

Georgia Agent Guide

February 2012

Policies and Procedures

Sales and Underwriting for Authorized Agents



BGAHB6342G



Contact Information

Please see the website, BCBSGa.com for additional contact information.

<u>Contacts</u>	<u>Call</u>	<u>Web</u>
Appointment/Licensing	Phone: 800-304-6470 option 7 Fax: 877-455-4097	licensingandcredentialing@wellpoint.com
Website Access Technical Issues Agent Connect	888-268-4361	software.support@wellpoint.com
Pre-Sales application status requests	866-215-4879	GABrokerServices@bcbsga.com
Underwriting Opinion Forms		GA_underwriting@Wellpoint.com *contains "underscore" after GA
Post Sale In-force contracts: Member issues ID card status Billing Options for renewing members	866-215-4879	GABrokerServices@bcbsga.com
Supplies		https://merrillconnect.iscorp.com/wellpoint/
Applications/Form Submission	Fax	Mail
New (Individual) Applications Short-term Applications Dental (only) Applications Term Life (only) Applications HCTC Applications All change requests regardless of underwriting requirement	866-538-0824	BCBSGa 3350 Peachtree Road GA G008-0005 Atlanta, GA 30326
New Individual Applications		Email dl-applicationexpressGA@bcbsga.com
Bank Draft Applications	800-327-9255	BCBSGa 3350 Peachtree Road GA G008-0005 Atlanta, GA 30326
Completed Medical Questionnaires and Re-review (Appeal) Requests	800-327-9255	BCBSGa Mail Code GA G008-0005 P.O. Box 4445 Atlanta, GA 30302-4445



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This guide is intended to be used as a general reference designed to assist you in determining Blue Cross and Blue Shield of Georgia's (BCBSGa) most common underwriting practices and to answer common questions regarding coverage for individuals under age 65. **The Agent's guide is not all-inclusive and is subject to change without prior notice.**

Helpful Hints for Completing the Application

Taking a few minutes now to review the following may avoid unnecessary delays in processing the application. **PLEASE MAKE SURE:**

1. Paper applications are completed in ink.
2. All questions have been answered completely including height/weight for all applicants.
3. All changes/corrections have been initialed and dated by the primary applicant. **Do not use correction fluid.**
4. The applicant (the spouse/domestic partner and any adult dependents, if applying for coverage) have all signed and dated all appropriate areas. **Please do not date the application for any applicant.**
5. The primary applicant is the older spouse/domestic partner.
6. Include additional pages as needed for applicant/medical information. Include the primary applicant's SSN on each additional page.
7. The agent has signed and dated the application. All requested agent information is completed including the complete agent number.
8. The agent is licensed and appointed to sell the program applied for.
9. The custodial parent or guardian has completed the health history for any underage dependent and the minor has been questioned regarding tobacco, alcohol and drug use. The applicant will be held accountable for the accuracy of all health information provided or omitted in the event retroactive action becomes necessary.
10. Proof of legal guardianship or other legal documents (e.g. Power of Attorney) is included (if necessary).
11. Any/all medical information is included if there is a questionable condition. **Completing the medical detail thoroughly can speed up the processing of the application.**
12. **The first month's premium must be made at the time of application. Payment may be made via check, electronic check, EFT or credit card.**
13. All appropriate medical questionnaires are completed in full, signed and dated by applicant. (See Medical Questionnaires)

No agent or representative has the authority to waive the answer to any question on the application, to pass on insurability, to waive any BCBSGa's rights or requirements, or to make or alter any contract.

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How to Apply

New applications, applications for Dental, Term Life and change request forms can be faxed to: **866-538-0824**, or mailed to: **Blue Cross and Blue Shield of Georgia; 3350 Peachtree Road NE; Mail Code GAG008-0005; Atlanta, GA 30326.**

New individual applications may also be emailed to dl-applicationexpressGA@bcbsga.com

Completed Medical Questionnaires and Re-review (Appeal) Requests can be faxed to: **800-327-9255** or mailed to: **Blue Cross and Blue Shield of Georgia; Mail Code GA G008-0005; P.O. Box 4445; Atlanta, GA 30302-4445.**

Bank Draft Agreements and any other correspondence can be faxed to: **800-327-9255** or mailed to: **Blue Cross and Blue Shield of Georgia; 3350 Peachtree Road NE; Mail Code GAG008-0005; Atlanta, GA 30326.**

Initial Premium Payment

Payments by check: Because the applicant's underwriting status is not yet determined when the initial premium payment is due, the initial premium payment due with the application is equivalent to the Level I rate. If underwriting determines that the applicant is rated up, the difference between the initial payment and the actual premium will be added to the member's first billing statement.

Payments by credit card or eCheck for one-time initial payment only, or EFT from a checking account for initial and on-going payments: The initial premium charged is the amount determined by underwriting, which may include a rate up. For this reason, it is recommended to quote applicants based on their health status.

Eligibility Requirements

Service Area

To purchase coverage, the applicant and spouse/domestic partner to be covered must be residents of the state of Georgia. Dependents up to age 26 who meet all other eligibility requirements may be covered under their parent/legal guardian policy.

Age

Primary applicants must be at least age 19 and up to the age limits noted below. Applicants under the age of 19 who qualify as dependents may apply for coverage as a dependent on a family application (primary subscriber must be at least 19 years of age). It is required that a parent or legal guardian must be approved for coverage on the same application with a child (under age 19) in order for a child to be eligible for coverage. If no parent or legal guardian is approved for coverage, no child on the application will be issued coverage.



BCBSGa's Individual policies are available to applicants age 19 to 64.5. Applicants must meet all other eligibility criteria in addition to passing medical underwriting. With the exception of short-term coverage, applicants enrolled in Individual coverage prior to turning age 65 may have their coverage continue, however, it is recommended that covered persons age 65+ who are enrolled in Medicare, purchase a Medicare Supplement policy.

Short-term coverage is available to applicants age 19 up to 65 years. Individuals enrolled in short-term coverage cannot turn 65 during the duration of the policy.

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Dependents (Eligible Family Members)

- **Applicant's spouse or domestic partner.** Our general definition for a domestic partnership is that each party is the sole domestic partner of the other, one person is at least 19 years of age, must have lived together for the previous six months, is financially inter-dependent, is not married to anyone else, and is not related by blood in a way that would prohibit marriage.
- **Applicant's natural child, adopted child, stepchild; or other child for whom the applicant or applicant's spouse/domestic partner is legally responsible.** "Child" also includes the insured's mentally or physically handicapped child, if the disability occurred prior to age 26, who is claimed as a dependent on the applicant's federal income tax return. BCBSGa requires written proof of such handicap within 31 days of the child's 26th birthday.
- **In the case of a natural child, adopted child, or stepchild, it is not mandatory that the child live with the applicant.** However, in the case of "other child" (e.g., foster child, grandchild), it is necessary that the child live with the applicant in a "natural parent-child setting". Please submit legal guardianship documentation with the application anytime the dependent falls into the "other child" category.
- Siblings cannot apply for a 2+ person contract without a parent or legal guardian included on the application.

Foreign Exchange Students

Coverage is available to Foreign Exchange Students who are enrolled in a foreign exchange student program and who pass medical underwriting. If a foreign exchange student has not resided in the U.S. for at least three months, he/she must have a physician complete our Medical History Form. If the form is not submitted with the application it will be requested during the underwriting process. The foreign exchange student cannot travel outside of the U.S. for more than 30 consecutive days during the term of the policy.

Medicare

Individuals are not eligible for an Individual health policy if they are currently eligible for Medicare.



Non-U.S. Citizens

Coverage is available to non-U.S. Citizens. If the applicant has lived in the U.S. for less than three months he/she must have a physician complete a Medical History Form. The form cannot be completed more than 30 days prior to submission of the application and the physician completing the form must be licensed in the U.S. The Medical History Form is available at **BCBSGa.com**. The effective date of the policy cannot be prior to the day after BCBSGa receives the Medical History form. If the applicant does not currently have coverage the earliest effective date will be the day after the Medical Report of Applicant is received by BCBSGa OR 10 days after the application is received by BCBSGa, whichever date is later. Submitting a completed Medical History Form with the application will expedite the underwriting process.

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Coverage in Addition to Blue Cross and Blue Shield of Georgia Individual Coverage

A person cannot purchase a BCBSGa Individual policy “in addition” to any other Individual policy regardless of the carrier. The applicant cannot purchase a BCBSGa Individual policy “in addition” to a short-term policy. The applicant may apply for an Individual policy “in addition” to a BCBSGa or any other carrier’s group policy.

Employer Payment of Premium

Our policies are Individual health insurance policies. As such, they shall not be used as employer provided health care benefit plans. No employer of any covered person under these policies may contribute to any premium directly or indirectly, including through wage adjustment, specific to coverage for health insurance. Wage adjustments that do **not** require the purchase of health insurance are allowed. “Employer” in this context does not include a trade or business wholly owned by an individual or individual and spouse/domestic partner that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an Individual policy if only purchasing it for one employee.

List Bill

Employers with two or more employees who decide not to be covered as a group can enroll onto a List Bill. The employer is required to sign the List Bill Agreement stating that he/she understands this coverage is not a Group Plan and the company may not contribute to any part of the premium either directly or through reimbursement. The completed List Bill form should be submitted with the applications for coverage along with the total first month’s premium. Premium refunds for List Bill members will be paid directly to the member.

Employers who have a List Bill Agreement with us who want to add employees on or after May 1, 2012 will receive a separate bill for employees added prior to May 1, 2012 and one for their new



employees added on or after May 1, 2012. It is very important that the employer pays the bills with two separate checks to ensure proper crediting of premium for each employee.

Military Service

An applicant or dependent is not eligible for an Individual health insurance policy if they are on active duty with any branch of the Armed Services.

A Georgia resident reservist who is a BCBSGa Individual policyholder at the time he/she is called to active duty will have the option to continue or cancel his/her coverage. If the policyholder continues his/her coverage, BCBSGa will be the primary payer and TRICARE will be the secondary payer. If the policyholder cancels his/her current coverage, he/she will be allowed to re-enroll without evidence of insurability (underwriting) if ALL of the following criteria are met:

1. Re-enrollment occurs within 2 years of the original activation date.
Note: If a reservist were on active duty for more than 2 years, we would still allow re-enrollment.
2. The re-enrollment request is received within 120 days of the discharge date.
3. The effective date of re-enrollment occurs within 120 days of the discharge date. A copy of the Orders returning the reservist to inactive duty or valid inactive status documentation will be required.
4. Re-enrollment must be in the previous product (even if it is a closed product) with the same deductible; coinsurance and out-of-pocket limit.

Reservists will receive portability credit for any time served under TRICARE as long as there is no more than a 120 day break in coverage and the re-enrollment guidelines are met.

Covered dependents may elect to:

1. Remain on the BCBSGa coverage
2. Remain on the BCBSGa coverage and enroll in TRICARE
3. Cancel the BCBSGa coverage and enroll in TRICARE

If covered dependents elect to cancel the BCBSGa coverage, they must do so when the reservist cancels his/her coverage in order to retain the opportunity to re-enroll without evidence of insurability (underwriting) when TRICARE coverage ends.

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Portability

Portability is defined as credit for time served on a previous group or Individual coverage towards the twelve month pre-existing waiting period of the new policy. An applicant that meets all eligibility requirements for portability may have part or all of the waiting period for pre-existing conditions waived.

Pre-existing condition limitations do not apply to applicants under the age of nineteen (19) years who are being enrolled in a non-grandfathered plan.



Applicants may receive up to 365 days of credit towards their waiting period for pre-existing conditions on products where portability credit is given. For each day of aggregate coverage on prior/current qualifying coverage in the past 12 months the applicant receives one day of portability credit. Portability is offered at the applicant level.

Aggregate creditable coverage is the total amount of time a person is enrolled in health plan(s) without a break in coverage of more than 63 days. Serving a waiting period for group coverage is not considered part of the 63-day break of coverage. The waiting period for group coverage will not be calculated into the portability credit to be issued.

The application for Individual coverage must be received within 63 days from end date of most recent coverage.

See the accompanying chart for specific Portability guidelines. To receive this credit the agent should have the applicant complete the “Other Health Coverage” section of the application in full for each applicant.

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Portability Matrix

From ↓	To →	BCBSGa SmartSense[®] Plus; Premier Plus; Forward Focus & Tonik plans;	BCBSGa Short-term
BCBSGa and Affiliated Group Health Plans (fully and self insured); Competitor’s Group Health Plans (fully and self insured); Competitor’s Individual Health Plans (including Group Trusts and Association Plans)		YES	NO
BCBSGa and Affiliated Individual Health Plans		YES	NO
“Other” Blue Health Plans’ Group and Individual		YES	NO
Medicaid or Medicare		YES	NO
Short-term and Limited Duration Plans		YES	NO
CHAMPUS, TRICARE or other Public Health Plans		YES	NO
Socialized Medical Plans and International Group Plans		YES	NO
COBRA		YES	NO
None		NO	NO



Pre-Existing Waiting Periods

For any applicant that is not eligible for Portability credit, coverage will not be provided for the 12 months (or 12 months minus time due to portability credit) following the effective date of all BCBSGa Individual Plans for any illness, injury, or other condition for which medical advice, diagnosis, care or treatment was recommended or received in the 12 months prior to the effective date. Any prescription medications associated with a pre-existing condition will not be covered until the 12 month (or 12 months minus time due to portability credit) pre-existing waiting period has expired. No pre-existing credit is given toward a short-term policy and pre-existing time does not accumulate with each short-term policy. Children under the age of 19 that are coming from a non-grandfathered policy or are new business will not be required to serve a pre-existing waiting period. This does not apply to grandfathered policies

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Additional Coverage Options

Consumer Choice Option – Available for all PPO products for an additional ten percent premium, and for all POS products for an additional seventeen point five percent premium, this option allows members to nominate an out-of-network doctor or hospital to provide services to the member as though he/she were part of the network. Physicians must first accept BCBSGa reimbursement rates and utilization management, and then be approved before services are received.

Maternity Rider – A Maternity rider is available with the Premier Plus and ForwardFocus plans with a deductible of \$2,500 or greater. There is a 12 month pre-existing waiting period for the Maternity Rider that is NOT waived by portability. Existing BCBSGa members that have a product with a Maternity rider will be given credit towards their 12 month Maternity waiting period if they downgrade to another BCBSGa plan with a Maternity rider. Maternity care for dependent children is not covered. Maternity care is available to the female subscriber, who is at least 19 years old, and/or female covered spouse or domestic partner of the subscriber, who is at least 18 years of age or an emancipated minor. The female subscriber or the female covered spouse of the subscriber must also be at least 18 years of age or an emancipated minor.

Buy-Up Drug Rider – The SmartSense® Plus programs are available with a “Buy-Up Drug Rider” if the applicant so chooses. This rider will provide coverage for a broader set of brand medications and will generally lower the member’s cost share.

Mental Health Rider – Tonik applicants can purchase a mental health rider to increase their benefit from 12 inpatient days and 12 visits per year to 30 inpatient days and 48 visits per year.

Dental Coverage is available to the applicants and can be approved regardless of medical underwriting outcome.



Life Coverage is available to the applicants. If the applicant is declined for medical coverage the life coverage will also be declined.

Short-term Coverage is available to applicant's age 30 days up to age 65 that may need health care protection for a short period of time. Individuals enrolled in short-term coverage cannot turn 65 during the duration of the policy. It is available in 30 day increments up to and including 180 days. A one-year waiting period is required after a second short-term policy is purchased.

Effective Dates

The effective date for a new application must be within 75 days of the applicant's signature date.

- The earliest effective date for an applicant who has current coverage will be the day after the application is received by BCBSGa through mail, fax, online or email submission. This applies if the applicant requests an ASAP effective date as well. For family applications, all applicants must have current coverage in order to receive an effective date of the day after receipt by BCBSGa.
- The earliest effective date for an applicant who currently does not have coverage will be 10 days from the receipt date (inclusive) by BCBSGa through mail, fax, online or email submission. This applies if the applicant requests an ASAP as well.
- The earliest effective date for ALL family members on the same application when at least one of the applicants does not currently have coverage will be 10 days after the application is received by BCBSGa.

Note: Current underwriting guidelines do not allow an effective date if any applicant is hospitalized as of that date. For effective date policies for change requests see the section titled "Changes in Coverage".

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Quoting Guidelines

Member's requesting an Effective Date prior to 5-1-12:

- Rates are based on the quarter the applicant signed the application and the age of the oldest applicant on the first day of the quarter.

New sales effective on or after 5-1-12:

- Rates are based on the quarter of the requested effective date and the age of the oldest applicant as of the first day of the effective month.

Members who have a roll-back effective on or after 5-1-12:

- Rates are based on the quarter of the requested effective date and the age of the oldest applicant as of the first day of the effective month. The renewal month will be the anniversary of the change.



Liability during Underwriting

BCBSGa will use all information obtained prior to the time the applicant's underwriting decision is made or the application is effective, applicant's effective date, whichever is later, to determine if individuals are eligible for coverage. This includes changes in health information that may have occurred after the applicant completed the application. Refer to Item 1 under the Significant Terms, Conditions and Authorizations section of the application.

Free Look Period

BCBSGa allows a thirty-day "free look" period from the day the member receives his/her policy. For short-term policies, the free look period is 10 days. During this time we allow the applicant to cancel his/her policy and provide a full refund. BCBSGa will not be responsible for any claims incurred between the effective date and cancellation date.

In addition, the following changes (with limitations) will be allowed during the thirty-day "free look" period (excluding short-term policies):

- Change the effective date to a future date (not more than 75 days from most recent signature on the application).
- Change the effective date to a past date. This is allowed **only** to avoid a break in coverage and is subject to underwriting review. The retro date cannot be prior to the day after the BCBSGa receipt date.
- Change the product selection or deductible - subject to underwriting review if moving to a product with richer benefits and/or lowering deductible.
- Add a supplemental rider to the policy - subject to underwriting review.
- Remove a supplemental rider from the policy.
- Split the application (move some applicants to different product) - subject to underwriting review if moving to product with richer benefits and/or lowering deductible.

Risk Determination

Health underwriting is the assessment of the medical history and the current health and lifestyle status of an applicant to determine the appropriate risk level and premium.

BCBSGa will make the final decision on the acceptance of any insurable risk. All information discovered during the underwriting process will be used, including, but not limited to the health questions on the application, any claims history available for review, any information taken over the telephone and any additional information that may be requested.

On the application, the applicant may request that no eligible applicants are enrolled unless ALL family members qualify.

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If a child or children under the age of 19 apply with a parent/parents or apply to be added to a parent/parents policy and that policy is non-grandfathered or it is a new business application, the child or children under the age of 19 cannot be declined medically. The child or children under the age of 19 will be medically underwritten and if that child or children under the age of 19 is medically declined they will be rated at the highest rating tier also known as the Guarantee Issue rate tier. This rate tier does not apply to grandfathered policies.

The following risk determination methodology is used at BCBSGa for the underwritten products (except Tonik):

- Level 1 (no rate up) – This level includes the healthiest of applicants.
- Level 2 (20% rate up) – This level designates the average healthy applicant who does not meet our most stringent underwriting guidelines.
- Level 3 (70% rate up) – This level includes health applicants who are at an increased risk of incurring health care claims in the future.
- Guarantee Issue – This level applies to non-grandfathered policies only and is offered to dependent children ages 0 – 18 on a parent or guardians policy who would receive a decline decision based on medical underwriting. The parent or guardian must be age 19 or older.
- Short-term coverage is offered on Approve or Deny basis only.

Note: Tonik rate ups amounts are 25%, 40%, 50%, 75% and 100%.

Rates for family contracts are blended based on the risk tier of each family member. There are a total of eight (8) possible rating tiers for family contracts. The family contract is assigned to the rating tier that most closely aligns with the average tier of the family participants.

Tobacco Use

Use of any tobacco product within the 12 months preceding the date of the application will cause an applicant to be ineligible for the Level 1 rating. The amount and frequency of use will determine whether the applicant will receive a Level 2 or level 3 rating.

Billing options

Bank Draft

Bank draft is the preferred billing method, which ensures your clients' monthly premiums are paid on time. Bank draft can only be set up with checking accounts and drafts monthly premiums on the first business day of each month. Bank draft is available for all Individual plans.



Paper Bill

Available for all plans with the exception of Short Term Medical. If elected, a paper bill is sent for the next month's premium. Paper bills are due on the 1st business day of the month for which premiums are being paid.

Credit Card Draft

Only available with Short Term Medical plans. Credit card drafts can be set up on Visa or MasterCard.

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Pregnancy – Eligibility policy for all products

- If a person to be covered is pregnant at the time of application, an application cannot be accepted from any member of the family.
- If the applicant's female spouse/domestic partner or significant other **is** pregnant at the time of application and is not to be covered, an application cannot be accepted from any member of the family. **This is due to the risk associated with the unborn child.** The exception is when the pregnant person or pregnant person's dependent is already covered on another Blue Cross and Blue Shield of Georgia group or Individual policy (COBRA policies not included).
- Short Option coverage is not available to any member of the family if any person in the family is pregnant or is an expectant parent.

Newborns and Infants – All products except Tonik

Newborns may be added to an existing parent's policy without medical underwriting if notification is received within 31 days from date of birth. For infants less than six months of age, except for those newborns eligible to be added to an existing policy without underwriting, we require information from the nursery records from the hospital where the infant was born and the office records from the infant's pediatrician. If this information is not submitted with the application we will forward a request to the infant's pediatrician. You may expedite this process by providing your client with a copy of the Newborn Questionnaire, available on the Broker Website at **BCBSGa.com** and/or provide the newborn's pediatrician's name and telephone number.

No medically underwritten applicant can be assigned an effective date that coincides with a hospitalization. The earliest effective date that can be assigned will be the day after the date of discharge.

Future Surgery or Procedures – All products

Applicants who have been advised of or scheduled for future surgery, tests or procedures are subject to further review for our underwritten products. Pertinent details should be provided on the application. This will expedite the underwriting process. This review may result in a higher rating or a denial of the coverage.



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Requesting Additional Medical Information

During the underwriting process there are occasions when the underwriter must obtain additional information to clarify or supplement the medical information on the application and/or in claims history.

Underwriting by Phone

When possible we will attempt to call the applicant to obtain the additional information necessary to complete medical underwriting. The determination to obtain information directly from the applicant over the telephone depends on the type and scope of information needed.

Provider Requests

When necessary the underwriter will request additional information directly from the provider. It is important to have your clients include their physician's name and phone number on the application. When possible we will fax requests directly to the provider to expedite processing.

Telephone Interviews

The applicant should be aware that the Underwriting Department may conduct a telephone interview to verify information on the application, or to obtain additional details or missing information for the purpose of underwriting.

Paramedical Exam

A paramedical exam will be requested by Underwriting to assess the current health status of Individual applicants age 55 or older who have not been seen by a physician in the last 24 months. These exams are at no cost to the applicant and will help us improve our underwriting process by making sure we have the most up-to-date medical information from all applicants.

Paramedical exams will be similar to a routine physical. A medical history will be gathered, and the certified paramedical professional will complete a review of the applicant's health (general health, neurological, musculoskeletal, etc.), vital signs will be taken, a urine specimen will be requested and blood will be drawn to check blood chemistry and lipids. There will also be a drug screen. The exam should take approximately 30 minutes to an hour.

Anthem's paramedical exam vendor will contact the applicant within 24 hours of Anthem requesting the exam. The vendor will attempt to contact the applicant by phone. Applicants will be given the option of scheduling the exam in their homes, in-office or at a clinic. A copy of the lab results will be sent to the applicant by the lab.

If an applicant has seen a doctor in the past 24 months please make sure they include the doctors' name on the application.



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Medication Denials - DENY if any applicant is taking or has taken any of the following medications within the past 12 months

Abraxane	Combivir	Fuzeon	Mozobil	Sinemet
Aeropin	Comtan	Gamastan	Namenda	Somavert
Aggrenox	Copaxone	Gamimone N	Navane	Spiriva
Agrylin	Coumadin	Gaminex	Nivalin	Stelara
Aldurazyme	Crixivan	Gammagard	Norvir	Stelazine
Alimta	CytoGam	Gammar	Novolin	Suboxone
Alphanate	Cytovene	Geodon	Octagam	Subutex
Aluvia	D4T	Gleevec	Onxol	Supartz
Amevive	DADDS	Haldol	Orap	Sustiva
Antabuse	Danazol	Helixate	Orgaran	Symbyax
Anzemet	Dapsone	Heparin	Oxycontin	Symlyn
Apokyn	Daraprim	Herceptin	Panglobulin	Synagis
Aptivus	Decadron	Hexalen	Panretin	Synvisc
Arava	DFS	Humate	Parcopa	Tarceva
Aricept	Dipentum	Humatrope	Pegasys	Tasmar
Arimidex	Dipyridamole	Humira	Pentamidine	Taxotere
Aromasin	Diucifon	Hycamtin	Pergonal	Thalomid
Artane	Dolophine	Imuran	Persantine	Ticlid
Atripla	Doxil	Imurel	Plaquenil	Trental
Avastin	Drixia	Invega	Platinol	Trihexane
Avonex	Duralith	Iressa	Plavix	Trilafon
Azasan	Eldepryl	Iveegam	Plenaxis	Trizivir
AZT	Eloxatin	Kaletra	Pletal	Truvada
Azulfidine	Emasm	Kemstro	Pneumopent	Tysabri
Baraclude	Emtriva	Lamprene	Polygam	Valcyte
Betaseron	Enbrel	Lantus	Praxada	Vantas
Bexxar	Entocort	Letairis	Prezista	Velcade
Bleomycin	Epivir	Levemir	Prialt	Vidaza
Bovine Colustrum	Eopgen	Levomethady	Procrit	Videx
Brovana	Epzicom	Lexiva	Prograf	Viracept
Byetta	Equetro	Lialda	Prolixin	Viramune
Campral	Erbitux	Lithane	Pulmozyme	Viread
Carbolith	Eskalith	Lithizine	Ranexa	Vistide
Carbovir	Exelon	Lithobid	Rapamune	Vitravene
Carimune	Exubera	Lithonate	Remicade	Vivitrol
Celegene	Fabrase	Lithotabs	Rescriptor	Xeloda
Ceredase	Fabrazyme	Lodosyn	Reyataz	Xyntha



Chlorpromazine	Faslodex	Lovenox	Risperdal	Zalcitabine
Cimzia	Femara	Loxitane	Roccatrol	ZDV
CinnoVex	Fibrogammin	Marinol	Roferon-A	Zenapax
Cisplatin	Flolan	Mellaril	Saizen	Zerit
Clolar	Folex	Mepron	Sandimmune	Ziagen
Clomid	Follistim	Methadone	Serentil	Zoladex
Clozaril	Fortovase	Methotrexate	Seroquel	Zolinza
Cognex	Foscavir	Moban	Simponi	Zyprexa

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High Deductibles

For certain conditions listed in the agent guide, there may be a lower risk tier available for members/applicants who currently have the specified condition. BCBSGa may allow a lower risk tier when a certain deductible option is selected by the member. Please see the specific health condition in the agent guide for the deductible options.

<u>Height and Weight Table</u> for children, age 15 and under
BMI less than or equal to 30.0 = Level 1
BMI 30.1-39.9 = Level 2
BMI 40.0 or greater = Decline

*Medical records may be requested for underweight children

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Height and Weight Table

Males Age 16 to 64

Height	Minimum	Level 1	Level 2 (APS for BMI 34.0-34.9)	Level 3 & APS
		Maximum	Maximum	
4'6" (54")	77	132	144	157
4'7" (55")	80	137	150	163
4'8" (56")	83	142	155	169
4'9" (57")	86	147	161	175
4'10" (58")	89	152	167	181
4'11" (59")	92	158	173	187
5'0" (60")	95	163	178	194
5'1" (61")	98	169	184	200
5'2" (62")	101	174	191	207
5'3" (63")	105	180	197	214
5'4" (64")	108	186	203	221
5'5" (65")	111	192	210	228
5'6" (66")	115	197	216	235
5'7" (67")	118	204	223	242
5'8" (68")	122	210	229	249
5'9" (69")	125	216	236	257
5'10" (70")	129	222	243	264
5'11" (71")	133	229	250	272
6'0" (72")	137	235	257	279
6'1" (73")	140	242	264	287
6'2" (74")	144	248	272	295
6'3" (75")	149	255	279	303
6'4" (76")	152	262	287	311
6'5" (77")	156	269	294	320
6'6" (78")	160	276	302	328
6'7" (79")	164	283	310	336
6'8" (80")	168	290	318	345
6'9" (81")	173	298	326	354
6'10" (82")	177	305	334	362
6'11" (83")	181	313	342	371
7'0" (84")	186	320	350	380
7'1" (85")	190	328	359	390
7'2" (86")	195	336	367	399
7'3" (87")	199	343	376	408

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Height and Weight Table

Females Age 16 to 64

Height	Minimum	Level 1	Level 2 (APS for BMI 33.0-33.9)	Level 3 & APS
		Maximum	Maximum	Maximum
4'0" (48")	58	101	111	121
4'1" (49")	60	105	115	126
4'2" (50")	63	110	120	131
4'3" (51")	65	114	125	136
4'4" (52")	68	119	130	142
4'5" (53")	70	123	135	147
4'6" (54")	73	128	140	153
4'7" (55")	76	133	146	158
4'8" (56")	78	138	151	164
4'9" (57")	81	143	156	170
4'10" (58")	84	148	162	176
4'11" (59")	87	153	168	182
5'0" (60")	90	158	173	189
5'1" (61")	93	163	179	195
5'2" (62")	96	169	185	202
5'3" (63")	99	174	191	208
5'4" (64")	102	180	197	215
5'5" (65")	105	186	204	222
5'6" (66")	109	191	210	228
5'7" (67")	112	197	216	235
5'8" (68")	115	203	223	243
5'9" (69")	119	209	229	250
5'10" (70")	122	215	236	257
5'11" (71")	126	221	243	264
6'0" (72")	129	228	250	272
6'1" (73")	133	234	257	280
6'2" (74")	136	241	264	287
6'3" (75")	140	247	271	295
6'4" (76")	144	254	278	303
6'5" (77")	148	261	286	311
6'6" (78")	152	267	293	319

The Height and Weight Tables show the minimum and maximum allowable weights for males and females age 16-64. This table is to be used as a general guide and is not the final determining factor. Heights and Weights that fall below the minimum or above the maximum may be subject to an APS (Attending Physician Statement) or denial.

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Health History Guidelines

Note: This is a listing of some of the most common conditions reviewed. It is not all-inclusive and is subject to change.

ABBREVIATIONS:

APS = Attending Physician Statement

D = Decline

IC = Individual Consideration

Note:

- For conditions where an Underwriting Consideration is not specified, the Underwriting Action is always applicable.
- The symptom and treatment free waiting period for Underwriting Considerations is calculated from last symptom or treatment date until the application receipt date.

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Acne	On Accutane, Amnesteem, Claravis, Sotret within 2 months	Decline	Decline	Decline	Decline
	Ongoing treatment with acne surgery or steroid injection	Decline	Decline	Decline	Decline
	Currently treated with topical ointments or antibiotics	Level 2	Level 1	Level 1	Level 1
	SST free and no Dr visit within 90 days	Level 1	Level 1	Level 1	Level 1
Acquired Immune Deficiency Syndrome or Aids Related Complex	Once diagnosed	Decline	Decline	Decline	Decline
Alcohol / Drug Dependency	Treatment within 5 years	Decline	Decline	Decline	Decline
	Treatment free for 5 years	IC / APS	IC / APS	IC / APS	IC / APS
Allergy	Seasonal/occasional use or no prescription medication use	Level 1	Level 1	Level 1	Level 1
	Daily prescription use, or allergy shots	Level 2*	Level 1	Level 1	Level 1
	Daily use of steroidal bronchodilator	Level 3*	Level 3*	Level 1	Level 1
	Long-term systemic steroid use, currently on steroid course > 10 days and/or 3+ steroid courses within last 12 months	Decline	Decline	Decline	Decline
	<i>*Refer to age adjustment section for final rating</i>				
Alzheimer's	Once Diagnosed	Decline	Decline	Decline	Decline
Amputation (not caused by disease)	Finger / Thumb / Toe	Level 1	Level 1	Level 1	Level 1
	Other limbs, SST within 30 days	Decline	Decline	Decline	Decline
	Other limbs, SST free 30 days	Level 1	Level 1	Level 1	Level 1
	With prosthesis	Level 3	Level 3	Level 3	Level 3
Angina	See Coronary Insufficiency	IC / APS	IC / APS	IC / APS	IC / APS



Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Anxiety (Mental Health questionnaire)	Stressful incident resolved, with < 6 month duration	Level 1	Level 1	Level 1	Level 1
	SST free 6 months	Level 1	Level 1	Level 1	Level 1
	Above criteria not met:				
	Counseling ONLY or Medication ONLY (2 or less)	Level 2*	Level 1	Level 1	Level 1
	Counseling AND Medication (or 3 or more medications)	Level 3*	Level 3*	Level 1	Level 1
	Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline
	<i>*Refer to age adjustment section for final rating</i>				
Arthritis Rheumatoid Osteoarthritis	Rheumatoid	Decline	Decline	Decline	Decline
	Osteoarthritis				
	Injection therapy or steroid use within 2 years, or hospitalization or narcotic medication within past 12 months, or 2+ injection series within 3 past years	Decline	Decline	Decline	Decline
	As needed prescription medication	Level 2	Level 1	Level 1	Level 1
	No prescription medication used	Level 1	Level 1	Level 1	Level 1
	Daily prescription medication use	Level 2	Level 1	Level 1	Level 1
	Of spine				
	Operated, SST within 12 months or unoperated, unresolved	Decline	Decline	Decline	Decline
Operated SST free 12 months or unoperated, resolved	Level 3	Level 3	Level 3	Level 3	
Ascites (all cases)	Once diagnosed	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Asthma	Acute attack within 6 months or smoking within past 12 months	Decline	Decline	Decline	Decline
	Acute attack > 6 months:				
	Age 2 and under, symptoms controlled	Level 3	Level 1	Level 1	Level 1
	Age 3 and over, meds used as needed	Level 2*	Level 1	Level 1	Level 1
	Age 3 and over, meds used daily	Level 3*	Level 3*	Level 1	Level 1
	No medication or treatment in the past 12 months	Level 1	Level 1	Level 1	Level 1
	<i>*Refer to age adjustment section for final rating</i>				
Attention Deficit Disorder (ADD/ADHD)	Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline
	Use of 2 or more medications within 30 days	Level 3*	Level 3*	Level 1	Level 1
	Less than 2 medications within 30 days and counseling	Level 3*	Level 3*	Level 1	Level 1
	Less than 2 meds within 30 days and no counseling w/in 30 days	Level 2*	Level 1	Level 1	Level 1
	SST free 12 months	Level 1	Level 1	Level 1	Level 1
	<i>*Refer to age adjustment section for final rating</i>				
Back Strain/Sprain	Not related to disc or nerve:				
	SST free 6 months	Level 1	Level 1	Level 1	Level 1
	SST within 6 months				
	Short course medication, OTC medication or no treatment	Level 1	Level 1	Level 1	Level 1
	Chiropractic adjustments	Level 2	Level 2	Level 1	Level 1
Other than above	Level 3	Level 3	Level 3	Level 3	

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Bronchitis (Allergy and/or asthma questionnaire)	Acute bronchitis, resolved and released from treatment	Level 1	Level 1	Level 1	Level 1
	Chronic bronchitis, within the past year or smoking with past year	Decline	Decline	Decline	Decline
Bursitis	Single occurrence, resolved, within 12 months	Level 2	Level 2	Level 2	Level 2
	Unresolved, current SST	Decline	Decline	Decline	Decline
Cancer (Tumor Questionnaire)	Breast Cancer				
	In Situ / Stage 0-1 within 2 years	Decline	Decline	Decline	Decline
	In Situ / Stage 0-1, SST free 2 years				
	No implants and no medication	Level 2	Level 2	Level 1	Level 1
	With implants or medication	Level 3	Level 3	Level 1	Level 1
	Other stages				
	Cancer within 10 years	Decline	Decline	Decline	Decline
	Over 10 years	Level 2	Level 2	Level 1	Level 1
	Prostate				
	Within 5 years	Decline	Decline	Decline	Decline
	After 5 years	Level 2	Level 2	Level 2	Level 2
	Other internal cancers				
	Within 10 years	Decline	Decline	Decline	Decline
After 10 years	Level 2	Level 2	Level 2	Level 2	

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Carpel Tunnel Syndrome	Operated, resolved	Level 1	Level 1	Level 1	Level 1
	Unoperated:				
	Mild, treated conservatively within 12 months	Level 2	Level 2	Level 2	Level 2
	SST free 12 months (use of splint not considered treatment)	Level 1	Level 1	Level 1	Level 1
	Other than mild, SST within 12 months (including physical therapy, etc.)	Decline	Decline	Decline	Decline
Cataracts	Unoperated	Level 2 or 3	Level 2 or 3	Level 2 or 3	Level 1
	Operated, released from care but SST within 3 months	Level 2	Level 1	Level 1	Level 1
Cerebral Palsy	Once diagnosed	IC / APS	IC / APS	IC / APS	IC / APS
Cholesterol (Fasting and test result must be in past 12 months)	Total cholesterol less than or equal to 199	Level 1	Level 1	Level 1	Level 1
	Total cholesterol 200-260 on medication	Level 2	Level 2	Level 2	Level 2
	Total cholesterol 200-260 <u>NOT</u> on medication	Level 3	Level 3	Level 3	Level 3
	Total cholesterol >260	Decline	Decline	Decline	Decline
	Total cholesterol >260	Decline	Decline	Decline	Decline
Triglycerides	>500	Decline	Decline	Decline	Decline
Cirrhosis of the Liver	Once diagnosed	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Chronic Fatigue Syndrome	Once diagnosed	IC	IC	IC	IC
Chronic Obstructive Pulmonary Disease (COPD, Emphysema)	Once diagnosed	Decline	Decline	Decline	Decline
Colitis Ulcerative	Unoperated or surgical procedure other than IPAA	Decline	Decline	Decline	Decline
	Total Proctocolectomy with IPAA(SST within 5 years)	Decline	Decline	Decline	Decline
	Total Proctocolectomy with IPAA(SST free > 5 years and APS)	Level 3	Level 3	Level 3	Level 3
Coronary Insufficiency	Angina, Angioplasty, Bypass Grafting (CABG), and Myocardial Infarction (Heart Attack):				
	Currently smoking or BMI \geq 28.0	Decline	Decline	Decline	Decline
	Heart attack within 2 years	Decline	Decline	Decline	Decline
	SST free 2 years, normal blood pressure, normal lipid and cardiac panel, no blood thinner medication, normal BMI and no smoking	APS	APS	APS	APS
	Stent placement	Decline	Decline	Decline	Decline
Coronary Occlusion	See Coronary Insufficiency				
Crohn's Disease	Unoperated or operated w/ stoma (i.e. ileostomy or colostomy)	Decline	Decline	Decline	Decline
	Operated without a stoma	APS	APS	APS	APS

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Cystic Fibrosis	Once diagnosed	Decline	Decline	Decline	Decline
Depression (Not Manic or Psychotic)-Mental Health Questionnaire	Stressful incident resolved, with < 6 month duration	Level 1	Level 1	Level 1	Level 1
	SST free 6 months	Level 1	Level 1	Level 1	Level 1
	Above criteria not met:				
	Counseling ONLY or Medication ONLY (2 or less)	Level 2*	Level 1	Level 1	Level 1
	Counseling AND Medication (or 3 or more medications)	Level 3*	Level 3*	Level 1	Level 1
	Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline
	<i>*Refer to age adjustment section for final rating</i>				
Deviated Septum	Not operated, with symptoms	Decline	Decline	Decline	Decline
	Operated, full recovery/released from care	Level 1	Level 1	Level 1	Level 1

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Diabetes **To be considered for coverage, diet or oral med controlled diabetics must be in preferred range for height and weight and must not have any associated medical conditions such as high blood pressure, high cholesterol, kidney disease, circulatory disorders, neuropathy or decreased feeling, numbness or tingling in extremities, diabetic retinopathy or other vision problems.	Juvenile Diabetes	Decline	Decline	Decline	Decline
	Type 1 Insulin Dependent Diabetes	Decline	Decline	Decline	Decline
	Type II:				
	Smoking within 12 months, hypertension or overweight	Decline	Decline	Decline	Decline
	Diet controlled, adult onset, excellent control **	Level 2 APS	Level 2 APS	Level 2 APS	Level 2 APS
	Diagnosed within 12 months	Decline	Decline	Decline	Decline
	Oral medication, excellent control** at least 12 months	Level 3 APS	Level 3 APS	Level 3 APS	Level 3 APS
	Diet/Oral controlled, Fair to Poor control	Decline	Decline	Decline	Decline
Disc Disorders	See Spinal Disorders				
Diverticulitis or Diverticulosis	Unoperated w/out hemorrhage/no IP hospital stay, SST w/in 6 months	Decline	Decline	Decline	Decline
	Operated/Unoperated w/hemorrhage or IP hospital, SST w/in 12 months	Decline	Decline	Decline	Decline
	Operated with stoma (i.e. colostomy, ileostomy)	Decline	Decline	Decline	Decline
	All other cases (varies by SST free period)	Level 2 / Level 3	Level 2 / Level 3	Level 1	Level 1

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Drug Treatment	See Alcohol/Drug Dependency				
Emphysema	Once diagnosed	Decline	Decline	Decline	Decline
Endometriosis	Symptoms controlled effectively	Level 2	Level 2	Level 2	Level 2
	Severe symptoms, uncontrolled	Decline	Decline	Decline	Decline
	Operated(hysterectomy) or menopausal	Level 1	Level 1	Level 1	Level 1
Epilepsy (Seizure Questionnaire)	Any seizure within past 12 months Or with vagus nerve stimulator	Decline	Decline	Decline	Decline
	No seizure > 1 year but < 5 years	Level 3*	Level 3*	Level 3*	Level 3*
	No seizure > 5 years	Level 2*	Level 2*	Level 2*	Level 2*
	<i>*Refer to age adjustment section for final rating</i>				
Fibrocystic Breast Disease (Tumor/Cyst Questionnaire)	Single cyst, unoperated, benign, no treatment required	Level 1	Level 1	Level 1	Level 1
	Single cyst, unoperated, benign, multiple episodes, treatment complete	Level 2	Level 1	Level 1	Level 1
	Single cyst, Ongoing testing or treatment	Decline	Decline	Decline	Decline
	Fibrocystic breast disease, treatment within 12 months	Level 2	Level 1	Level 1	Level 1

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Fibromyalgia	No medication or symptoms within past 6 months	Level 1	Level 1	Level 1	Level 1
	Controlled on maintenance medication (non-narcotic)	Level 3	Level 3	Level 3	Level 3
	Chronic with narcotic medication or other treatment within 30 days (other than maintenance medication)	Decline	Decline	Decline	Decline
Friedreich's Ataxia	Once diagnosed	Decline	Decline	Decline	Decline
Gallbladder Disease	Not operated, with symptoms	Decline	Decline	Decline	Decline
	Operated, full recovery/released from care	Level 1	Level 1	Level 1	Level 1
Gastric Bypass/Lap Band Surgery	< 3 years	Decline	Decline	Decline	Decline
	> 3 years, weight stable at least 2 years, no complications	Level 1	Level 1	Level 1	Level 1
Gastric Reflux(GERD)	No medication or OTC medication ONLY	Level 1	Level 1	Level 1	Level 1
	Prescription medication required, age 12 months or over	Level 3	Level 3	Level 1	Level 1
	Prescription medication required, under age 12 months	Level 2	Level 2	Level 2	Level 2
	With Implant present (i.e. ENTERYX, etc.)	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Glaucoma	No attack / treatment within 2 years/suspect/pre-glaucoma no treatment	Level 1	Level 1	Level 1	Level 1
	Controlled with prescription medication/no surgery recommended	Level 2	Level 2	Level 2	Level 2
Graves Disease	See Thyroid Disorders				
Heart Attack (Myocardial Infarction)	See Coronary Insufficiency				
Heart Murmur	Single episode resolved/ benign flow/no treatment	Level 1	Level 1	Level 1	Level 1
	Others	IC / APS	IC / APS	IC / APS	IC / APS
Heart Palpitations	Symptoms controlled within 12 months with or without medication	Level 2	Level 2	Level 2	Level 2
	Symptoms uncontrolled Or multiple surgical procedures	Decline	Decline	Decline	Decline
Hemophilia	Once diagnosed	Decline	Decline	Decline	Decline
Hemorrhoids	Unoperated, treated with topical medication only or no treatment required	Level 1	Level 1	Level 1	Level 1
	Operated, full recovery	Level 1	Level 1	Level 1	Level 1
Hepatitis	A / E within 3 months	IC / APS	IC / APS	IC / APS	IC / APS
	B SST within 2 years	Decline	Decline	Decline	Decline
	C / D (Lifetime)	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Hernia	Unoperated, with current symptoms, not a surgical candidate/unresolved	Level 3	Level 3	Level 3	Level 3
	Operated, complete recovery	Level 1	Level 1	Level 1	Level 1
Herpes, Genital	Daily medication (**Level 1 for \$1500 deductible or higher)	Level 3*	Level 1	Level 1	Level 1
	As needed medication or ointment (** Level 1 for \$1500 deductible or higher)	Level 2*	Level 1	Level 1	Level 1
	If diagnosed with 3 or more STD's in past 5 years	Decline	Decline	Decline	Decline
	<i>*Refer to age adjustment section for final rating</i>				
High Blood Pressure (Hypertension Questionnaire)	Uncontrolled, Malignant Hypertension or with Diabetes or with 3 or more co-morbid	Decline	Decline	Decline	Decline
	Controlled on medication, combined with 0-1 co-morbid conditions	Level 2	Level 2	Level 2	Level 2
	Controlled on medication, combined with 2 co-morbid conditions	Level 3	Level 3	Level 3	Level 3
	Ongoing use of 3 or more medications(diuretic Rx ok)	Decline	Decline	Decline	Decline
Hodgkin's Disease	Within 10 years	Decline	Decline	Decline	Decline
	Over 10 years	Level 2	Level 2	Level 2	Level 2

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Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Huntington's Chorea	Once diagnosed	Decline	Decline	Decline	Decline
Hypoglycemia	Mild, controlled	Level 2	Level 2	Level 2	Level 2
	Severe or uncontrolled	IC / APS	IC / APS	IC / APS	IC / APS
Hysterectomy	Benign cause	Level 1	Level 1	Level 1	Level 1
	Due to Cancer within 10 years	Decline	Decline	Decline	Decline
Infertility Treatment	Post-menopausal, tubal ligation or hysterectomy performed	Level 1	Level 1	Level 1	Level 1
	If above criteria does not apply: use of infertility drugs/treatment within past 2 years or multiple miscarriages within the past 2 years	Decline	Decline	Decline	Decline
Interstitial Cystitis	Symptoms controlled with no treatment or treated with medication only within the past 12 months	Level 3	Level 3	Level 3	Level 1
	Symptoms not controlled or treatment other than medication (nerve stimulation, bladder distention etc.)	Decline	Decline	Decline	Decline
Irritable Bowel Syndrome	Controlled on diet or medication for at least 6 months	Level 1	Level 1	Level 1	Level 1
	Not controlled	Level 2	Level 2	Level 1	Level 1

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Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Joint Replacement	Toe or finger (cause also rated)	Decline	Level 1	Level 1	Level 1
	Done age 60-64 and over one year ago, not due to RA	Level 3	Level 3	Level 3	Level 3
	Done under age 60 or under one year ago or due to Rheumatoid Arthritis	Decline	Decline	Decline	Decline
Kidney Failure or Dialysis	Once diagnosed	Decline	Decline	Decline	Decline
Kidney Stones	Multiple episodes within 12 months	Decline	Decline	Decline	Decline
	Single episode in past year controlled with preventative Rx	Level 2	Level 2	Level 2	Level 1
	Single Episode in past year with no preventative medication	Level 3	Level 3	Level 3	Level 1
	SST free 12 months	Level 1	Level 1	Level 1	Level 1
Leukemia	Within 10 years	Decline	Decline	Decline	Decline
	Over 10 years	Level 2	Level 2	Level 2	Level 2
Maintenance Medications for any condition	Will be underwritten based on number of medications and costs	IC / COM	IC / COM	IC / COM	IC / COM

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Melanoma ** Applies to \$1500 deductible or higher only	In situ/stage 1 and single occurrence:				
	SST free 5 years	Level 1	Level 1	Level 1	Level 1
	SST free 2-5 years**	Level 1	Level 1	Level 1	Level 1
	SST within 2 years	Decline	Decline	Decline	Decline
	All other stages or multiple occurrences:				
	SST free 10 years	Level 2	Level 2	Level 2	Level 2
	SST free 5-10 years	Level 3	Level 3	Level 3	Level 3
	SST within 5 years	Decline	Decline	Decline	Decline
Meningitis	Bacterial, within 6 months	Decline	Decline	Decline	Decline
	Viral, within 6 months	Level 3	Level 3	Level 3	Level 3
Migraines	2 or more ER/urgent care visits within the past 12 months, or diagnosed within the past 90 days	Decline	Decline	Decline	Decline
	Above criteria does not apply:				
	One ER/urgent care visit within 1 year	Level 3*	Level 3*	Level 1	Level 1
	Rx medication used within 6 months	Level 3*	Level 3*	Level 1	Level 1
	No treatment within past 6 months (OTC medication ok)	Level 1	Level 1	Level 1	Level 1
	<i>*Refer to age adjustment section for final rating</i>				

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Mitral Valve Prolapse (Heart Murmur/MVP Questionnaire)	Unoperated, no symptoms or treatment required (antibiotics with dental work ok)	Level 1	Level 1	Level 1	Level 1
	Unoperated, no symptoms within last 2 years, controlled on medication	Level 2	Level 2	Level 2	Level 2
	Unoperated, symptoms within last 2 years OR operated within 12 months	Decline	Decline	Decline	Decline
Motor or Sensory Aphasia	Symptoms and treatment within 5 years	Decline	Decline	Decline	Decline
Multiple Sclerosis	Once diagnosed	Decline	Decline	Decline	Decline
Muscular Dystrophy	Once diagnosed	Decline	Decline	Decline	Decline
Myotonia	Once diagnosed	Decline	Decline	Decline	Decline
Obesity	(see Height/Weight Build Charts)				
Obsessive Compulsive Disorder	Hospitalization or substance abuse within 5 years	Decline	Decline	Decline	Decline
	Diagnosed within 2 years or unstable	Decline	Decline	Decline	Decline
	SST free 2 years	Level 1	Level 1	Level 1	Level 1
	SST within 2 years, diagnosed more than 2 years, stable	Level 3	Level 3	Level 3	Level 3
Open Heart Surgery	See Condition				
Organ Transplant Recipient/Candidate	Any condition	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Osteoporosis Osteopenia	No history of fractures *Level 1 if OTC supplements or hormone replacement therapy only	Level 2*	Level 1	Level 1	Level 1
	With history of fracture, surgery advised or continuous use of narcotic medication(s)	Decline	Decline	Decline	Decline
Otitis Media (Ear/Otitis Questionnaire)	Tubes inserted or single episode, recovered	Level 1	Level 1	Level 1	Level 1
	2-3 episodes within 12 months	Level 2*	Level 1	Level 1	Level 1
	4 or more episodes within 12 months	Level 3*	Level 3*	Level 1	Level 1
	*Refer to age adjustment section for final rating				
Ovarian Cyst ** Applies to \$1500 deductibles or higher only	SST free 12 months	Level 1	Level 1	Level 1	Level 1
	SST within 12 months and resolved or controlled on medication**	Level 1	Level 1	Level 1	Level 1
	Cyst(s) present but not a surgical candidate	Level 3	Level 3	Level 1	Level 1
Pacemaker Implant	Implant present	Decline	Decline	Decline	Decline
Palpitations	See Heart Palpitations				
Pancreatitis	SST within 12 months or recurrent / multiple episodes	Decline	Decline	Decline	Decline
	Single episode, SST free 12 months	IC / APS	IC / APS	IC / APS	IC / APS
Pap Smears (Cervical Dysplasia)	Class I or II - clean pap obtained	Level 1	Level 1	Level 1	Level 1
	Clean pap NOT obtained	Decline	Decline	Decline	Decline
	Class III or more	IC / Decline	IC / Decline	IC / Decline	IC / Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500-\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Parkinson's Disease	Once diagnosed	Decline	Decline	Decline	Decline
Peptic Ulcer (Ulcer Questionnaire)	Unoperated, current symptoms	Decline	Decline	Decline	Decline
	Unoperated, no current symptoms, current treatment	Level 3	Level 3	Level 1	Level 1
	Operated within one year, resolved	Level 2	Level 2	Level 1	Level 1
	Operated more than one year, resolved	Level 1	Level 1	Level 1	Level 1
Phlebitis (DVT)	Current symptoms or treatment	Decline	Decline	Decline	Decline
	Resolved, but symptoms/treatment within 3 years	Level 3	Level 3	Level 3	Level 3
	No symptoms/treatment within past 3 years	Level 2	Level 2	Level 2	Level 2
Polycystic Ovaries ** with a \$25K single deductible can be Level 1	Both ovaries removed or menopausal	Level 1	Level 1	Level 1	Level 1
	SST free 2 years, no current treatment other than BCP **	Level 3	Level 3	Level 3	Level 3
	Within 2 years	Decline	Decline	Decline	Decline
Pregnancy	Currently pregnant	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Prostate Disorders	BPH (benign prostate hypertrophy), unoperated				
	No symptoms, on medication	Level 2	Level 2	Level 1	Level 1
	Current symptoms	Decline	Decline	Decline	Decline
	BPH, operated				
	Within 6 months	Level 3	Level 3	Level 1	Level 1
	After 6 months	Level 1	Level 1	Level 1	Level 1
	Prostate Disorders (Malignant) < 5 years	Decline	Decline	Decline	Decline
Prostatitis	Acute prostatitis				
	SST free 12 months	Level 1	Level 1	Level 1	Level 1
	Resolved, but SST within 12 months	Level 2	Level 2	Level 2	Level 2
	Current symptoms or treatment	Decline	Decline	Decline	Decline
	Chronic prostatitis				
	SST free 12 months	Level 2	Level 2	Level 2	Level 2
	Resolved, but SST within 12 months	IC / Level 3	IC / Level 3	IC / Level 3	IC / Level 3
Current symptoms or treatment	Decline	Decline	Decline	Decline	
Psychotic Disorders (Mental Health Questionnaire)	Schizophrenia, Bipolar Disorder, Major Depression				
	SST within 10 years or 2 or more hospitalizations	Decline	Decline	Decline	Decline
	SST free 10 years	Level 2	Level 2	Level 2	Level 2
	All other severe psychotic disorders	Decline	Decline	Decline	Decline

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Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Quadriplegia (Paralysis)	All cases	Decline	Decline	Decline	Decline
Rheumatoid Arthritis	Once diagnosed	Decline	Decline	Decline	Decline
Skin Cancer	Basal cell, resolved and less than 3 excisions	Level 1	Level 1	Level 1	Level 1
	Basal cell, 3 or more excisions within 5 years	Level 3*	Level 3*	Level 1	Level 1
	Squamous cell				
	Completely excised, within 12 months	Level 3	Level 3	Level 3	Level 3
	Over 12 months	Level 2	Level 2	Level 2	Level 2
	Over 5 years	Level 1	Level 1	Level 1	Level 1
	Malignant Melanoma: See condition				
	*Refer to age adjustment section for final rating				
Skin Disorders Psoriasis Rosacea	Psoriasis				
	Oral medication or injections or UV therapy within 12 months or not stable for 2 years	Decline	Decline	Decline	Decline
	Controlled with topical medication	Level 1	Level 1	Level 1	Level 1
	Medication other than topical within 2 years (not within 12 months) 2 or less courses	Level 3	Level 1	Level 1	Level 1
	Rosacea				
	Symptoms controlled without treatment for 6 months	Level 1	Level 1	Level 1	Level 1
	Controlled with medication within 6 months / no eye complications	Level 2	Level 1	Level 1	Level 1
	Uncontrolled or complications	Decline	Decline	Decline	Decline

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Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Sleep Apnea	CPAP or BiPAP use within past 12 months	Decline	Decline	Decline	Decline
	Operated, SST free 6 months, post-surgical sleep study shows resolved	Level 2	Level 1	Level 1	Level 1
	Operated, above criteria not met	Decline	Decline	Decline	Decline
	Unoperated, no treatment required, no tobacco use in 12 months, Level 1 weight	Level 2	Level 1	Level 1	Level 1
	Unoperated, with treatment or tobacco use or ratable weight	Level 3	Level 3	Level 3	Level 3
Spinal Disorders (Back Pain Questionnaire) ** Documented by MRI, X-ray, etc.	Scoliosis				
	Operated, within 12 months	Decline	Decline	Decline	Decline
	Unoperated				
	SST free 5 years	Level 1	Level 1	Level 1	Level 1
	SST within 5 years, mild to moderate curvature	Level 2	Level 2	Level 1	Level 1
	SST within 5 years, severe curvature, no treatment in past 12 months	Level 3	Level 3	Level 3	Level 3

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Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Spinal Disorders (Back Pain Questionnaire) ** Documented by MRI, X-ray, etc.	Disc Disorder				
	Multiple disc surgeries (multiple dates)	Decline	Decline	Decline	Decline
	Operated				
	SST free 6 months	APS	APS	APS	APS
	SST within 6 months	Decline	Decline	Decline	Decline
	Unoperated				
	Single disc resolved and SST free 12 months **	Level 2	Level 2	Level 1	Level 1
	Multiple discs, Or single disc with herniation, rupture or protrusion present, symptom and treatment free 12 months	Level 3	Level 3	Level 3	Level 3
Surgical candidate, symptoms or treatment within past 12 months	Decline	Decline	Decline	Decline	
Stent	(Lifetime)	Decline	Decline	Decline	Decline
Stroke	Once diagnosed	Decline	Decline	Decline	Decline
Syringomyelia	Once diagnosed	Decline	Decline	Decline	Decline

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Temporomandibular Joint Syndrome (TMJ)	SST* free 2 years	Level 1	Level 1	Level 1	Level 1
	SST* free 12 months - 2 years	Level 2	Level 1	Level 1	Level 1
	SST* free 6 – 12 months	Level 3	Level 1	Level 1	Level 1
	SST* within 6 months * mouthpiece not rated as treatment	Decline	Decline	Decline	Decline
Tendinitis	Current symptoms or treatment	Decline	Decline	Decline	Decline
	Resolved, SST within 1 year	Level 2	Level 2	Level 2	Level 2
	Resolved, SST free 1 year	Level 1	Level 1	Level 1	Level 1
Thyroid Disorders Hyperthyroidism Hypothyroidism Goiter Graves Disease	Controlled > 3 months with annual office visit or replacement therapy	Level 1	Level 1	Level 1	Level 1
	Controlled > 3 months with treatment other than replacement therapy	Level 2	Level 1	Level 1	Level 1
	Diagnosed in past 3 months or not stable in the past 3 months	Decline	Decline	Decline	Decline
Tonsillitis	1 episode within the past 12 months	Level 1	Level 1	Level 1	Level 1
	2 episodes within the past 12 months	Level 2	Level 2	Level 2	Level 2
	3 or more episodes within the past 12 months and not a surgical candidate	Level 3	Level 3	Level 3	Level 3
	Operated and released from care	Level 1	Level 1	Level 1	Level 1

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Health History Guidelines

Condition	Criteria	Rating Level Percentage			
		Single Member Deductible Levels			
		\$2400 or lower Deductible	\$2500 -\$4900 Deductible	\$5000-\$9000 Deductible	\$10,000 Deductible or higher
Varicose Veins	Operated				
	SST free 2 years	Level 1	Level 1	Level 1	Level 1
	SST within 6 months - 2 years	Level 2	Level 2	Level 2	Level 2
	SST within 6 months	Decline	Decline	Decline	Decline
	Unoperated				
	SST free 5 years	Level 1	Level 1	Level 1	Level 1
	Single episode, treated with stocking or due to pregnancy	Level 2	Level 2	Level 2	Level 2
	Multiple episodes or SST within 30 days	Level 3	Level 3	Level 3	Level 3
Wilson's Disease	Once diagnosed	Decline	Decline	Decline	Decline

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Age Adjusted Conditions

Some conditions in the health history guideline section contain a reference to the below age adjustment chart. The adjustments more accurately rate an applicant based on his or her age for a specific condition. If the condition referenced an age adjustment and indicated a level 2 rating refer the first chart labeled "Level 2 Adjustment" and look up the final rate based off the age range. If the condition referenced an age adjustment and indicated a level 3 rating refer to the second chart labeled "Level 3 Adjustment" and look up the final rate based off the age range.

Level 2 Adjustment				
Condition	Age Range			
	0-29	30-39	40-49	50-64
Allergic Rhinitis	Level 2	Level 2	Level 1	Level 1
Depression, minor	Level 2	Level 2	Level 2	Level 1
Asthma	Level 2	Level 2	Level 1	Level 1
Acne	Level 2	Level 2	Level 1	Level 1
Herpes	Level 2	Level 2	Level 1	Level 1
Otitis Media	Level 2	Level 2	Level 1	Level 1
Dermatitis	Level 2	Level 2	Level 1	Level 1
ADD	Level 2	Level 2	Level 1	Level 1
Seizures	Level 2	Level 2	Level 1	Level 1

Level 3 Adjustment				
Condition	Age Range			
	0-29	30-39	40-49	50-64
Allergic Rhinitis	Level 3	Level 3	Level 2	Level 2
Depression, minor	Level 3	Level 3	Level 2	Level 2
Asthma	Level 3	Level 3	Level 2	Level 2
ADD	Level 3	Level 3	Level 2	Level 2
Migraine Headaches	Level 3	Level 3	Level 3	Level 2
Basal Cell Carcinoma	Level 3	Level 3	Level 3	Level 3

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Re-Reviews (Appeals)

All applicants who receive an adverse underwriting decision for a request for Individual coverage will receive written notification of our decision. Every applicant who receives an adverse underwriting decision has the right to appeal the decision.

Our policy gives the applicant 180 days from the date of written notification of the adverse decision to submit a written or verbal appeal. We recommend applicants submit their appeal in writing in order to ensure the appeal is accurately understood. This written request may be from the applicant or a person acting on behalf of the applicant such as a health care provider, broker or family member. All responses to appeal requests will be sent to the applicant.

The purpose of an appeal is to provide additional information that was not available during the initial review or to provide corrections to the information that was provided. To expedite the appeal process the applicants should submit supporting information from their provider with the written appeal. If supporting information is not submitted with the written appeal it will be requested if necessary during the appeal review.

Retroactive Process for Material Misrepresentation

BCBSGa has 24 months to initiate retroactive action due to false or omitted health information on the application. Claims submitted during that period are reviewed for pre-existing conditions not listed on the application. If a pre-existing condition that should have been disclosed is discovered or if any other material misstatements are discovered, the Policy may be retroactively canceled.

Changes in Coverage

Changes in coverage are necessary from time to time to meet the policyholder's changing needs. Changes to existing policies can be made effective the first of the month if the request is received on or before the first of that month. Additional detailed information regarding changes in coverage is available in the BCBSGa [Product Movement Guidelines](#) located on the broker website at BCBSGa.com.

Adding Maternity Rider (available for Premier and ForwardFocus only)

Medical underwriting required: No

Credit for prior time given: No

When allowed: Anytime, only once in a 12 month period.

Form required: [GA Downgrade/Policy Change Form](#)

Effective date: 1st of month following Change Request receipt



Deleting Maternity rider (from Premier or ForwardFocus)

Medical underwriting required: No

Credit for prior time given: N/A

When allowed: Anytime

Form required: [GA Downgrade/Policy Change Form](#)

Effective date: 1st of month following Change Request receipt.

Name or Address Change

Medical underwriting required: No

Credit for prior time given: N/A

When allowed: Anytime.

Form required: [GA Downgrade/Policy Change Form](#)

Name changes require legal documentation: e.g. driver's license, state issued ID, marriage certificate

Effective date: Anytime, no earlier than receipt date of request.

Cancel Requests

Medical underwriting required: No

Credit for prior time given: N/A

When allowed: We will allow cancelation retro to the first of the month if the request is received within the first 7 days of the month

Form required: [Downgrade/Policy Change Form](#) (or via written request)

Effective date: 1st of the month only.

Policy or Product Upgrades & Downgrades

Please refer to the Product Movement Guideline for detailed information regarding deductible and product changes and if the change is an upgrade or downgrade.

Downgrades – increasing deductible; moving to a lower benefit plan

Medical underwriting required: No

Credit for prior time given: Yes*

When allowed: Anytime

Form required: [GA Downgrade/Policy Change Form](#)

Effective date: 1st of month following Change Request receipt

Upgrades – decreasing deductible; moving to higher benefit plan; rating level review

Medical underwriting required: Yes*

Credit for prior time given: Yes*

When allowed: Anytime, and then twice within a 12-month period – Does not have to be at renewal*

Form required: [GA Change of Coverage Application](#)

Effective date: 1st of month following receipt



Plan Changes 60 days prior to Renewal or Age Band Rate Change

Medical underwriting required: No, if moving to comparable plan – see [Product Movement Grid](#)

Credit for prior time given: Yes*

When allowed: Request must be received on or before renewal date

Form required: Renewal Option Card or call our Health Plan Advisors at 866-630-1561 – Member must be on the call.

Effective date: Date of renewal

Note: See Renewal Process and Options section of this manual for specific details

Rollbacks (Available on open POS plans only)

Medical underwriting required: Yes

Credit for prior time given: Yes*

When allowed: Once every 12 months after the first renewal date

Form required: Call our Health Plan Advisors at 866-630-1561 – Member must be on the call

Effective date: 1st of month following receipt

Note: To qualify, all members on the contract must meet the lowest risk tier after going through the rollback underwriting process

Risk Tier Reviews (all open and closed plans with risk tiers)

Medical underwriting required: Yes

Credit for prior time given: Yes*

When allowed: Anytime

Form required: [GA Change of Coverage Application](#)

Effective date: 1st of month following receipt

Changes in Family Status

Addition of Dependent (Not available for Tonik or Short-term)

Medical underwriting required: Yes (exception is newborns to an existing policy w/written request)

Credit for prior time given: Yes*

When allowed: Anytime

Form required: [GA Change of Coverage Application](#)

Effective date: 1st of month following receipt

Adding a Newborn or Adopted Child (Not available for Tonik)

Medical underwriting required: No, if written request received within 31 days of date of birth

Credit for prior time given: Yes*

When allowed: Anytime

Form required: [GA Downgrade/Policy Change Form](#)

Effective date: Date of birth or placement for adoptions

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Cancellation of Dependent

Medical underwriting required: No

Credit for prior time given: N/A

When allowed: Anytime

Form required: [GA Change of Coverage Application](#)

Effective date: 1st of month following request

Aging off Dependent

Medical underwriting required: No, if moving to same product at the same or higher deductible

Credit for prior time given: Yes*

When allowed: Request must be received within 30 days of dependent ineligibility

Form required: [GA Change of Coverage Application](#)

Effective date: 1st of month following ineligibility

* Credit for prior time is not offered for members enrolled in the following legacy plans: Blue Value, Blue Value Select, Hospital/Surgical and HDHP.

Product Movement Between PPO and POS Plans

Any product change between a PPO and a POS plan requires an upgrade change of coverage application.

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Renewal Process and Options

Member's with an Effective Date prior to 5-1-12:

These members renew each year on the first day of the calendar quarter in which they initially signed their application. At the time of each annual renewal, the premium rate for the policy may change based on the new rates in effect for that product, quarter, and duration (if applicable). In addition, a policy's premium may change based upon the age of the primary insured. During the first policy year, any age changes will not be reflected until the first annual renewal. Following that, age band rate changes will take effect on the first day of the calendar quarter after the month of the birthday.

New sales and members who have a roll-back effective on or after 5-1-12:

These members will renew the following year on the 1st of the month of the effective date of the policy or change. At the time of each annual renewal, the premium rate for the policy may change based upon the new rates in effect for that product, month, and duration (if applicable). In addition, a policy's premium may change based upon the age of the primary insured. Age changes will be applied during the annual renewal.



Approximately 60 days prior to the renewal month, you (the agent) will receive a list containing each of your clients. This list will include:

- Your client's name
- Their current plan and monthly premium amount
- Their new monthly premium amount
- Up to three product movement options

Your client will receive a renewal kit that includes a letter outlining the renewal changes, new premium amount, up to three product movement options, and a Renewal Option Card.

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Agent Services

For information regarding application status, please login to the agent services section of **bcbsga.com** using your user name and password. For assistance with Agent Services or to request a user name and password please call **888-268-4361**.

Policyholders who Move Outside the State of Georgia

Policyholders who move outside the state of Georgia should have their coverage transferred to the Blue Cross and Blue Shield Licensee of the new resident state. Policyholders should notify us of their new address by calling the Customer Service number on the back of their ID card or fax to 866-538-0824. Upon notification that the member has moved outside the state of Georgia, a Validation of Residency Form is sent to the policyholder's new address.

The Validation of Residency form should be returned within 30 days of receipt. If the member is no longer a resident of Georgia, BCBSGa will mail a HIPAA authorization form to the member that will allow BCBSGa to transmit his/her personal data to the receiving Blue Cross Blue Shield Licensee and a request to pay the policy 60 days in advance. The advance payment allows the coverage to stay active while the receiving licensee processes the request and contacts the member to offer coverage. If a policyholder moves out of the state of Georgia the member is no longer eligible for coverage through BCBSGa and may transfer to the Blue Cross and Blue Shield Licensee of the new resident state within 90 days. If the member fails to complete this process the member's policy will be cancelled for non-compliance.

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Cancellation Requests

Requests for cancellation of coverage may only be made in writing by the primary member or the parent/guardian of a dependent member. Cancellations may be made on the entire policy, or on any covered member. To cancel coverage, the member may call our Health Plan Advisors at 866-630-1561. Cancellation will be effective on the first day of the month following the request. No change



form is required if cancellation is requested by the member.

In the event of the death of a covered member, the cancellation request from a family member of the deceased should be made in writing as soon as possible. No death certificate is required if the request is received within 1 year of the date of death.

Cancellation of any riders, (e.g., dental, vision, life) while maintaining the medical policy must be requested on a GA Downgrade/Policy Change Form.

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Agent of Record Changes:

Our goal is to partner with you to conserve your clients who have coverage with BCBSGa. We prefer that a client never has a need to seek out a new agent.

Agent Requirements:

1. Agent must be licensed and actively appointed with BCBSGa.
2. Agent must have a BCBSGa Individual writing number.
3. Agent must be appointed with BCBSGa for 12 months.

Guidelines:

1. The request must be from the customer on our BCBSGa Agent of Record Change Request Form. No other letter or form will be accepted.
2. The "Authorization to Release PHI" form completed in full indicating the new agent's name and signed by the client must accompany the BCBSGa Agent of Record Change Request form.
3. Member's Contract must be in place for 12 months prior to Agent of Record Change Request.
4. Completed forms must be received by BCBSGa by the 15th of the month in order to be effective the 1st of the following month.
5. Retroactive commission adjustments are not allowed
6. Commissions will be paid at five percent for all approved Agent of Record Changes. These contracts will not count as new sales, and are excluded from all incentive bonus plans.
7. Only one Agent of Record Change is permitted per 12 calendar months on each contract.
8. If the request for Agent of Record Change is missing information or denied, BCBSGa will notify the agent by fax.



Communication:

If you submit an Agent of Record Change to BCBSGa that does not meet the above guidelines, you will be notified via fax from BCBSGa indicating the reason for denial.

The agent should fax the completed Agent of Record Change Request form along with the Authorization to Release PHI form to: 800-327-9255

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