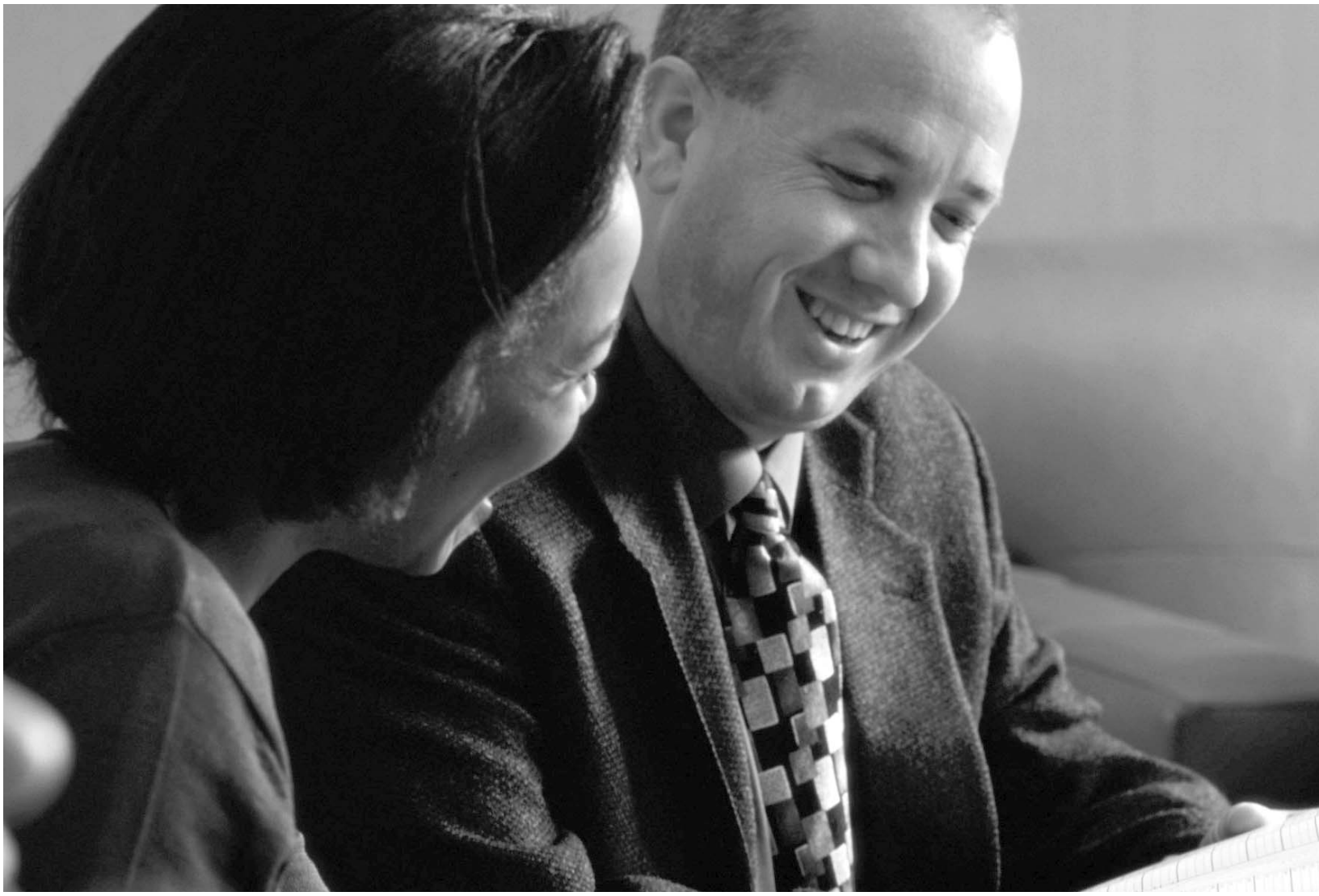
BlueCross BlueShield of Tennessee



Individual Products Agent's Guide

Revised February 2006

This document contains confidential information

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Regarding the Agent's Guide

The Agent's Guide was developed to serve as a guide to assist you in understanding and marketing BlueCross BlueShield of Tennessee, Inc. (BCBST) individual health care products.

This manual includes administrative guidelines for writing new business, billing and general policy information. This guide is compiled of the most frequently asked questions. The Underwriting Department does retain the authority to differ from these guidelines based on a case by case basis. This manual is a reference, not a legal document. Updates to the Agent's Guide are available on our Web site www.bcbst.com.

We are pleased to partner with you to offer individual products designed to better meet the health care financing needs for Tennesseans purchasing personal health care insurance. We hope you will use this information to bring better health care to the people of Tennessee.

For More Information Contact:
Home Office Support Team
1-800-351-9325 or
Your Agent Representative

Licensing Requirements

To solicit an application for insurance, an individual must hold a Tennessee agent's license. A licensed agent can quote a contract without being appointed and without an Agency Agreement, but the Agency Agreement must be signed before a policy is sold and the producing agent must be appointed to represent BlueCross BlueShield of Tennessee (BCBST) within thirty days.

All appointment paperwork must be included with the first application submitted by the agent.

An Agency Agreement can be with an individual or with an agency. If it is with an agency, the employer identification number must be listed and the producing agent must be appointed. If the agency agreement is with an individual, the social security number must be used.

To be appointed to represent BCBST, we must have an Agency Agreement, a copy of the Tennessee agent's license, the Producer Request for Appointment form, a W-9, and evidence of Errors & Omissions coverage, and a Business Associate Agreement.

Individual Under 65 Product Guidelines

Age Determination

To be eligible to enroll in any Individual Under 65 products applicants must be residents of Tennessee*, must not reside outside the United States for more than six months out of the year and must not be covered under any other individual or group health policy plan or benefits. The applicant must maintain a work/student visa and/or a valid green card if not a U.S. citizen.

**Must have a street address and not a P.O. Box.*

Plan premiums are based on the actual age of the applicant as of the policy date. Plan premiums are rated by age bands. The rates are guaranteed for twelve months.

Newborns will be considered for coverage at 6 weeks of age. See page 20 for more details.

Adults may be issued coverage up to age 65. Applicants over the age of 65 who are not eligible for Medicare are permitted to apply for coverage. Applicants can apply to cover their dependents on a parent's plan through age 23 or to age 24. The dependent must be unmarried and dependent on the applicant or applicant's spouse for at least 50% of his/her support.

Dependents include the applicant's current spouse, as recognized under Tennessee law. Dependents also include the applicant or the spouse's (1) natural children; (2) legally adopted children (including children placed with them for the purpose of adoption); (3) step-child(ren); or (4) children for whom the applicant or his or her spouse is the legal guardian.

Completing Applications

BCBST uses two different application formats for our individual underwritten products:

- The Personal Health Coverage product uses the "F" form (APP-117). This legal-size form is printed with red ink for use with OCR technology for scanning.
- All other products use a new letter-size application and are printed in black ink.

The applicant must complete an application in black or blue ink. The application has medical questions and the applicant must answer for himself/herself and all eligible dependents he or she wants to cover. All medical questions must be answered as they relate to each applicant. Those questions answered "yes" require additional details. The application must be fully completed for the underwriting process to begin. **Incomplete applications may not only delay effective dates, but can also result in the termination of the underwriting process.** The Personal Health Coverage application must be signed and dated by the applicant and spouse, if applicable. For all other products using the new application format, signatures of dependents age 18 and older are also required. A spouse who has declined coverage must also sign the application when other dependents are included on the application. The agent must sign the application also if he or she assisted in completing the application.

Applicants will have 50 days to submit medical records, if requested. When medical records are not received within this timeframe, the application will be rejected due to missing information and a policy will not be issued. The applicant will have to start the application process over.

Applications should be submitted as soon as possible after the applicant signs them. However, no initial submission of an application will be accepted if the signature date is more than 30 days old when received at BCBST. Pending applications will be closed out after 50 days at BCBST if the requested information has not been received. The oldest possible signature date on an application pending for processing is 90 days.

Once the applicant submits the application, BCBST will determine if he or she is eligible. We will medically underwrite the applicant and any dependents. We may tell the applicant that some of his/her dependents are not eligible to be covered dependents under this policy, or that some of the applicant's or the dependent(s)' conditions will not be covered.

Effective Dates

The effective date guidelines vary based on which application format is used. **For Personal Health Coverage plans, a space is provided on the application for the requested policy date. The effective date will be:**

1. The first day of the following month after the BCBST receipt of the completed application if no effective date is requested;

2. The date the applicant requests; however, the requested date must be noted on the completed application and must be after the BCBST receipt date; or
3. The termination date of any insurance to be replaced. The subscriber will provide a letter from their current carrier as to when the coverage is ending and this cannot be more than 90 days out from the date the application is signed. Otherwise, a current health statement would be required.

No policy will be dated prior to the day after the application is received by BCBST.

Effective dates may be moved forward one time. This request may be up to 45 days from the original effective date. This request must be received in writing from the applicant and must be received within the free look period of the policy. Proof of other coverage must be provided to move an effective date forward.

For products using the new application format, the applicant will have four choices for the effective date:

1. First day of the month following approval.
2. Day after approval.
3. Day after their BCBST Short-Term policy terminates.
4. Other requested effective date.

With the first two options, the effective date may be moved forward one time, using the same guidelines as Personal Health Coverage. If the applicant elects to have his underwritten policy become effective the day after his short-term policy terminates, we will allow the length of time he was covered under one or two consecutive short-term policies to be applied towards the pre-existing condition waiting period of the underwritten policy. If an applicant requests a specific effective date, we will not change that date, even with proof of other coverage. The applicant will be responsible for all premiums due from the requested date forward.

If the applicant does not select one of these four options, the default effective date will be the first day of the month following approval.

Adding Dependents

After the applicant is covered, he/she may apply to add a dependent, who becomes eligible after the initial enrollment, as follows:

1. A newborn child is covered from the moment of birth, and a legally adopted child, or a child for whom the member or the member's spouse has been appointed legal guardian by a court of competent jurisdiction, will be covered from the moment the child is placed in their physical custody. The subscriber must enroll the child within thirty-one (31) days from when he or she acquires the child by completing a change application. Do not submit a new application on a newborn if the parent(s) already has an individual contract. A new application will establish a pre-existing waiting period for this newborn.

   If the subscriber fails to do so, and an additional premium is required to cover the child, the policy will not cover the child after thirty-one (31) days from when the subscriber acquired the child. If no additional premium is required to provide coverage to the child, the member's failure to enroll the child does not make the child ineligible for coverage. However, BCBST can not add the child to the subscriber's coverage, until notified of the child's birth. If the legally adopted (or placed) child has coverage for his/her medical expenses from a public or private agency or entity, the subscriber may not add him or her to the policy until that coverage ends.
2. Any other new family dependent, (e.g. if the subscriber marries) may be added as a covered dependent if the subscriber completes and submits a signed application to us within 31 days of the date that person first becomes eligible for coverage. We will determine if that person is eligible for coverage.

When adding or deleting family members, the appropriate Individuals Request for Change in Personal Coverage form should be submitted to BCBST. Note: There are different change forms for different products.

Children Only Policies

BCBST accepts applications for minor dependent children who reside in Tennessee. The application should be signed by the parent or legal guardian who has knowledge of the health of the minor child.

In the case of applications involving more than one child, there should be an application per child. The application should list the minor child as the proposed insured. **Any other children should have separate applications. Each application requires a separate premium payment.**

Confidentiality and Release of Information

It is the intent of BlueCross BlueShield of Tennessee to provide our members protection against financial loss due to "unforeseen" medical conditions. Therefore, any applicant whose current physical/mental condition or whose past medical history that in the sole judgement of the Individual Underwriters gives rise to conditions that are not "unforeseen" must be either rejected for coverage or issued a policy with an increase in premium or Benefit Exclusion Rider.

Medical information is protected by federal law and therefore, it is the policy of the Individual Underwriting Department not to release medical information received on applications, submitted medical records or medical records currently on file. Any information obtained is used solely for insurability determinations. If an applicant requires an explanation of the underwriting decision or requests reconsideration of a decision or rider, requests must be submitted in writing to:

Individual Underwriting Department - 6P
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402

Billing

Additional information on billing can be located in the section titled Billing and Premium Processing

BCBST requires the first month's premium be submitted with the application. Separate premium payments should be submitted for family members submitting separate applications. Applications will be returned for separate premium payments.

Premium payments should be made payable to BlueCross BlueShield of Tennessee. The initial premium payment must be paid by check, credit card or debit card. Reoccurring payments may be made by:

1. Check. We do not charge a service charge for this method of billing;
2. Bank Draft; or
3. Credit Card (Visa or MasterCard) or Debit Card

We do not bill members on a quarterly or semi-annual basis; however, we will accept payments on a quarterly or semi-annual basis.

Applicants and Dependents May Not Be Pregnant

BCBST will not accept an application if a family member is pregnant. This applies also to the father of an unborn child. To be eligible for coverage, the mother must have had her post partum exam.

Individuals can apply for Guaranteed Issue coverage, if eligible.

Tips for Submitting Applications

- Applications can be submitted by mail or fax.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.
- Faxed applications must be paid with a MasterCard or Visa credit card. Applications paid by check must be mailed with the check attached.

Non-Tobacco Rates

Non-Tobacco Rates

To qualify for a non-tobacco rate, each eligible person must not have smoked cigarettes or used tobacco in any form within the past twelve (12) consecutive months.

Misrepresentation

Misrepresentation Policy

It is the policy of BlueCross BlueShield of Tennessee to rely upon the information provided on the application for coverage by the applicant in determining eligibility and insurability for participation in the Individual programs. Following the issuance of coverage, if information becomes available though any source that indicates the information on the application may have been incomplete, we will conduct an investigation. If this investigation provides documented information that was not provided on the application but that was "material" to our initial decision to provide coverage, we have the right to rescind the coverage to the original effective date.

Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine and denial of insurance benefits.

Federal Restrictions on Marketing Practices

HIPAA Restrictions Regarding the Use of PHI

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) prevent the use of protected health information (PHI), collected in the process of selling and submitting applications for individual health products, for the purposes of marketing other insurance or financial products. PHI includes such data as name, address, age, gender, insurance status, and other contact information.

Simply put, HIPAA does not allow insurance companies or insurance agencies to use mailing lists, comprised of individuals who have purchased health insurance from the company or agency, for direct mail or telemarketing solicitation for non-health related products (e.g. property and casualty, life insurance and disability).

In order to market non-health related products and services to an existing health insurance customer, you must have a signed authorization form from that customer.

Please refer to the chart below for a guideline of what is allowed:

Authorization Required to Use PHI

- Materials using the BlueCross BlueShield of Tennessee logo or name.
- Direct mail or telemarketing for non-health related (e.g. property and casualty, life insurance and disability) using a database of PHI collected during the sale of individual health insurance products.
- Newsletters that include articles about non-health related products.

No Authorization Required to Use PHI

- During face-to-face meetings with the customer.
- Items of nominal value

Communications that describe health-related products or services provided by the recipient's health insurer can be sent to the customer using PHI. Examples include:

- Network Directories
- Replacements or enhancements to a health plan (e.g. Medicare supplement plans)

- Added-value products or services that are not part of the plan benefits but are available only to enrollees in the health plan (e.g. Blue Perks program)
- Newsletters that are limited to non-marketing topics, such as wellness, value-added products or services, health-related products, legislative information and advocacy.

New FCC Telemarketing Regulations

The Federal Communications Commission issued new telemarketing regulations in July of 2003. These regulations incorporate the Federal Trade Commission's national do-not-call registry, clarify the scope of that registry and place additional restrictions on telephone and fax solicitations.

Recent updates have clarified the application of the joint Federal Communications Commission and Federal Trade Commission's Do Not Call telemarketing regulations to insurance agents and brokers. Specifically, all do not call regulations apply to insurance agents and brokers (see below for details). However, unlike an insurance company, an existing business relationship between customer and broker does not extend for the term of the insurance policy. Agents are not allowed to make telephone solicitations beyond the customary 18-month period allowed for existing business relationships without express written consent from the customer.

Here are other key telemarketing rules to keep in mind:

- It is against the law to make calls to any residential telephone phone number on the "Do Not Call" registry for the purpose of encouraging the purchase or rental of, or investment in property goods or services.
- The same rules apply to pre-recorded telephone solicitations or facsimile messages.
- Agents engaged in telemarketing practices are required to check the national registry at least every 31 days and may not contact any telephone number listed without express written permission from the consumer or unless there is an established business relationship.
- An established business relationship is defined as a purchase from or transaction with the seller within the previous 18 months of the date of the call or an inquiry or application regarding products or services offered by the seller within the previous three months of the date of the call.
- Consumers have the right to opt out of telephone solicitations from any business, even if an established relationship exists. Entities must maintain these requests on a company specific do not call list for a minimum of five years.
- Calls before 8 a.m. and after 9 p.m. are prohibited regardless of the existence of a business relationship.
- Pre-recorded or automated unsolicited advertisements and solicitations are prohibited unless an established business relationship exists.
- Effective Jan. 29, 2004, caller identification information must be transmitted. (Businesses cannot block caller ID on outgoing telemarketing calls.)
- Telemarketers must make sure that the abandonment rate of calls placed using a predictive dialer remains at no more than three percent. (A call is considered abandoned if it is not transferred to a live sales agent within two seconds of the recipient's greeting.)
- Unsolicited faxes are prohibited, unless the sender has written permission from the receiver, regardless of the existence of a business relationship.

An established business relationship is defined as a purchase or transaction within the last 18 months or an inquiry or application received within the last 3 months.

The above restrictions do not encompass all of the rules regarding telemarketing. Please see the full text version of the FCC regulation, 64 C.F.R. § 64.1200 for complete information or visit www.ftc.gov/conline/pubs/alerts/dncbizalt.htm.

This section includes general information HIPAA-Administrative Simplification and FCC Regulations regarding telemarketing practices. It is not intended to replace or service as legal counsel. Seek advice from your legal counsel on compliance with these regulations.

Features of the Broker Section of bcbst.com

The broker section of bcbst.com features useful information to help you sell BlueCross BlueShield of Tennessee individual products. By clicking on the broker link from the home page you can access:

- Broker licensing information
- Product information
- Application forms
- Individual Products Marketing Materials
- Online rate delivery system

Individual Products Marketing Materials

This link from the main (non-secure) broker section of bcbst.com takes you to our online catalog of marketing materials that should be included in each specific products sales package. To order these materials please, print a copy of the Literature Request Form from the main page of the catalog. **Fax completed forms to: (423) 535-6247.**

Online Rate Delivery System

Using this tool, you can receive quick quotes on Personal Health Coverage, Basic Blue, Short-Term Personal Health Coverage, BluePartner and SimplyBlue.

- Click on the Individual Products Rate Delivery System link.
- Select the product type from the pull down menu.
- Select the maternity or dental rider if applicable (Personal Health Coverage only).
- Enter your applicant's information.
- Select a low, middle or high rate (or combination).
- Click "Submit."

You will receive a monthly estimate of the premium based on information you submitted.

BlueAccess Broker Secure Section

Sensitive information is available on the secure area of our broker Web site, BlueAccess. Registration is required to access:

- e-Health Services®
- Application status
- Underwriting guidelines
- Updated Agent Guide
- Agent commission schedule
- Marketing Assistance Program
- Past issues of the Individual Products Sales Bulletin

How to Register for BlueAccess

1. Visit www.bcbst.com.
2. Click on the "Register" link under BlueAccess on the home page.
3. Select to register as an "Agent/Broker."
4. Follow the instructions for requesting a PIN.
5. You will be asked to enter your name and your tax ID number or your Social Security number.
6. Once, you have entered all the information, click on the "Submit" button.
7. Please check to make sure the address shown on the screen is your correct mailing address. If it is not please contact your agent representative or the HOST Team to provide a correct address.
8. You will receive a PIN number in the mail within 7 to 10 days.
9. Once you have your pin, go back to e-Health Services and click on the "Register" button and follow the instructions provided to complete the registration process.

You will be asked to create a user ID and a password during the registration process. Please note if you have previously registered for e-Health Services, your user ID and password are the same for BlueAccess.

Now that you have a user ID and password you can begin using two more online tools to help manage your individual products business.

Individual Application Status

If you need information during the application process click on the **"Individual Application Status."** To request access to this tool:

1. Logon to BlueAccess using your user ID and password.
2. Select "Individual Application Status."
3. A system-generated e-mail will pop up. Simply hit send. It is not necessary to add anything to the e-mail or create your own e-mail.
4. You will be notified by e-mail once your access has been granted. (This process takes 1 to 3 days.)

The most recent transactions since you last logged in will automatically be displayed. Other information and tools include:

- Application status – Approved, Pending, Approved with Rider(s) or Denied.
- View and print policy face pages, riders, information requested letters, and reconsideration letters.
- Access any applicant record that has been updated by BlueCross BlueShield of Tennessee in the last 90 days.
- Data can be sorted by selecting column headings such as name, application date, product, status, Social Security number, and effective date. When searching for a particular applicant, the easiest way is to enter the first letter of the last name in the last name field of the search engine. Your search will return all of your applicants with a last name beginning with that letter.

You are required to go to the Web site to retrieve this information. BlueCross BlueShield of Tennessee is not able to fax it to you.

e-Health Services

For information after a customer's policy becomes effective, select **"e-Health Services."** For the first 30 days, you have access to the following information to provide the customer assistance with his or her new policy:

- Benefit, eligibility and coverage details.
- Medical and behavioral health claims (except prescription drug and Personal Dental Coverage claims)
- Prior authorization status
- Provider referrals
- Order replacement ID cards.

If you have any questions or problems with registration or with using this system, please contact the Host Unit at 1-800-351-9325.

Submitting Applications Online

You can offer your customers the convenience of applying online for BlueCross BlueShield of Tennessee individual coverage and still receive commission for the electronic application. Simply contact **Angela Lanier at (423) 535-3215** for a link to the online application which you can place on your agency's Web site or e-mail to your customer. Your agency name and number will automatically be recorded on any online application submitted through this link. Currently, online applications are only available for the Personal Health Coverage and Short-Term Personal Health Coverage products. Applications for all other products must be submitted by fax or by mail.

To include this link on your agency's Web site, you must follow all the instructions for linking to www.bcbst.com found on pages 37 - 39 and sign a Web Linking Agreement. You are also required to post a privacy policy on your Web site. See page 39 for a content guide for your privacy policy.

Health History Guidelines

Automatic Declines for Individuals Under 65

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

AIDS/HIV infection
Addison's Disease
Adrenal Disorders
Adult Respiratory Distress Syndrome (ARDS)
Alcohol Abuse (within last 5 years)
ALS (Amyotrophic Lateral Sclerosis-Lou Gehrig's Disease)
Alzheimer's Disease
Anticoagulant Therapy
Aneurysm (within the last 10 years)
Angina
Ankylosing Spondylitis
Aortic Arch Arteritis
Aplastic Anemia
Arterial Embolism (blood clot)
Arteritis
Ataxia Telangiectasia
Atrial Fibrillation-Chronic
Autism
Banti's Syndrome
Bipolar Disorder
Cancer (within the last 10 years, see underwriting guidelines for exceptions)
Cardiomegaly
Charcot-Marie-Tooth Disease
Cardiomyopathy
Cerebrovascular Accident (CVA) Stroke
Chronic Bronchitis
Chronic Obstructive Pulmonary Disease (COPD)/ Emphysema
Cirrhosis of the Liver
Congestive Heart Failure
Connective Tissue Disease
Coronary Artery Disease
Crohn's Disease
Cushing Syndrome
Cystic Fibrosis
Dementia
Diabetes (includes insulin resistance, glucose intolerance; excludes gestational diabetes)
Down's Syndrome
Eating Disorders (within the last year)
Ebstein's Malformation
Ehlers-Danlos Syndrome
Eisenmenger's Complex
Esophageal Varices
Factor IX Deficiency (Christmas Disease)
Factor VIII Deficiency (Hemophilia)
Hand-Schuller-Christian Disease
Heart Attack-Myocardial Infarction (within last 10 years)
Heart By-Pass Surgery (within last 10 years)
Heart Enlargement/hypertrophy
Heart Valve Replacement
Heart-Lung Transplants
Hemiplegia
Hemochromotosis
Hepatitis C
Histocytosis X
Hodgkin's Disease
Huntington's Chorea
Hydrocephalus
Hypoplastic Anemia
Intermittent Claudication
Interstitial Cystitis
Kidney Failure (Chronic Renal Failure)
Kidney Transplant
Letterer-Siwe Disease
Leukemia
Liver Transplant
Lymphoblastoma
Lymphoma
Malaria
Manic Depression
Marfan's Syndrome
Mitral Stenosis
Mixed Connective Tissue Disorder
Mongolism
Multiple Myeloma
Multiple Sclerosis
Muscular Dystrophy
Nephrocalcinosis
Nephrosclerosis
Neurogenic Bladder
Obesity Surgery
Osteogenesis Imperfecta

Automatic declines for individuals under 65 *(continued)*

Pacemaker
Pancreatitis, Chronic
Paralysis
Paraplegia
Parkinson's Disease
Peripheral Vascular Disease (Arteriosclerosis Obliterans, ASO)
Pervasive Developmental Disorder
Pituitary Dwarfism
Polyarteritis
Polycystic Kidney
Polycystic Ovarian Disease (PCOD)
Polycythemia Vera
Porphyria
Primary Pulmonary Hypertension
Pseudotumor Cerebri
Psoriatic Arthritis
Pulmonary Insufficiency
Quadraplegia
Reflex Sympathetic Dystrophy/Autonomic Neuropathy
Sarcoma
Schizophrenia
Scleroderma
Sick Sinus Syndrome
Sickle Cell Anemia
Sjogren's Syndrome
Sleep Apnea
Splenomegaly
Suicide Attempt (within last 10 years)
Systemic Lupus Erythematosis (SLE)
Tetrology of Fallot
Thalassemia Major
Thrombocytopenia
TIA (Transient Ischemic Attack)
Transposition of the Great Velssels
Tricuspid Atresia
Trisomy 21 Syndrome
Ulcerative Colitis
Ulcerative Proctitis
Wegener's Granulomatosis
Wilson's Disease
Zollinger-Ellison Syndrome

Individuals can apply for Guaranteed Issue coverage, if eligible.

Adult Height and Weight Using BMI

The build charts on the following pages were developed using Body Mass Index (BMI), a measurement of height and weight. BMI correlates with body fat.

The formula for calculating a person's BMI score is:

$$\text{BMI} = \frac{\text{Weight in Pounds}}{(\text{height in inches}) \times (\text{height in inches})} \times 703$$

The National Heart, Lung, and Blood Institute classifies adult BMI as follows:

Weight Class	BMI Score
Underweight	< 18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese, Class I	30.0 – 34.9
Obese, Class II	35.0 – 39.9
Extreme Obesity	40.0+

While the height and weight tables on the following pages are in a familiar format, the average BMI for each column is included for reference.

Adult* Height & Weight - Female

Height	Minimum**	Standard Maximum	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:		
			Age 15-17	Age 18-29	Age 30+
4 Ft. 8” (56”)	80	130	131-145	131-150	131-152
9” (57”)	83	135	136-151	136-156	136-158
10” (58”)	86	140	141-156	141-161	141-163
11” (59”)	89	145	146-162	146-167	146-169
5 Ft. 0” (60”)	92	150	151-167	151-172	151-174
1” (61”)	95	155	156-173	156-178	156-180
2” (62”)	98	160	161-178	161-183	161-186
3” (63”)	102	166	167-185	167-190	167-193
4” (64”)	105	171	172-191	172-196	172-199
5” (65”)	108	176	177-196	177-202	177-205
6” (66”)	112	181	182-203	182-209	182-212
7” (67”)	115	187	188-209	188-215	188-218
8” (68”)	118	193	194-215	194-221	194-224
9” (69”)	122	198	199-221	199-228	199-231
10” (70”)	125	204	205-228	205-235	205-238
11” (71”)	129	210	211-235	211-242	211-245
6 Ft. 0” (72”)	133	216	217-241	217-248	217-252
1” (73”)	136	223	224-249	224-255	224-259
2” (74”)	140	228	229-255	229-263	229-267
3” (75”)	144	234	235-262	235-270	235-274
4” (76”)	148	241	242-269	242-277	242-281
5” (77”)	152	247	248-276	248-284	248-288
6” (78”)	156	254	255-283	255-292	255-296
7” (79”)	160	260	261-291	261-300	261-304
Average BMI:	18.0	29.3	29.5-33.2	29.5-33.7	29.5-34.1

Note: Base rates are subject to increase depending on underwriting determination.

*Applicable for primary applicants and spouses age 15 or older.

**For applicants whose weight is below the minimum guideline, a letter from the attending physician with a statement of the applicant’s health is required, including any information regarding current or prior medical conditions. In addition, applicants age 50 or over must submit the results of a DEXA scan.

Adult* Height & Weight - Male

Height	Minimum**	Standard Maximum	The following weight ranges are acceptable, but subject to higher rates as determined by underwriting:			
			Age 15-17	Age 18-24	Age 25-39	Age 40+
4 Ft. 8” (56”)	80	136	137-151	137-154	137-156	137-158
9” (57”)	83	141	142-157	142-159	142-162	142-164
10” (58”)	86	146	147-162	147-164	147-167	147-169
11” (59”)	89	151	152-168	152-170	152-173	152-175
5 Ft. 0” (60”)	92	156	157-174	157-177	157-179	157-182
1” (61”)	95	161	162-180	162-183	162-185	162-188
2” (62”)	98	166	167-186	167-188	167-191	167-194
3” (63”)	102	172	173-192	173-195	173-198	173-201
4” (64”)	105	177	178-198	178-201	178-204	178-207
5” (65”)	108	184	185-204	185-207	185-210	185-213
6” (66”)	112	189	190-211	190-214	190-217	190-220
7” (67”)	115	195	196-217	196-220	196-223	196-226
8” (68”)	118	201	202-224	202-227	202-231	202-234
9” (69”)	122	206	207-231	207-234	207-238	207-241
10” (70”)	125	212	213-237	213-241	213-244	213-248
11” (71”)	129	218	219-244	219-248	219-251	219-255
6 Ft. 0” (72”)	133	224	225-251	225-254	225-258	225-262
1” (73”)	136	232	233-258	233-262	233-265	233-269
2” (74”)	140	238	239-265	239-269	239-273	239-277
3” (75”)	144	244	245-273	245-277	245-281	245-285
4” (76”)	148	251	252-280	252-285	252-289	252-293
5” (77”)	152	257	258-287	258-291	258-296	258-300
6” (78”)	156	264	265-295	265-299	265-304	265-308
7” (79”)	160	270	271-302	271-307	271-311	271-316
Average BMI:	18.0	30.5	30.6-34.0	30.6-34.5	30.6-35.0	30.6-35.5

Note: Base rates are subject to increase depending on underwriting determination.

*Applicable for primary applicants and spouses age 15 or older.

**For applicants whose weight is below the minimum guideline, a letter from the attending physician with a statement of the applicant’s health is required, including any information regarding current or prior medical conditions.

Underwriting Guidelines for Brokers/Agents Effective 11/1/05

Note: These guidelines replace the guidelines which appear in the September 2005 version of the Individual Products Agent's Guide.

The following information provides possible underwriting decisions for the conditions listed. If a rider is placed on a policy, the rider will be in effect throughout the life of the policy unless indicated otherwise. In all cases, the final underwriting decision will be based on the member's overall medical history.

We will consider removal of a rider upon the member's written request and a current medical report regarding the condition. Subscribers must wait one year after initial acceptance of the policy to request removal of the exclusion rider.

Underwriting guidelines are subject to change without prior notice. Items noted in blue represent changes from previous guidelines.

Acne	1) Decline for severe 2) Decline if currently taking Accutane/ Amnesteem, or if have taken within the past year 3) Rider for moderate or mild 4) Rate up for medications
ANA (anti-nuclear antibody) Positive Tests	1) Decline for ANA titer 1:80 or above 2) Decline for ANA titer 1:40 or above, underlying disorder under investigation 3) ANA titer 1:40 or above (but not 1:80 or greater), asymptomatic, autoimmune disorder ruled out, no rating 4) ANA titer <1:40, no rating
ADD/ADHD	1) Rate up or decline based on severity, prescribed medications and/or receiving psychotherapy 2) Rider if current or treatment within the past 2 years
Alcohol	1) Individual consideration following 5 years of abstinence, rate up or decline based on current condition. Medical records for past 5 years required on all applicants.
Allergy/Hayfever	1) Rider if currently receiving allergy injections or if testing, injections planned in the future. 2) Rate up for medications.
Anemia	Underwriting based on specific type of anemia and severity of condition. Medical records may be required.
Anxiety/Depression	See Neurotic Disorders
Arnold Chiari Malformation	1) Decline applicants less than age 20 if unoperated 2) Rate up applicants age 20 and older if unoperated 3) Operated and asymptomatic, no rating
Arthritis	
Osteoarthritis	1) Rider if under treatment 2) Rate up for medications
Rheumatoid	Individual consideration for applicants in remission, asymptomatic, no treatment for more than 5 years. Medical records required for all applicants.

Asthma	1) Rider or decline based upon severity, amount of time since last attack and medical history 2) Rate up for medications
Back Disorders	1) Disc disorder, rider if current or surgery within the past 5 years. 2) Spinal curvature, rider. 3) Spinal manipulations, rider for frequent (greater than 2 per month) chiropractic visits 4) Strain or sprain, rider if current 5) Others, underwriting is based upon the specific condition, diagnosis, prognosis, treatment and medical history
Breast Disorders	1) Rider if applicant has had augmentation mammoplasty (breast implants), silicone or saline (rider does not exclude coverage for breast cancer)
Cancer (guidelines for consideration of local cancers has changed, see page 20)	1) Decline 10 years following diagnosis and completion of treatment for most cancers 2) Applicants diagnosed with certain local cancers may be considered before 10 years following diagnosis and completion of treatment. Individual consideration based on type of cancer and current status. 3) Basal cell/Squamous cell carcinoma, rider.
Cardiac Arrhythmias (benign or palpitations)	1) Diagnosed less than one year, decline 2) Asymptomatic and no treatment after one year, no rating 3) Asymptomatic and controlled with one medication, rate up 4) Decline if symptomatic
Cervical Dysplasia/ Abnormal Pap Smears	1) Reactive cellular changes, subsequent normal pap, no rating or rider 2) ASCUS (abnormal squamous cells of unknown significance), HPV (human papilloma virus) negative, subsequent pap smear normal, no rating or rider 3) ASCUS, HPV positive, rider until at least 3 subsequent pap smears normal and at least 18 months since abnormal pap 4) Dysplasia of cervix , mild or moderate, rider until at least 3 subsequent pap smears normal and at least 18 months since abnormal pap 5) Decline for abnormal pap without follow up 6) Severe dysplasia will be rated as local cervical cancer
Cataracts	Rider if unoperated or only one eye operated. No rider if both eyes operated and complete recovery for 2 years.
Cholesterol/ Lipid disorders	Underwriting based on risk assessment, current level of control and medications used in treatment. Current medical records required for underwriting.
Chronic Fatigue Syndrome	Underwriting based on severity of condition and current treatment. Medical records required for underwriting.
Colitis	Underwriting based on the specific diagnosis and medical history.
Colon Polyps	Rider for 3 years if history of one episode; rider for 5 years if history of multiple episodes
Congenital Abnormalities	Underwriting is based on the specific diagnosis and medical history.

D & C (Dilation & Curettage)	Underwriting is based on the diagnosis and the specific cause for the procedure.
Deafness	Underwriting based on the severity and cause.
Deviated Septum	Rider if unoperated.
Dislocations	Rider based on the specific diagnosis and location as well as medical history.
Drug Abuse	Individual consideration based on time since abuse and type of abuse.
Ear Infections	Rider if frequent ear infections and/or have tubes in ears.
Eating Disorders	Will be declined for at least 1 year following complete recovery and treatment. Rate up for 1-7 years following complete recovery (this is a high rating, therefore, may decline younger applicants) Medical records from previous 5 years will be required to consider.
Eclampsia/Preclampsia	1) Preclampsia, child-bearing age, with one normal delivery, no rating. No normal delivery since episode, decline. 2) Eclampsia, child-bearing age, with two normal deliveries, no rating. Less than two normal deliveries since episode, decline. 3) No longer of child-bearing age, no rating.
Endometriosis	Rider unless treated with complete hysterectomy
Eye Impairments	
Cataracts	Rider
Glaucoma	Rider
Stribismus	Rider
Other	Underwriting is based on the specific condition and medical history
Fibromyalgia	1) Diagnosed less than one year, decline. 2) Diagnosed greater that one year, rate up or decline based on medical history and treatment. Medical records required for underwriting.
Fractures	1) Underwriting is based on fracture location and medical history. 2) Rider will be placed if hardware in place.
Gall Bladder	Rider if unoperated. Underwriting based on specific diagnosis.
GERD	1) Rider if current treatment or treatment within the year preceding application for coverage. 2) Rate up for medications
Gout	Rider and/or rate up based on medical history and uric acid level.
Headache/Migraine	1) Rider or decline based on severity, frequency and medical history. 2) Rate up for medications.
Heart Conditions	Underwriting based on specific diagnosis and medical history.
Hemorrhoids	Rider based on severity of condition and treatment required.

Hepatitis

Hepatitis A	Present, decline. Complete recovery with no residual health conditions, no rating.
Hepatitis B	1) Acute (present) or chronic, decline. 2) Recovered, negative Hepatitis B surface antigen (HbsAg) normal liver functions tests, no rating. Medical records that include current hepatitis profile and liver functions tests required.
Hepatitis C	Decline.

Hernia	Rider if unoperated. If operated, underwriting is based on the extent of recovery, the amount of time since the procedure was performed and medical history.
Hypertension	1) Rated for degree of control and cost of medications. Medical records required for underwriting. 2) Additional rate up for tobacco users
Hysterectomy	Underwriting is based on the cause for the hysterectomy and the medical history.
Irritable Bowel Syndrome	Rider if less that 5 years since last treatment
Kidney Stones	Rider based on medical history and frequency of episodes.

Lupus Erythematosus

Systemic Lupus	Decline
Discoid Lupus	Decline or rating based on medical history

Marijuana abuse	1) Current abuse, decline 2) Past abuse, less than 2 years since last use, decline 3) Past abuse, 2-5 years since last use, rate up or decline 4) Past abuse, >5 years, no rating
Meniere's Disease	1) Progressive symptoms, vertigo not controlled, decline 2) Current treatment with diuretic or anti-vertigo medications, no progression of symptoms, rating and rider 3) No treatment, in remission, <2 years, rating and rider; >2 years, no rating, rider only
Mental Retardation	Underwriting based on applicant's age and severity of condition.
Mitral Valve Prolapse	1) Asymptomatic, no treatment (other than endocarditis prophylaxis), no evidence of greater than trace mitral regurgitation, no rating 2) Asymptomatic, treatment with one medication, no evidence of greater than trace mitral regurgitation, rating (medical records required for underwriting) 3) Symptomatic, decline
Mital Valve Regurgitaion (Insufficiency)	1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rating 2) No cardiac studies available, decline 3) Symptomatic or greater than mild regurgitation, decline

Neurotic Disorders

(Phobias, obsessive-compulsive disorders, post traumatic stress, anxiety, and non-psychotic depression)

1) Applicants currently taking, or within the last year have taken two medications concurrently for the treatment of neurotic disorders will be declined
2) Rider will be placed if currently in counseling or have been in counseling in the past, based on severity of disorder; medical rating will be placed if currently in counseling or in counseling within the past 2 years
3) Medical records required for all applicants; rate up or decline based on stability and severity of condition. Applicants with chronic or recurrent neurotic disorders will be considered on an individual basis.
4) Applicants taking benzodiazepines/sedatives for the treatment of neurotic disorders must meet the following criteria to be considered for coverage:
   - Must have had stable or near stable dosage of medication over a period of at least 2 years
   - No mental health related inpatient admissions for a minimum of 5 years
   - Evidence that the applicant has had little to no disruption of "activities of daily living" (e.g. if employed, then little or no work loss or job turnover during the past 2 years)
   - No hospitalizations or emergency room visits for anxiety/panic related symptoms
   - Must not have taken 2 medications concurrently within the past 12 months
5) Rate up for medications

Newborn

Newborn infants will be considered for coverage at 6 weeks of age. The infant must have had a well baby exam with any adverse findings disclosed on the application. All underwriting guidelines apply in determining coverage. If baby born at 37 weeks gestation or less, please refer to prematurity guidelines.

Osteoporosis

1) Underwriting based on severity, risk factors, and medical management. Medical records required for underwriting.
2) Applicants diagnosed before age 50, and applicants with history of osteoporosis with stress fracture will be declined.
3) Rate up for medications

Phlebitis

Rider or decline based on specific diagnosis, frequency of occurrence, and medical history.

Pneumonia

1) Present, decline.
2) Complete recovery, no underlying health conditions, no rating.

Pregnancy

1) Decline if the subscriber or any member of the family is pregnant at the time of application. The mother will be eligible for coverage following the post partum exam.

Prematurity

1) Gestational age 32-37 weeks and birth weight over 1750 grams (3 lbs, 14 ounces), decline for one year after birth. After one year of age, underwriting based on medical condition. Medical records required for underwriting.
2) Gestational age less than 32 weeks or birth weight less than 1750 grams, decline for 2 years after birth. After two years of age, underwriting based on medical condition. Medical records required for underwriting.
3) Applicants receiving immunization for RSV will be declined until two years of age.
4) Gestational age more than 37 weeks will be considered full term.

Raynaud's Disease

1) Progressive symptoms or complications, decline
2) Mild, not progressing, no complications, rating
3) Operated successfully, asymptomatic, rating if < 2 years since surgery; > 2 years since surgery, no rating
4) Rating for medications

Reproductive Disorders

Endometriosis Rider

Menstrual Disorders Underwriting based on type of disorder and medical history.

Miscarriage Underwriting based on cause and medical history.

Ovarian Cyst Rider

Uterine Fibroids Rider unless applicant has had hysterectomy or is post menopausal

Sarcoidosis

1) Current, decline
2) Stable, no treatment, no pulmonary involvement, <2 years, decline; 2 –10 years, rating; >10 years, no rating

RSV

1) Premature infants receiving RSV immunizations will be declined until two years of age
2) Applicants with a viral infection caused by the RSV virus, completely recovered, no rating

Sinusitis Rider if chronic.

Skin disorders Underwriting based on type of disorder and medical history.

Stroke Decline if within the 10 years preceding application for insurance. Medical records required for current health status.

Thyroid disorders

1) Goiter present, nontoxic, rider.
2) Goiter present, toxic (hyperthyroid or Grave's disease), decline unless treated surgically or medically, asymptomatic, and thyroid levels within normal limits.
3) Hypothyroid, diagnosed less than one year, rider
4) Hypothyroid, treated and thyroid levels within normal limits, after one year, no rating or rider

Tobacco use

1) Medical records will be required for all applicants age 45 and older who currently use or have used tobacco products within the past year.
2) Records should be from current health care provider for past 2 years and include a full physical exam (typical health exam for this age applicant would include screening for lipid disorders and chest x-ray).
3) If medical records and/or results of current full physical exam are not provided, applicant will be declined.

Tricuspid valve regurgitation (insufficiency)

1) Asymptomatic, minimal or mild regurgitation, normal cardiac studies, no other cardiac abnormalities, no rating
2) No cardiac studies available, decline
3) Symptomatic or greater than mild regurgitation, decline

Ulcer Rider or decline based on the location, frequency of recurrence, and treatment received.

Varicose veins Rider or decline based on severity and medical history.

Guidelines for Consideration of Localized Cancer

Decline applicants with a current or prior diagnosis of cancer unless (1) the applicant is fully recovered and (2) the elapsed time since his/her last treatment is at least 10 years. After 10 years, the applicant should be rated as standard. Exceptions to this guideline are listed below.

- Decline applicants with a current or prior diagnosis of multiple myeloma or anaplastic carcinoma of the thyroid gland, regardless of recovery status or elapsed time since last treatment.
- Applicants diagnosed with the following types of cancer may be considered for coverage if (1) the applicant is fully recovered and (2) the cancer was localized (i.e. confined to the organ of origin with no lymph involvement). Applicants may still be rated or declined based on underwriting review.

Type of cancer	Elapsed Time Since Last Treatment
Cervix/Uterus	3 years
Corpus Uterus	5 years
Eye; Retinoblastoma	3 years
Eye; Medulloepitheliomas	3 years
Eye: Intraocular Melanoma and Lymphoma	1 year
Gallbladder	3 years
Larynx*	8 years
Oral Cavity; Pharynx*	
Lips Only	1 year
Other	3 years
Prostate	2 years
Sarcoma	5 years
Skin Melanoma	1 year
Soft Tissue	5 years
Testicular	3 years
Thoracic	3 years
Thyroid Gland; Papillary, follicular and lymphomas, carcinomas	3 years
Urinary Bladder	2 years

* Applicants with these conditions must also have stopped using tobacco for more than 10 years to be considered for coverage.

Eligibility and Requirements for Newborns and People Age 65 and Over

Newborn

Newborn infants will be considered for coverage at 6 weeks of age. The infant must have had a well baby exam with any adverse findings disclosed on the application. All underwriting guidelines apply in determining coverage. If baby born at 37 weeks gestation or less, please refer to prematurity guidelines.

Age 65 and over

All applicants age 65 and over will be required to submit medical records which document medical history and current state of health.

This requirement only applies to applicants over age 65 applying for one of the underwritten products, such as Personal Health Coverage, BluePartner, SimplyBlue or BasicBlue. It **does not** apply to our BlueCross65, BlueCross65 *Select*, BlueAdvantage or BlueAdvantage*Plus* products.

Reconsideration Guidelines

If an entire application has been declined or if one or more members of a family have been excluded from an otherwise approved policy, a written request for reconsideration along with additional information or medical records may be submitted for consideration up to 90 days following the signature date on the application. If the reconsideration request is received more than 90 days after the application signature date, the applicant must submit a new application (or a change form for persons excluded from a policy). Applicants may submit a reconsideration request up to two times. Applicants may file a grievance regarding their declination of coverage.

If an applicant receives an additional rating or benefit exclusion rider and feels that one or both have been placed in error due to incorrect medical information, the applicant may submit a written request for reconsideration along with additional information or medical records. The additional information must be received within 30 days of receipt of the offer of coverage. If no additional information is received within the 30 day period, the rate and/or exclusion rider(s) will remain on the policy. After the policy has been effective for 12 months, additional medical information may be submitted for reconsideration of the rate and/or benefit exclusion rider(s).

Please note that requesting a reconsideration of a rate or rider does NOT extend the free look period.

Billing and Premium Processing

Initial Premium Payment

The first month's premium is required with applications for all underwritten Individual Under 65 Products. The entire premium is required with Short-term applications. Premium payment is not required with BlueCross65 Supplement applications.

If the premium submitted is less than the amount due, the subscriber will be billed for the additional premium. If the amount submitted is more than the amount due, the difference will be credited to the subscriber's account and reflected on their next billing statement. If additional premium payment is required, we will bill the applicant for the additional amount. The applicant may request recurring payments to be made by credit card or bank draft. These modes of payment require an authorization form be completed.

Short-term applications require exact premium payments. BCBST will not refund or bill on short-term applications.

Initial credit card payments and premium checks will be processed/deposited the day the application is processed, even if prior to the effective date.

Billing Modes and Payment Methods

Individual Under 65 Products
Mode-**Monthly**
Method-**Check, Bank draft or Credit Card**

Short-Term Policies
Mode-**Entire premium is required at time of application**
Method-**Check or Credit Card**

Guaranteed Issue Plans Policies
Mode-**Monthly**
Method-**Check, Bank draft or Credit Card**

BC65 Supplement Policies
Mode-**Monthly or Quarterly**
Method-**Check, Bank draft or Credit Card**

Money orders are also acceptable. All money orders and checks should be made payable to BlueCross BlueShield of Tennessee.

Bank draft and recurring credit card methods of payment require an authorization form be completed. A voided check or deposit slip must be attached to the bankdraft authorization form.

A credit card payment (not recurring payments) can be made over the telephone by calling the telephone number listed on the subscriber's billing statement.

Billing

Paper Billings

Subscribers on the paper bill method will be billed approximately the 15th day of the month prior to the due date, if their previous payment was received timely. The subscriber will not be billed for the next billing period until payment for the previous billing period is received and processed. The due date is always the first day of the month for the period billed.

If payment is not received by the 10th day of the month in which the premium is due, a reminder notice will be sent. If premium payment is not received within 31 days from the due date, the policy will be cancelled for non-payment and a termination letter will be sent to the subscriber.

Bank drafts

Bank drafts are processed on the 4th day of the month for which the premium is due. The draft from the subscriber's account usually occurs between the 6th and 10th day of the month. If the bank draft is rejected by the subscriber's bank, the policy will be changed to a paper billing and billed for premiums due. The subscriber must complete a new bank draft authorization form to return to the bank draft method of payment.

Credit Card Payments

Recurring credit card payments are submitted to the credit card company on the 1st day of the month in which the premiums are due. We accept MasterCard and Visa. If the credit card is rejected by the credit card company or it is past the expiration date and we have not been informed of the change in the expiration date, the policy will be changed to a paper billing and billed for premiums due. A new credit card authorization form will be required to return to the credit card payment option.

Accounts set up for a credit card or bankdraft arrangement will not receive a paper billing or receipt of the transaction. A record of these transactions should be available through the subscriber's bank or credit card company.

Terminations and Reinstatement

Terminations

The entire premium amount due must be paid in full. Partial payments are not acceptable and will be returned to the subscriber. Any overpayments will be credited to the subscriber's account and reflected on their next billing statement.

Claims processing and pre-certification will be suspended 15 days after the due date if premiums have not been applied to the subscriber's account. Policies will be terminated 31 days after the premium due date if premiums are not received.

Reinstatements

If a policy has been terminated for non-payment, it is eligible for reinstatement one time. The request to reinstate must be in writing and must be received at BCBST within 60 days from the last day the policy was in effect. No policy is eligible to be reinstated a second time. If reinstated, the effective date of the reinstatement will be retroactive to the termination date, without a lapse in coverage. The subscriber will be responsible for paying all premiums due at the time of reinstatement, including the premiums for the next billing cycle, if it is time for that cycle to bill.

Policy Changes

This section contains information on how and when changes can be made.

Changes Within the Same Product

Use the appropriate Change Application to request changes on existing coverage. These changes include:

- Adding a spouse or dependent. The health questionnaire on the back of the application must be completed. All medical questions must be answered. Those questions answered "yes" require additional details. The application must be fully completed for the underwriting process to begin. Incomplete applications may not only be delayed, but can also result in the termination of the underwriting process.
- Applying for removal of the tobacco rating.
- Applying for a change in plan or deductible.
- Requests to downgrade coverage does not require medical underwriting. The effective date of the change will be the first of the month following receipt of the application.
- Request to upgrade coverage will require medical underwriting. The health questionnaire on the back of the application must be completed. All medical questions must be answered. Those questions answered "yes" require additional details. The application must be fully completed for the underwriting process to begin. Incomplete applications may not only be delayed, but can also result in the termination of the underwriting process. The effective date of approved upgrades will be the first of the month following the receipt of the application
- Requesting a change in address. A change in address may be requested in writing and must be signed by the insured or by contacting the Customer Service Department. BCBST subscribers must be residents of Tennessee. A move outside of Tennessee will require an Interplan transfer.

Additional information on Interplan transfer can be located in the section titled Guaranteed Issue Plans.

Changes From One Product to Another Product

Transfers from one product to another product require the completion of a new application. Upgrades in coverage always require re-underwriting.

Members may transfer from BluePreferred or PHC 2 guaranteed issue coverage to SimplyBlue guaranteed issue coverage. These transfers will not receive a first year commission as there is no underwriting involved. We do not allow upgrades in guaranteed issue coverage.

The only products for which a member can purchase maternity or dental are PHC 2 and SimplyBlue. Both are only available at the time of the **initial purchase** of the medical coverage. The maternity rider may be added at a later date subject to a qualifying event of 1) marriage, or 2) spouse's loss of employer-sponsored coverage.

An "initial" purchase is defined as follows:

1) The first time an applicant purchases an individual product from BCBST
2) A subsequent purchase of a BCBST individual product, as long as there has been at least six months between the termination of the first product and the effective date of the second product.

Maternity & Dental Riders

Maternity Rider (only available on PHC "H" plans and Simply Blue "S" plans)

The maternity rider can be added at issue or with one of the following two qualifying events:

1) within 30 days of marriage (a copy of the marriage certificate must be provided); or

2) within 30 days of a spouse's loss of employer sponsored coverage (a copy of the certificate of creditable coverage must be provided).

The maternity rider may be requested on the original application or added or deleted by completing the appropriate change application. The applicant or applicant's spouse cannot be pregnant at the time of application.

Once the maternity rider has been removed, the rider cannot be re-added to the policy.

Dental Option (only available on PHC "H" plans and Simply Blue "S" plans)

The dental option may be added at initial enrollment or one time during the life of the contract. It can be deleted without terminating the medical contract. A change application must be used to add or remove dental.

Once the dental option has been removed, the option cannot be re-added to the policy.

BlueCard PPO Program

With BCBST, subscribers carry an ID card that's recognized and accepted by doctors and hospitals throughout the United States. BlueCard® Worldwide is a special hospital network designed for our subscribers who need health care services when traveling outside of the BCBST service area. BCBST will help locate the nearest PPO doctor or hospital and the subscribers medical bill will be handled through the BlueCard system.

REMEMBER: Subscribers are responsible for receiving prior authorization from BCBST. If prior authorization is not received, benefits may be reduced or denied. Subscribers can call the BlueCard PPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583) for prior authorization. In case of an emergency, subscribers should seek immediate care from the closest health care provider.

Guaranteed Issue Plans

BlueCross BlueShield of Tennessee offers Guaranteed Issue Plans. These policies are sold to applicants who qualify under Interplan Transfer, Group Conversion, Health Coverage Tax Credit (HCTC) and HIPAA regulations.

We offer two Personal Health Coverage plans and six SimplyBlue Plans as Guaranteed Issue Policies. The rates for the Guaranteed Issue Policies are higher than the underwritten plans. There are separate rates for the Guaranteed Issue Policies plans. You may request material on these plans from your agent representative.

Interplan Transfers

If a member of another BlueCross BlueShield plan moves to Tennessee, and if the member has the premium bills sent to his or her new address, the member's coverage will be transferred to BCBST.

This policy will provide coverage without a medical exam or a health statement. If the member accepts the conversion policy:

- The premium rates and benefits available from BCBST may vary from those offered by the other plan.
- The member will receive credit for the length of their enrollment with the BCBS plan toward the Guaranteed Issue Plan's waiting periods.

Group Conversion

A current BCBST group subscriber, under an insured policy, may convert from group coverage to Guaranteed Issue coverage. This policy will provide coverage without a medical exam or health statement. The subscriber must have had BCBST group coverage, and must have exercised and exhausted his or her COBRA coverage (if available), to be eligible for this policy. The following termination reasons are not eligible for Group Conversion:

- the member fails to pay a required premium contribution.
- the member becomes eligible for Medicare,
- the group agreement is replaced by similar group coverage within thirty-one (31) days.

These policies are to be effective the day after the prior group coverage ends, giving continuous coverage. The application must be received within 31 days from the time the group coverage is terminated or the subscriber is notified, whichever is later.

Health Coverage Tax Credit (HCTC)

The Trade Adjustment Assistance (TAA) Reform Act of 2002 created a tax credit for the purchase of private health insurance for certain individuals whose jobs have been moved overseas, or who are covered under the Pension Benefit Guaranty Corporation. The tax credit is available only for "qualified" health insurance.

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

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

1. Coverage must be guaranteed issue;
2. Pre-existing condition limits are not permitted;
3. The premiums charged may not be greater than premiums charged to similarly situated individuals; and
4. The benefits must be the same as coverage offered to similarly situated individuals.

We have agreed to make our PHC guaranteed issue (HIPAA) plans H31 and H32 available to applicants who qualify for the tax credit effective Oct. 1, 2003. To apply, applicants must submit their HCTC eligibility notification form and their Notice of Creditable Coverage from their prior employer. They must have had at least three months of continuous coverage, and the application must be received within 63 days of either:

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before the subscriber enrolls. If the subscriber or any person for whom he or she is applying had at least 18 consecutive months of group, COBRA, federal government or church coverage, the applicant may qualify for a waiver of pre-existing condition exclusions. There must not be a gap of more than 63 days from the date the prior group coverage ended and the date we receive the application for coverage under this contract. In addition, the applicant must not be enrolled in other medical coverage and must have exercised **and exhausted** any COBRA or other State or Federal continuation coverage options.

Policies are to be effective the day after receipt of the application at BlueCross BlueShield of Tennessee if received after the termination date of the prior coverage. Or, effective the day after the current coverage ends if application is received prior to the termination of the previous coverage. The application must be received within 63 days from the time the previous coverage is exhausted or the subscriber is notified, whichever is later.

If the applicant applies for an underwritten product with BlueCross BlueShield of Tennessee within the 63 days noted above, is approved for the underwritten product and declines the offer of coverage within the free look period, the applicant will still be allowed to exercise his/her HIPAA rights. The applicant will be required to submit a Guaranteed Issue application with a notification letter declining the offer of coverage for the underwritten product. The effective date of the Guaranteed Issue policy will be the effective date of the underwritten product the applicant declined. If the previous coverage is still active at the time of this request, the effective date will be the day after this coverage ends.

If BlueCross BlueShield of Tennessee declines the applicant for the underwritten product, the applicant will then be allowed to apply for a Guaranteed Issue Policy if requested within 31 days of the denial letter. If eligible, the effective date will be what would have been given for the underwritten product had it been approved.

The subscriber does not have to answer any health questions for these Guaranteed Issue Plans. All pre-existing waiting periods are waived for this plan also.

Broker Note

Some employers are experimenting with a different approach to controlling their health benefits costs. They simply give employees a fixed amount of money and then instruct them to obtain coverage on their own from the individual market–perhaps allowing a particular company to solicit their employees. How should brokers advise their clients when asked about this risky approach to employee benefits? The answer is simple. Advise your clients contemplating such a move to consult with their legal counsel. Such a move could present certain legal risks for the employer under the Employee Retirement Income Security Act (ERISA), the federal law which regulates most employee benefit plans.

Short-Term Coverage

This temporary health coverage is for families and individuals who need a policy for a short period of time. Good prospects are:

- Waiting on underwriting for PHC;
- Recent college graduates;
- Dependents who are reaching the age limit under their parent's contract;
- Adults between jobs; and
- Adults waiting for employer group coverage.

This policy is designed to provide medical coverage on a temporary basis, 1 month, 2 months or 3 months, to fill a short term need. It is not intended to be a permanent plan, and it is not to be issued to people who already have a medical plan.

Applicants are limited to the purchase of two consecutive short-term policies, with combined coverage not to exceed three months. Any condition that may have occurred during the term of the first policy will be treated as a pre-existing condition and excluded from coverage under the second policy. If additional coverage is needed the applicant must wait six months before submitting an application.

Short-Term Coverage may be considered creditable coverage for individual HIPAA coverage. However, it cannot be the last type of coverage the individual had. The last coverage must be employer-sponsored or government health coverage to meet HIPAA eligibility requirements.

Eligibility

Applicants must be a resident of Tennessee, not covered under any other individual or group health policy plan or benefits, and not pregnant to be eligible to enroll in Short-Term Health coverage. The applicant must maintain a work/student visa and/or a valid green card if not a U.S. citizen. Those applicants contemplating imminent or extended travel are not eligible to apply for Short-Term coverage.

Adults may be issued short-term coverage up to age 64. Applicants over the age of 64 who are not eligible for Medicare are permitted to apply for Short-Term coverage. Applicants can apply to cover their dependents through age 23, or to age 24. The dependent must be unmarried and dependent on the applicant or applicant's spouse for at least 50% of his/her support.

Dependents include the applicant's current spouse, as recognized under Tennessee law. Dependents also include the applicant or the spouse's (1) natural children; (2) legally adopted children (including children placed with them for the purpose of adoption); (3) step-child(ren); or (4) children for who the applicant or his or her spouse is the legal guardian.

The applicant must complete an application and send in the appropriate premium. All applications must be completed in blue or black ink.

Children Only Policies

BCBST accepts Short-Term applications for minor dependent children who reside in Tennessee. The application should be signed by the parent or legal guardian. Legal guardians should include guardianship papers with the application.

In the case of applications involving more than one child, there should be an application per child. The application should list the minor child as the proposed insured. **Any other children should have separate applications. Each application requires a separate premium payment.**

Pre-existing Policy

Short-Term medical does not cover pre-existing conditions. A pre-existing condition is defined as any physical or mental condition, which was present prior to the effective date of the policy for which symptoms existed, medical advice, diagnosis, care or treatment was recommended, received or should reasonably been received from a provider of health care services. A condition does not have to be diagnosed or treated to be considered pre-existing.

Effective Dates

Short-Term coverage will be effective at 12:01 a.m. on the date after the postmark or on the requested effective date, whichever is later. This date may not be later than 60 days after the date of this application. The effective date of this coverage will not be backdated.

Note: if the envelope containing the application is not postmarked by the U.S. Post Office, or if the postmark is not legible, the policy date will be the later of:

- The date after BCBST receives the application, or
- The date requested on the application.

Billing

BCBST requires the entire premium be submitted for the Short-Term Health Coverage plans. Separate premium payments should be submitted for family members submitting separate applications. Applications will be returned for separate premium payments.

Premium payments should be made payable to BlueCross BlueShield of Tennessee. We accept premium payment several different ways. The applicant or subscriber can pay by:

1. Check;
2. Money order; or
3. Credit Card (Visa or Mastercard)

Tips for Submitting Applications

- Applications can be submitted by mail or fax.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.
- Faxed applications must be paid with a MasterCard or Visa credit card. Applications paid by check must be mailed with the check attached.
- Application should be submitted in the oldest persons name when applying for family coverage.
- If there are only two family members applying, it may be cheaper to purchase two individual policies instead of one family policy.

BlueCross65

Benefit Overview

BlueCross65 is BlueCross BlueShield of Tennessee's Medicare supplement policy. We offer a choice of government-approved plans – ranging from basic to the broadest supplemental protection available. We sell these plans in every county in Tennessee.

After this coverage is approved, the subscriber will be mailed a BlueCross65 contract and identification card in one envelope. The subscriber will receive the premium statement in a separate envelope.

BlueCross65 Eligibility

To be eligible to enroll, the applicant must

- be a resident of Tennessee (no P.O. Box address);
- be age 65 or over;
- be enrolled in Medicare Part A and B. (Most applicants will have Medicare Parts A and B); and
- cannot have another federally regulated Medicare supplement policy.

If under the age of 65 and eligible for Medicare based on a disability, the applicant must currently be enrolled with BCBST through a group or individual policy. The premium rates are higher for these individuals.

BlueCross65*Select*

Benefit Overview

BCBST offers Plans C and F as BlueCross65*Select*. The only difference in this supplement and our regular BC65 supplement is the member must live in one of the designated *Select* counties and must agree to use the hospitals participating in the BlueCross65*Select* hospital network for non-emergency services.

The member saves approximately 10% to 15% on monthly premiums by choosing a BC65*Select* plan C and F instead of the regular BC65 supplement.

The penalty for not using the hospitals in the directory is that the Part A deductible becomes the member's responsibility. This penalty is not applied on emergency admissions or on urgent care received while traveling out of the service area. The member may use any doctor he or she chooses, but the member must use a hospital in the BC65*Select* network for non-emergency services. This is a hospital network only.

After this coverage is approved, the subscriber will be mailed a BlueCross65*Select* contract and identification card in one envelope. The subscriber will receive the premium statement in a separate envelope.

BlueCross65*Select* Eligibility

To be eligible to enroll, the applicant must:

- be a resident of Tennessee (no P.O. Box address);
- be a resident of a BlueCross65*Select* service area (live within 30 miles or 30 minutes of a participating hospital);
- be age 65 or over;
- be enrolled in Medicare Part A and B. (Most applicants will have Medicare Parts A and B); and
- cannot have another Medicare supplement policy.

If under the age of 65 and on Medicare based on a disability, the applicant must currently be enrolled with BCBST through a group or individual policy. The premium rates are higher for these individuals.

Service Area

The BlueCross65*Select* service area includes the following counties:

Anderson, Bradley, Cannon, Cheatham, Coffee, Davidson, Dickson, Fentress, Franklin, Giles, Hamblen, Hamilton, Hawkins, Hickman, Houston, Humphreys, Knox, Lawrence, Loudon, Marion, McMinn, Monroe, Overton, Perry, Robertson, Scott, Sevier, Smith, Sullivan, Unicoi, Warren, and White.

Premiums

BCBST does not require the first month's premium payment for BlueCross65 and BlueCross65*Select*.

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

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

Premium Payments

BCBST will send out a 30-day advance notice on any change in premium rates, including those related to a change in age band.

BCBST can accept premium payments several different ways. The subscriber or member can pay by:

1. Check for monthly or quarterly billing. We do not charge a service charge for this method of billing;
2. Automatic bank draft; or
3. Credit Card (Visa or Mastercard)

Bank Drafts

Bank drafts are processed on the 4th day of the month for which the premium is due. The draft from the subscriber's account usually occurs between the 6th and 10th day of the month. If the bank draft is rejected by the subscriber's bank, the policy will be changed to a paper billing and billed for premiums due. BCBST would require the subscriber to complete a new bank draft authorization form to return to the bank draft method of payment.

Effective Dates

BCBST will coordinate its effective date with that of Medicare. This would mean if the application is received by mid month (the 15th), we would still give a 1st of the month effective date.

All other applications will be made effective the 1st day of the month following the BCBST receipt date. The normal processing time for a BC65 application is two weeks.

Health Qualifications

State and federal laws guarantee a Medicare beneficiary the right to buy a Medigap policy of his or her choice regardless of any health problems, as long as the applicant is applying for coverage within six months of turning age 65, or within six months of becoming eligible for Medicare Part B (can be over 65 years old). BCBST also waives medical underwriting when an applicant is transferring from an existing BCBST contract (group or individual), or when an applicant is enrolled in a BC65 plan offered by another BCBS plan, and is moving into the BCBST service area. Applicants who meet the above mentioned requirements do not have to answer the health questions on the application.

Applicants who do not meet these requirements must answer four health questions. They are in regards to:

- heart attack
- stroke
- cancer
- kidney failure

BCBST will not insure the applicant **over** age 65 that has had any of these illnesses in the last five years.

There is no pre-existing waiting period on this policy.

30-Day Review

The new member has a full 30 days after receiving the BC65 policy to examine it and make sure the coverage is right for him or her. If, for any reason, the member is not completely satisfied, he or she can return the policy to us within 30 days of receipt. BCBST will refund any premiums the member has paid, less any benefits we have paid.

Replacing Other Medicare Supplement Coverage

If the applicant is terminating his or her existing Medicare supplement coverage and replacing it with a BlueCross65 or BlueCross65 Select policy, the Medicare Supplement Replacement Notice (APP-20-I) must be signed and included with the application.

Tips for Submitting Applications

- Applications can be submitted by mail or fax.
- If you fax an application, do not mail the original. This creates a duplicate record and can delay processing.

Effective Date Guidelines

Personal Health Coverage

- Process for 1st of the month following receipt of the application or the requested effective date. The requested effective date must be later than the day after the application is received by BlueCross BlueShield of Tennessee and cannot be more than 90 days in the future from the date the application is signed.
- If the requested effective date is prior to the day after the application is received, the effective date will be the day after the application is received by BlueCross BlueShield of Tennessee.

An effective date can be moved forward, one time, up to 45 days at the subscriber's request. The request must be received within the "10-day free look period". The request must be in writing, signed and dated by the applicant.

The subscriber must provide documentation from their prior carrier indicating medical coverage was maintained during this period of time.

Note: Any subscriber/member denied coverage and later approved will receive a current, not retroactive, effective date.

All Other Underwritten Under 65 Plans

Applicants have four choices for an effective date (these choices appear on the new application format):

1. First day of the month following approval.
2. Day after approval.
3. Day after their BCBST Short-Term policy terminates.
4. Other requested effective date.

With the first two options, the effective date may be moved forward one time, using the same guidelines as Personal Health Coverage. If the applicant elects to have his underwritten policy become effective the day after his short-term policy terminates, we will allow the length of time he was covered under one or two consecutive short-term policies to be applied towards the pre-existing condition waiting period of the underwritten policy. If an applicant requests a specific effective date, we will not change that date, even with proof of other coverage. The applicant will be responsible for all premiums due from the requested date forward.

If the applicant does not select one of these four options, the default effective date will be the first day of the month following approval.

Adding a Spouse or Dependent

When adding a spouse or a dependent to a policy, the effective date of that coverage will be the first day of the month following the receipt of the change application. However, if the spouse or dependent is being added as a result of a qualifying event under HIPAA (marriage, birth of a child or adoption) and the change application is received within 31 days of the qualifying event, the effective date is the date of the qualifying event.

Short-Term Coverage:

- Policies are to be effective at 12:01 a.m. on the day after the postmark date (postmark date can be the date the application is mailed to a broker, agency or BlueCross BlueShield of Tennessee, whichever is first) or the requested effective date which ever is later. If no postmark, we will use the date received at BlueCross BlueShield of Tennessee as the postmark date. The envelope is required and must be attached to the application to verify the postmark date.
- The requested effective date cannot be more than 60 days after the date of the application.

Note: If payment is made by credit card and the credit card is rejected the policy will not be issued. If the payment is made by check and the check does not clear, the policy will be terminated back to the effective date. In either case it will require the applicant to reapply and they will receive a current effective date in accordance to the above guidelines. The requested effective date from the prior policy will not be an option for the applicant.

Over 65 Supplement Coverage

- Medicare supplements will be made effective the first day of the month following receipt of the application.
- If the applicant has just become eligible for Medicare Part A and Part B, and their application is received by the 15th of the month in which the Medicare Part A and Part B become effective, the effective date will be back dated to the first of the month.

Example: Application received 7-15-04 and Medicare is effective 7-1-04, we would assign a 7-1-04 effective date unless subscriber requests otherwise.

- The effective date can be adjusted to the date an existing BlueCross BlueShield Individual or Group Policy terminates, if the application is received within two weeks of the termination of other coverage.

Note: BlueCross65 applications are accepted up to 90 days from the requested effective date provided that the applicant's signature on the application is also dated within 90 days. If the signature is dated more than 90 days from the requested date, the application will be returned for an updated signature

Guarantee Issue Coverage

- Policies are to be effective the day after receipt of the application at BlueCross BlueShield of Tennessee if received after the termination date of the prior coverage. Or, effective the day after the current coverage ends if application is received prior to the termination of the previous coverage. The application must be received within 63 days from the time the previous coverage is exhausted or the subscriber is notified, whichever is later.
- If the applicant applies for an underwritten product with BlueCross BlueShield of Tennessee within the 63 days noted above, is approved for the underwritten product and declines the offer of coverage within the free look period, the applicant will still be allowed to exercise his/her HIPAA rights. The applicant will be required to submit a Guaranteed Issue application with a notification letter declining the offer of coverage for the underwritten product. The effective date of the Guaranteed Issue policy will be the effective date of the underwritten product the applicant declined. If the previous coverage is still active at the time of this request, the effective date will be the day after this coverage ends.
- If BlueCross BlueShield of Tennessee declines the applicant for the underwritten product, the applicant will then be allowed to apply for a Guaranteed Issue Policy if requested within 31 days of the denial letter. If eligible, the effective date will be what would have been given for the underwritten product had it been approved.

Group Conversion

- These policies are to be effective the day after the prior group coverage ends, giving continuous coverage. The application must be received within 31 days from the time the group coverage is terminated or the subscriber is notified, whichever is later.

Inter-Plan Transfers

- The effective date will coincide with the termination date of the coverage through the other BlueCross BlueShield plan. The application must be received prior to the termination date indicated by the transferring BCBS Plan.

Commission Payments

For the Individual PPO and Medicare supplement contracts, all broker commissions are annualized.

Agent or agency of record letters are not accepted on individual contracts.

First Year Commissions

For each individual case sold, you will receive your monthly commission amount times 12 **based on premium received for the first full monthly billing.** By using the first full month's billed premium to calculate your commissions, you are guaranteed to receive the full commission you are entitled to based on the actual monthly premium your customer pays.

Renewal Commissions

Annualized commissions for renewals will be based on the 13th month's premium.

Short-Term Coverage Commissions

Commissions for short-term contracts will be based on the one-time processed payment for the contract.

Agent of record letters are not accepted on individual contracts.

In order to sell BlueCross BlueShield of Tennessee individual insurance products, you must follow the licensing and appointment requirements outlined on page 2 of this guide.

When Are Commissions Paid?

Commission statements will be mailed no later than the 10th of the month following the month in which the premium is posted. A schedule of commission cut-off dates is available on the broker section of www.bcbst.com. Please note that cut-off dates vary each month.

Please note that effective dates and the timing of payments can affect when you will receive commissions for a particular contract.

For Odd Effective Dates

If a contract is effective on any day of the month other than the 1st, (this is considered an odd effective date) your commissions will be paid as of the **next** month's billing due date, which, would represent the first full month's billing, as stated above. For example, if the contract is effective on July 5, 2004, your commissions would become effective as of August 1, 2004. In this example, if premiums are processed prior to the date that commissions are paid for July, then you will receive your commissions on your July statement. If, however, premiums are not processed prior to the commission run date, then you will more than likely receive your commissions on your August statement.

For Partial Premium Payments

Commissions are calculated and paid based on premiums received up to the amount of premium billed for the first full monthly billing. If the total premium for a particular due date has not been paid prior to commission processing, you will receive a pro-rated commission amount for that commission run. **However, once the premium is paid in full, you will receive the balance of your commissions for that due date.** This, of course, could mean that it may take more than one month to receive your full commissions for a contract that was not paid in full at the time of your commission payments.

Possible Commission Payment Delays

To insure accuracy of every Individual contract issued, each contract is subject to a series of quality checks before the first billing is released. Commissions are calculated and paid based on premium processed up to the first full months billing. If the contract has not billed, commissions cannot be determined. Consequently, if a contract is issued toward the end of the month when commission payments are calculated, the contract may still be in the quality assurance process and the billing has not been released. In this case, you should receive your commission with the next month's commission run.

For contracts paid by bank draft, commissions will be paid on the next monthly commission statement after the first bank draft processes.

How Do I Verify the Status of New Contracts Sold?

You can verify the status of new contracts through BlueAccess on www.bcbst.com. Please see page 9 for more details on how to use this online tool.

How Do Contract Changes and Terminations Affect Commission Payments?

Contract Changes

Commissions for any contract changes within the year after you receive your commissions, whether first year or renewal, will be reflected at the time your next commission for that contract is paid. This would include any increase or decrease in benefits that would affect the amount billed and subsequently the amount of commission paid.

Contract Terminations

Because your commissions are annualized, if a contract cancels within the year after you have received your full annual commission, a chargeback amount will be applied. This amount represents the prorated portion of the commission based on the termination date of the contract. It will appear as a negative adjustment at the end of your commission statement.

What Does a Negative Balance on the Commission Statement Mean?

Because your commissions are annualized and chargeback amounts are applied toward your commissions, you may see a negative balance on your commission statement. This is an amount that BlueCross BlueShield of Tennessee has overpaid you. You are required to repay any overpayment, which results in a negative balance. You will receive instructions with your negative statement on how to repay this amount.

Agent Guidelines for Advertising and Marketing

The BlueCross BlueShield logo is one of the most widely recognized symbols in the world. BlueCross BlueShield of Tennessee strives to maintain a high level of brand awareness through the proper use, placement and position of the company's name and logo.

To maintain brand positioning, BlueCross BlueShield of Tennessee requires responsible use of the company logo and name by its own employees and carefully evaluates each request for the use of the brand by people or organizations outside the company.

Agents, who have a signed agent agreement with BlueCross BlueShield of Tennessee, may use the company's name and logo in advertising and marketing materials. Logos for use in advertising and marketing materials are available upon request from the Advertising and Marketing Communications Department.

Any materials that include the BlueCross BlueShield of Tennessee name or logo, must follow the specified guidelines below and must be approved prior to use by the Advertising and Marketing Communications Department of BlueCross BlueShield of Tennessee. **BlueCross BlueShield of Tennessee will use all legal remedies to enforce compliance. Unapproved use of the BlueCross BlueShield of Tennessee name or logo by an agent can result in the immediate termination of the agent's agreement.**

Restrictions for Advertising and Marketing Materials

1. You may **not** represent yourself or your agency as an employee or office of BlueCross BlueShield of Tennessee in any advertising and marketing materials. All materials produced by agents must be worded and designed so that the reader understands that the material is coming from the agent or agency and not BlueCross BlueShield of Tennessee.
2. You must use the phrase "an authorized agent (or agency) for" or "offering" before the name or the logo at least one time in the materials.
3. You must use the full name and full logo in your materials. The logo may be used only as provided. The logo cannot be distorted or used in a way not explicitly approved by BlueCross BlueShield of Tennessee or described in the brand regulations from the BlueCross BlueShield Association. See examples below for the correct name and logo:

   Correct Name:
   BlueCross BlueShield of Tennessee

   Correct Logos:

4. All materials using the logo must contain the following legal disclaimer somewhere. It can be in very small print (6 or 8 point type).

   BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield of Tennessee Association

   ® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

5. The BlueCross BlueShield of Tennessee name or logo may **not** be used on your business cards.
6. Approval to use the BlueCross BlueShield of Tennessee name or logo on one particular type of material does not imply approval for any other use. Additional uses of the name or logo must also be submitted for approval.
7. BlueCross BlueShield of Tennessee will not allow its name or logo to be used on endorsements of any kind.

8 You may not use the logo in connection with any local sponsorships in which you choose to participate.

9. When used in conjunction with other insurance carriers, the BlueCross BlueShield of Tennessee logo must be displayed in a size no greater than that of any other carrier.

10. By using the BlueCross BlueShield of Tennessee logo, you are committed to channeling any prospective customer that BlueCross BlueShield of Tennessee cannot service to the BlueCross BlueShield Association.

11. All materials are subject to the approval of the BlueCross BlueShield of Tennessee Legal Department and must comply with BlueCross BlueShield Association brand regulations contained in these guidelines.

12. Use caution when listing other lines of non-BlueCross BlueShield of Tennessee products, such as life or auto insurance. You must not give the appearance that these products are also offered by BlueCross BlueShield of Tennessee.

13. Agents are not allowed to include Guaranteed Issue products in any advertising or sales solicitation materials.

Print Advertising

For pre-approved print ads, please see the Pre-Approved Advertising Program section in this booklet. You can tag your own newspaper or magazine ads with the BlueCross BlueShield of Tennessee logo. Requirements for approval:

1. Submit a draft copy or proof of your ad to the Advertising and Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.

2. If your ad is two color, the cross and shield symbols may not appear in any colors except blue or black. The words "BlueCross BlueShield of Tennessee" should always be in black.

3. The disclaimers indicated in general guideline No. 4 must be included.

4. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.

5. All general restrictions apply. (See pages 34 and 35.)

6. You are responsible for all production and placement costs.

7. Provide a list of publications the ad will appear in and the number of times the ad will run in each publication.

8. Approvals are good for one year, and must be submitted for approval again each year.

An example of the correct usage of the logo in a print ad is shown below.

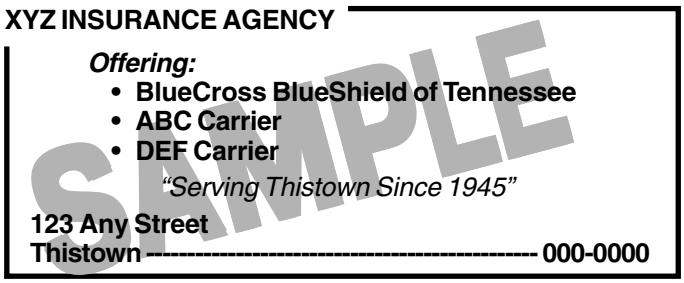
Yellow Page Advertising

BlueCross BlueShield of Tennessee now allows agents to list its name and logo in yellow page advertising.

Requirements for approval:

1. Yellow and white page listings must be under your agency's name, not BlueCross Blue Shield of Tennessee's name.
2. If your ad includes the name or logo of other insurance carriers, the BlueCross BlueShield of Tennessee name or logo may not be larger than the name or logo of any other carrier.
3. Submit a draft copy or proof of your ad to the Advertising and Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.
4. If your ad is two color, the cross and shield symbols may not appear in any colors except blue or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
5. The disclaimers indicated in general guideline No. 4 must be included.
6. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
7. All general restrictions apply. (See pages 34 and 35.)
8. Please provide the name of the book the ad will appear in.
9. You are responsible for all production and placement costs.
10. Approvals are good for one year, and must be submitted for approval again each year.

Examples of the correct usage of the logo or name in a yellow page ad:



Direct Mail

You can mention BlueCross BlueShield of Tennessee in direct mail campaigns, such as letters to prospective customers. Requirement for approval:

1. Submit a draft copy of your letter or direct mail piece to the Advertising and Marketing Communications Department via fax, mail or e-mail.
2. All letters are subject to approval by the BlueCross BlueShield of Tennessee Legal Department.
3. Letters should be on your agency's letterhead. Do not create a letterhead look with the BlueCross BlueShield of Tennessee logo.
4. If your direct mail piece is two color, the cross and shield symbols may not appear in any colors except blue (PMS 300) or black. The words "BlueCross BlueShield of Tennessee" should always be in black.
5. The disclaimers indicated in general guideline No. 4 must be included if the logo is used.
6. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
7. All general restrictions apply. (See pages 34 and 35.)
8. Please provide what areas you plan to mail and who your audience is.
9. You are responsible for all production and mailing costs.
10. Approvals are good for one year, and must be submitted for approval again each year.

Outdoor Advertising

You can use the BlueCross BlueShield of Tennessee logo on outdoor advertising for your agency. Requirements for approval:

1. If your ad includes the name or logo of other insurance carriers, the BlueCross BlueShield of Tennessee name or logo may not be larger than the name or logo of any other carrier.
2. The disclaimers indicated in general guideline No. 4 must be included.
3. Submit a layout of your outdoor board to the Advertising and Marketing Communications Department via fax, mail or e-mail. If you submit draft copy, the final layout will still have to be submitted for approval.
4. The cross and shield symbols may not appear in any colors except blue (PMS 300). The words "BlueCross BlueShield of Tennessee" should always be in black.
5. If changes are requested, you will be required to submit a corrected proof before approval will be given. Please allow time for this process.
6. All general restrictions apply. (See pages 34 and 35.)
7. Please provide the location, size of the board and the length of the contract.
8. You are responsible for all production and placement costs, as well as maintenance of all outdoor advertising.
9. Approvals are good for one year, and must be submitted for approval again each year.

Examples of the correct usage of the logo on an outdoor advertising board:

or

Radio Advertising

Radio advertising using the BlueCross BlueShield of Tennessee name is permitted. Requirements for approval:

1. The radio advertising must be worded to come from your agency, not BlueCross BlueShield of Tennessee.
2. You must identify yourself or your agency as "an authorized agent (or agency) for BlueCross BlueShield of Tennessee."
3. Submit a draft copy to the Advertising and Marketing Communications Department via fax, mail or e-mail for approval.
4. If changes are requested you will be required to submit corrected copy before approval will be given. Please allow time for this process.
5. All general restrictions apply. (See pages 34 and 35.)
6. Please provide a list of stations and the dates the commercial will air.
7. You are responsible for all production and placement costs.
8. Approvals are good for one year, and must be submitted for approval again each year.

Television Advertising

You may use the BlueCross BlueShield of Tennessee logo in your television advertising. Requirements for approval:

1. The television advertising must be worded to come from your agency, not BlueCross BlueShield of Tennessee.
2. You must identify yourself or your agency as "an authorized agent (or agency) for BlueCross BlueShield of Tennessee" either visually on screen or in the voiceover.
3. Because of the expense involved in television production, please submit a draft copy the Advertising and Marketing Communications Department via fax, mail or e-mail for approval. This copy should indicate how the logo is to be used in the commercial.
4. The cross and shield symbols should be in blue and the "BlueCross BlueShield of Tennessee" should be in black.
5. The disclaimers indicated in general guideline No. 4 must appear on screen during the commercial.
6. Once production is complete, a VHS copy of the commercial must be submitted before airing for approval. Please be advised that if the general guidelines are not followed, you will be required to correct the spot before airing and submit another VHS copy for approval.
7. All general restrictions apply. (See pages 34 and 35.)
8. Please provide a list of stations and the dates the commercial will air.
9. You are responsible for all production and placement costs.
10. Approvals are good for one year, and must be submitted for approval again each year.

Internet Advertising

All of the restrictions on pages 34 and 35 apply to Internet advertising. You may not use the BlueCross BlueShield of Tennessee logo or name or any variation of the name as a link or a Web address in an Internet ad. Ads should represent your agency.

You may list that you are "an authorized agent for BlueCross BlueShield of Tennessee" or that you "offer BlueCross BlueShield of Tennessee" in descriptive copy in an Internet ad.

Agency Office Signage

You may include the BlueCross BlueShield of Tennessee logo on signage for your agency at your own expense. Requirements for approval:

1. Use the language "An Authorized Agent (or Agency) for" with the logo.
2. Submit your design to the Advertising and Marketing Communications Department via fax, mail or e-mail for approval.
3. All general restrictions apply. (See pages 34 and 35).

Other Uses of the Logo or Name

Please contact BlueCross BlueShield of Tennessee's Advertising & Marketing Communications Department for approval and guidance on any other uses of the name or logo not covered in this guide.

Marketing Assistance Program

BlueCross BlueShield of Tennessee offers agents pre-approved advertising materials, which can be purchased via our Marketing Assistance Program (MAP) at bcbst.com using your MasterCard or Visa. Materials offered include:

- Newspaper Ads
- Yellow Page Ads
- Newspaper Inserts
- Postcards
- Tri-fold Direct Mail Brochures

Materials are segmented by business line (individual, group, Medicare supplement and generic/all products). All materials will be customized for your agency. You see a proof online and complete your transaction by entering your credit card information.

Direct mail services are also available with the postcard and direct mail brochures. You have the opportunity to order a one-time mailing list for businesses or consumers. BlueCross BlueShield of Tennessee commercial customers are suppressed from any mailing lists you purchase. You select your list criteria online based on age, geographic area, gender, income, etc. MAP will take care of the list rental, customizing the materials and your outbound postage for one inclusive price. Minimum order quantity is 500 on all pieces. Once you order a list, no other agent can purchase the exact same list of names for 30 days through this program.

Pricing for all products is available on the MAP Web site. You must be a registered user of the BlueAccess secure area of bcbst.com. Please see page 8 for instructions on how to register for BlueAccess.

Newspaper and yellow page ads are usually provided electronically to you with 2-3 business days. Printed pieces are usually delivered to you (or the post office if you are using the direct mail services) in 7 to 10 business days.

Resizing of ads or special printing requests are available for an additional charge. If you have special requests you should contact the Advertising and Marketing Communications Department before you place your order.

To get started with MAP:

1. Log on to BlueAccess from the homepage of bcbst.com
2. Click on the Marketing Assistance Program.
3. First time visitors will be asked to fill out a profile. Your profile will be used pre-populate some items on your order form.
4. Click on the Order Print Materials button.
5. Select the item you wish to purchase from the main menu.
6. Follow the instructions for completing your customization information.
7. If you are using the direct mail services, please follow the instructions to order your mailing list before you complete the customization portion of the form.
8. Review your proof carefully. If you need to make changes, hit the back button at the bottom of the screen (don't use your browser's back button).
9. Once you are satisfied with your proof, enter your credit card information to complete your transaction.

If you need assistance at any time with MAP, please call the Advertising and Marketing Communications Department. If you experience technical problem with the MAP Web site, call the help line at 1-888-411-3111.

Linking to www.bcbst.com

You can use the BlueCross BlueShield of Tennessee logo on your agency Web site, provided you follow these guidelines and receive approval from the Advertising and Marketing Communications Department. Requirements for approval:

1. Your Web site must represent your agency, not BlueCross BlueShield of Tennessee.
2. If your Web site includes the logos of other carriers you represent, the BlueCross BlueShield of Tennessee logo cannot be larger than the other logos.
3. All Web restrictions apply. (See pages 40 and 41)
4. If you decide to include a link to the BlueCross BlueShield of Tennessee Web site, you must provide a description of how the link is to be used on your site and sign a Linking Agreement that will be provided by the Advertising and Marketing Communications. Upon receipt of this agreement, instructions for linking to www.bcbst.com will be provided to you.

5. You must submit a link to your proposed site so that it may be viewed and approved by the Advertising and Marketing Communications Department and the Legal Department prior to the site going live.
6. You are not allowed to generate and send SPAM e-mail using the BlueCross BlueShield of Tennessee name or logo nor can you include a link from any SPAM e-mail that directs recipients to your Web site featuring the BlueCross BlueShield of Tennessee name or logo.
7. Your Web site must have a privacy policy posted that meets the requirements on page 41.

Your Web site will be monitored by BlueCross BlueShield of Tennessee to ensure compliance with the general guidelines and linking agreement. If your site is not in compliance, your linking relationship will be terminated.

Restrictions for Use of BlueCross BlueShield of Tennessee Logo on Agency Web Sites and Linking to www.bcbst.com

1. Your Web site must represent your agency not BlueCross BlueShield of Tennessee or the BlueCross BlueShield Association.
2. You may only link directly to the BlueCross BlueShield of Tennessee home page. Special permission must be granted to link to other parts of the Web site.
3. You must use the phrase "an authorized agent (or agency) for" or "offering" with any use of the logo on the Web site.
4. The BlueCross Blue Shield of Tennessee pages cannot be framed within your agency's site or otherwise implied to be a part of your Web site. A new browser window should open when the user goes to the BlueCross BlueShield of Tennessee Web site to help make a distinction between the two Web sites. This approach will also keep your Web site accessible to the user in the previous browser window.
5. You must use the full name and full logo on your Web site. The logo may be used only as provided. The logo cannot be distorted or used in a way not explicitly approved by BlueCross BlueShield of Tennessee or described in the brand regulations from the BlueCross BlueShield Association. See examples below for the correct name and logo:
   - Correct Name: **BlueCross BlueShield of Tennessee**
   - Correct Logos:

6. If your Web site includes our logo, you must include the following legal disclaimer somewhere in close proximity to the logo. It can be in very small print (6 or 8 point type).

   BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield of Tennessee Association

   ® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

7. Approval to use the BlueCross BlueShield of Tennessee name or logo on your Web site does not imply approval for any other use. Additional uses of the name or logo must also be submitted for approval.
8. BlueCross BlueShield of Tennessee will not allow its name or logo to be used on endorsements of any kind.
9. You may not use the logo in connection with any local sponsorships in which you choose to participate.
10. When used in conjunction with other insurance carriers, the BlueCross BlueShield of Tennessee logo must be displayed in a size no greater than that of any other carrier.

11. By using the BlueCross BlueShield of Tennessee logo, you are committed to channeling any prospective customer that BlueCross BlueShield of Tennessee cannot service to the BlueCross BlueShield Association.
12. All Web sites are subject to the approval of the BlueCross BlueShield of Tennessee Legal Department and must comply with BlueCross BlueShield Association brand regulations contained in this booklet.
13. Your Web site must have a privacy policy posted that meets the content requirement below.

Web Site Privacy Policy Content

1. Must contain a brief description of your organization and the activities that can be performed on your site. Describe public sections of your site and the information that your site may retain from each visitor (i.e. domain, date & time stamp, IP address, etc).
2. Identify secure sections that require login and password, if applicable. If you have a secure section, describe the activities that will be conducted on the secure section. Identify the information that is required to access the secure site for registration purposes. How will access be granted (i.e. immediately, mailed pin, etc).
3. Address child users under the age of 13 and what activities that may perform on your site without parental consent. Also cover your secure sections, if applicable.
4. Address how e-mails forwarded to you from the site will be addressed, including how the e-mail address may be used in the future. Also include directions on how someone can remove their email address from your database.
5. Address questionnaires or surveys if used by your site.
6. Disclosure of non-public personal information (GLB requirement). Address how your site protects non-public personal information. Include an opt-out statement if the information may be used for purposes outside the web site.
7. A section that identifies how long the information collected on your site will be retained before it is destroyed. Also include a way to correct personal information that is available on your site.
8. If your site uses cookies, you must describe how cookies will be used.
9. Add a section about linking to other sites. Include a statement about reviewing those privacy policies since they may be different from your site.
10. Include a section describing the security of your Web site and how the information that is collected from your site will be protected from intrusion.
11. Include a reservation of rights in your policy that will allow you to change your policy without notice and advise visitors to review the policy frequently for any changes.

How to Contact the Advertising and Marketing Communications Department

You may submit advertising and marketing materials for approval, requests for logos, requests for information on the Marketing Assistance Program and requests regarding linking to www.bcbst.com by mail, fax, or e-mail to the following contact in the Advertising & Marketing Communications Department:

Alan Cooper
Communications Project Manager,
Advertising & Marketing Communications
BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
Phone: (423) 535-7123
Fax: (423) 535-6355
e-mail: alan_cooper@bcbst.com

Please allow 5 business days for your request to be processed. Every effort is made to process requests as quickly as possible. However, requests that are product specific may require approval from the BlueCross BlueShield of Tennessee Legal Department.

BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, TN 37402

www.bcbst.ocm

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