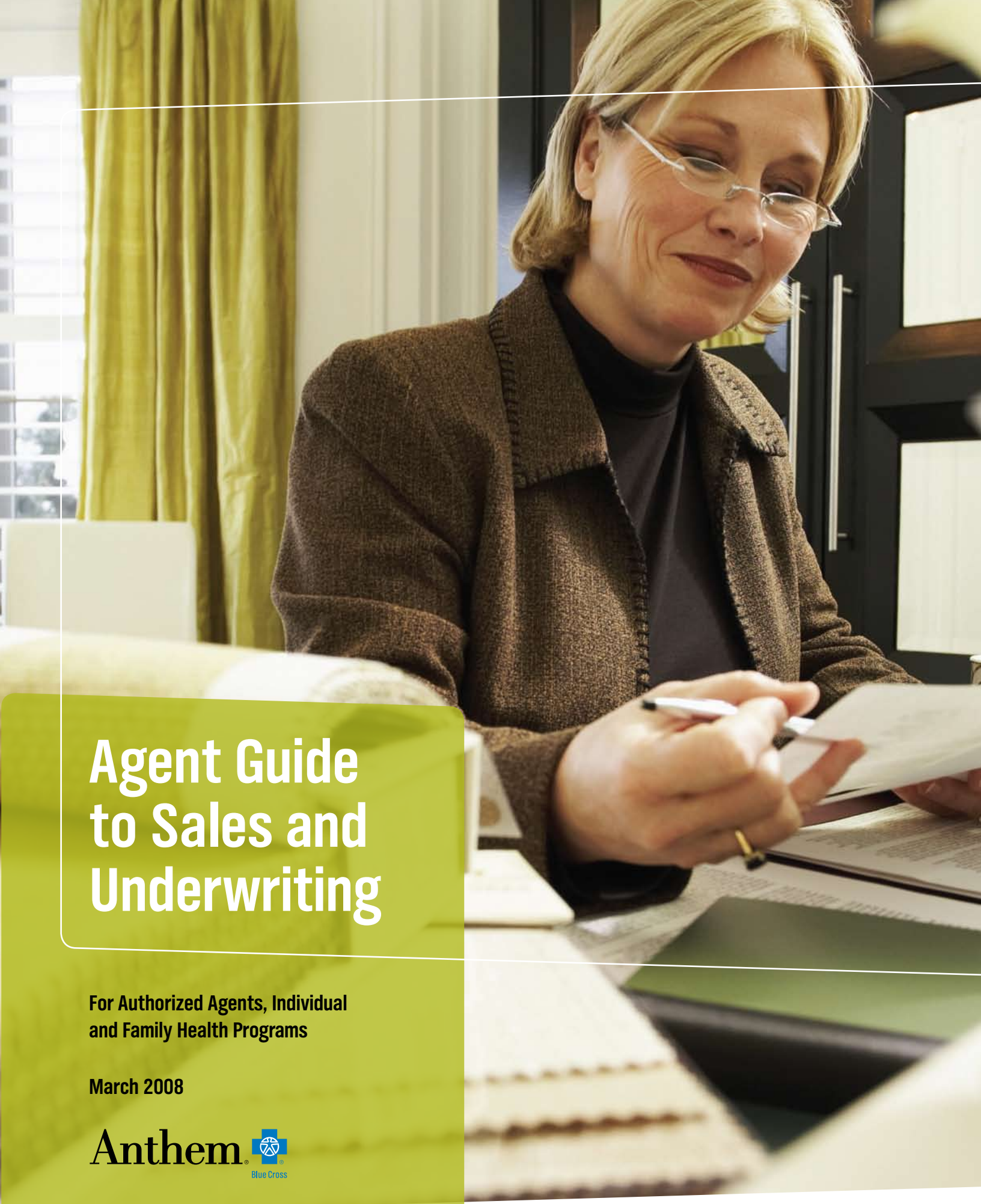


Agent Guide to Sales and Underwriting

For Authorized Agents, Individual and Family Health Programs

March 2008

Anthem Blue Cross

BCAHB3570C (7/08)

Important Addresses and Phone Numbers

Individual Services Address
Anthem Blue Cross
P.O. Box 9041
Oxnard, CA 93031-9041

Individual Dedicated Customer Service Units
1-866-297-7647

Tonik Customer Service
1-866-333-4820

Agent Sales Support
1-800-678-4466

Anthem Blue Cross Web Site
www.anthem.com/ca

Table of Contents

Table of Contents

This manual was developed to answer many of the questions you, the agent, may have when writing Anthem Blue Cross Individual business.

Introduction

These Agent Underwriting Guidelines were developed to answer many of the questions you may have when writing Anthem Blue Cross Individual business.

This manual can help save valued time and money, taking some of the guesswork out of health care underwriting. By advising your clients of the likely consequences of their coverage choices, and ensuring the accurate completion of their applications, the enrollment process can become a means to a prosperous outcome and positive experience for both you and your clients.

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

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

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

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

- Important news and updates on Anthem Blue Cross products and services
- Agent Services linking you to applicant, member and billing information for your clients
- Agent Supplies: order or print forms and sales materials directly from the Internet
- Agent Data Entry: This tool allows you to start online applications for your clients and easily manage/track application progress
- Plan rates, a Provider Finder and Anthem Blue Cross pharmacy formularies
- Your commission and account maintenance
- Information and downloads for agent sales technology, (AgentConnect, Agent Download and AgentOnline)
- Other general information including a services directory and available discounts especially for Anthem Blue Cross agents

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

About Anthem Blue Cross Companies

For more than 65 years, Californians have partnered with Anthem Blue Cross to obtain the coverage that helps protect their health and financial security. Generation after generation, Anthem Blue Cross has earned the trust of agents, consumers and providers through integrity, stability, choice, service and value.

Anthem Blue Cross' health care coverage products are provided by Anthem Blue Cross, a health care service plan regulated by the Department of Managed Health Care, or an insurance company regulated by the California Department of Insurance.

About Anthem Blue Cross Companies

Product Overview

Lumenos Plans

Key Features

- Plans with maternity coverage and plans without
- **Choice:** Direct access to a vast PPO network of more than 50,000 doctors and 400 hospitals statewide.
- **Control:** Your clients can control a portion of the dollars theyspend on their health.
- **Healthy Rewards Incentives:** Your clients can earn health care dollars through participation in tobacco cessation programs, weight loss programs and other activities.
- **$5,000,000 of lifetime coverage (plans with maternity)**
- **$7,000,000 of lifetime coverage (plans without maternity)**

SmartSense Plan

Key Features

- Affordability: among our lowest monthly rates
- Choice: four annual deductible options, choice of comprehensive or generic only prescription drug benefits
- Immediate benefits: first three office visits before deductible
- $7,000,000 of lifetime coverage
- No maternity coverage is provided.

HSA-Compatible Plans are compatible with Health Savings Accounts, which your clients can open and fund to help pay for qualified medical and prescription drug expenses. Your clients can choose from many different plans which vary by deductible and out-of network maximums.

HIA Plans have a Health Incentive Account funded by Healthy Rewards Incentives for our clients. The HIA helps pay for the cost of their medical and prescription drug expenses. Your clients can choose from many different plan which vary by deductible and out-of network maximums.

HIA Plus Plans have a Health Incentive Account funded by the health plan. The HIA helps pay for the cost of their medical and prescription drug expenses. Your clients can choose from three different plans which vary by deductible and out-of network maximums.

Other PPO Plans

Key Features

- **Choice:** Direct access to a vast network of more than 50,000 doctors and 400 hospitals statewide.
- **Discounted Rates:** Discounts for in-network services apply even before the deductible is met on most plans except Basic PPO 2500 and Basic PPO 1000.
- **Lower Premiums:** Clients share more upfront costs (coinsurance and deductibles) in exchange for lower premiums.
- **$5,000,000 of lifetime coverage**

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

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

Product Overview

The ***RightPlan PPO 40**** has no medical deductible and features a convenient office visit copay and three options for prescription drug coverage. Designed for specific life stages, this plan is written and priced on a single policyholder basis. A separate application for each applicant is preferred. No maternity coverage is provided. Options include

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

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

*These plans are offered by Anthem Blue Cross Life & Health Insurance Company.

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

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

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

HMO Plans

Key Features

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

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

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

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

† This plan is offered by Anthem Blue Cross.

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

General Information

Levels of Coverage

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

Level 1 coverage is offered for all of our Lumenos/PPO, HMO and EPO plans. An applicant with no medical conditions or medical conditions of low underwriting risk, as determined by Anthem Blue Cross, may be placed in a Level 1 plan.

Level 1 +20 20 rate-up plans are the same as Level 1 plans, but with rates that are 20 percent higher. Effective April 1, 2007, applicants who use tobacco products, and who have no other medical condition(s), will receive a 20% rate up for tobacco use. Tobacco products include cigarettes, cigars, pipe tobacco, and chewing tobacco. Other applicants who may receive a 20% rate up are those applying for HMO plans and who have a medical condition(s) of moderate underwriting risk as determined by Anthem Blue Cross, and/or who are receiving medical treatment. In some areas, persons enrolling in an HMO for certain providers will be assigned this rate because of higher health care costs. PPO/EPO members whose original effective date is prior to March 1, 2004 may be on a Level 1+20 plan. When these members request a plan downgrade, they may be downgraded to the requested plan at Level 1 +20 rates.

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

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

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

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

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

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

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

General Information

Conditions of Eligibility

All applicants for Individual plans must meet the following requirements:

1. Must have resided in the United States for three months prior to applying for enrollment. (See United States Residency Requirements on page 10.)
2. Under age 64-3/4.
3. Not eligible for Medicare A or B.
4. **Applicants under age 18** – Applications must be signed and dated by the natural parent, adoptive parent or legal guardian.
   Newborn to six months – Acceptable only after review of the Individual Enrollment Application by the Underwriting Department. *Medical records will be required.* Newborn Telewrite Form will be used. Medical records will be requested when not enough information has been obtained via telephone.
5. Dependents:

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

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

   Foster children – Foster children are eligible as dependents under the foster parents' Anthem Blue Cross health care plan. A foster child may qualify as an underage member, provided that underage member requirements are met. Medical underwriting is required.

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

   Spouse or Domestic Partner – Anthem Blue Cross' definition for a domestic partnership is each party is the sole domestic partner of the other, each are at least 18 years of age, must heave lived together for the previous 6 months, are finacially inter-dependent, are not married to anyone else and are not related by blood in a way that would prohibit marriage. Anthem Blue Cross will accept a domestic partner selected under marital status and require no further investigation. This policy applies to both same sex as well as opposite sex partners.

   For more information, visit www.ss.ca.gov/dpregistry.

   Dependent children –

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

General Information

United States Residency Requirements

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

California Residency Requirements

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

Medical Report of Applicant (MRA)

Applicants who do not meet the United States Residency Requirements may be eligible for enrollment in an Individual plan if they submit a completed Medical Report of Applicant (MRA) form along with proof of state residency.

1. The Applicant(s) must meet all other Individual Medical Underwriting Guidelines.
2. Non-United States citizens who submit an MRA, and proof of state residency, may apply for any Individual plan, including Short Term plans.
3. If the underwriter determines that the Applicant(s) may be eligible for enrollment, an MRA form along with a letter explaining the purpose of the form, what information is required, and how a physician can be located is sent to the Applicant.
4. If, based upon the information provided on the Health Statement or Claims History, the underwriter determines that the Applicant(s) is not eligible for enrollment, the application is declined without sending an MRA.
5. The MRA form can only be completed by a participating physician.
6. The MRA form must be submitted to underwriting within 30 days of the date of the MRA explanation letter.
7. The MRA is not in lieu of an Attending Physician's Statement and underwriting reserves the right to request an Attending Physician's Statement in lieu of, or in addition to, the MRA.
8. Items accepted as proof of State Residency for non-United States citizens applying for coverage with an MRA form are:
    - Rent or mortgage receipts in the Applicant's name
    - Utility bills in the Applicant's name
    - Medical records documenting treatment or residency in the United States
9. P.O. Boxes are not an acceptable form of state residency.
10. The completed MRA form must be returned to Individual Medical Underwriting within thirty (30) days of the date of the MRA letter. At the discretion of management, this may be extended (on a case-by-case basis) to 45 days.

Short-Term Coverage

Overview

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

Issuing a Short-Term Health Care Policy

Anthem Blue Cross Life & Health Insurance Company offers PPO coverage to qualifying residents of California on a short-term basis. Following is a list of plans for Short-Term health care coverage:

- Anthem Blue Cross Life and Health PPO 250 (NM04)
- Anthem Blue Cross Life and Health PPO 500 (NM05)
- Anthem Blue Cross Life and Health PPO 1000 (NM06)
- Anthem Blue Cross Life and Health PPO 2000 (NM07)

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

Eligibility and Eligible Dependents

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

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

A qualified dependent is

- The legally married spouse or domestic partner of the applicant
- The applicant's child, or the child of the applicant's spouse/enrolled domestic partner, under 19 years of age OR
- The applicant's unmarried dependent child between 19 and 23 years of age ('Dependent' as defined by the Internal Revenue Service)

It is written for the length of time (start and end date) requested by the applicant. There are no effective date changes and no refunds of premium paid.

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

Duration of the Short-Term Policy

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

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

Short-Term Policy Effective Date

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

Enrollment

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

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

Short-Term Coverage

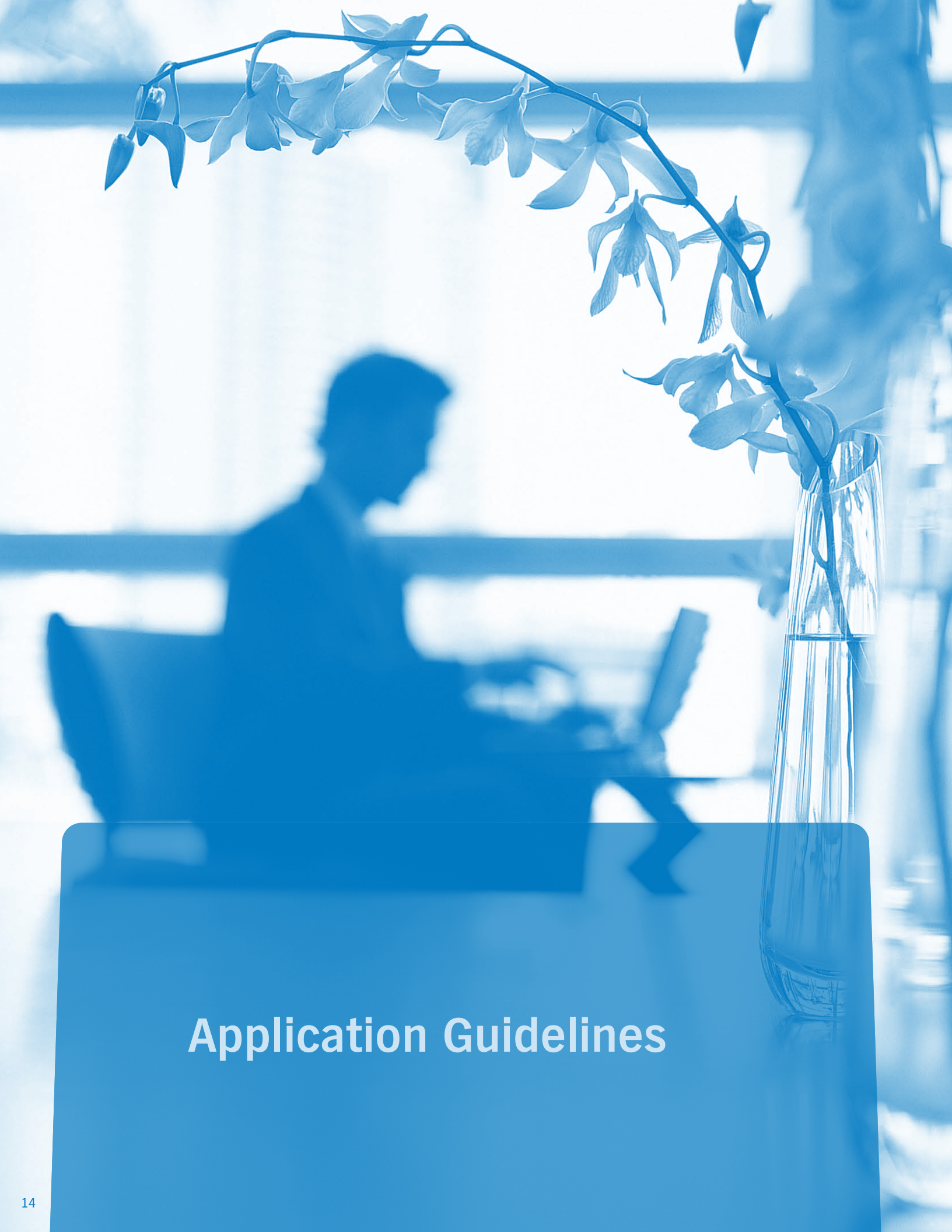
Payment Discrepancies

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

Adding Members

Anthem Blue Cross does not allow adding dependents on short term coverage. Once an applicant has been approved on a short term, Anthem Blue Cross can not add a dependent to that policy. The dependent will ned to apply on their own short term coverage.

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



Application Guidelines

Application Guidelines

Key Points to Remember

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

Member Language of Record

- If the applicant does not read or write English, a **statement of accountability** must be completed.
- The application is available in other languages.

Application Guidelines

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

Section 1: Applicant Information

Application information must be completed by the applicant.

Social Security or ID Number – A Social Security Number is strongly recommended (Not required) for faster turnaround time.

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

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

Do not submit an application for immigrants until they have proof of U.S. residency. (Three months of continuous residency in the United States is not required prior to enrollment. Applicants will need to submit a MRA Medical report form.)

Home Address – Must be the applicant's actual physical address. A post office box is acceptable. Applicant must be a permanent legal resident of California.

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

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

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

Language (optional) – Indicate language choice.

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

Section 2: Choice of Anthem Blue Cross Individual Coverage

FamilyElect®

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

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

Application Guidelines

Medical Coverage

Lumenos Coverage:

HSA 1500, 2500, 3000, 5000
HIA 1500, 2500, 3000, 5000
HIA Plus 1500, 2500, 3000, 5000

Lumenos Coverage without Maternity and SmartSense effective 12/1/07

Other PPO Coverage:

Basic PPO 1000 (7900)
Basic PPO 1000 without Life (PE25)
Basic PPO 2500 (R418)
Basic PPO 2500 without Life (R419)
PPO Saver (NM31)
PPO Saver without Life (PE27)
Share 5000 (H062)
CORE 5000 (DL96)
RightPlan PPO 40-No Rx (P958)
RightPlan PPO 40-Generic Rx (PE48)
RightPlan PPO 40-Comprehensive Rx (PE49)
3500 Deductible PPO (R420)
PPO Share 500 (1929/7895)
PPO Share 1000 (1930/1393)
PPO Share 1500 (7889)
PPO Share 2500 (7891)
PPO 3500 (HSA-Compatible) (T160)
EPO (HSA-Compatible) (7892)

HMO Coverage:

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

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

HIPAA Enrollment:

To determine eligibility, go to Section 5.

Dental Coverage

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

Section 3: Applicants for Medical Coverage

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

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

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

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

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

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

3C. Dependent Information – This section must be completed for eligible dependents ages 19-22 years of age. These applicants must also read, sign and date Section 7, Application Understandings, Conditions and Agreement.

Section 4: Anthem Blue Cross Life & Health Term Life Coverage

Applicants and/or any dependents that are approved for coverage will also qualify for Anthem Life coverage at an additional charge. Applicants under the age of one year are not eligible for Term Life coverage. DO NOT SUBMIT PREMIUM FOR TERM LIFE COVERAGE. If premium is submitted and only after approved, we will apply amount to cover premium. If member elected the recurring option, we will bill accordingly.

The $50,000, $75,000 and $100,000 amounts are not available to applicants under the age of 19. If selected by an approved applicant under the age of 19, the selection will default to $30,000. If beneficiary information is not listed and the policy is issued, death benefits will be paid in accordance with the Beneficiary Provision as stated in the policy.

Application Guidelines

Section 5: Prior Insurance History and HIPAA Eligibility

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

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

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

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

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

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

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

Section 6: Health History

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

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

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

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

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

Application Guidelines

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

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

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

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

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

Statement of Accountability

For non-English speaking applicants, the Statement of Accountability must be signed.

Section 7: Application Understandings, Conditions and Agreement

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

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

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

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

Lumenos, PPO 3500 (HSA-Compatible) and EPO (HSA-Compatible) Applicants Only – Having this coverage does not establish an HSA. To do so, the applicant must contact a qualified financial institution.

Application Guidelines

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

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

Section 8: Payment Method

Members may choose the following payment methods:

8A: Monthly Checking Account Automatic Premium Payment or Monthly Credit/Debit Card debit—these options DO NOT require your client to send in any other payment for the initial premium.

8B: Initial payment by paper check, electronic check or one time credit card. If these options are chosen, after initial payment is applied, your client will automatically default to bi-monthly paper billing.

NOTE: When applicants send a check to us, they authorize Anthem Blue Cross to convert the check into an Electronic Fund Transfer (EFT) and will incur an administrative fee added to every bill. If an applicant is approved for coverage, the bank account will be debited for the amount indicated on the check. If an applicant does not qualify for coverage, the check will not be submitted for a fund transfer. The check will not be returned to the applicant.

For more information regarding these Payment Methods, please see page 22.

To Be Completed by the Anthem Blue Cross-Appointed Agent

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

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

Application Guidelines

Situations That May Cause an Application to Be Returned

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

Common Errors/Omissions That Delay Processing of Applications

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

Application Guidelines

Payment Options

Monthly Checking Account Automatic Premium Payment – By having their premium paid automatically each month from their personal checking account, your client will save postage, paperwork and give them one less thing to worry about. In addition, they can **select any day of the month (1st to 28th)** for the debit to occur. Also, when your client applies with this payment option, there is **no need to send a paper check** as initial payment. If approved, we will automatically debit one month premium the next business day after approval, subsequent debits will occur on their selected debit day. We also no longer require a voided check for set up.

To select this option, new applicants should complete section 9A & 9C of the Individual Enrollment Application (form #IU2138). Existing members should complete and submit the Monthly Checking Account Automatic Premium Payment Authorization (form #IS7134) OR they can call **866-249-4844** (CA ONLY) to set up this payment option with our automated system or a Customer Service Associate.

Credit Card – This option is available to new applicants who wish to pay initial and/or monthly health, dental or life premiums with a VISA, MasterCard or Discover credit card. **Also, when your client applies and selects this option for recurring monthly payments, there is no need to send a paper check for the initial payment.** If they choose to pay their initial premium by one time credit card, they will default to bi-monthly paper billing for future payments.

Applicants should complete section 9A & 9D of the NEW Individual Enrollment Application (form #IU2138) to select monthly credit card deduction for their initial and subsequent premium payments. OR, if they wish to have their credit card debited for the initial premium payment only, please have them complete section 9B & 9D. Existing members can also choose this option by calling **866-249-4844** (CA ONLY) and using our automated system or have a Customer Service Associate help.

Personal Check – New applicants may submit their first premium payment by personal check. When this option is chosen, their future billings will default to bi-monthly paper bills. NOTE: If your client writes a paper check for initial or ongoing premium payments there will be an administrative fee added to every bill, Anthem Blue Cross will convert the check into an electronic payment, store a copy of the check and destroy the original paper check*. The payment will appear on your client's bank account or credit union statement. The transaction will be listed as an Electronic Funds Transfer (EFT) and categorized under ATM withdrawals, as a direct or electronic payment, or under check listing.

*(Not all checks qualify to be converted to Electronic Funds Transfer.)

Applicants should complete section 9B of the Individual Enrollment Application (form #IU2138) to choose this option.

Electronic Check — In lieu of sending a paper check for their initial premium payment, applicants can now choose to pay with an Electronic Check. Just like a personal check, their payment will be converted to an Electronic Funds Transfer—see NOTE under Personal Check for more info. Also, like paper check, when this option is chosen, their future billings will default to bi-monthly paper bills and an administrative fee will be added to every bill.

Applicants should complete section 9B of the Individual Enrollment Application (form #IU2138) to choose this option.

Automated IVR Payments — Any client receiving a billing by mail, can choose to pay their premium by using our Automated Phone Payment System. If a member chooses to use an associate in lieu of the automated IVR, there is a $15 fee for one time payments. This is waived if they elect recurring payments. The system offers four options:

1. One Time Check by Phone*
2. One Time Credit Card Payment*
3. Recurring Monthly Checking Deduction**
4. Recurring Monthly Credit Card Deduction

*These options will default to bi-monthly billing by mail after current premium has been debited.

**The IVR will allow your client to select any day for this debit from the 1st to the 28th of the month.

The number for this service is 866-249-4844.

Application Submission Options

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

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

Fax – Completed applications may also be faxed to 805-713-8840 or 800-327-9255. To benefit from the expedited fax submission process, the applicant should choose either the monthly checking account automatic premium payment or credit card option.

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

The Application and Underwriting Process

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

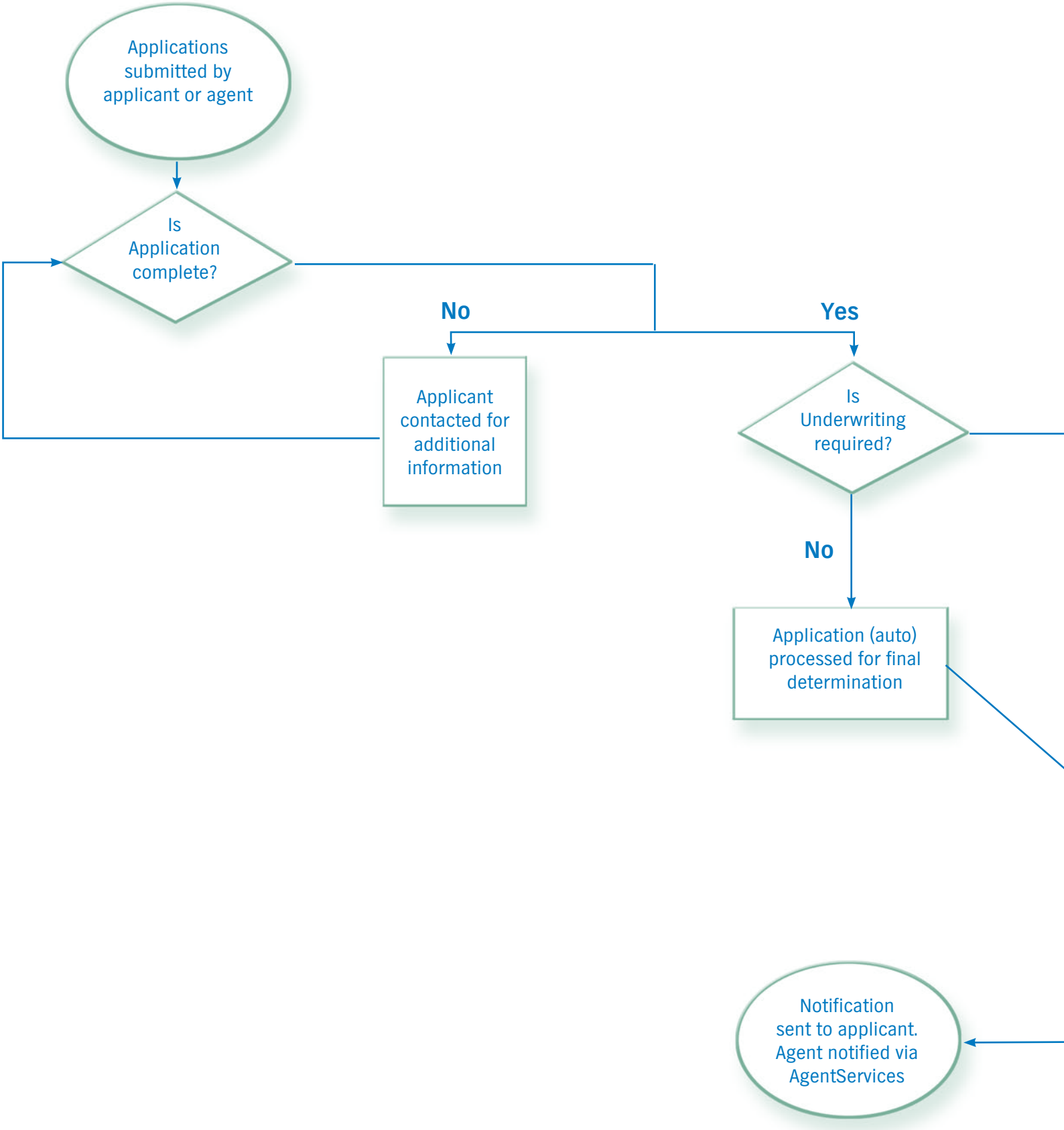
Tracking Applications

Check application status online.

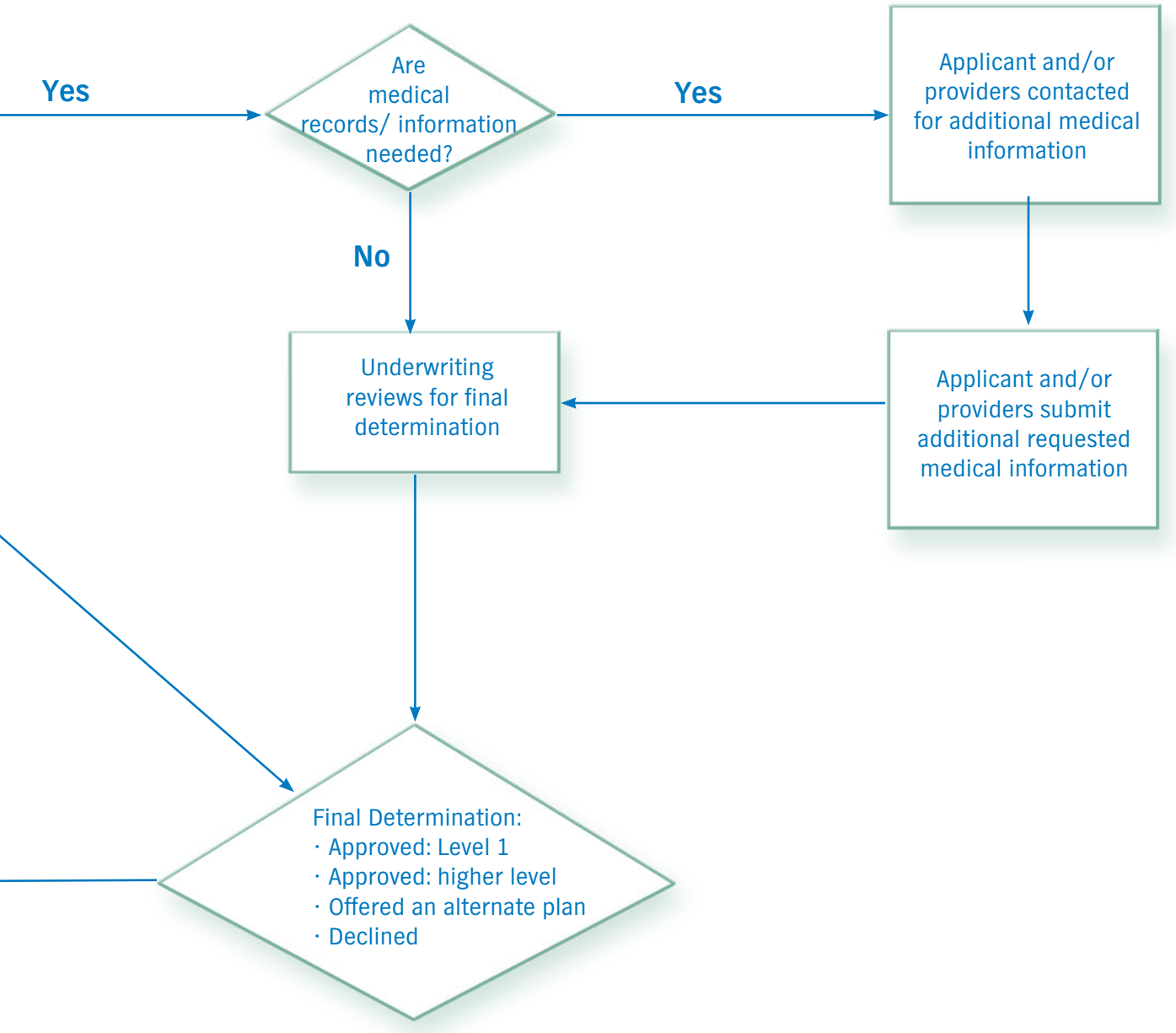
- Go to www.anthem.com/ca
- Click on Agents/Brokers
- Log on
- Click AgentServices
- Click Applicants

The Application and Underwriting Process

The Application and Underwriting Process



For certain conditions (asthma, back disorders, newborn, seizures), underwriters will be calling applicants directly to get the information needed, instead of relying on Attending Physician Statements. This should reduce turnaround time for applications and eliminate the need for some medical requests. Plus, we'll get a fuller understanding of the member's individual situation. In most cases, we will be able to collect the required information without requesting medical records, however there may be some instances where these may be requested after speaking with the applicant. We will make up to three attempts to reach the applicants. If we are unable to reach them, we will move forward with requesting the Attending Physician Statements.



Insurability

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

Body Mass Index

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

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

Tobacco Use

Studies show that individuals who smoke and/or use tobacco products are at a greater risk for certain health conditions than non-smokers. The applicant's smoking history will be taken into consideration when underwriting certain medical conditions. While certain medical underwriting guidelines already incorporate the applicant's smoking history, applicants who use tobacco products, and have no other medical condition(s), will receive a 20% tobacco use rate up. Tobacco products include cigarettes, cigars, pipe tobacco and chewing tobacco.

Prescription Medications

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

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

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

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

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

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

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

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

- INH
- Clomid
- Femara
- Coumadin

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

*These plans are offered by Anthem Life Insurance Company.

Full Disclosure of Medical History

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

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

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

Health Care Underwriting Guidelines

BMI Reference Chart Male Ages 18 – 64

Height	APS	Level 1		Level 1 + 25		Level 1 + 50		Decline
	BMI ≤ 18.5	Weight Range in lbs. BMI 18.5 – 31.9		Weight Range in lbs. BMI 32.0 – 34.9		Weight Range in lbs. BMI 35.0 – 38.9		BMI ≥ 39.0
4'6" (54")	< 77	77	132	133	144	145	161	162+
4'7" (55")	< 80	80	137	138	150	151	167	168+
4'8" (56")	< 82	82	141	142	155	156	173	174+
4'9" (57")	< 86	86	147	148	161	162	179	180+
4'10"(58")	< 88	88	151	152	166	167	185	186+
4'11"(59")	< 92	92	158	159	173	174	192	193+
5'0" (60")	< 94	94	162	163	177	178	197	198+
5'1" (61")	< 98	98	168	169	184	185	205	206+
5'2" (62")	< 100	100	172	173	189	190	210	211+
5'3" (63")	< 104	104	179	180	196	197	219	220+
5'4" (64")	< 108	108	186	187	204	205	227	228+
5'5" (65")	< 111	111	191	192	209	210	233	234+
5'6" (66")	< 115	115	198	199	216	217	241	242+
5'7" (67")	< 118	118	203	204	222	223	247	248+
5'8" (68")	< 122	122	210	211	229	230	256	257+
5'9" (69")	< 125	125	215	216	236	237	263	264+
5'10"(70")	< 129	129	222	223	243	244	271	272+
5'11"(71")	< 132	132	227	228	249	250	277	278+
6'0" (72")	< 136	136	235	236	257	258	287	288+
6'1" (73")	< 139	139	240	241	262	263	293	294+
6'2" (74")	< 144	144	248	249	271	272	302	303+
6'3" (75")	< 149	149	256	257	280	281	312	313+
6'4" (76")	< 152	152	262	263	286	287	319	320+
6'5" (77")	< 156	156	269	270	295	296	329	330+
6'6" (78")	< 160	160	275	276	301	302	335	336+
6'7" (79")	< 164	164	283	284	310	311	346	347+
6'8" (80")	< 168	168	289	290	316	317	353	354+
6'9" (81")	< 173	173	298	299	326	327	363	364+
6'10"(82")	< 176	176	304	305	332	333	371	372+
6'11"(83")	< 181	181	312	313	342	343	381	382+
7'0" (84")	< 185	185	319	320	349	350	389	390+
7'1" (85")	< 190	190	328	329	359	360	400	401+
7'2" (86")	< 193	193	333	334	365	366	406	407+
7'3" (87")	< 199	199	343	344	375	376	418	419+

BMI Reference Chart Female Ages 18 – 64

Height	APS	Level 1		Level 1 + 25		Level 1 + 50		Decline
	BMI ≤ 17.5	Weight Range in lbs. BMI 17.5 – 30.9		Weight Range in lbs. BMI 31.0 – 33.9		Weight Range in lbs. BMI 34.0 – 38.9		BMI ≥ 39.0
4'0" (48")	< 58	58	101	102	111	112	127	128+
4'1" (49")	< 60	60	104	105	115	116	131	132+
4'2" (50")	< 62	62	109	110	120	121	137	138+
4'3" (51")	< 65	65	115	116	126	127	144	145+
4'4" (52")	< 67	67	118	119	129	130	149	150+
4'5" (53")	< 70	70	123	124	135	136	155	156+
4'6" (54")	< 72	72	128	129	140	141	161	162+
4'7" (55")	< 75	75	133	134	146	147	167	168+
4'8" (56")	< 78	78	137	138	150	151	173	174+
4'9" (57")	< 81	81	142	143	156	157	179	180+
4'10"(58")	83	83	147	148	161	162	185	186+
4'11"(59")	87	87	153	154	168	169	192	193+
5'0" (60")	89	89	157	158	172	173	197	198+
5'1" (61")	92	92	163	164	179	180	205	206+
5'2" (62")	94	94	167	168	183	184	210	211+
5'3" (63")	98	98	174	175	191	192	219	220+
5'4" (64")	102	102	181	182	198	199	227	228+
5'5" (65")	105	105	185	186	202	203	233	234+
5'6" (66")	108	108	192	193	210	211	241	242+
5'7" (67")	111	111	196	197	215	216	247	248+
5'8" (68")	115	115	203	204	223	224	256	257+
5'9" (69")	118	118	209	210	229	230	263	264+
5'10"(70")	122	122	215	216	236	237	271	272+
5'11"(71")	125	125	220	221	241	242	277	278+
6'0" (72")	129	129	228	229	250	251	287	288+
6'1" (73")	132	132	232	233	255	256	293	294+
6'2" (74")	136	136	240	241	263	264	302	303+
6'3" (75")	140	140	248	249	272	273	312	313+
6'4" (76")	144	144	253	254	278	279	319	320+
6'5" (77")	148	148	261	262	286	287	329	330+
6'6" (78")	151	151	266	267	292	293	335	336+

Using the Underwriting Guidelines

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

Scenario 1

A 42-year-old self-employed married man with two children is seeking health care coverage for his entire family. After the applicant determines the plan or plans for which the family will apply and completes an application, you review the application for completeness. While all other family members report no conditions, you notice that the applicant has been diagnosed with hypercholesterolemia (high cholesterol) and has been taking medication for two years. You check the Common Conditions list on the pages that follow and note that hypercholesterolemia requires full medical records. You ask the applicant to provide copies of his medical records, ensuring he has also disclosed exact medications he has taken. You then submit all information to Anthem Blue Cross, along with an Authorization for Use of Protected Health Information form (form # 9680), and wait for a final determination of coverage level offered or insurability.

Scenario 2

A 30-year-old divorced, single mother of two is seeking health care coverage for herself and one child. After the applicant determines the plan or plans for which she will apply and completes an application, you review the application for completeness. You notice that the child has a history of chronic bronchitis and the mother has had one instance of cervical dysplasia. You check the Common Conditions list on the pages that follow and note that chronic bronchitis requires full medical records. The instance of cervical dysplasia, however, occurred more than four years prior with no apparent recurring instances. You ask the applicant to provide copies of full medical records for the child and inform her that additional records may be required for her. You then submit all information to Anthem Blue Cross, along with an Authorization for Use of Protected Health Information form (form # 9680), and wait for a final determination of coverage level offered, insurability or if more medical records are required.

Common Conditions

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

Condition	Specifics	Medical Records Needed?	Possible Coverage at the Tier 1 Rating	Possible Coverage at the Higher Rating	Possible or Probable Decline
Heart Conditions	***Will require complete medical records & current cardiac exam & specific blood tests/echocardiogram***				
Angina	After 2 years, depending on the cardiac risk factors	Always		X	X
Arrhythmias	Depending on type, treatment, after 6 months	Always	X	X	
By pass surgery (cardiac)/ Angioplasty	After 2 years, depending on other risk factors, no stent	Always		X	X
Heart Attack (myocardial infarction)	After 2 years, BMI less than 28, depending on cardiac risk factors	Always		X	X
Heart Murmur	Depending on type, severity and treatment	Always		X	X
Mitral Valve Prolapse (MVP)	Best cases	Always	X		
	All others			X	X
Pacemaker	All cases				Decline
Valve Replacement	All cases				Decline
Hemorrhoids	Operated or no symptoms	As needed	X	X	
	Not operated, or severe			X	X
Hepatitis					
Any type	Current, chronic or persistent				Decline
Hepatitis A	After 3 months	Always	X	X	
Hepatitis B carrier	No virus detected and/or HBA DNA at 0, for 2 years	As needed		X	X
Other Hepatitis (C,D,E)					Decline
Hernia					
Femoral, umbilical, inguinal	Operated, after 3 months	As needed	X	X	
Hiatal	No treatment required	As needed	X		
	Treated less than 1 year ago			X	X
Herpes					
Genital	Within past 5 years	As needed	X	X	X
Zoster (Shingles)	1-2 episodes, after 6 months		X	X	X
Hodgkin's Disease	(see Cancer)				
Hydrocele	Operated, after 60 days	As needed	X		
	Not operated			X	X
Hypercholesterolemia (High Cholesterol)	Most cases controlled without medication	Always	X		
	Control with medication, BMI less than 34, no other risk factors		X	X	

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Common Conditions (continued)

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

Situations Causing Automatic Declination

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

- Based on "Declinable Conditions" list (see page 48)
- BMI of 39 or greater
- Infertility evaluated or treated within the past 5 years (male, female or spouse)
- Insulin dependent diabetic
- Intravenous drug use/abuse history
- Medical records requested incomplete or not current
- Medications use that does not meet the "Drug Underwriting" criteria
- Organ transplant history or awaiting an organ transplant
- Pregnant or in the process of adopting or surrogate pregnancy (applicant or spouse whether or not listed on the application)
  - Male applicant expecting a child within the next ten (10) months, by either natural or artificial means. (The mother may or may not be listed on the application, or he may or may not be legally married to the mother of their child.)
- Male applicants whose spouse or significant other is pregnant can be enrolled in the RighPlan PPO 40 plan
- Prosthesis replacement: Candidate or age 18 years or younger with a removable prosthesis
- Sexually transmitted diseases: 3 or more within the past 5 years
- Shunt or stent, or placement of a shunt required
- Signs, symptoms, and/or abnormal diagnostic test results for which a conclusive diagnosis has not been established
- Surgery candidate
- Suicide attempted within the past 5 years

MEDICATIONS THAT MAY RESULT IN DECLINATION (GENERIC)

The following is a partial list of medications that either alone, in combination with other medications, and/or due to associated medical conditions, may result in declination. This list is subject to change at any time and without notice.

abacavir
acarbose
adalimumab
adrenocorticotropin hormone
agalsidase beta
agenerase
aldesleukin
alglucerase
alendronate sodium
alitretinoin gel
amiloride HCL
anagrelide HCL
anastrozole
antihemophiliac factor
aripiprazole
aspirin-dipyzidamole
atovaquone
azathioprine
azulfidine
baclofen
bleomycin
bromocriptine mesylate
budesonide
calcitriol
capecitabine
choriogonadatropin
cilostazol
cisplatin
clofazimine
clomiphene citrate
clopidogrel bisulfate
cloprostenol
clozapine
cortisone, corticotropin
cyclosporine
cytomegalovirus immune globulin
daclizumab
dalteparin sodium
danazol
danparoid sodium
dapzone
daunorubicin citrate
delavirdine mesylate
didanosine
dipyridamole
disulfiram
docetaxel
dolasetron mesylate
donepezil HCL
dornase alfa Inhal
doxorubicin HCl
dronabinol
efavirenz
enfuvirtide
enoxaparin sodium
entacapone
epoetin alpha
esomeprazole magnesium
etanercept
exemstane
fampridine
felbamate
filgrastim
follitropin beta
fomirvirsen
foscarnet sodium
flutamide
fulvestrant
gabapentin
ganciclovir
glatiramer acetate
goserelin acetate implant
guanfacine HCl
heparin sodium
hydroxyurea
ibandronate sodium
IGIV
imiglucerase
immune globulin
indinavir sulfate
infliximab
irbesartan
insulin
interferon, interferon beta
isoniazid
isoprinosine
isotretinoin
lamivudine
leflunomide
letrozole
lymphocyte immune globulin
mazinol
mBACOD
memantine
methadone
methotrexate
miglitol
muromonab CD3

Declinable Medications (continued)

- mycophenolate mofetil
- nateglinide
- nevirapine
- nifedipine
- nipent
- octreotide acetate
- olsalazine sodium
- paclitaxel
- palivizumab
- pergolide mesylate
- peginterferon alfa-2
- pentamidine
- pilocarpine HCL
- pioglitazone HCl
- pyrimethamine
- rabeprazole sodium
- rasogiline mesylate
- repaglinide
- ribavirin
- rifabutin
- risperidone
- ritonavir
- rituximab
- rosuvastatin calcium
- saquinavir
- selegiline HCl
- simvastatin
- somatrem
- somatropin
- stavudine
- sulfasalazine
- tacrine hydrochloride
- tamoxifen citrate
- tegaserod maleate
- testosterone
- thalidomide
- threonine
- tolcapone
- topotecan
- trihexyphenidyl HCL
- thyrotropin
- trandolapril
- trastuzumab
- urofollitropin
- valrubicin
- warfarin
- zalcitabine
- zidovudine

MEDICATIONS THAT MAY RESULT IN DECLINATION (BRAND NAMES)

The following is a partial list of medications that either alone, in combination with other medications, and/or due to associated medical conditions, may result in declination. This list is subject to change at any time and without notice.

Alferon-N
Abilify
Accutane
ACTH
Adalat
Aggrenox
Agrylin
Alphanate
Amnesteem
Amprenavir
Antabuse
Anzemet
Arava
Aricept
Arimidex
Aromasin
Artane
Atgam
Avapro
Avonex
Axura
AZT
Azilect
Azulfidine
Betaseron
Capoxone
Cellcept
Ceredase
Cerezyme
Claravis
Clomid
Clozaril
Cognex
Combivir
Comtan
Copaxone
Coumadin
Crixivan
Cytogam
Cytovene
d4T
Danocrine
Daunoxome
ddC
ddI
DHPG
Daraprim
Dipentum
Dopar
Doxil
Droxia
Eldepryl
Enbrel
Entocort
Epivir
Epogen
Fabrazyme
Faslodex
Felbatol
Femara
Fertinex
Follistim
Fortovase
Foscavir
Fragmin
Fuzeon
Gammagard, Gamimmune, Gamunex
Gonal F
Glyset
Herceptin
HIVID
Humate
Humatrope
Humegon
Humira
Hycantin
Immunivir
Imuran
INH
Intron-A
Invirase
Lamprene
Leponex
Lioresal
Lovenox
mBACOD
Marinol
Mazanor
Mavik
Mepron
Mycobutin
Neoral
Neupogen
Neurelan
Neurontin
Norvir
Orgaran
Orthoclone OKT3

Declinable Medications (continued)

Panretin
Parlodel
Pegasys
Peg-Intron
Pentam
Pentostatin
Pergonal
Persantine
Platinol
Plavix
Pletal
Pneumopent
Prandin
Precose
Procrit
Proleukin
Protropin
Pulmozyme
Rebif
Rebetron
Remicade
Repronex
Rescriptor
Retrovir
Risperdal
Ritonavir
Rituxan
Rocaltral
Salagen
Sandimmune
Sandostatin
Sanorex
Serophene
Sotret
Starlix
Sustiva
Synagis
Tasmar
Taxotere
Tenex
Threostat
Thyrogen
Valstar IVes
Videx
Viramune
Vitravene
Xeloda
Zenapax
Zerit
Ziagen

Declinable Conditions

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

- Achalasia, Cardiospasm
- Acromegaly
- Acquired Immune Deficiency Syndrome
- Acute Poliomyelitis
- Addison's Disease
- AIDS & AIDS Related Complex (ARC)
- Alcoholic Cirrhosis of Liver
  - Psychosis
- Alzheimer's Disease
- Amyloidosis
- Amyotrophic Lateral Sclerosis (ALS)
- Anemia, Aplastic
  - Cooley's
  - Hemolytic
  - Mediterranean (Thalassemia Major)
  - Sickle Cell
- Ankylosing Spondylitis
- Ankylosis
- Arterial Embolism, Thrombosis
- Arteritis
- Arthritis, Rheumatoid
- Autism, Infantile
- Banti's Disease (Liver Disorder)
- Biliary Cirrhosis
- Blastomycosis
- Brain Damage (Organic)
- Bright's Disease (Glomerulonephritis)
- Bronchiectasis
- Buerger's Disease (Thromboangitis Obliterans)
- Burkett's Tumor (Malignant Lymphoma)
- Cachexia
- Cardiomyopathy
- Cardiospasm, Achalasia
- Cerebral Palsy (Infantile)
- Charcot-Marie Tooth Disease
  - (Peroneal Peripheral Neuropathy)
- Chronic Glomerulonephritis
- Chronic Hepatitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Pulmonary Heart Disease
- Cirrhosis, Biliary
- Congestive Heart Failure
- Cooley's Anemia
- Cushing's Syndrome
- Cystic Fibrosis
- Cystic Kidney Disease
- Dermatomyositis
- Dentofacial Function Abnormalities (Crouzon's
  - Disease)
- Disorders of Autonomic Nervous System
- Drug Psychosis
- Emphysema
- Glomerulonephritis, Chronic
- Hemiplegia
- Hemolytic Anemia
- Hemophilia, Von Willebrand's Disease
- Henoch's Purpura
- Hepatitis, Chronic
- Hepatomegaly
- Human T-Cell Leukemia Virus
- Human T-Cell Lymphotropic Virus
- Huntington's Chorea
- Hydrocephalus
- Hypersplenism
- Immunodeficiency Disorder
- Infantile Autism
- Kaposi's Sarcoma
- Klinefelter's Syndrome (Gonadal Dysgenesis)
- Legionella Pneumophilia
- Leukoencephalopathy
- Lipisosis (Neiman-Pick Disease)
- Lupus Erythematosus, Systemic
- Lymphadenitis
- Mediterranean Anemia (Thalassemia Major)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Myelopathy
- Neiman Pick Disease (Lipidosis)
- Neurofibromatosis (Von Recklinghausen's Disease)
- Neuropathy, Inflammatory Toxic (Guillain Barre's Syndrome)
- Occlusion of Cerebral Arteries
- Osteitis Deformans (Paget's Disease)
- Paraplegia
- Paget's Disease (Osteitis Deformans)
- Parkinson's Disease
- Pemphigus
- Peroneal Peripheral Neuropathy
- Pneumoconiosis
- Poliomyelitis, Acute
- Polyarteritis Nodosa
- Polycythemia
- Polymyositis
- Polyneuropathy
- Porphyria
- Postinflammatory Pulmonary Fibrosis
- Psoriatic Arthropathy
- Psychosis Organic Brain Syndrome
- Pulmonary Alveolar Proteinosis
- Pulmonary Heart Disease, Chronic
- Purpura

Declinable Conditions (continued)

Quadriplegia
Raynaud's, Phenomenon, Syndrome
Renal Failure, Chronic, Uremic
Sarcoma, Kaposi's
Scleroderma
Senile, Pre-senile Organic Syndromes
Sickle Cell Anemia
Silicosis
Sjogren's Disease
Spina Bifida
Spinocerebellar Disease
Spondylitis
Syringobulbia, Syringomyelia
Systemic Lupus Erythematosus
Tabes Dorsalis
Tay-Sach's Disease (Cerebral Lipidosis)
Temporal Arteritis
Testicular Dysfunction
Tetralogy of Fallot
Thalassemia, Anemia Major
Thromboangitis
Thrombotic Thrombocytopenia Purpura
Transient Organic Psychotic Conditions
Uremia
Varices, Esophageal
Von Recklinghausen's Disease (Neurofibromatosis)
Von Willebrand's Disease (Hemophilia)
Werlhof's Disease (Purpura, Thrombocytopenia)

Conditions Requiring Medical Records

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

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

Medical Record Authorization

A signed Authorization for Use of Protected Health Information (form # 9680) must accompany any request for medical records. If the authorization is not received within 10 days of request, the application will be withdrawn.

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

Legal Requirements

Applicant/Client Responsibility

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

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

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

Agent Responsibility

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

Translations for Non-English Speaking Applicants

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

Important Information About Medicare

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

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

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

Questions your Medicare-eligible clients may have:

Q: Do I need both Medicare Part A (hospital coverage) and Part B (health care coverage including doctor visits and outpatient hospital care) coverage?
A: Please encourage your clients to apply for both.

Q: What options do my dependents have if I go on Medicare and drop my Individual coverage?
A: The dependents would be entitled to be covered under a separate Individual plan in their own names. The same plan may be continued without underwriting and we would only need an Individual Enrollment Application.

Anthem Blue Cross does offer Medicare Supplemental policies at affordable rates. The member has guaranteed issue with any supplemental plan, including those with prescription drug benefits, for the first six months after obtaining Part B of Medicare. These policies are designed to cover deductible and copay amounts not covered by Medicare.

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

Frequently Asked Questions

Applying for Coverage

Q: What form should new Individual clients (applicant and dependents) complete to apply for health care and/or dental coverage?

A: The Individual Enrollment Application (form # IU2138).

Q: Where can my client list additional medical information and/or applicants for health care and/or Term Life coverage?

A: The additional information should be listed on a Supplement to Individual Enrollment Application (form # 3955) and submitted with the Individual Enrollment Application (form # IU2138).

Q: If my client completed and submitted an Individual Enrollment Application to Anthem Blue Cross in the past, may my client use this same application to apply or reapply for coverage?

A: Yes, if the date your client signed the Individual Enrollment Application is older than 30 days but under 75 days and there has been no change in health status. However, your client must also submit an Exceptions to Standard Enrollment Form (form # IU2071). Part A of this form must be completed, signed, dated and submitted within 30 days from the date the original application was withdrawn, cancelled or denied.

Q: How can my non-English speaking clients update information on an application that they have already submitted?

A: If the application has been submitted within the last 30 days, your clients may update the information on the Exceptions to Standard Enrollment Form (form # IU2071). If someone is completing the form in English on their behalf, that person must also sign and date Part C, the Statement of Accountability.

Q: May a person who is not a natural or adoptive parent of an applicant, but who is assuming financial and/or legal responsibility for that applicant, sign an Individual Enrollment Application for an applicant who is unable to do so?

A: No. The person assuming financial and/or legal responsibility must complete, sign and date Part B of an Exceptions to Standard Enrollment Form (form # IU2071). This form and court papers authorizing the legal guardianship must accompany the application. The responsible adult must be able to authorize access to medical, legal and psychiatric records.

Q: Since the RightPlan PPO 40 is for single policyholders, does each applicant within a family need to complete a separate Enrollment Application?

A: For ease of processing the applications, it's recommended that each applicant complete a separate application and submit a separate premium check for each RightPlan PPO 40 applicant.

Q: What are the U.S. residency requirements?

A: Refer to page 10 for a list of requirements an applicant must meet.

Q: What are the dependent limitations?

A: Refer to page 9 for information on dependent eligibility.

Q: Can there be a newborn/child only policy?

A: Yes. Refer to page 9 for information on dependent eligibility.

Q: If my client is submitting an application for two children, who would be the main applicant?

A: The youngest child would be the main applicant.

Q: Can my clients request any day of the month effective date?

A: Yes. For PPO and HMO applicants, the late requested can be any date following but not greater than 75 days after the signature date.

Q: What is the difference between the Anthem Blue Cross products and the Anthem Life products?

A: The Anthem Life products are regulated by the Department of Insurance. The Anthem Blue Cross products are regulated by the Department of Managed Health Care.

Frequently Asked Questions

Q: What is an "APS"?

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

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

A: A Letter to Attending Physician is a form used by the Underwriting Department to obtain an APS, medical records or additional medical history from a provider due to information listed on the application or due to prior claims history with Anthem Blue Cross. If the physician from whom the additional information is required is listed on the application, the form letter is sent directly to the physician. An Authorization for Use of Protected Health Information form (form # 9680) signed by the client must accompany the request. The applicant then receives a notification letter (Notice to Applicants Regarding Attending Physician Statement) stating that this action has been taken.

If there is a diagnosis but no physician listed on the application, if the physician listed has not seen the applicant within 12 months of the signature date on the application, or if the physician's address is not complete, then the applicant will receive both the notification letter and the letter to the physician requesting medical information. **The cost of any necessary examination is not reimbursed by Anthem Blue Cross.**

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

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

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

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

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

Frequently Asked Questions

Changing Coverage

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

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

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

Refer to the Individual Plan Option Table on page 56.

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

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

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

Payment Options

Q: What premium payment options do my clients have?

A: Your clients have three options:

1. Monthly checking account automatic premium payment
2. Payment by credit card
3. Bi-monthly bills by mail – pay by personal check or use automated Interactive Voice Response (IVR) system to make a Check by Phone or one-time credit card payment. Please note: Members can call to set up automated recurring payment at no additional cost.

For more information, see the Payment Options section on page 22 .

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

A: New applicants and existing members who are changing coverage and must complete a new Individual Enrollment Application (form # IU2138) can complete Section 8A of the form. Existing members can complete and submit the Monthly Checking Account Automatic Premium Payment Authorization Form (form # IS7134). Your clients should note that authorization received after the 15th of the month may not be activated the 1st of the following month. Their premiums should be current to avoid cancellation. Please note: Members can call to set up automated recurring payment at no additional cost.

Individual Plan Option Table

Individual Plan Option Table

Anthem Blue Cross

To: Level 1

Effective February 1, 2008

Move From:

Move From:	DL96 CORE 5000	R418 Basic PPO 2500	7900 Basic PPO 1000	T160 PPO 3500 (HSA-Compatible)	R420 3500 Deductible PPO	H062 PPO Share 5000	NM31 PPO Saver	7891 PPO Share 2500	7892 EPO	7889 PPO Share 1500	1393 PPO Share 1000 (BCC)	7895 PPO Share 500 (BCC)	1930 PPO Share 1000 (BCL&H)	1929 PPO Share 500 (BCL&H)	PE43 Select HMO	7896 HMO Saver	7899 Individual HMO	PE48 RightPlan PPO 40 (Generic Rx)	PE49 RightPlan PPO 40 (Comprehe	P958 RightPlan PPO 40 (No Rx)	DN13 Tonik 1500	DN14 Tonik 3000	DN15 Tonik 5000	DX26-28 HSA 1500	DX32-34 HSA 2500	DX38-40 HSA 3000	DX44-46 HSA 5000	DX47-49 HIA Plus 2500	DX53-55 HIA Plus 3000	DX59-61 HIA Plus 5000	DX62-64 HIA 1500	DX68-70 HIA 2500	DX74-76 HIA 3000	DX80-82 HIA 5000	Z126-128 HSA 1500 Non-Maternit	Z132-134 HSA 3000 Non-Maternity	Z129-131 HSA 5000 Non-Maternit	Z135-137 HIA Plus 1500 Non-Mate	Z141-143 HIA Plus 3000 Non-Mate	Z138-140 HIA Plus 5000 Non-Mate	Z144-146 HIA 1500 Non-Maternity	Z150-152 HIA 3000 Non-Maternity	Z147-149 HIA 5000 Non-Maternity	Z153-154 SmartSense 500 Generi	Z155-156 SmartSense 1500 Gene	Z157-158 SmartSense 2500 Gene	Z159-160 SmartSense 5000 Gene	Z161-162 SmartSense 500 Compr	Z163-164 SmartSense 1500 Comp	Z165-166 SmartSense 2500 Comp	Z167-168 SmartSense 5000 Comp
CORE 5000		A	A	A	A	A*	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Basic PPO 2500	C		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Basic PPO 1000	C	W		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
PPO 3500 (HSA-Compatible)	W	W	W		C	C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
3500 Deductible PPO	W	W	W	W		C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 5000	W	W	W	C	C		C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Saver	W	W	W	C	C	W		C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 2500	W	W	W	C	C	W	W		C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
EPO	W	W	W	W	W	W	W	C		C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 1500	W	W	W	C	C	W	W	W	W		C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 1000 (BCC)	W	W	W	C	C	W	W	W	W	W		C	W	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 500 (BCC)	W	W	W	C	C	W	W	W	W	W	W		W	W	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 1000 (BCL&H)	W	W	W	C	C	W	W	W	W	W	W	C		C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
PPO Share 500 (BCL&H)	W	W	W	C	C	W	W	W	W	W	W	W	W		C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
Select HMO	W	W	W	A	A	A	A	A	A	A	A	A	A	A		A	W	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
HMO Saver	W	W	W	A	A	A	A	A	A	A	A	A	A	A	W		W	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Individual HMO	W	W	W	A	A	A	A	A	A	A	A	A	A	A	W	W		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
RightPlan PPO 40 (Generic Rx)	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C		C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
RightPlan PPO 40 (Comp Rx)	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W		W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
RightPlan PPO 40 (No Rx)	C	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C		A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
Tonik 1500	W	W	W	C	C	C	W	C	C	C	C	C	C	C	A	A	A	W	C	W		W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
Tonik 3000	W	W	W	C	C	C	W	C	C	C	C	C	C	C	A	A	A	W	C	W	A		W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
Tonik 5000	W	W	W	C	C	C	W	C	C	C	C	C	C	C	A	A	A	C*	C	C*	A	A		C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
HSA 1500	W	W	W	W	W	W	W	W	W	W	C	C	C	C	C	C	C	W	C	W	A	A	A	C	W	W	W	W	W	W	W	W	W	W	W	W	W	W	W	W	W	W	W	C	C	C	C	C
HSA 2500	W	W	W	W	W	W	C	W	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C		W	W	W	W	C	W	W	W	C	W	W	C	W	W	C	W	W	C	W	C	C	C	C	C
HSA 3000	W	W	W	W	W	W	C	C	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C		W	C	W	W	C	W	W	C	W	W	C	W	W	C	W	W	C	W	W	C	C	C	C
HSA 5000	W	W	W	C	C	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C		C	C	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
HIA Plus 2500	W	W	W	W	W	W	C	W	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	W	W	W		W	C	W	W	W	C	W	W	C	W	W	C	W	W	C	W	C	C	C	C	C
HIA Plus 3000	W	W	W	W	W	W	C	C	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	W	W	C		W	C	C	W	C	W	W	C	W	W	C	W	W	C	W	C	C	C	C	C
HIA Plus 5000	W	W	W	C	C	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	W	C	C		C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
HIA 1500	W	W	W	W	W	W	W	W	W	W	C	C	C	C	C	C	C	W	C	W	A	A	A	W	W	W	W	W	W	C		W	W	W	W	W	W	W	W	W	W	W	W	C	C	C	C	C
HIA 2500	W	W	W	W	W	W	C	W	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	W	W	W	W	W	W	C		W	C	W	W	C	W	W	C	W	W	C	W	C	C	C	C	C
HIA 3000	W	W	W	W	W	W	C	C	W	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	W	W	C	W	W	C	W		C	W	W	C	W	W	C	W	W	C	W	C	C	C	C	C
HIA 5000	W	W	W	C	C	W	C	C	C	C	C	C	C	C	C	C	C	W	C	C	A	A	A	C	C	C	W	C	C	C	C	C	C		C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
HSA 1500 Non-Maternity	W	W	W	W	W	C	W	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C		W	W	W	W	W	W	W	C	C	C	C	C	C
HSA 3000 Non-Maternity	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C		W	C	W	W	C	W	W	C	C	C	C	C	C
HSA 5000 Non-Maternity	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C		C	C	C	C	C	C	C	C	C	C	C	C
HIA Plus 1500 Non-Maternity	W	W	W	W	W	C	W	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	W	W	W		W	W	W	W	W	C	C	C	C	C	C
HIA Plus 3000 Non-Maternity	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	W	W	C	W		C	W	W	C	C	C	C	C	C	C
HIA Plus 5000 Non-Maternity	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	W	C	C		C	C	W	C	C	C	C	C	C
HIA 1500 Non-Maternity	W	W	W	W	W	C	W	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	W	W	W	W	W	W		W	W	C	C	C	C	C	C
HIA 3000 Non-Maternity	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	W	W	C	W	W	C	C		W	C	C	C	C	C	C
HIA 5000 Non-Maternity	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	W	C	C	C	C	C	C	C	C	C	C	C	C
SmartSense 500 Generic	W	W	W	W	W	C	W	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C		W	W	W	C	C	C
SmartSense 1500 Generic	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C		W	W	C	C	C
SmartSense 2500 Generic	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	C	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C		W	C	C	C
SmartSense 5000 Generic	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C		C	C	C
SmartSense 500 Comprehensive	W	W	W	W	W	C	W	C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	W	C	W	W
SmartSense 1500 Comprehensive	W	W	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	C		W
SmartSense 2500 Comprehensive	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	W	W	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	W	C	C	
SmartSense 5000 Comprehensive	W	W	W	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	A	A	A	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	W	C	C	C

A = Full Application C = Change of Coverage Application (underwriting required) W = Written Request (underwriting not required).

A* = Full Application with the Following Exception: If a CORE 5000 member changes to the PPO Share 5000 within six months from the CORE 5000 original effective date, a Written Request (underwriting not required) will be allowed.

- Moving to a higher deductible plan is not allowed once the member's out-of-pocket maximum has been met.
- Tonik members can move to a higher deductible Tonik plan with a Written Request. Tonik members can move to a lower deductible Tonik plan by completing a Tonik Application which will be reviewed by Underwriting. Tonik members can move to a non-Tonik Anthem Blue Cross plan by completing an Individual Enrollment Application which will be reviewed by Underwriting.
- Any change from a Basic or HIPAA plan to any other product requires a Full Application. EXCEPTION: A change from the Basic PPO 1000 plan, or the Basic 2500 plan, to the CORE 5000 plan requires a Change of Coverage Application.

The following plans are offered by Anthem Blue Cross: PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and Dental SelectHMO. The following plans are offered by Anthem Life Insurance Company: CORE 5000, Basic PPO 2500/1000, PPO Saver, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), HSA 1500/2500/3000/5000, HIA 1500/2500/3000/5000, HIA Plus 2500/3000/5000, SmartSense 500/1500/2500/5000, PPO Share 5000/1000/500, RightPlan PPO 40 plans, Tonik plans, Short-Term PPO plans, PPO Dental and Term Life products. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross names and symbols are registered marks of the Blue Cross Association.

Agent Tools

Technology

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

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

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

The Web site is also your exclusive portal to:

- AgentServices – where you can review real time status of your book of business and submissions
- AgentConnect – where you can link your clients to our online application and other helpful sales tools
- Agent Assistant Download – where you can download the latest information for use in your marketing and quoting activities.

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(800) 678 - 4466

For more information, please visit anthem.com/ca.

The following plans are offered by Anthem Blue Cross: PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO, and DentalSelect HMO plans. The following plans are offered by Anthem Blue Cross Life & Health Insurance Company (BCL&H): LUMENOS® plans, CORE 5000, Basic PPO 2500/1000, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), Short-Term PPO Plan, Dental Blue, Dental PPO, and Term Life products.

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