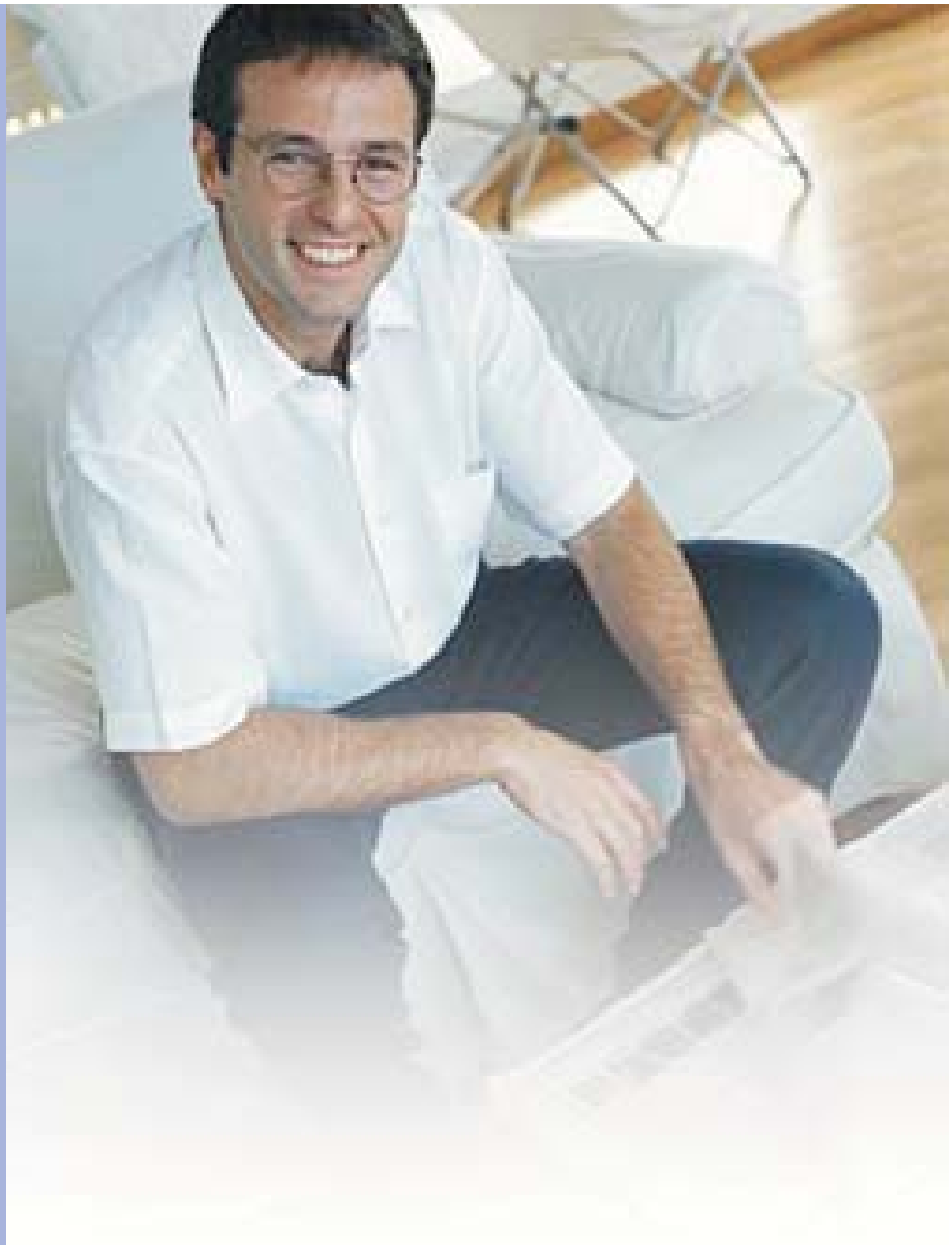
of Tennessee

Short-Term Personal Health Coverage



Quality
Health Insurance
for 1, 2 or 3 months

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 Pharmacy Network RX03, our most cost-effective pharmacy network. Visit www.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.** Travel with confidence knowing that through BlueCard® Worldwide you have access to a special hospital network when you are out of the BlueCross BlueShield of Tennessee service area.

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 were in existence prior to 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.

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

Four Plan Options

Deductible		Coinsurance				Out-of-Pocket Maximum	
		In-Network		*Out-of-Network**			
Individual	Family	Plan Pays	You Pay	Plan Pays	You Pay	Individual	Family
$ 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

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 24. (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 cannot have other health care coverage in place and may not be pregnant.

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 your full premium payment.

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 check does not clear the bank or your credit card 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 two consecutive BlueCross BlueShield of Tennessee short-term policies for a total of three months of coverage. After that, applicants must wait six months before applying for additional short-term coverage. For example, if you purchase a one-month policy in January and a two-month policy for February and March, you would not be eligible for another short-term policy until October.

Any medical condition that occurs during your first policy, will be considered a pre-existing condition on your second 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.

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

BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Reminder

Premium for the coverageperiod requested must beincluded with this application.

Short-Term Personal Health Coverage for Individuals

Application for Coverage

TYPE OR PRINT

Last Name	First Name	MI

Street Address (PO Box cannot be accepted - please provide address of residence.)

City	State	ZIP code

Applicant's Social Security Number	Applicant's Birthday

❑ Male ❑ Female

❑ Single ❑ Married

Are you a United States citizen? ❑ Yes ❑ No

Daytime Telephone Number [ ]	E-Mail Address

Are you covered by Worker's Compensation? ❑ Yes ❑ No

Plan's Use Only

ID No. _____

Group No. _____ Class _____

Plan ID _____

Effective Date _____/_____/_____

Term of Coverage:

Length of Coverage: ❑ 1 month ❑ 2 months ❑ 3 months

Type (Check One) ❑ Individual ❑ Family

Deductible Option (Check One) ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500

Requested Effective Date: _____ (Mo. Day Year)

You may request a coverage period for 1 month, 2 months or 3 months. 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. Coverage will end on 12:01 a.m. at the end of the term.

❑ Payment Amount Enclosed $_____ ❑ Charge Premium to Credit Card *(Complete Credit Card Authorization)*

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

Dependent Information

First Name	MI	Last Name (If Different)	Relationship	Sex	Birthdate Mo.	Day	Year	Social Security Number
Spouse			Spouse					
Dependent								
Dependent								
Dependent								

Please read carefully and sign below

I hereby declare that persons to be covered as listed above:

- Do not have any other health care coverage or insurance as of the requested effective date
- Are not pregnant

I 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 knowledge.

— that any contract which may be issued to me shall be binding only if each statement included in this Application is complete and true.

— that any contract which may be issued to me will be effective, subject to all the terms and conditions of the contract issued to me.

— that a broker or agent may receive a portion of my premium as commission. For more information, I will contact my broker or agent.

— that my signature on this Application will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee, Inc. any and all medical records pertaining to any person who is to be covered by the contract, and I am responsible for any fee for these records.

— that I may apply for up to two consecutive BlueCross BlueShield of Tennessee short-term policies for a total of three months of coverage. After that, I must wait six months before applying for additional short-term coverage.

— that any contract issued to me is directly between BlueCross BlueShield of Tennessee, Inc. and me 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 for any condition for which I or my dependents have had medical treatment, symptoms, or any manifestations thereof, before the effective date of this contract.

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.

Date: _____ Sign X _____ Relationship to Applicant _____

(This application is not acceptable unless completely filled out and signed by the applicant, parent or guardian if the applicant is a minor. If relationship is guardian, please provide copy of legal guardianship paper, finalized by court / agency.)

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent's Name: _____ *(Print Clearly)*

Agent's I.D. Number: _____

Agent's Signature: X _____ Date: _____

Arrangement Code: | | | | - | | | - | | | | - | | | |

APP-110 (2/06) *A scanned, imaged or photocopied version of this completely executed application will have the same force and effect as the original document.*

Complete This Form for Credit Card Payment

Policyholder Name:_____

Social Security Number:_____-_____-_____

Card Holder Address:_____

City: _____ State:_____ Zip: _____

Daytime Phone Number: _____

Type of Credit Card: ❑ Visa ❑ MasterCard

Card Holder Name:_____

Credit Card Number:_____

Expiration Date: Month _____ Year _____

I do hereby authorize BlueCross BlueShield of Tennessee, Inc. to charge my credit card, as listed at left, premiums for health insurance coverage under BlueCross BlueShield of Tennessee. This approval is given regardless of whether such Contract is listed in my name, the name of the Policyholder listed at left, or the name of one of the applicants listed on the front of the attached application. I understand that the premiums charged to my credit card will be accurately reflected as those which are shown on the health insurance policy or the most recent premium change notifications issued to the health insurance policyholder (the subscriber) by BlueCross BlueShield of Tennessee. This authorization is valid until such time as I provide written notice of cancellation of this agreement to BlueCross BlueShield of Tennessee, Inc.

Card Holder Signature_____

Date: _____

If you have any questions, please call 1-800-725-6849, ext. 3037.

BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, TN 37402

www.bcbst.com

COMM - 317 (2/06)