

**AGENT GUIDE**  
**FOR**  
**AVMED HEALTH PLANS**  
**INDIVIDUAL UNDER 65 PRODUCTS**

**ELIGIBILITY AND UNDERWRITING GUIDELINES**

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**ELIGIBILITY AND UNDERWRITING GUIDELINES**

**Age Requirements**

Age requirements are based on age as of the application date. However, the premium rate is based on the actual age of the applicant as of the policy effective date.

- ❖ **Adults – 18 to 64 ½**
- ❖ **Dependents**
  - **Spouse** – Under 64 ½
  - **Children** – Unmarried, through age 18 or until age 25 if a full-time or part-time student. If less than two months of age, the newborn must have had a well-child examination after release from the hospital. There is no underwriting for a newborn once the contract is in force, if the newborn is added within 60 days of the date of birth. See **Changes to an Existing Contract** section.

**Dependent Eligibility Requirements**

Eligible dependents are a spouse, unmarried natural children, legally adopted children, or stepchildren living in the custody of the primary applicant. A child for whom the applicant has been appointed legal guardian may also be covered as an eligible dependent, pursuant to a valid court order. Foster children or other children in a court ordered custody are not eligible dependents.

- ❖ **Spouse** – Legally married and residing in an AvMed Service area where the Individual products are offered. Common Law spouses and Domestic Partners may not be covered as a dependent spouse.
- ❖ **Children** – Unmarried and dependent upon the primary applicant for support. A child not residing with the primary applicant must still reside in the counties where the AvMed individual products are available. The address of the child's primary residential address must be included on the application. The parent with whom the child resides should provide the answers to the application health questions. If an underwriting interview is required, the custodial parent will be interviewed. All applicants age 18 and older must validate the information provided on the application by signing or e-signing the application. Legal court ordered Guardianship papers or a Certificate of Adoption must be provided with the application when applicable. These forms will need to be scanned and emailed to Underwriting upon submission of an electronic application. See the Contact List for additional information.

All children in an immediate family, residing in the same household, are expected to apply for coverage, unless the child has health history that includes one of the ineligible health conditions listed in the **Ineligible Health Conditions** section.

## **Children Only Policies**

- ❖ Children, 2 years through age 17 may have their own policy. Children only applications should be submitted with the signature of a custodial parent who has knowledge of the health of the minor child(ren). If the policy is being applied for by a non-custodial parent (i.e.; a divorced parent), the non-custodial parent should sign or e-sign the application as the Applicant and the custodial parent should also sign, attesting to the child(ren)'s medical history provided on the application. If the child(ren) resides with a legal guardian, a copy of the court ordered Guardianship papers must be provided with the application. This form will need to be scanned and emailed to Underwriting upon submission of an electronic application. See the Contact List for additional information.

If an underwriting interview is required, the custodial parent who completed the health history on the application will be interviewed.

In the case of applications involving more than one child, all children must reside in the same household. The youngest child will be the primary applicant, and any other children will be listed as dependents, for the purpose of the Application for Individual Coverage.

All children in an immediate family, residing in the same household, are expected to apply for coverage, unless the child has health history that includes one of the ineligible health conditions listed in the **Ineligible Health Conditions** section, or if they are less than 25 months of age.

## **Current Pregnancy/Expectant Parent**

An application will not be accepted for a pregnant female, the spouse of a pregnant woman, pregnant dependents, or prospective fathers (married and single). The mother or the father of the unborn child may apply for coverage after delivery and after the mother has been released from the physician's care. The newborn must have had a well-child examination after release from the hospital to be considered for coverage.

## Residency Requirements

The address of the applicant's primary residence must be in the State of Florida, and in an AvMed operational county for the Individual products, at least six full months of the year. This includes a minor child applying as the primary applicant.

- **The Individual U65 Products are available only to residents of Broward and Miami-Dade counties.**

A student, attending a college/university outside an AvMed Service Area, and/or the State of Florida, is not eligible to apply as the Primary Insured. However, they would be eligible to apply as a dependent on their parent's policy, assuming the residency requirement is met by the parent. A college student, covered as a dependent on their parent's policy, can attend a college/university outside an AvMed operational county for the Individual products.

- Please caution the applicant that benefits are reduced if the dependent student seeks care outside the AvMed Service area and/or from an out-of-network Provider.
- For dependent children who do not reside with the Primary Applicant, see the **Dependent Eligibility Requirements** section.

## Non United States Citizens

Applicant's that are not U.S. Citizens may be considered for coverage if they have been a legal resident of the United States for a minimum of one year and have a valid Resident Alien Card (Green Card), or unexpired VISA in force through the next 18 months. They must intend and/or expect to remain in the U.S. for the next 18 months and their primary residence must be in the State of Florida (see **Residency Requirements** section). If more than one applicant is a non-U.S. citizen, each applicant must indicate a response to all residency questions on the application.

Additionally, non-U.S. citizens must have consulted a physician in the U.S. within the past two years and complete medical records for this care must be available. An applicant with significant health history, such as cancer history, heart disorder, etc., may not be considered unless they have established a physician/patient relationship with a doctor in the U.S. Medical records will be obtained by AvMed.

## Social Security Number Requirement

Social Security numbers are required for all applicants, including dependents. All social security numbers will be maintained in confidence by AvMed. Policy ID numbers, other than a social security number, will be assigned as Policy/Contract numbers. If the primary applicant or spouse does not have a social security number, an e-application cannot be completed, the application process will terminate. It is extremely important that only a valid social security number be entered. An invalid or incorrect social security number will cause excessive delays in application processing, and could require an application to be declined and/or re-submitted. In addition, submission of an incorrect or invalid social security number can be considered as applicant material misrepresentation and can result in cancellation or rescission of coverage.

## **Ineligible Occupations**

Although not an all-inclusive list, examples of ineligible occupations are:

- Active Armed Forces Personnel
- Asbestos & Toxic Chemical Workers
- Carnival, Circus or Rodeo Workers
- Explosives Dealers, Makers or Handlers
- Firefighters
- Hazardous Waste Handlers
- High risk aviation such as: Crop Dusters, Helicopter Pilots & Aerial Photographers
- Off-shore Oil Workers
- Police, Law Enforcement Personnel, or Armed Security Guards
- Professional & Semi Professional Athletes involved in contact sports or high risk for injury
- Race Car Drivers
- Sky Diving Instructors
- Underwater or Caisson Workers
- Wild Animal Trainers

## **Foreign Travel**

An applicant who is contemplating extended travel outside the United States of three months or more, is not eligible for coverage. This includes students who travel abroad or study overseas.

## **Other Medical Insurance**

An AvMed Individual Under 65 policy may not be issued if the applicant has other medical insurance coverage in force (with the exception of Hospital Cash, Daily Benefit plans, Critical Illness plans, Cancer Insurance plans, and Specified Disease plans) that the applicant does not intend to replace.

If an illness or injury is covered by a Worker's Compensation plan, AvMed does not provide benefits for that illness or injury. No benefits will be provided by AvMed for a work-related injury or illness which would have been covered by the Worker's Compensation carrier if an insured was required by state law to maintain Worker's Compensation insurance, but elected not to do so. AvMed will provide benefits for a work related illness or injury if an insured was not required by state law to carry Worker's Compensation insurance and voluntarily elected not to do so.

If the AvMed Individual policy is replacing other coverage, the applicant will be asked to provide the name of the other carrier, the effective date and the termination date of the other coverage. If the other coverage is currently in-force we need to be notified of the paid-to-date so that continuity of coverage can be maintained. See **Replacement of Existing Insurance** and **Effective Date Assignment** sections.

## **Replacement of Existing Insurance and Portability of Pre-Existing Credit**

The State of Florida Replacement of Accident or Sickness insurance statutory requirements affect the Insurance products only. **Because AvMed is an HMO carrier, the Replacement of Existing Insurance statute does not apply, thus, AvMed will not be notifying other carriers of potential customer cancellations.**

It is important to AvMed that any applicant intending to replace their current medical coverage does so with an understanding of the full significance of this action. Replacement of existing coverage should be considered only when it is in the applicant's best interest to do so.

The applicant must agree to cancel any existing group or health plan coverage (does not apply to Hospital Cash, Daily Benefit plans, Critical Illness plans and Specified Disease plans) if the AvMed coverage being applied for is issued; however, the current coverage should not be canceled until the AvMed coverage offer is made, or coverage is issued. If the applicant makes a premium payment on their current coverage while their AvMed application is being underwritten, Medical Underwriting should be advised so the effective date for the AvMed coverage can be coordinated accordingly.

The 1996 Florida Senate Bill 910, Portability of Insurance, applies to insurance products only and does not apply to HMO carriers. Because AvMed is an HMO carrier, the statute does not apply thus, credit for pre-existing coverage is not provided.

### **Small Group Reform Impact on Individual Health Coverage**

The 1993 Florida Senate Bill 1914 was enacted to limit the participation of a small business owner in the contribution of premium payments for an individual's non-group health coverage. The legislation stipulates the following:

- A small business owner (employees 1-50) cannot contribute to an individual employee's individual medical contract, and
- A small business owner (employees 1-50) cannot provide administrative support for the billing of an employee's individual medical contract and if coverage is approved, all premium billings will be sent to the primary contract holder. The exception to this is a List Billing arrangement enacted by Florida legislation in 2005 (HB 811). (A List Billing arrangement is not currently available for the AvMed Individual Under 65 Product).
- An exception to the above is that an employer may contribute a portion of the premium for an individual under the following circumstances:
  - The individual is self-employed and has elected to purchase individual coverage
  - The individual is a part-time employee working less than 25 hours per week and is not eligible for a group plan
  - The individual is a temporary or substitute employee
  - The individual is an employee working under an independent contractor agreement

## **Work Related Illness or Injury**

If an illness or injury is covered by a Worker's Compensation plan, AvMed does not provide benefits for that illness or injury. No benefits will be provided by AvMed for a work-related injury or illness which would have been covered by the Worker's Compensation carrier if an insured was required by state law to maintain Worker's Compensation insurance, but elected not to do so. AvMed will provide benefits for a work related illness or injury if an insured was not required by state law to carry Worker's Compensation insurance and voluntarily elected not to do so.

## **Split Policies**

The company prefers that all family members be enrolled under one contract. However, to assist applicants in achieving the most appropriate coverage to meet their needs, applications for family members may be split **except for same product**.

- Different products for each family member are acceptable.
- Separate applications with separate premium payment information are required, and separate underwriting will occur.
- The applications will **not** be linked together and will be processed as they are approved.
- Different effective dates are likely.

## **Prior Medical Visit Requirements for Applicants age 55 or Older**

Individuals, age 55 or older, who have not seen a physician within the past two years, are not eligible for coverage. It is preferable that the applicant has had a complete physical examination by a family physician within the past two years. Exams for employment, FAA physicals, Immigration physicals, DOT physicals, exams by a family member, and exams for other insurance companies will typically not suffice in that the medical records are generally not sufficient and/or not available for underwriting evaluation.

## **Tobacco Usage**

To qualify as a non-tobacco user, an adult applicant must not have used tobacco products in any form (cigarettes, cigars, pipes, snuff or chewing tobacco) in the past 12 months. Tobacco products include the use of smoking cessation products such as nicorette gum, nicotine patch, etc. For change consideration from the smoker to non-smoker rate, see **Changes to an Existing Contract section**.

## Applicants Not Eligible For Coverage

The following is a list of applicants that are not eligible for coverage, **that have not been referenced elsewhere in this document:**

- Applicant's that are currently in the process of adoption or surrogate pregnancy. However, once the child is placed in the home, is two months old, and has established care with a physician, the family is eligible to apply for coverage.
- Currently receiving Social Security Disability and/or early Medicare benefits, or unable to work due to disability or receiving Worker's Compensation or disability income benefits.
- Are about to be seen by a physician or about to enter a hospital, sanitarium, rest home, prison or other institution, or who are sick, infirm, or otherwise not healthy at the time of the application.
- Have a medical appointment scheduled within the next 30 days, including appointments for routine physicals, until after the physician has been seen and all test results are known (generally two weeks after the exam).
- Recently had or anticipate testing or surgery and/or have not been released from the physician's care.

## Completion of the Application

The following information will be needed for completion of the application:

- Date of birth for all persons applying for coverage
- Social Security Number for all persons applying for coverage, including dependents
- Complete primary resident address (P.O. Box is not acceptable), including dependent children living elsewhere, (must be residents of Broward or Miami-Dade counties). See **Residency Requirements**
- E-mail address is required
- Telephone numbers. We may contact the applicant for an interview or to obtain additional information.
- Employment information (name and address of employer) for the primary applicant and spouse. If applicant is under age 55 and retired, we need specific details of reason for early retirement (health history, investment income, sold business, etc.). Will also need source of income for early retirees (under age 55) or if applicant is unemployed.
- Occupation for the primary applicant and spouse. Refer to the Ineligible **Occupations** list
- College/University information (name and address) if primary applicant is an adult (age 18+) full-time student. See **Residency Requirements**
- Student status for any dependent, age 18 through 25
- Height and Weight for all persons applying for coverage
- Medical history information for all persons applying for coverage; including name/address/phone number of treating physician(s), hospitals, clinics and dates of treatment. Also, name and dosage of any medications.
- Premium payment information for the first premium payment (not deducted until the application is approved), as well as ongoing premium payments. Bank account information including the name, address, and phone number of the bank, as well as the bank account number, and ABA routing number located on check and deposit slips.

## Effective Date Assignment

When applying for coverage the applicant will be asked to choose an effective date. The effective date selected can be:

- Current date + 1 day
- Must be a date other than the 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month
- Must be a date less than 60 days from the current date

AvMed Medical Underwriting will determine the actual Effective Date available for coverage once underwriting is complete.

If the Applicant is **NOT REPLACING** other coverage:

- The Effective Date will be the date requested by the applicant but in no case earlier than the Underwriting approval date + 7 days.
- There is no coverage between the application submission date and the Effective Date of the policy.
- The Effective Date must be within 90 days of the application submission date.
- The Effective Date, as determined by Underwriting, cannot be less than the originally Requested Date. Issuing with an earlier date than originally requested will require a re-application.

If the Applicant is **REPLACING** other coverage:

It is assumed the applicant has requested an Effective Date based on the paid-to-date of their current coverage. If the applicant makes a premium payment on their current coverage during the underwriting process of the AvMed application, either the applicant or agent should notify Medical Underwriting so the effective date for the AvMed coverage will be advanced accordingly.

- The Effective Date must be after the application submission date.
- The Effective Date will, in most cases, correspond to the termination date of the previous coverage.
- The Effective Date must be within 90 days of the application submission date.

### **Payment upon approval:**

Upon acceptance of the offer of coverage, the first monthly premium will be electronically withdrawn from the applicant's bank account within 24 hours. If a retroactive effective date was required to provide continuity of coverage with the applicant's current policy, additional premium(s) will also be withdrawn in order to bring the account to a current status. The Billing date of the applicant's policy will subsequently be moved to the 1<sup>st</sup> of the month for successive bank drafts.

## **Pre-Existing Conditions**

There is no coverage for Health Care Services directly or indirectly related to or caused by a Pre-existing condition that was initially disclosed to AvMed before the Effective Date, until the applicant has been continuously covered for a 12-month period. Additionally, there is no coverage for Health Care Services to treat otherwise identified Pre-existing Conditions, until the applicant has been continuously covered for a 24-month period. This exclusionary period also applies to any Prescription Drug that is prescribed in connection with a Pre-existing Condition.

Because the AvMed Individual plans have only a 12-month pre-existing period for conditions disclosed on the application, it is in the applicant's best interest to disclose their full and complete health history.

## **Pre-existing Condition Definition**

A Pre-existing Condition means any condition that manifests itself in such a manner as would cause an ordinary prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 24-month period immediately preceding the applicant's effective date of coverage under the contract.

## **Material Misrepresentation**

If during the course of a claims investigation, AvMed determines that an applicant was not eligible for coverage, or a pre-existing condition existed that, if known at time of underwriting, would have caused the application to be declined, coverage will be rescinded. All premiums received, less claims paid, will be refunded to the client. Agent commissions will be adjusted accordingly.

## **Medical Underwriting Requirements**

The Individual Health Plans for Individual and Families are not guaranteed issue plans. All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and placement within the appropriate risk category.

The Medical Underwriting area relies on the applicant and agent to obtain and properly record the applicant's health history, past and current, in accordance with the questions on the electronic application. Please note that the pre-existing condition period for Individual Health plans is 12 months for pre-existing conditions disclosed on the application and 24 months for pre-existing conditions not disclosed. See the **Pre-Existing Condition** section.

In the underwriting evaluation of an applicant, an underwriter may require additional information such as medical records, a paramedical examination, or a telephone interview with the applicant.

### **Tele-Interviews**

AvMed will be performing tele-interviews on a segment of the applicant population. While most interviews will take as little as 10 minutes, interviews for families or applicants with more complex medical histories make take longer. Tele-interviewing is used to clarify medical history or other information provided on the application and/or to confirm details regarding medical care, the treating physician (primary and/or referred), prior claims history or prescription drug use. Tele-interviewing has proven to reduce cycle time by reducing the number of Attending Physician Statements requested and eliminate the need for requesting information from the agent.

Agents should advise their client of the possibility of a tele-interview, so that the client may prepare in advance for the call. If a tele-interview is requested and the applicant refuses the interview or doesn't make them self available for the interview within the usual underwriting time period, the application will be declined/closed-out. This generally occurs 30 days after the initial call is made.

### **Attending Physician Statements/Medical Records**

Medical records are obtained in order to properly evaluate an applicant's medical history. AvMed works through a vendor to secure the records in a timely manner at no expense to the applicant. Under certain circumstances, however, applicant assistance may be required in procuring the records; particularly in cases where fees charged for the records exceed the norm. It is AvMed's desire to avoid the need to order medical records as this typically prolongs the underwriting process. The agent can assist with this by encouraging the applicant to provide as much detail regarding their health history as possible. The details provided often make the difference as to whether medical records are obtained or not.

## Paramedical Examinations

A Paramedical Examination, when determined to be necessary, will be ordered by the Medical Underwriting area at no expense to the applicant. The Paramedical exam will include a check of the applicant's height, weight, blood pressure and pulse. In addition to routine urine and fasting blood testing, the applicant will also be tested for nicotine, cocaine, pregnancy, hepatitis and HIV. The examination will also include completion of a medical history questionnaire.

AvMed works through a vendor to obtain the paramedical examination. The Paramedical exam service will contact the applicant to schedule an appointment for the examination at the applicant's earliest convenience at a location most convenient for them (generally this is their home or business). The examination must be completed in the state of Florida and preferably in the county where they reside.

The results of the completed examination, blood and urine analysis will be received by the Medical Underwriting area within 7 to 10 calendar days from the examination date.

As mentioned above, the examination should be scheduled and completed as quickly as possible. Should the paramedical examination service report difficulties in scheduling the required examination, the Underwriter will contact the writing agent and request the agent's assistance. If the applicant refuses to complete the examination, or if the examination is not completed within the usual underwriting time period, the application will be declined/closed-out. This generally occurs 45 days after the paramedical has been ordered by Underwriting.

## Rate Modifications/Substandard Risk Ratings

While the majority of applicants and their dependents will qualify for coverage at standard rates, when an individual does not qualify for coverage at the standard rate, a counter offer of coverage may be made offering coverage at a higher premium rate or with a different coverage option. AvMed offers various risk categories based on the existing and predicted medical risk factors of each applicant.

There are eleven possible surcharges that can be assessed for the Individual products. The lowest surcharge available is 10% additional premium and the highest surcharge available is 150% additional premium.

The final determination of the substandard rating will be made by the Medical Underwriter after a comprehensive review of the application and additional medical information. In order to complete this review, AvMed routinely obtains prescription drug information and prior AvMed claim history, in addition to any requested medical records and/or a paramedical examination.

AvMed does not place Medical Exclusionary riders on any of the Individual Under 65 Products (excluding a condition from all benefits under the contract). If a pre-existing medical condition can not be assessed with a risk rating, the applicant will be declined, see **Member Exclusion**.

## Member Exclusion

There are situations when a person applying for coverage on a family application is so seriously impaired that it is not possible to issue health coverage to them. In these situations, a family member is declined but coverage is offered to the remaining family members. When this underwriting action is necessary, the following process is required:

- In most cases the underwriter will contact the agent as early in the process as possible and ask that the agent verify with the applicant that coverage, with a member excluded, will be accepted. If the applicant is unwilling to accept the coverage with a family member excluded, the agent should advise the underwriter and the application will be withdrawn accordingly.
- On the other hand, if the applicant will accept the coverage with the family member excluded, the agent should advise the underwriter immediately. The following will occur, as applicable:
  - If a dependent family member is being excluded, the member's name will be indicated on an Amendment form excluding them from coverage, which the applicant will sign prior to enrollment. The excluded family member will also be indicated on the Consumer Acceptance form which is either accepted by or withdrawn by the applicant.
  - If the unacceptable family member is the primary applicant, the application will be declined and a new application will be required for the other family member(s) to be issued coverage. When the new application is completed and signed by the new primary applicant, the agent is asked to make the underwriter aware of the newly re-written application in the messages/notes section of the application. The agent is also asked to send an email to the Medical Underwriting area at: [individualsales@avmed.org](mailto:individualsales@avmed.org) to let them know that the new application is being submitted and to expect it (provide the name of the new applicant). The underwriter will then be able to expedite handling of the new application by cross-referencing the new application with the prior application.

## **Declination of Entire Application**

If an applicant's health history and/or condition are indicated on the Ineligible Medical Conditions list, see **Ineligible Medical Conditions section**, an application for coverage should not be submitted to AvMed.

There are some health conditions that result in an applicant being so heavily impaired that the issuance of coverage is not possible. Due to the complexities of multiple impairments that do not lend themselves to a reliable standardized classification, each applicant's situation must be separately and individually considered. A combination of conditions, such as overweight, hypertension and smoking, could result in a declination, while the conditions individually would not.

AvMed relies on the applicant to accurately complete the Application and fully disclose medical history. When an application contains significantly inadequate, understated or incomplete health history, the underwriter is unable to properly assess the risk and the underwriter may also suspect whether there is additional undisclosed health history. When significant health history is omitted, AvMed reserves the right to decline the application.

If coverage cannot be issued, the applicant and agent will be advised and the reason for the declination will be provided, if possible.

An applicant who has been medically declined for coverage may not reapply for coverage for a minimum of one year, unless otherwise communicated to the agent by the Medical Underwriter.

For reconsideration of a declination or postponement, see **Appeal and Reconsideration Process and Procedures**.

## **Ineligible Health Conditions**

**This is a partial listing of Health Conditions that will result in declination. This list is not all inclusive:**

### **A**

Acromegaly  
Addison's Disease  
Acquired Immune Deficiency Syndrome (AIDS)  
AIDS Related Complex (ARC)  
Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease  
Alzheimer's Disease  
Anemia-Aplastic, Cooley's, Hypoplastic, Macrocytosis (B12 Deficiency), Mediterranean, Sickle-Cell, or Thalassemia Major  
Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)  
Angina  
Angioplasty  
Arteriosclerosis, atherosclerosis  
Arteriosclerosis Obliterans  
Arteritis  
Ascites  
Asperger's Syndrome  
Autoimmune Disease  
Autism

### **B**

Banti's Syndrome  
Berger's Disease (IgA Nephropathy)  
Bipolar Disorders  
Bright's Disease  
Buerger's Disease, Thromboangiitis Obliterans  
Burkitt's lymphoma (malignant lymphoma)

### **C**

Cancer (with lymph node involvement or metastasis)  
Cardiac risk factors (three of the following: overweight, tobacco usage within 12 months, elevated lipids (cholesterol & triglycerides) and elevated blood pressure (or hypertension).  
Cardiomyopathy  
Cerebral Hemorrhage (Stroke), Embolism, Thrombosis, Transient Ischemic Attack (TIA)  
Cerebral Palsy  
Chronic Obstructive Pulmonary Disease (COPD)  
Cirrhosis of the Liver  
Coarctation of the Aorta  
Collagen Diseases

Congenital Heart Defects, unoperated  
Congestive Heart Failure  
Cor Pulmonale  
Coronary Artery bypass surgery  
Coronary Artery Disease  
Coronary Heart Disease  
Coronary Insufficiency  
Crohn's Disease  
Cushing's Syndrome/Disease  
Cystic Fibrosis

## **D**

Dermatomyositis  
Diabetes Mellitus

## **E**

Embolism (arterial)  
Emphysema  
Encephalopathy  
Esophageal Varices

## **F**

Factor V deficiency  
Factor VIII or IX deficiency  
Friedreich's ataxia

## **G**

Gastric bypass/banding/stapling  
Gender Identity disorder  
Glomerulosclerosis  
Goodpasture's Syndrome

## **H**

Heart Conditions and Disorders (includes Angina Pectoris, Angioplasty, Coronary Occlusion, Coronary Insufficiency, Myocardial Infarction [Heart Attack], Coronary bypass, Coronary Thrombosis, Ischemia, Cardiomyopathy, Hypertrophy)  
Heart enlargement/hypertrophy  
Heart Valve Replacements or Pacemakers  
Hemochromatosis  
Hemophilia or Von Willebrand's Disease, Factor V, or Factor VIII Deficiencies  
Hepatitis C & D & E & G  
Heart Attack or Disease  
Heart enlargement/hypertrophy  
HIV positive  
Hodgkin's Disease  
Human T-Cell Leukemia Virus  
Human T-Cell Lymphotropic Virus

Huntington's Chorea  
Hydrocephalus

**I**

IgA Nephropathy  
Ischemic Heart Disease

**K**

Karposi's Sarcoma

**L**

Leukemia  
Locomotor Ataxia  
Lymphadenitis  
Lymphoma, Lymphosarcoma, & Lymphoblastoma

**M**

Manic Disorders  
Marfan's Syndrome  
Multiple Myeloma  
Multiple Sclerosis  
Muscular Dystrophy  
Myasthenia Gravis  
Myocardial Infarction  
Myocardial ischemia

**N**

Nephrosclerosis  
Neurofibromatosis  
Niemann-Pick Disease

**O**

Organ Transplant (recipient)

**P**

Pacemaker of the Heart  
Paget's Disease  
Parkinson's Disease  
Peripheral Vascular Disease or intermittent claudication  
Pneumoconiosis  
Pneumocystitis carinii pneumonia  
Polyarteritis  
Polycystic Kidney Disease  
Polycythemia vera

Polyglandular autoimmune disease  
Polyneuropathy  
Psychotic Disorders (Bi-polar or Uni-polar disorder, manic depression, schizophrenia, etc.)  
Pulmonary Fibrosis  
Pulmonary Heart Disease

## **Q**

Quadriplegia

## **R**

Renal failure, chronic  
Rheumatic Heart Disease

## **S**

Schizophrenia  
Sjogren's Syndrome  
Stroke  
Syringomyelia  
Systemic Lupus Erythematosus

## **T**

Tabes Dorsalis  
Tetralogy of Fallot  
Thalassemia major  
Thrombocythemia  
Transposition of the Great Vessels (arteries)  
Transient ischemic attack (TIA)  
Turner's Syndrome

## **V**

Valve Replacement  
Von Willebrand's Disease/pseudohemophilia

## **W**

Wegener's Granulomatosis/Syndrome

**Ineligible Medications List (currently being taken)**

Accutane  
Amaryl  
Aricept  
Coreg  
Coumadin/Warfarin/Jantoven  
Diabeta/Glyburide  
Glucophage/Metformin  
Glyburide/ Diabeta/Micronase  
Humira  
Interferon  
Isosorbide Mononitrate  
Jantoven/Coumadin/Warfarin  
Lithium  
Lovenox  
Metformin/Glucophage  
Methotrexate  
Micronase/Glyburide  
Mirtazapine/Remeron  
Nitrostat/Nitroglycerin/Nitroquick  
Pacerone  
Plavix/Clopidogrel Bisulfate  
Remeron/Mirtazapine  
Ribavirin  
Risperdal  
Seroquel  
Soriatane  
Symbyax  
Warfarin/Coumadin/Jantoven  
Zyprexa

## Standard Health Conditions

Because AvMed uses a debit system to assess a risk which also relates to the age of the applicant, it is very difficult to provide a list of Standard health conditions.

The following is a partial listing of Health Conditions that will result in Standard action. This list is not all inclusive:

- **Acne**
  - Mild to Moderate
  - Rosacea - all cases
- **Adenitis**
  - History, cured without surgery
- **Adenoiditis**
  - Asymptomatic, more than 1 year ago
- **Amputations**
  - Due to injury
    - Thumb, fingers or toes, fully recovered
- **Anal Fissure**
  - Unoperated, fully recovered
- **Anal Stricture**
  - Operated, more than 1 year ago
- **Anemia, Iron Deficiency**
  - Anemia resolved- asymptomatic, no medication
- **Appendicitis**
  - Operated, no complications, full recovery
- **Benign Prostatic Hypertrophy (BPH) – See Prostate Hypertrophy**
- **Blindness – See Eye Disorders**
- **Breast Reduction (No Implantation)**
  - Successful surgery more than 2 years ago
- **Bright's disease – See Nephritis**
- **Burns**
  - First or second degree, treatment concluded
- **Cerebrospinal Meningitis – See Meningitis**

- **Cervicitis**
  - Single episode, after full recovery
- **Cholelithiasis (Gallstones)**
  - Surgical removal, fully recovered, more than 1 year ago
- **Collapsed Lung – See Pneumothorax**
- **Conjunctivitis – See Eye Disorders**
- **Cystitis**
  - Acute
    - Female, infrequent attacks (less than 4), fully recovered, more than 1 year since last attack
    - Male, one episode, fully recovered, more than 1 year ago
- **Diaphragmatic Hernia**
  - Operated, asymptomatic, no medication, more than 2 years ago
- **Exostosis (Bone Spur)**
  - Operated, more than 2 years ago
- **Eye Disorders**
  - **Blindness**
    - Congenital or due to trauma
  - **Conjunctivitis**
    - Acute, fully recovered
    - Chronic, fully recovered, more than 1 year ago
  - **Strabismus**
    - Operated, fully recovered, more than 2 years ago
- **Fibroid Tumor**
  - Operated, more than 2 years ago
- **Fractures**
  - Extremities, Hips, Pelvis, Ribs
    - After complete recovery, no complications
- **Gallstones - See Cholelithiasis**
- **Gastroenteritis**
  - Single acute attack, fully recovered
- **Gingivitis**
  - Not due to systemic disease
- **Glomerulonephritis – See Nephritis**
- **Heat Prostration or Exhaustion**
  - Single episode, with no residuals, more than 2 years ago
- **Hernia, Diaphragmatic or Hiatal – See Diaphragmatic Hernia**

- **Hernia (Other than Diaphragmatic or Hiatal)**
  - Operated, fully recovered, more than 1 year ago
- **Herpes Zoster – See Shingles**
- **Hiatal Hernia - See Diaphragmatic Hernia**
- **Horseshoe Kidney**
  - Asymptomatic
- **Influenza**
  - Not present
- **Jaundice**
  - Of a newborn, complete recovery, more than 3 months ago
- **Kidney Stone**
  - One episode, operated or passed spontaneously, more than 1 year ago
- **Laryngitis**
  - Single episode, unrelated to tuberculosis, complete recovery
- **Lyme Disease**
  - Asymptomatic, more than 1 year ago
- **Mastoiditis**
  - Unoperated, fully recovered, no surgery anticipated
- **Measles**
  - After recovery
- **Meningitis**
  - Fully recovered, no residuals, more than 1 year ago
- **Mononucleosis**
  - Asymptomatic, fully recovered, more than 6 months ago
- **Myositis**
  - Single attack, fully recovered
  - Severe or multiple occurrences, more than 5 years ago
- **Near Sightedness**
- **Nephritis (Glomerulonephritis or Bright's disease)**
  - Single, acute attack, without residuals or complications, fully recovered, more than 4 years ago
- **Otitis Externa (outer ear)**
  - After recovery

- **Otitis Media (middle ear)**
  - Acute attacks, less than 3 within 12 months, after complete recovery
  - No episodes in past 12 months
- **Pharyngitis**
  - After recovery
- **Phlebitis**
  - Single attack, fully recovered, no remaining edema, elastic stocking or bandage not required, more than one year ago
- **Pink Eye**
- **Pneumonia**
  - Single episode, hospitalization not required
- **Pneumothorax (Collapsed Lung)**
  - Traumatic, fully recovered, more than 1 year ago
  - Spontaneous, one episode, fully recovered, more than 1 year ago
- **Polyps**
  - **Bladder**
    - Benign, single tumor, operated, more than 2years ago
  - **Gastrointestinal or Rectum**
    - Benign, operated, more than 5 years ago
  - **Nasal**
    - Operated, no recurrence, more than 3 years ago
- **Proctitis**
  - Single episode, fully recovered, more than 3 months ago
- **Prostate Hypertrophy (BPH)**
  - Unoperated, asymptomatic or minimal symptoms, PSA normal
  - Operated, no symptoms or residual complications, more than 1 year ago
- **Psychosis, Psychoneuroses, Neurosis**
  - Most common classifications of Neuroses include anxiety reaction, depressive reaction, nervous breakdown, hysteria, hyperventilation and panic attacks
    - No prior hospitalization, no prior counseling or psychotherapy, more than 1 year ago
- **Pyelonephritis**
  - Acute, single episode, fully recovered, more than 1 year ago
  - Surgically corrected, fully recovered, asymptomatic, more than 1 year ago
- **Rabies**
  - Fully recovered, no residuals

- **Radial Keratotomy**
  - Post surgery, fully recovered, more than 3 months ago
- **Rectal Prolapse or Stricture**
  - Operated, fully recovered, more than 1 year ago
- **Respiratory Synovial Virus (RSV)**
  - Fully recovered, no remaining complications, more than 3 years ago
- **Scarlet Fever (Scarlatina)**
  - Mild uncomplicated attack, fully recovered, more than 3 months ago
- **Shingles (Herpes Zoster)**
  - Single attack, after recovery, more than 3 months ago
- **Shoulder Sprain**
  - Acute, single episode, fully recovered, more than 2 years ago
- **Sinus Arrhythmia**
  - All cases
- **Sinusitis**
  - Acute, infrequent attacks (less than 3), full recovery, more than 6 months ago since last attack
  - Operated, fully recovered, more than 3 years ago
- **Splenectomy**
  - Due to trauma, fully recovered
- **Strabismus – See Eye Disorders**
- **Toxoplasmosis**
  - Fully recovered, more than 9 months ago
- **Upper Respiratory Infection**
  - After recovery
- **Urinary Tract Infection (Bladder) – See Cystitis**
- **Vaginal Stricture**
  - Unoperated - Fully recovered, more than 4 years ago
  - Operated - Fully recovered, no residuals
- **Varicose Veins**
  - Unoperated - Mild
- **Vertigo**
  - Cause unknown, single attack
    - Under age 40, fully recovered, more than 1 year ago
    - Age 40 and over, fully recovered, more than 5 years ago

## Height and Weight

One of the most indispensable items in evaluating an individual's insurability is to determine if an individual's weight has a satisfactory relationship to the applicant's height. Disproportion between height and weight can result in a possible additional risk.

**Overweight** is often a significant underwriting consideration:

- It increases the likelihood of developing degenerative cardiovascular-renal diseases, diabetes, stroke, GERD, sleep apnea, respiratory problems, osteoarthritis, and others.
- It increases difficulty in surgery.
- It delays recovery of injuries to weight bearing bones, and thus, complicates or prolongs a sickness or injury.
- It may also be an indication of other health problems.

A combination of overweight with other health conditions such as high blood pressure, hyperlipidemia, and other cardiovascular risks are of increased underwriting significance and could result in a higher rating or declination.

Pronounced **underweight** may also be of significance. Abnormally thin individuals may be unable to gain weight due to:

- Nervous problems
- Chronic illnesses
- Lack of proper nutrition; possibly due to excessive alcohol or drug use.

Thin individuals frequently have poor resistance to respiratory infections and other acute illnesses.

**Changes** in weight of more than 10 pounds can also be of underwriting significance. Complete details regarding weight loss, other than due to a weight-loss program, within the 12-month period prior to the application date are requested as part of the application completion process. Of significance to underwriting is:

- The reason(s) for the changes in weight, and
- the period of time these changes occurred, and
- whether the weight is now stabilized or still changing (e.g. childbirth), and
- if stabilized, how long the present weight has been maintained.
- The name and address of any physician consulted regarding the weight loss.

## Build Chart

Because AvMed uses a debit system to assess a risk which also relates to the age of the applicant, it is not possible to provide a Build Chart with Standard, Rated and Declinable limits for Height and Weight. The underwriter will take all health factors into account in evaluating the risk.

**Underwriting Pre-Screening Form  
Prior to Application Submission**

While AvMed has published partial lists of **Ineligible Health Conditions** and **Standard Health Conditions**, AvMed is not able to publish a Build Chart, or a list of substandard Medical Conditions indicating a potential Risk Rating. Because of this, the Underwriting Area is happy to provide a response to an agent’s inquiry regarding whether a policy may be written on a specific potential applicant. **It is expected that this form will be used only when an agent feels their client is most likely not insurable.**

Please keep in mind that any response provided by the Medical Underwriting area is not a guarantee of coverage. A formal offer of coverage may only be extended after submission of a completed application and full medical underwriting review.

To request an opinion:

- Procure an Underwriting Pre-Screening Form (available through the AvMed Web Agent Portal or Agent Sales Center). Complete this form providing complete and accurate details regarding the potential applicant’s health history. The completed form should be sent via email or fax to the Agent Sales Center (the email address is provided on the form).
- The Pre-Screening Form will be reviewed and sent to the Medical Underwriting area at [individualsales@avmed.org](mailto:individualsales@avmed.org).
- The Medical Underwriting area will provide a response on the form and return it to the Agent/Broker (with a copy to the Agent Sales Center) as quickly as possible (within 24 – 48 hours).
- If an application is subsequently completed, the agent is asked to make the underwriter aware of the prior Pre-Screening form in the messages/notes section of the application. The agent is also asked to email a copy of the completed form to the Medical Underwriting area at email: [individualsales@avmed.org](mailto:individualsales@avmed.org).

**Underwriting Pre-Screening Form**

Name	Age	Gender	Height	Weight	Smoker Y/N	Diagnosis / Conditions Include Dates	Medications

**Additional Remarks:**

**Medical Underwriting Response:**

**Date:**

## Appeal and Reconsideration Process and Procedures

There are situations that pose challenges for the agent in placing non-standard coverage or in explaining the medical or contractual reasons for postponement or declination of coverage. While AvMed's goal is to provide the agent with insight into the source of an underwriting action during the actual underwriting process, this may not always be possible.

- If you feel the Underwriter did not have a complete picture of all the facts related to a particular assessment and believe it necessary to *appeal* the original underwriting decision, please contact the Underwriter by sending an email via the Individual Medical Underwriting mailbox at [individualsales@avmed.org](mailto:individualsales@avmed.org). The underwriter will review the additional information, determine if the original decision can be modified and respond via email or a phone call to the agent. If the agent is still not satisfied and feels that further consideration should be given, the agent may escalate the issue via a call to the Underwriting area at 904-858-1311.
- Please remember that if the Advanced Rejection Notice indicates a **permanent rejection** due to medical records reviewed and/or paramedical laboratory results, an appeal of this decision should not be requested.
- Also, refer to the **Changes to an Existing Contract section, Removal of a Sub-Standard Risk Rating** of this Agent Guide.

Reconsideration of a previously submitted application should be addressed as follows. A **postponement** of an applicant will occur when additional treatment and/or testing has been recommended by the applicant's physician but it has not yet been completed by the applicant. A postponement may also occur due to contractual requirements having not been met; such as attainment of legal residency status, etc. When an applicant is postponed, the underwriter will notify the agent of the additional requirements needed for reconsideration of coverage. Upon receipt of the additional information and underwriting review, the agent will be notified whether a new application (or add-on application) can be submitted.

1. If an applicant is postponed due to additional testing (including lab or Pap smear) having not been completed, the recommended additional/repeat testing and a physician's assessment which includes his interpretation and treatment plan, if applicable, is required for reconsideration. Additionally, the applicant should be released from the physician's care, if applicable, before reconsideration can be given.
2. If an applicant is postponed due to symptoms for which a firm cause/diagnosis has not been established, a physician's assessment which includes a final cause/diagnosis and treatment plan is required. All treatment should be completed and the applicant should be released from the physician's care before further underwriting consideration may be given.
3. If postponement is based upon a paramedical exam and/or laboratory results, a physician of the patient's choice should be consulted, at their expense. Repeat normal laboratory results and the physician's office notes, including cause for the abnormal results and current assessment, must be provided for underwriting review. If the unacceptable results are determined to be the result of illness, the records should indicate a diagnosis and indication that treatment has been completed, and the applicant has been released from care. Please keep in mind, there may be situations where reconsideration may not be given for a period of time, after treatment has been initiated, in order to determine that the applicant's condition is under good control. Situations of this nature include high blood pressure and elevated cholesterol and/or triglycerides. The underwriter will advise you when the applicant may be reconsidered.

Reconsider information, after postponement, can be emailed to the Individual Medical Underwriting area @ [individualsales@avmed.org](mailto:individualsales@avmed.org). Faxes can be sent to 904-858-1352. Please include the applicant's name, social security number, and system identification number (ID #).

### Not-Taken Policies

The AvMed Individual Health Policies have a 10-day Free Look provision. Should an applicant decide their policy does not meet their needs within 10 days of the policy delivery date, they may return the policy to Enrollment and Premium Services and request it be marked Not Taken. All paid premium will be refunded.

**See the Contact List at the front of this Guide for Enrollment & Premium Services address.**

### Request For Changes to an Existing Contract

CHANGE	ACTION
<b>Addition of an adopted child</b>	Addition of an adopted child, within 60 days of placement, does not require medical underwriting evaluation. Written notification/ <i>Change Status Form</i> and a copy of the adoption agreement and/or proof of legal placement is required.
<b>Addition of a newborn</b>	Addition of a newborn, within 60 days of the birth, does not require medical underwriting evaluation. Addition of a newborn within the first 11 months of the policy effective date will be fully investigated for possible misrepresentation. Written notification/ <i>Change Status Form</i> is required.
<b>Addition of a newborn or adopted child to a child-only policy</b>	Addition of a newborn or adopted child to a <b>child-only policy</b> requires medical underwriting evaluation. Child must be a minimum of 2 months of age and must have had a well-child exam after release from the hospital. A fully completed application and copy of adoption agreement and/or proof of legal placement, if applicable, is required.
<b>Addition of a spouse and/or dependent child(ren)</b>	Addition of a spouse or dependent child(ren), other than a newborn within 60 days of the birth, requires medical underwriting evaluation. A fully completed application is required.
<b>Addition or Removal of the Optional Maternity Benefit</b>	Addition or Removal of the Optional Maternity benefit for the Value Plan and Plus Plan does not require medical underwriting evaluation and may be submitted any time after policy issue. Written notification/ <i>Change Status Form</i> is required. The maternity benefit has a 12 month waiting period.
<b>Addition of the Optional Prescription Drug Benefit</b>	Addition of the Optional Prescription Drug benefit will only be allowed on the policy anniversary date. A fully completed application is required and will be subject to medical underwriting evaluation. The application may be submitted up to 60 days prior to the policy anniversary date, although if approved, the change effective date will be the policy anniversary date.
<b>Removal of the Optional Prescription Drug Benefit</b>	Removal of the Optional Prescription Drug benefit may be submitted any time after policy issue and does not require medical underwriting evaluation. A written request/ <i>Change Status Form</i> is required.

<b>Decrease of Plan deductible or Prescription Drug deductible</b>	A Plan <b>upgrade</b> will only be allowed on the policy anniversary date. A fully completed application is required and will be subject to medical underwriting evaluation. The application may be submitted up to 60 days prior to the policy anniversary date, although if approved, the change effective date will be the policy anniversary date. Refer to Changes from Plan to Plan Section.
<b>Increase of Plan deductible or Prescription Drug deductible</b>	A Plan <b>downgrade</b> may be submitted any time after policy issue and does not require medical underwriting evaluation. A written request/ <i>Change Status Form</i> is required. Refer to Changes from Plan to Plan Section.
<b>Policy Effective Date Change</b>	A request to change the policy effective date will be considered only if the applicant is replacing other coverage and the request is made to coincide with the prior coverage termination date. A written request is required within 30 days of policy issue.
<b>Removal of a Substandard Risk Rating</b>	<p>Although Substandard Risk Ratings are permanent, consideration for removal or reduction may be considered under the following situations:</p> <ul style="list-style-type: none"> <li>▪ The coverage has been in-force for a minimum of two years, and</li> <li>▪ The rated condition is not permanent and no longer exists, and</li> <li>▪ There have been no symptoms or treatment for the condition rated within the previous 24 months, and</li> <li>▪ The condition rated does not require periodic medical treatment or evaluation</li> </ul> <p>A written request is required and should be accompanied with current medical documentation from the physician familiar with the policyholder's health status. The records should include office notes and results of any laboratory or other testing performed within the previous 24 months. Requests should be submitted to the Underwriting Dept. See the Contact List.</p>
<b>Removal of Tobacco Rating</b>	A request may be made if the policyholder has discontinued all tobacco products, including medication for smoking cessation, for a minimum of 12 consecutive months. A signed statement from the policyholder, to this effect, accompanied with proof of a current negative urine cotinine test (at the policyholder's expense), submitted to the Individual Underwriting department, is required.
<b>Address Change</b>	A policyholder change of address may be submitted any time after policy issue. A written request/ <i>Change Status Form</i> is required. If the address change is within the same County, the rates will not be affected. However, if the address is in a different County, it must be in a Service Area and the applicable rates will apply. If the policy holder moves outside the AvMed Individual products service area, coverage will end.
<b>Name Change</b>	A policyholder or dependent name change may be submitted any time after policy issue. A written request/ <i>Change Status Form</i> is required. In addition, a valid marriage license or a court ordered name change document must be submitted with the <i>Change Status Form</i> .
<b>Transfer of Coverage</b>	If a currently insured dependent child becomes ineligible for coverage under a parent's plan due to age, marital status, or student status; or, if a currently insured dependent spouse becomes ineligible as a result of the primary insured's death or divorce, coverage may be transferred to the dependent's own policy. Residential status for AvMed operational counties must apply. If met, the same plan benefits as the prior coverage, or a downgrade of benefits, if desired, will apply. The transfer will not be subject to medical underwriting, however, any ratings applicable to the prior coverage will apply. Additionally, the new policy will have a current effective date and any calendar year expenses applied to the deductible for that individual will be carried over to the new policy.

<b>Changes from Plan to Plan</b>	<b>Plus Plan to Plus Plan:</b> <ul style="list-style-type: none"> <li>• If the current deductible for the base plan decreases ==&gt; upgrade</li> <li>• If the current deductible for the Rx benefit rider decreases ==&gt; upgrade</li> <li>• If the current deductible for the base plan increases ==&gt; downgrade</li> <li>• If the current deductible for the Rx benefit rider increases ==&gt; downgrade</li> </ul>
	<b>Value Plan to Value Plan</b> <ul style="list-style-type: none"> <li>• If the current deductible decreases ==&gt; upgrade</li> <li>• If the current deductible increases ==&gt; downgrade</li> </ul>
	<b>HSA Plan to HSA Plan</b> <ul style="list-style-type: none"> <li>• If the current deductible decreases ==&gt; upgrade</li> <li>• If the current deductible increases ==&gt; downgrade</li> </ul>
	<b>Plus Plan to Value Plan</b> <ul style="list-style-type: none"> <li>• If the current Plus Plan individual deductible is \$5,000 (\$10,000 family) with no Rx benefit to a Value Plan with a \$2,500 individual deductible (\$5,000 family) ==&gt; upgrade</li> <li>• All other changes from a Plus Plan to a Value Plan ==&gt; downgrade</li> </ul>
	<b>Value Plan to Plus Plan</b> <ul style="list-style-type: none"> <li>• If the current Value Plan individual deductible is \$2,500 (\$5,000 family) to a Plus Plan with an individual deductible of \$5,000 (\$10,000 family) with no Rx benefit ==&gt; downgrade</li> <li>• All other changes from a Value Plan to a Plus Plan ==&gt; upgrade</li> </ul>
	<b>Value Plan to HSA Plan</b> <ul style="list-style-type: none"> <li>• All changes from a Value Plan to a HSA Plan ==&gt; upgrade</li> </ul>
	<b>HSA Plan to Value Plan</b> <ul style="list-style-type: none"> <li>• If the current individual HSA deductible is \$5,000 (\$10,000 family) to a Value Plan with an individual deductible of \$2,500 (\$5,000 family) ==&gt; upgrade</li> <li>• All other changes from a HSA plan to a Value Plan ==&gt; downgrade</li> </ul>
	<b>HSA Plan to Plus Plan without Prescription Drug Benefit</b> <ul style="list-style-type: none"> <li>• If the current HSA Plan individual deductible is \$2,500 (\$5,000 family) to a Plus Plan no Rx of \$1,000 or less ==&gt; upgrade</li> <li>• If the current HSA Plan individual deductible is \$2,500 (\$5,000 family) to a Plus Plan no Rx individual deductible of \$2,500 (\$5,000 family) ==&gt; individual consideration due to aggregate vs. individual deductible differences*</li> <li>• If the current HSA Plan individual deductible is \$2,500 (\$5,000 family) to a Plus Plan no Rx individual deductible of \$5,000 (\$10,000 family) or higher ==&gt; downgrade</li> <li>• If the current HSA Plan individual deductible is \$5,000 (\$10,000 family) to a Plus Plan no Rx of \$2,500 or less ==&gt; upgrade</li> <li>• If the current HSA Plan individual deductible is \$5,000 (\$10,000 family) to a Plus Plan no Rx individual deductible of \$5,000 (\$10,000 family) ==&gt; individual consideration due to aggregate vs. individual deductible differences*</li> </ul>
	<p>* Referral to the Individual Underwriting area is necessary for determination of whether the change is a downgrade or upgrade.</p>

	<p><b>HSA Plan to Plus Plan with Prescription Drug Benefit, or Plus Plan with Prescription Drug Benefit to HSA Plan</b></p> <ul style="list-style-type: none"> <li>Any requests for a change between these two Plans must be referred to the Individual Underwriting area for a determination of whether it is a downgrade or upgrade.</li> </ul>
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*\* For Non-underwritten changes, a Change Status Form, or system Policy Administration must be completed. For Changes prior to development of the Change Status Form or implementation of the system functionality, please call Member Services for assistance.*

### **HIPAA Guaranteed Issue Eligibility**

HIPAA-eligible individuals are guaranteed access to healthcare coverage according to state-specific requirements. AvMed’s Guaranteed Issue products are offered in compliance with Florida Statute 627.6487.

To be considered HIPAA-eligible, the following conditions must be met:

- An individual must have had at least 18 months of continuous creditable coverage without any significant breaks (greater than 63 days); **and**
- The most recent coverage was under a group health plan, governmental plan, church plan, or health insurance offered in connection with such a plan; **or** the most recent prior Creditable Coverage was under an individual plan issued in this state by a health insurer or HMO and such coverage was terminated due to the insurer or HMO becoming insolvent or discontinuing to offer individual coverage in the State of Florida, or due to the individual moving out of the service area of the insurer or HMO that provides coverage through a network plan in the State of Florida; **and**
- The most recent health coverage was not canceled due to non-payment of premium or fraud; **and**
- An individual with the option of continuation of coverage under COBRA or Florida COBRA (Florida Health Coverage Continuation Act), must have elected and exhausted such continuation of coverage under this provision or program; **and**
- **Residential status for AvMed operational counties must be met (currently Miami-Dade and Broward counties, only).**
- An individual must live, reside or work in the State of Florida and be a legally domiciled Florida resident

Individuals are **not** HIPAA eligible if any of the following apply:

- They are eligible for coverage under another group plan or conversion policy
- They are eligible for Medicare Part A or Part B, or Medicaid
- They had less than 18 months of continuous creditable coverage or the most recent coverage terminated more than 63 days ago

If applying for an AvMed Guaranteed Issue product, application must be made within 63 days of the termination of the prior Group Health Plan or most recent individual health care coverage.

The AvMed Guaranteed Issue products are written solely by the Direct Sales area. Applicants interested in these products should be advised to contact **Direct Sales at 1-800-390-9355**.

**AGENT GUIDE**  
**FOR**  
**AVMED HEALTH PLANS**  
**INDIVIDUAL UNDER 65 PRODUCTS**

**ELIGIBILITY AND UNDERWRITING GUIDELINES**

Page Numbers need to be verified noting changes/additions PGS 1/22/09

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