

Coverage Highlights

Benefits	Network	Out-of-Network
Maximum Coverage	\$1,000,000 Includes out-of-network payments	\$100,000
Deductible	\$250, \$500 or \$1,000	\$1,500
Out-of-Pocket Maximum (plus Deductible)	\$2,000, \$2,500 or \$3,000 (Coinsurance percentage limit)	\$3,500
Inpatient Facility Services*		
Inpatient Hospital Facility Services	80% Combined: 31-day maximum per admission Does not include maternity	60%
Skilled Nursing Facility Services	80% Combined: 30-day maximum	60%
Outpatient Services*		
Emergency Room	80% \$100 copayment waived if admitted	Network benefit level
Diagnostic Testing	80% Combined: \$10,000 maximum	60%
Outpatient Hospital Facility Services	80%	60%
Surgery, Anesthesia, Chemotherapy, Radiation Therapy	80%	60%
Primary Care Physician (PCP), Specialist Office Visits	80% Combined: 2 PCP and 2 Specialist visits	60%
Preventive Care		
Routine Gynecological Visit/ PAP Test; Routine Mammogram; Pediatric Immunizations	80% No deductible	Not covered
Prescription Drugs*		
\$100 Deductible; \$25,000 Maximum per Coverage Period	80%	Not covered
* subject to Pre-Existing Condition limitation		

You can quickly get the
**SHORT-TERM
MEDICAL INSURANCE**
you need!



**Short-term health coverage
for 31 to 180 days**

- Easy to obtain
- Flexible and affordable
- Up to \$1 million in coverage
- No physical exam required

Single-Term Comprehensive Major Medical
Individual PPO Coverage Without A Gatekeeper
Marketed As "ShortTermBlue"

HIGHMARK®
ShortTermBlue™ 

An Individual Preferred-Provider Program

*Highmark Blue Cross Blue Shield is an Independent
Licensee of the Blue Cross and Blue Shield Association*

Application enclosed ...

ShortTermBlueSM is the answer to your temporary health insurance needs!

There are many reasons you may need temporary medical insurance, no matter what stage of life you are in. Perhaps you are between jobs. Or at a new job waiting for permanent insurance coverage to begin. Or maybe you recently graduated from school and are awaiting employment.

Whatever the reason, you don't need to go a single day without the peace of mind of knowing you have health insurance. With ShortTermBlue through Highmark Blue Cross Blue Shield, you can have up to \$1 million of coverage.

There's no physical exam to apply – just a short medical questionnaire.

Your coverage start dates and end dates are flexible to meet your needs.

You can request to start coverage as early as the day after your Application is submitted electronically. You also choose your last day of coverage – anywhere from a minimum of 31 days up to and including 180 days.

Because it is designed to meet your health coverage needs while you are waiting for a more permanent health coverage policy to begin, this coverage is not renewable. However, if you need to, you can re-apply for additional coverage.*

ShortTermBlue is very affordable!

The cost for ShortTermBlue is a few dollars per day. You simply choose your deductible, then multiply the number of coverage days selected by the daily cost for your age, and you'll have your total cost for this coverage.

For instance, if you are 25 and want coverage for 31 days with a \$500 deductible, your cost will be just \$81.22. Or, if you are 35 and select coverage for 155 days with a \$1,000 deductible, it will cost you \$440.20. It's that easy and that inexpensive!

ShortTermBlue provides important coverage!

Here are some of the medical expenses and services that are partially or fully covered:

- Inpatient and outpatient hospital facility
- Skilled nursing facility services
- Respiratory therapy services
- Emergency room services
- Primary Care Provider and Specialist office visits
- X-ray, lab and other diagnostic testing
- Routine gynecological visit and PAP test
- Routine mammograms
- Pediatric immunizations
- Prescription drugs
- Blues On CallSM

To help keep rates low, Pre-Existing Conditions are not covered.

ShortTermBlue will not provide benefits for pregnancy and any condition for which medical advice, care, treatment or diagnosis has been recommended by or received from a health care provider within the five-year period immediately prior to your Effective Date.

It's quick and easy to apply!

You won't need to have a physical exam to be approved for this coverage. Everything you need to apply is right here. Just complete the attached Application and give it to your insurance producer along with your payment information.

If you want coverage for a spouse or child(ren), complete a separate Application for each person.

If you are approved, your coverage could begin as early as the day after your Application is submitted electronically. Make sure you let us know the exact date you want your coverage to begin.

* Certain restrictions apply to the number of additional consecutive Coverage Periods allowed. (See specific information in the Conditions of Enrollment section in this brochure.)

If you have questions or need more information, please contact your insurance producer.

Application and Health Questionnaire for Single-Term Comprehensive Major Medical Individual PPO Coverage

How to complete this Application

- Each individual, including any dependents applying, must complete a separate Application. Please copy both sides of this Application if you need additional Applications.
- Choose your Coverage Period, from a minimum of 31 days up to and including 180 days.
- Choose the dates you want your Coverage Period to begin and end. The date your coverage begins ("Effective Date") will be the later of (a) the day after the date the Application is submitted electronically or (b) the date you request. Your requested Effective Date must be within 30 days of the date your application is submitted electronically.
- Read the "Conditions of Enrollment" on the back of the Application. Sign and date where indicated.
- If you are applying for insurance coverage through an insurance producer, this Application will be submitted electronically for you by that producer. Please do not mail this Application.
- Keep a copy of the Application and Conditions of Enrollment for your records.

Your satisfaction is guaranteed!

If you're not completely satisfied with ShortTermBlue, just return your identification card and Subscription Agreement within 10 days after receipt. Indicate in writing that you no longer want this protection and, once we have received your written response, any premium you have paid will be promptly and fully refunded.

Questions?

Please contact your insurance producer if you have any questions about this coverage or how to complete this Application.

If changes in your eligibility occur ...

Please note: If you receive medical advice or treatment from a physician or other professional provider for a condition which occurred after this Application is signed, but prior to the Effective Date of coverage, you must notify Highmark Blue Cross Blue Shield by calling 1-800-544-6679.

Keep this page for your records.

Date: _____

Amount Remitted: _____

Deductible Amount Chosen: _____

Dates of Coverage: _____

HIGHMARKBCBS.COM

HAVE A
GREATER HAND
IN YOUR HEALTH.®



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ShortTermBlue and Blues On Call are service marks of the Blue Cross and Blue Shield Association.

Highmark and Have A Greater Hand In Your Health are registered marks of Highmark Inc.

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It's easy to figure out the cost of your policy.

ShortTermBlue costs just a few dollars per day, and you choose the Coverage Period that is right for you.

The following chart shows the daily rate by age group and deductible amount:

Age	Deductible Amount	Rate Per Day
under 25	\$ 250	\$ 2.66
	\$ 500	\$ 2.22
	\$1,000	\$ 1.87
25-29	\$ 250	\$ 3.17
	\$ 500	\$ 2.62
	\$1,000	\$ 2.18
30-34	\$ 250	\$ 3.74
	\$ 500	\$ 3.07
	\$1,000	\$ 2.53
35-39	\$ 250	\$ 4.24
	\$ 500	\$ 3.46
	\$1,000	\$ 2.84
40-44	\$ 250	\$ 4.85
	\$ 500	\$ 3.93
	\$1,000	\$ 3.21
45-49	\$ 250	\$ 5.73
	\$ 500	\$ 4.62
	\$1,000	\$ 3.75
50-54	\$ 250	\$ 7.02
	\$ 500	\$ 5.63
	\$1,000	\$ 4.53
55-59	\$ 250	\$ 8.60
	\$ 500	\$ 6.87
	\$1,000	\$ 5.50
60-64	\$ 250	\$10.46
	\$ 500	\$ 8.32
	\$1,000	\$ 6.63

Using the chart above, you can figure out your cost of coverage:

- Choose the dates you want your Coverage Period to begin and end. The length of your Coverage Period can be from a minimum of 31 days up to and including a maximum of 180 days.

EFFECTIVE START DATE: _____
(can be no earlier than the day after the date your Application is submitted electronically)

END DATE: _____

- Now figure out your exact cost here:

_____ X \$ _____ = \$ _____
NUMBER OF DAYS DAILY RATE YOUR COST
OF COVERAGE (from chart above) (entire payment)

Single-Term Comprehensive Major Medical Individual PPO Coverage without a Gatekeeper



An Individual Preferred-Provider Program

Utilizing the KeystoneBlue Health Plan West Network of Providers

PLEASE PRINT

Applicant's Last Name		First Name	Middle Initial	Birth Date	Social Security Number
Home Address		City	State	Zip Code	County
Home Phone Number ()			Home E-mail		
Work Phone Number ()			Work E-mail		

Please answer the following questions completely and accurately.

DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe that you may be at risk.

Prior to approving your Application for enrollment, Highmark reserves the right to review previous and current Applications for coverage as well as claims history. Highmark may deny this Application, in which case any premium submitted will be refunded.

- Have (Are) you:
 - Been denied insurance for health conditions that continue to require monitoring, medications or treatment?

Medical policies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Life policies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 - Now in the process of adopting a newborn (31 days or younger) child or undergoing infertility treatment? Yes No
 - Been diagnosed or treated by a licensed medical professional for current pregnancy? Yes No
 - Using medical equipment (such as a walker, wheelchair, cane or hospital bed)? Yes No
 - Currently receiving home health care? Yes No
 - Enrolled in or eligible for Medicare due to age or disability? Yes No
 - Been diagnosed or treated by a licensed medical professional for obesity such as morbid obesity, Class Three (3) obesity or a Body Mass Index (BMI) of 40 or greater? Yes No
- Have you been notified by your physician of any abnormal test results; received medical or surgical treatment, consulted with a licensed medical professional, or taken medication for any of the following conditions within the last five (5) years? Yes No
 - Behavioral Health:** behavioral disorders such as alcoholism, bipolar, eating disorders, schizophrenia, substance abuse? Yes No
 - Cancer:** adenoma, granuloma, malignancy of any type, multiple myeloma, sarcoma? Yes No
 - Gastro-Intestinal:** Barrett's esophagitis, bariatric surgery such as lap band or gastric bypass, cirrhosis of the liver, chronic pancreatitis, peptic ulcer disease, ulcerative colitis? Yes No
 - Genitourinary:** hydronephrosis, kidney disease? Yes No
 - Heart/Cardiovascular, Circulatory, Blood/Immune System:** AIDS or AIDS-related complex (ARC), aneurysm, angina, angioplasty, aortic valve disorder, bypass surgery, cardiomyopathy, cerebral aneurysm, clotting disorders (coagulation issues), congestive heart failure, coronary artery disease, endocarditis, heart attack, hepatitis (autoimmune, B or C), HIV, leukemia, lymphoma (Hodgkin's or non-Hodgkin's), lupus, myocarditis, phlebitis (recurrent), pulmonary embolism, pulmonary hypertension, stroke, transient ischemic attack (TIA)? Yes No
 - Medications:** antiarrhythmics, anti-rejection drugs, blood thinners, chemotherapy, insulin, nitroglycerin, oral diabetes medication, steroids (for 30 days or more)? Yes No

- Nervous System/Musculoskeletal:** any debilitating neuromuscular condition such as amyotrophic lateral sclerosis (ALS), multiple sclerosis, myasthenia gravis, paralysis, scleroderma, seizure disorder (including epilepsy diagnosed or having seizure within the past three (3) years)? Yes No
- Respiratory:** active tuberculosis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, pulmonary hypertension, sleep apnea? Yes No

- Have you ever been diagnosed, treated or otherwise told by a licensed medical professional that you have a disease, injury, illness or other health care condition that requires ongoing, continuing or future medical treatment? Yes No

If you answered "yes" to any part of questions 1, 2 or 3, you are not eligible for coverage in the Short Term products. Do not complete the rest of this form.

- Is this coverage for which you are applying intended to replace any other accident or health insurance you currently have in force? (This includes any current Blue Cross Blue Shield policy.)

<input type="checkbox"/> Yes – If you answered "Yes" to Question 4, please proceed to Item 4a.
<input type="checkbox"/> No – If you answered "No" to Question 4, please skip Item 4a.

 - If you answered "Yes" to Question 4, please provide the insurance company name and applicable group and identification numbers:

Company Name	
Group Number	Agreement/ID Number

- Length of Coverage** - Select first and last dates of coverage. Once selected, Length of Coverage (# of days) cannot be changed.

Requested first date of coverage	_____
Requested last date of coverage	_____
Requested # of days of coverage	_____

- Select Deductible** (check one) \$250 \$500 \$1,000

7. Total Payment

\$	_____	X	_____	= \$	_____
	DAILY RATE		# OF DAYS		TOTAL PAYMENT

Total payment must be sent with Application. Payment is non-refundable. The policy cannot be terminated once payment is received with the exception of the 10-Day Satisfaction-Guaranteed Period.

Payment Enclosed	Group Number
\$	039000-00
Applicant's Social Security Number	

Conditions of Enrollment

I, the undersigned, hereby apply for coverage.

I represent, to the best of my knowledge and belief, that:

1. I have read and have supplied all the requested information on this form.
2. No material information has been withheld or omitted about the past or present state of my health.
3. The information provided on this Application is true and correct.

I understand and agree that:

1. This Application will be submitted electronically by my insurance producer.
2. Receipt of my credit card payment does not constitute enrollment; and
3. Coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield (referred to herein as "Highmark"); and
4. The terms and conditions of coverage are controlled by the written Agreement with Highmark and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of the Agreement, to administer the program; and
5. Coverage will only apply to admissions that occur and services that are provided on or after the Effective Date of coverage.

I also understand and agree that Highmark may:

1. **Deny** this Application, in which case any premium submitted will be refunded and accepted by me; or
2. **Terminate** this Agreement if I have performed an act or practice constituting fraud or have made an intentional misrepresentation of a material fact; or
3. **Void** this Agreement or deny a claim for loss incurred or disability (as defined in the Agreement) within two (2) years of the Effective Date of this Agreement if I have made a fraudulent misstatement or a material misrepresentation in the Application

Pre-Existing Conditions. I understand and agree that the Agreement will not provide benefits for pregnancy and any condition for which medical advice, care, treatment or diagnosis has been recommended or received from a health care provider within the five (5) years immediately prior to the Effective Date of coverage.

I acknowledge and agree that any personally identifiable health information ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy laws, and that, in accordance with those laws, Highmark

may use and disclose Protected Health Information for payment, treatment and health care operations. A copy of Highmark's Notice of Privacy Practices is available on Highmark's website, or from the Highmark Privacy Office.

Premium Payment. The **total premium amount** payable to Highmark must be submitted with the Application. I understand that I cannot terminate this policy once payment is received by Highmark with the exception of the 10-Day Satisfaction Guaranteed Period.

Nonrenewable Coverage. This plan is not renewable. To obtain coverage after a Coverage Period ends, you must submit a new Application. You may enroll for two consecutive Coverage Periods. Coverage Periods are considered consecutive only if there are **60 days or less** between the end of one Coverage Period and the beginning of the next Coverage Period. There can be no overlap of days between Coverage Periods. For example, if the last day of your first Coverage Period is the 15th of the month, the earliest your second Coverage Period can start is the 16th of the same month. You must wait **90 days**, after enrolling in consecutive Coverage Periods, before you can apply for a third Coverage Period.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Minors. If applicant is under age 18, a parent or guardian must sign this Application.

This is my first Application for ShortTermBlue.

Under no circumstances can coverage become effective prior to the day after the date this Application is submitted electronically.

Applicant's Signature

Date