



## Short-Term Personal Health Coverage

Quality Health Insurance for 1, 2 or 3 month terms



One Cameron Hill Circle  
Chattanooga, TN 37402

[bcbst.com](http://bcbst.com)

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Short-Term Personal Health Coverage

## Four Plan Options

Deductible		Coinsurance				Out-of-Pocket Maximum	
Individual	Family	In-Network		Out-of-Network*		Individual	Family
		Plan Pays	You Pay	Plan Pays	You Pay		
\$ 250	\$ 750	80%	20%	60%	40%	\$1,250	\$2,750
\$ 500	\$1,500	80%	20%	60%	40%	\$1,500	\$3,500
\$1,000	\$3,000	80%	20%	60%	40%	\$2,000	\$5,000
\$2,500	\$7,500	80%	20%	60%	40%	\$3,500	\$9,500

### You May Need Short-Term Health Coverage If You Are:

- *Waiting for employer group coverage to begin*
- *A recent college graduate*
- *Between jobs or in need of temporary coverage*

If any of these situations describe you, then apply today for BlueCross BlueShield of Tennessee Short-Term Personal Health Coverage. Accidents and unexpected illnesses happen. Short-term health coverage provides financial protection for you and your family.

### Short-Term Coverage Advantages

- Choice of coverage length – Choose from one, two or three months.
- A choice of deductible amounts. Choose individual deductibles from \$250, \$500, \$1,000 or \$2,500. Deductibles for family coverage are three times the individual deductible.
- Access to Blue Network P, our broadest provider network, and a broad network of pharmacies. Visit [bcbst.com](http://bcbst.com) for a current list of network providers and pharmacies.
- Automatic claims filing when you use network providers – no paperwork.
- An ID card that's recognized around the world. If you travel outside the BlueCross BlueShield of Tennessee service area, you still have access to network hospitals with the BlueCard® Worldwide network.

### How The Plan Works

Once your deductible is met, BlueCross BlueShield of Tennessee pays 80 percent of the maximum allowable charge for covered expenses when you use network providers. The maximum allowable charge is the amount that BlueCross BlueShield of Tennessee has determined is appropriate, based on negotiated contracts with providers, for a covered service. You pay the remaining 20 percent up to your out-of-pocket maximum.

The out-of-pocket maximum is the amount you pay out of your own pocket before your plan begins to pay 100 percent of the maximum allowable charge for in-network covered expenses up to the \$1 million plan maximum. Your out-of-pocket maximum is based on the deductible you choose.

\* Separate deductibles and out-of-pocket maximums apply to in-network and out-of-network services.

### Pre-Existing Conditions Are Not Covered

No benefits will be paid for services performed for conditions that existed before the effective date of your policy. A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care or treatment was recommended, received or should reasonably have been received from a Provider of health care services. If you reapply for Short-Term Coverage, any illness or injury that began before your new policy's effective date will be considered a pre-existing condition.



## Benefits Paid at 80 Percent\* After Your Deductible Has Been Met:

- Medically necessary and appropriate services in a physician's or other practitioner's office.
- Routine diagnostic services.
- Prescription drugs.
- Inpatient hospitalization including room and board in a semi-private room, general nursing care, medications, injections, diagnostics and special care units. (Certain services require prior authorization; out-of-network benefits are provided at 50 percent when prior authorization is not obtained.)
- Emergency care services.
- Skilled nursing facilities (10-day limit per benefit period).
- Therapy services including physical, speech, occupational, manipulative, cardiac and pulmonary rehabilitative (10-visit limit per benefit period).
- Home health services (10-visit limit per benefit period; prior authorization must be obtained).
- Durable medical equipment.
- Prosthetics and orthotics.
- Ambulance services (ground transportation only).

This is only a partial list of plan benefits. A complete list of benefits is included in your short-term contract, which you will receive with your identification card after you enroll.

## Who is Eligible?

- Residents of Tennessee.
- Dependent children through age 23. (Children must be unmarried and depend on the parents for at least 50 percent of their support.)
- Foreign residents living in the U.S. with proof of a Green Card, or a school or work visa.

*Note: Applicants must be under age 65, cannot have other health care coverage in place, and may not be pregnant or an expecting parent.*

## How to Apply

Applying for a BlueCross BlueShield of Tennessee short-term health policy is easy. All you do is:

1. Review the short-term health coverage options available to you.
2. Choose the plan that's right for you.
3. Complete the application.
4. Return your completed application to your insurance agent or in the convenient envelope provided. Make sure you include the full premium payment amount when completing the eCHECK payment information.

## When Will Your Short-Term Coverage Begin?

Your coverage becomes effective at 12:01 a.m. on the date after the postmark on your mailed application or on your requested effective date, whichever is later. The requested date may not be later than 60 days after the date of the application.

Your full premium payment is due with your completed application. Payment must be for the entire period of coverage. BlueCross BlueShield of Tennessee can cancel coverage back to the effective date if your eCHECK payment is declined.

## Calculating Your Premium

Determining your full premium payment is easy. Use the rate chart on the next page to calculate each enrollee's monthly rate for your selected deductible. Next, multiply the rate by the number of months (up to three) of coverage you need. For family coverage, select the rate that applies to the oldest family member to be covered.

## Continuing Your Short-Term Coverage

You may apply for up to four consecutive BlueCross BlueShield of Tennessee short-term policies for a total of 12 months of coverage. After that, you must wait six months before applying for additional short-term coverage.

Any medical condition that occurs before or during your current short-term policy will be considered a pre-existing condition on any future short-term policy. Your policy can be extended if you are hospitalized at the time your coverage expires.

## Exclusions from Coverage

To keep your coverage affordable, this policy does not provide benefits for the following services, supplies or charges:

- Pre-existing conditions.
- Routine examinations and immunizations.
- Treatment of nervous or mental disorders.
- Treatment of alcohol or substance abuse.
- Care which is not medically necessary.
- Eyeglasses, contact lenses or hearing aids, including prescription or fittings.
- Removal of corns, calluses or trimming of nails.
- Allergy testing.
- Services or supplies provided in connection with an experimental or investigative treatment, procedure or supply.

*This brochure is a summary and is not all-inclusive. Your policy provides a complete list of benefits, limitations, exclusions and provisions.*

## 1 Month Rate Chart

\$250 Deductible	Individual		Family	
	Age	Male	Female	All
	0 - 6	\$57.03	\$51.01	-
	7 - 17	\$33.60	\$30.05	-
	18 - 24	\$34.18	\$54.57	\$147.43
	25 - 29	\$41.63	\$69.07	\$162.93
	30 - 34	\$47.39	\$78.56	\$177.06
	35 - 39	\$57.76	\$93.14	\$208.38
	40 - 44	\$68.20	\$106.14	\$230.77
	45 - 49	\$80.75	\$120.49	\$248.81
	50 - 54	\$105.91	\$138.80	\$277.31
	55 - 59	\$143.64	\$171.17	\$343.88
	60 - 64	\$200.45	\$202.71	\$429.01
\$500 Deductible	Individual		Family	
	Age	Male	Female	All
	0 - 6	\$45.60	\$40.78	-
	7 - 17	\$26.86	\$24.02	-
	18 - 24	\$27.33	\$43.62	\$117.84
	25 - 29	\$33.27	\$55.21	\$130.24
	30 - 34	\$37.88	\$62.80	\$141.52
	35 - 39	\$46.17	\$74.45	\$166.57
	40 - 44	\$54.51	\$84.85	\$184.47
	45 - 49	\$64.55	\$96.32	\$198.88
	50 - 54	\$84.66	\$110.95	\$221.67
	55 - 59	\$114.82	\$136.82	\$274.88
	60 - 64	\$160.24	\$162.04	\$342.93
\$1000 Deductible	Individual		Family	
	Age	Male	Female	All
	0 - 6	\$35.08	\$31.37	-
	7 - 17	\$20.66	\$18.47	-
	18 - 24	\$21.03	\$33.55	\$90.66
	25 - 29	\$25.60	\$42.47	\$100.20
	30 - 34	\$29.14	\$48.31	\$108.88
	35 - 39	\$35.52	\$57.27	\$128.14
	40 - 44	\$41.94	\$65.27	\$141.91
	45 - 49	\$49.66	\$74.10	\$153.00
	50 - 54	\$65.13	\$85.36	\$170.53
	55 - 59	\$88.34	\$105.27	\$211.47
	60 - 64	\$123.27	\$124.66	\$263.82
\$2500 Deductible	Individual		Family	
	Age	Male	Female	All
	0 - 6	\$22.61	\$20.23	-
	7 - 17	\$13.32	\$11.91	-
	18 - 24	\$13.56	\$21.63	\$58.45
	25 - 29	\$16.51	\$27.38	\$64.59
	30 - 34	\$18.79	\$31.14	\$70.20
	35 - 39	\$22.90	\$36.93	\$82.62
	40 - 44	\$27.04	\$42.08	\$91.50
	45 - 49	\$32.02	\$47.77	\$98.64
	50 - 54	\$41.99	\$55.03	\$109.94
	55 - 59	\$56.95	\$67.87	\$136.34
	60 - 64	\$79.48	\$80.37	\$170.08



**REMINDER**  
Your full premium is due with your completed application. Payment must be for the entire period of coverage.

**Short-Term Personal Health Coverage for Individuals Application for Coverage**

**Primary Applicant and Dependents** (Primary applicant must be oldest person on application. Please use black ink only.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Street Address (No P.O. Boxes accepted) \_\_\_\_\_ Mailing Address (if different) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Are you a citizen or legal resident of the U.S.?  Yes  No *You must reside in the State of Tennessee and legally reside in the United States to be eligible for this coverage.*

Are you or anyone you are applying for currently pregnant / expectant parent (including fathers)?  Yes  No

Spouse Last Name \_\_\_\_\_ Spouse First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

To include additional dependents, please record information on a separate sheet of paper and attach it to this application.

**Selected Coverage**

**Term of Coverage:**

Length of Coverage (Check One):  1 month  2 months  3 months  
 Deductible Option (Check One):  \$ 250  \$ 500  \$ 1,000  \$ 2,500

Requested Effective Date:

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|2|0|\_\_\_\_\_|\_\_\_\_\_|

**Payment Information**

\$ Amount Authorized \_\_\_\_\_  eCHECK  
 Bank Routing Number \_\_\_\_\_ Checking Account Number \_\_\_\_\_

**Please read carefully and sign below**

- I/We hereby declare that persons to be covered as listed above do not have other health care coverage or insurance as of the requested effective date. I/We understand and agree
- that BlueCross BlueShield of Tennessee, Inc. is entitled to rely solely on the statements made on this application, which are complete and correct to the best of my/our knowledge.
- that any contract which may be issued to me/us shall be binding only if each statement included in this application is complete and true.
- that any contract which may be issued to me/us will be effective, subject to all the terms and conditions of the contract issued to me/us.
- that a broker or agent may receive a portion of my/our premium as commission. For more information, I/We will contact my/our broker or agent.
- that any contract issued to me/us is directly between BlueCross BlueShield of Tennessee, Inc. and me/us and affirm that no third party is involved.

I also declare that I understand that coverage is limited. I understand that the Short-Term Personal Health Coverage does not provide benefits for any condition for which I or my dependents have had medical treatment (including taking prescription medication), symptoms, or any manifestations thereof, before the effective date of this contract. A policy will not be activated if payment is not approved by my financial institution.

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, fines and denial of coverage.

(This application is not acceptable unless completely filled out and signed by the applicant, parent or guardian if the applicant is a minor.)

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_|2|0|\_\_\_\_\_|\_\_\_\_\_|

Guardian Name: \_\_\_\_\_ (If primary applicant is under age 18)

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_|2|0|\_\_\_\_\_|\_\_\_\_\_|

Agent's Signature: \_\_\_\_\_ Agent's ID: \_\_\_\_\_ Date: \_\_\_\_\_|2|0|\_\_\_\_\_|\_\_\_\_\_|