

Short-Term Medical Coverage



**BlueCross
BlueShield**
of Missouri

Up to \$2,000,000
in benefits

**You select from
30 to 180 days**

Questions: call 1-800-497-4010



Short-Term Medical Coverage

through Blue Cross and Blue Shield of Missouri

The Short-Term Medical plan through Blue Cross and Blue Shield of Missouri provides protection when you only need temporary coverage. If you are between jobs, graduating from college or waiting to be accepted for other individual or group coverage, this plan is the solution for your short-term health care protection needs (see “Note” below).

You select your coinsurance percentage, deductible and the number of days of coverage you will need.

You can select from 30 to 180 days of coverage. This will be your plan’s benefit period. You may also choose one of four deductible options and one of two coinsurance options. The plan provides up to \$2,000,000 in benefits during a benefit period.

Benefit Outline

Total Plan Benefits:	\$2,000,000
Benefit Period:	30 to 180 days
Deductible per Benefit Period (per person):	\$250, \$500, \$1,000, \$2,500
Coinsurance (amount you pay):	20% or 50%

After you meet the deductible, you are responsible for 20% or 50% (depending on the option you select) of the next \$5,000 in eligible expenses during the benefit period you select. After the deductible and the first \$5,000 in eligible expenses during the benefit period, you pay nothing for any remaining eligible expenses up to the \$2,000,000 plan maximum.

Important: Precertification required for inpatient care. We must precertify all nonemergency inpatient admissions **before** you receive care and recertify your stay if you need care longer than originally certified. To obtain certification, simply call the Blue Cross and Blue Shield of Missouri Certification Center. If you do not obtain certification, eligible expenses will be reduced 20% before the deductible and coinsurance are applied.

Easy-to-Use Benefits: Many hospitals, physicians and other types of health care providers have signed participating agreements with us. In most instances, these providers will file claims for you. Also, most participating physicians have agreed to accept the Blue Cross and Blue Shield of Missouri allowed amount as full payment for the service and not to bill for any charges above that amount. Be sure to ask the provider if he or she is a Blue Cross and Blue Shield of Missouri participating provider before you receive care. If you do not use Blue Cross and Blue Shield of Missouri participating providers, you may have to pay charges over the Blue Cross and Blue Shield of Missouri allowed amount and you may have to file your own claims.

Note: Applicants who buy short-term medical coverage lose eligibility for HIPAA (Health Insurance Portability and Accountability Act) coverage.

Covered Services

Inpatient Hospital Care

- Semiprivate room and board and intensive care
- Operating and recovery rooms and supplies
- Prescribed drugs, injections and solutions
- Blood
- Miscellaneous services and supplies
- Diagnostic services
- Therapy services

Outpatient Hospital Care

- Emergency care for injuries
- Medical emergencies
- Preadmission testing
- Surgery
- Diagnostic services
- Certain therapy services*

Physician Care

- Inpatient medical care
- Medical care provided in the office and home
- Surgical services
- Assistant surgeon (inpatient only)
- Anesthesia services
- Consultation services
- Diagnostic services
- Certain therapy services

Other Providers of Care

- Home health agency care — up to 40 visits
- Ambulatory surgical center care
- Skilled nursing facility care — up to 30 days

Other Services and Supplies

- Durable medical equipment, home respiratory therapy and home infusion therapy
- Prescription drugs
- Prosthetic appliances

**Therapy care is limited to a maximum of \$500 unless it immediately follows a hospital stay.*

Note: *Certain limitations apply to benefits for mental health and substance abuse treatment. See "Limitations."*

Exclusions

- Preexisting conditions. This means any condition that existed prior to your enrollment date if, within one year before the enrollment date, one or more of the following applied:
 - 1) The condition was known to you; or,
 - 2) You exhibited signs and/or symptoms of the condition and the condition could have been diagnosed with reasonable certainty by a physician; or,
 - 3) You had been under a provider's care or a provider had recommended care for the condition; or
 - 4) The condition had been diagnosed by a provider.**Note:** A pregnancy shall be deemed a preexisting condition if the pregnancy existed on your enrollment date, as determined by Blue Cross and Blue Shield of Missouri.
- Charges in excess of eligible expenses. Eligible expenses are limited to the Blue Cross and Blue Shield of Missouri allowed amount.
- Care covered under a government program.
- Care for any condition resulting from acts of war or while on active or reserve military duty.
- Care for any illness or injury that happened because of your employment if Workers' Compensation benefits are available, whether or not you claim those benefits.
- Services provided after termination of the Certificate.
- Care that is not considered medically necessary or that is investigational or obsolete.
- Care not expressly specified in the Certificate.
- Maternity care. (However, complications of pregnancy will be covered the same as any other illness.)
- Infertility treatment.
- Expenses incurred outside the United States.
- Care for an intentionally self-inflicted injury or illness, while sane.
- The difference between the hospital's average charge for a semiprivate room and the charge for a private room.
- Charges for cosmetic or beautification services.
- Routine or periodic physical examinations, including Pap smears.
- Routine well-baby care.
- Foot care.
- Dental treatment.
- Corrective lenses or hearing aids or examinations to prescribe or fit them.
- Convalescent, domiciliary or custodial care.
- Organ transplants, except in the case of an accident or injury.
- Obesity or weight loss.
- Elective abortions.

Limitations

- Coverage for substance abuse is limited to 10 episodes of treatment. Inpatient and residential care is limited to 21 days each calendar year and up to 6

days each calendar year for medical and social detoxification. Outpatient care is limited to 26 days of treatment each calendar year.

- Coverage for inpatient mental health care is limited to 90 days each calendar year.

Eligibility: To be eligible for this coverage, you must live in our 85-county service area in Missouri, and you must be 30 days old or older and not eligible for Medicare. Dependent children are eligible for coverage from the moment of birth (or in the case of an adopted child, from the date of placement in the physical custody of the adoptive parent), up to age 19.

You are NOT eligible to apply for this coverage if:

- you will turn 65 or become eligible for Medicare during the benefit period
- you are pregnant
- within the last five years, you have received medical care or treatment, or had a sign or symptom that could have been reasonably diagnosed, for the following conditions: heart or circulatory system disorder, including heart attack or chest pain; stroke; cancer or tumor; diabetes; immune system disorder including acquired immune deficiency syndrome (AIDS); a nervous, mental or emotional condition; alcoholism, drug abuse or chemical dependency
- you have other medical coverage that will not terminate prior to the effective date of this Short-Term Medical program.

When Coverage is Effective: You may request an effective date. If Blue Cross and Blue Shield of Missouri receives the properly completed application and correct payment **before** the date you requested, and your application is approved, your coverage will begin at 12:01 a.m. on the day you request.

If you do not request a specific effective date and you or your agent/broker mails or delivers your application and correct payment to Blue Cross and Blue Shield of Missouri, and your application is approved, we will assign the effective date as follows:

1. 12:01 a.m. the day **after** the postmark date on the application envelope; or
2. if the postmark is illegible, one day **before** the date Blue Cross and Blue Shield of Missouri receives the application; or
3. if personally delivered, 12:01 a.m. the day **after** Blue Cross and Blue Shield of Missouri receives your completed application and correct payment. If you are applying for an individual health benefits plan through Blue Cross and Blue Shield of Missouri at the same time you are applying for this short-term coverage, the effective date of the health benefits plan will correspond with the end date of this short-term coverage.

Additional Benefit Periods: This short-term medical plan is **not renewable**. The purpose of this coverage is to provide temporary medical protection only. If, however, you wish **additional coverage** beyond the benefit period you initially selected, you

can reapply for additional benefit period(s) if all the following conditions are met: The total days of coverage of the combined benefit periods for you and your dependents do not exceed 360 days, there has been no significant change in the health of anyone included on your application, and you continue to meet our eligibility criteria. If you or any covered family member(s) have incurred claims during the preceding benefit period(s), your new application might be declined. In addition, if your combined benefit periods equal the 360-day maximum, you will not be eligible for short-term coverage again until 365 days after your last benefit period ended.

If your new application is approved, you will have a new effective date. You will receive a new certificate and identification card. No benefits will be provided for any conditions or symptoms that existed prior to the new effective date. In addition, any deductibles or coinsurance incurred by you will not be applied to the new Short-Term Medical plan or any other coverage through Blue Cross and Blue Shield of Missouri or its affiliates. Coverage is not continuous between any two benefit periods.

Extension of Benefits: Two provisions may extend coverage beyond your plan's expiration date:

1. If, during the benefit period, you or a covered family member becomes totally disabled and receives treatment for the disabling condition, benefits for treatment of the disabling condition will be extended to the earliest of: 12 months following the termination date; the end of total disability; payment of the \$2,000,000 maximum benefit; or the date on which treatment is no longer required.
2. If you or a covered family member met the deductible during the benefit period and treatment for an illness or injury commenced during that time, benefits may be extended for follow-up treatment of that particular condition. If these conditions are met, up to a maximum of \$1,000 in eligible expenses will be provided if care is received within 60 days after the expiration date of your coverage. The person does not need to be totally disabled to qualify for this benefit.

How to apply for coverage:

1. Complete, **sign** and date the application. Be sure to answer all questions.
2. Put application and full payment in envelope.
3. Mail or deliver envelope to your agent/broker, or mail as follows:

Blue Cross and Blue Shield of Missouri
P.O. Box 66859
St. Louis, MO 63166-9713

4. **If your application is approved**, we will mail the **certificate** and ID card to you. Your coverage will start at 12:01 a.m. on the effective day you requested or according to the provisions at left (see "When Coverage is Effective").

The rate chart shows both the 30-day rate and the daily rate for each deductible and benefit level. Rates are based on the applicant's/dependent's age at the time the coverage is effective. These rates are subject to change periodically.

To calculate your rates, first:

1. Choose a deductible: \$250, \$500, \$1,000 or \$2,500.
2. Choose a coinsurance percentage: 20% or 50%.
3. Determine the number of days you wish to be covered (30-180 days).

Then, if you want 30 days of coverage, add together the applicable 30-day rates for all members to be covered.

If you want more than 30 days of coverage: Add all of the daily rate(s) for each person to be covered and multiply the total by the number of days of coverage you'll need. **For example,** to obtain the rate for 35 days for two people (\$250 ded./20% coinsurance), add the daily amounts:

Male age 34 (\$2.07) + Female age 32 (\$2.76) = \$4.83 x 35 days = \$169.05 (total rate).

Deductible	\$250				\$500				\$1,000				\$2,500				
	20%		50%		20%		50%		20%		50%		20%		50%		
Period of Coverage	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	30 Days	Daily Rate	
Age 30 days thru 24 yrs.	M	48.30	1.61	38.70	1.29	38.10	1.27	30.30	1.01	27.60	.92	22.20	.74	24.30	.81	19.20	.64
	F	62.10	2.07	49.80	1.66	48.30	1.61	38.70	1.29	31.20	1.04	24.90	.83	27.60	.92	22.20	.74
25-29	M	55.20	1.84	44.10	1.47	41.40	1.38	33.00	1.10	31.20	1.04	24.90	.83	27.60	.92	22.20	.74
	F	69.00	2.30	55.20	1.84	51.90	1.73	41.40	1.38	34.50	1.15	27.60	.92	31.20	1.04	24.90	.83
30-34	M	62.10	2.07	49.80	1.66	48.30	1.61	38.70	1.29	34.50	1.15	27.60	.92	31.20	1.04	24.90	.83
	F	82.80	2.76	66.30	2.21	62.10	2.07	49.80	1.66	45.00	1.50	36.00	1.20	38.10	1.27	30.30	1.01
35-39	M	72.60	2.42	57.90	1.93	62.10	2.07	49.80	1.66	41.40	1.38	33.00	1.10	38.10	1.27	30.30	1.01
	F	96.60	3.22	77.40	2.58	75.90	2.53	60.60	2.02	51.90	1.73	41.40	1.38	45.00	1.50	36.00	1.20
40-44	M	89.70	2.99	71.70	2.39	69.00	2.30	55.20	1.84	51.90	1.73	41.40	1.38	41.40	1.38	33.00	1.10
	F	103.50	3.45	82.80	2.76	89.70	2.99	71.70	2.39	62.10	2.07	49.80	1.66	51.90	1.73	41.40	1.38
45-49	M	117.30	3.91	93.90	3.13	96.60	3.22	77.40	2.58	69.00	2.30	55.20	1.84	51.90	1.73	41.40	1.38
	F	124.20	4.14	99.30	3.31	103.50	3.45	82.80	2.76	75.90	2.53	60.60	2.02	58.80	1.96	46.80	1.56
50-54	M	138.00	4.60	110.40	3.68	110.40	3.68	88.20	2.94	82.80	2.76	66.30	2.21	65.70	2.19	52.50	1.75
	F	144.90	4.83	115.80	3.86	117.30	3.91	93.90	3.13	86.40	2.88	69.00	2.30	69.00	2.30	55.20	1.84
55-59	M	186.30	6.21	149.10	4.97	158.70	5.29	126.90	4.23	117.30	3.91	93.90	3.13	96.60	3.22	77.40	2.58
	F	179.40	5.98	143.40	4.78	151.80	5.06	121.50	4.05	110.40	3.68	88.20	2.94	89.70	2.99	71.70	2.39
60-64	M	248.40	8.28	198.60	6.62	200.10	6.67	160.20	5.34	144.90	4.83	115.80	3.86	124.20	4.14	99.30	3.31
	F	234.60	7.82	187.80	6.26	186.30	6.21	149.10	4.97	131.10	4.37	105.00	3.50	103.50	3.45	82.80	2.76
1 dependent child		38.10	1.27	30.30	1.01	27.60	.92	22.20	.74	20.70	.69	16.50	.55	13.80	.46	11.10	.37
2 dependent children		76.20	2.54	60.60	2.02	55.20	1.84	44.40	1.48	41.40	1.38	33.00	1.10	27.60	.92	22.20	.74
3+ dependent children		114.30	3.81	90.90	3.03	82.80	2.76	66.60	2.22	62.10	2.07	49.50	1.65	41.40	1.38	33.30	1.11

This brochure gives only a summary of benefits and exclusions. Complete plan details are contained in the Short-Term Medical Coverage Certificate issued with your identification card when coverage is approved. If, after reviewing the Certificate, you are not satisfied for any reason, **you may return the membership material, along with your written request for cancellation, within 10 days after you receive the material, and we will refund your full premium payment. If you cancel your coverage after the 10 days have passed, your premium will not be returned to you. Send your written request to: Blue Cross and Blue Shield of Missouri, P.O. Box 66859, St. Louis, MO 63166-9713.**



**For more information, call
Blue Cross and Blue Shield of Missouri**

toll free (in Missouri) 1-800-497-4010

**Visit our World Wide Web site at
www.showme-insurance.com**

Blue Cross and Blue Shield of Missouri is the name RightCHOICE® Managed Care, Inc. (RIT) uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by Healthy Alliance® Life Insurance Company (HALIC). RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.

Short-Term Medical Application

Requested Effective Date

Month	Day	Year

The Companies are Healthy Alliance® Life Insurance Company (HALIC), its parent, RightCHOICE® Managed Care, Inc. (RIT), and certain affiliates. Blue Cross and Blue Shield of Missouri is the name RIT uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.



Applicant's Name (Print last, first, middle)				Sex	Birthdate / /	Social Security Number - -		
Street Address				City, State, Zip Code				
Day Telephone ()				Evening Telephone ()				
Spouse's Name (If to be covered)				Sex	Birthdate / /	Social Security Number - -		
Children (First Name) (If to be covered)	Sex	Birthdate	First Name	Sex	Birthdate	First Name	Sex	Birthdate
1.			3.			5.		
2.			4.			6.		

Answer the following questions completely and accurately

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you or any person to be covered have any hospital, major medical group health or medical insurance coverage that will not terminate prior to the effective date of this coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) When will existing coverage expire? ____/____/____ | | |
| 2. Are you currently applying for any other coverage with us? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you, your spouse or any dependent applying for this coverage now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

Note: Pregnant women are not eligible to apply.

- | | | |
|---|--------------------------|--------------------------|
| 4. Within the last five (5) years, have you, your spouse or any dependent to be covered, received any medical or surgical consultation, or treatment including medication for: heart or circulatory system disorder including heart attack, chest pain or high blood pressure; stroke; diabetes; cancer or tumor; immune system disorder including acquired immune deficiency syndrome (AIDS); a mental, nervous or emotional condition; substance abuse or chemical dependency including alcoholism or alcohol abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Note: The program cannot take effect before the termination date of existing coverage. Under no circumstances can coverage become effective before the date this application is signed. This coverage cannot be issued if YES is answered on Question 3. This coverage might not be issued if YES is answered on Question 4. If you answered YES because of any of the conditions in Question 4, please provide a brief description and status of the condition(s):

- | | | |
|---|--------------------------|--------------------------|
| 5. Is this form being handled by an independent producer (broker or agent)? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|
- If YES, please note that the Companies may share with the producer the medical information that is listed on this form, and that we discover in the process of underwriting your application, concerning you or other listed family members.

Benefit Period	Deductible Amount	Rate of Payment After Deductible	Total Program Rate
30-180 days	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500	<input type="checkbox"/> 80/20 to \$5,000 <input type="checkbox"/> 50/50 to \$5,000	

Application Agreement: I, the undersigned applicant, acknowledge that I have read, or have had read to me, the completed application. I realize that if I omit any information or provide any false or incomplete information that is considered fraud or material misrepresentation, this can result in claim denial and/or cancellation of this coverage. I agree to repay promptly any benefit payment to which I or my dependents were not entitled. As explained in the "Exclusions" section of my marketing brochure, I understand that the program applied for will not provide benefits for any expenses incurred due to any condition that manifested itself before the program date. This exclusion applies to any preexisting medical condition, and is not limited to the conditions indicated in Question 4, above. I also understand that this program is not a continuation of any previous medical coverage, including any prior Short-Term Medical program.

Applicant's Signature if Age 18 or Older/Parent's or Legal Guardian's Signature for Children under Age 18 _____ **Date** _____

Note: If you cancel your coverage more than 10 days after receiving your Coverage Certificate, we will not refund your premium.

Producer Information: This section is to be completed by the producer, if any, who represents the applicant.

Important: Before this application can be accepted for processing, the submitting producer's current Missouri health and life license must be on file with Blue Cross and Blue Shield of Missouri and the producer must be authorized by Blue Cross and Blue Shield of Missouri.

Name: David Lloyd Signature: _____

Telephone No. () _____ Fax No. () _____ If you have previously written business with us, please provide:

BCBSMo Producer No. MB4642 BCBSMo Agency No. M5984

Office Use Only	Group #	I.D. #	Plan ID	Class	Effective Date	Coverage Through
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