

## Short-Term Blue Premium Rates

Daily Rates for Coverage  
Effective Jan 1, 2011 through December 31, 2011

### \$500 Deductible

Age	Coinsurance	
	50/50	80/20
< 25	\$2.92	\$3.64
25 - 29	\$2.75	\$3.43
30 - 34	\$3.08	\$3.86
35 - 39	\$3.78	\$4.72
40 - 44	\$4.12	\$5.15
45 - 49	\$4.80	\$6.01
50 - 54	\$6.52	\$8.15
55 - 59	\$8.93	\$11.15
60 - 64	\$12.01	\$15.01
1 Child	\$1.54	\$1.92
2+ Children	\$3.08	\$3.84

### \$1000 Deductible

Age	Coinsurance	
	50/50	80/20
< 25	\$2.57	\$3.21
25 - 29	\$2.23	\$2.78
30 - 34	\$2.23	\$2.78
35 - 39	\$2.92	\$3.64
40 - 44	\$3.26	\$4.07
45 - 49	\$4.12	\$5.15
50 - 54	\$5.50	\$6.87
55 - 59	\$7.21	\$9.01
60 - 64	\$9.95	\$12.44
1 Child	\$1.37	\$1.72
2+ Children	\$2.74	\$3.44

### \$2500 Deductible

Age	Coinsurance	
	50/50	80/20
< 25	\$1.89	\$2.35
25 - 29	\$1.54	\$1.92
30 - 34	\$1.72	\$2.14
35 - 39	\$2.06	\$2.57
40 - 44	\$2.40	\$3.00
45 - 49	\$2.92	\$3.64
50 - 54	\$4.12	\$5.15
55 - 59	\$5.32	\$6.64
60 - 64	\$7.21	\$9.01
1 Child	\$0.86	\$1.08
2+ Children	\$1.72	\$2.16

Enter the rate for the deductible and coinsurance you have selected on the premium section of your application.

## Premium Calculation Instructions

Please refer to the rate chart.

### Step 1

List each applicant's daily rate.

a) Applicant rate \_\_\_\_\_  
b) Spouse rate \_\_\_\_\_  
+ \_\_\_\_\_  
**Subtotal** = \_\_\_\_\_

### Step 2

Enter the 1 Child daily rate if only one child \_\_\_\_\_  
Enter the 2+ Children daily rate if two or more children \_\_\_\_\_

**Subtotal** = \_\_\_\_\_

### Step 3

Add the subtotals from Steps 1 and 2 = \_\_\_\_\_

### Step 4

Enter the number of days of coverage (30 to 183) \_\_\_\_\_  
Multiply the number of days by the subtotal in Step 3 \_\_\_\_\_

x \_\_\_\_\_

### Step 5

Total (from Step 4) = \_\_\_\_\_

If the amount paid is less than the required amount for the number of coverage days requested, BCBSMT will reduce the days of coverage accordingly.

### Payment Options

Payment is due in full at the time of application. If your application is not accepted, any premium payment received will be refunded.

Check or Money Order     Visa/Discover/MasterCard

I authorize Blue Cross and Blue Shield of Montana to charge my credit card the full payment for the Short-Term Blue policy.

Cardholder Name \_\_\_\_\_

Address \_\_\_\_\_

City, State ZIP \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_ / \_\_\_\_ CVV \_\_\_\_\_

Authorized Amount \_\_\_\_\_

Enter the amount from Step 5 on the Premium Calculation Instructions table

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Submit completed application and payment to your local BCBSMT agent or:**

Blue Cross and Blue Shield of Montana FAX to: (406) 442-6941

P.O. Box 4309, Helena, MT 59601 **OR** For Customer Service, please call:

Attn: Finance Department 1-800-447-7828 Toll-free

# SHORT-TERM BLUE

A benefit program designed specifically for temporary health care coverage.

## Outline of Coverage and Application

Is your life in transition, leaving you temporarily without health care coverage? Are you:

- Seeking an affordable alternative to COBRA?
- A temporary or seasonal employee?
- A dependent but no longer eligible on your parents' plan?
- Between semesters at school?
- A recent college graduate?
- Fulfilling your probationary period on a new job?
- Relocating?

**Between Jobs?**

**Starting Your Career?**

**Relocating?**

Short-Term Blue may be the plan for you!



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### OFFICE USE ONLY

Org Policy	<input type="checkbox"/> Approved as Applied _____	Date Stamps
Universal ID Number	<input type="checkbox"/> Declined (Reason) _____	
Medical Notes	<input type="checkbox"/> Modified Approval _____	
Effective Date		

## How Short-Term Blue Works

Short-Term Blue is a non-renewable transition plan. You can choose health care coverage for yourself and your dependents for as few as 30 days or as many as 183 days. All members, including covered dependents, will have a maximum coverage period of 183 days.

Although your Short-Term Blue plan is not renewable, you can re-apply for coverage. If you wish to re-apply for coverage under Short-Term Blue, you must submit a new application to Blue Cross and Blue Shield of Montana (BCBSMT). Prior acceptance and enrollment do not guarantee acceptance of the new application.

### Benefit Highlights

<b>Lifetime Maximum Benefit</b>	\$5,000,000
<b>Benefit Period</b>	Coverage for 30 to 183 days
<b>Deductible</b>	<i>Individual Coverage</i> \$500, \$1,000 or \$2,500
<b>Coinsurance</b> (BCBSMT/Member)	50/50 or 80/20
<b>Application Fee</b>	None
<b>BlueCard</b>	Nationwide Benefits
<b>Out of Pocket Amount</b>	\$5,000

Any amount you pay for balances owed to nonparticipating providers does not apply to the out-of-pocket amount.

Benefit	Covered Services
<b>Hospital and Professional Provider Services</b>	Hospital and Professional Provider benefits for medical and surgical services, including both inpatient and outpatient. Ambulance transportation service.
<b>Durable Medical Equipment and Prostheses</b>	Initial purchase and rental.
<b>Well-Child Care</b>	Well-child exams, lab tests and immunizations through seven years of age.
<b>Mammograms</b>	Paid at 100% of the actual charge or \$70, whichever is less. Deductible and coinsurance apply to any balance after the first \$70 is paid.
<b>Diabetic Education</b>	\$250 per benefit period for outpatient services.
<b>Severe Mental Illness</b>	Processed under regular medical benefits.
<b>Autism Spectrum Disorder</b>	Diagnosis and treatment of Autistic disorder, Asperger's disorder or pervasive developmental disorder. Habilitative or rehabilitative care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas therapy; discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention; medications; psychiatric or psychological care; therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist. The following maximums apply: \$50,000 a year for a child 8 years of age or younger; \$20,000 a year for a child 9 years of age through 18 years of age.
<b>Ambulance</b>	Processed under regular medical benefits.

For a comprehensive list of Noncovered Expenses, refer to your contract.

Prior Authorization, which is not a guarantee of payment, is recommended for some services, supplies, treatments and drugs to help the member identify potential expenses, payment reductions, or claim denials the Member may have if these proposed services, etc. are not Medically Necessary or not a Covered Medical Expense. Examples of such services are: Hospice and Durable Medical Equipment over \$500. Refer to your Contract.

### Participating Providers—The Best Value for Your Health Care Dollar

Receiving services from participating BCBSMT network providers maximizes your health care benefits and limits your out-of-pocket expenses.

"No Balance Billing" is a key benefit of using a BCBSMT participating provider. Participating providers accept the BCBSMT allowable fee, plus any deductible and coinsurance, as payment in full for the services they provide.

BCBSMT pays nonparticipating providers 20% less than allowed for their services. Nonparticipating providers can bill you directly for the difference between the BCBSMT payment and their total charge, including your deductible and coinsurance. Consequently, your out-of-pocket expenses may be significantly higher. **For the most current list of participating providers, go to [www.bcbsmt.com](http://www.bcbsmt.com).**

### Eligibility—Immediate Coverage for You and Your Dependents

To be eligible, you must: be a Montana resident under age 65; complete the Short-Term Blue application; and not be eligible for, or enrolled in, another health care plan (regardless of the carrier) at the time the Short-Term Blue policy becomes effective.

After your application is approved, coverage becomes effective at 12:01 a.m. MST on the date you requested, or at 12:01 a.m. on the day after your application is received by BCBSMT—whichever is later.

## Short-Term Blue Application Form



REQUESTED EFFECTIVE DATE \_\_\_\_\_

APPLICANT'S NAME (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBER *
MAILING ADDRESS		CITY, STATE, ZIP CODE	
SPOUSE'S NAME (if to be covered) (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBERS *
CHILDREN (if to be covered) NAME (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBER *
1.			
2.			
3.			
4.			
5.			
6.			

\*Your SSN may be included in your subscriber identification number

### BENEFIT PERIOD

Indicate number of days applying for 30-183 Days \_\_\_\_\_

**Deductible Amount**  \$500  \$1,000  \$2,500

**Copayment Amount**  50/50  80/20

### Answer the following questions completely and accurately.

Please do not provide any information regarding any genetic tests you or any family member has taken, the results of such tests, or any family medical history (other than medical history requested in this application) that may indicate genetic predisposition to any disease or disorder.

(If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.)

- Do you or any person to be covered have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage or is any person expected to become eligible for medical coverage prior to the expiration of this coverage?
- With regard to you or any person to be covered, is there reason to believe anyone is an expectant mother or father through birth or adoption?
- Within the last ten years has any person to be covered sought treatment or medical advice for heart problems; stroke; diabetes; cancer or tumor; immune system disorder including HIV or AIDS; alcohol or drug use; nervous system disorder, including multiple sclerosis; or hepatitis C?
- Has any person to be covered been recommended to receive any medical treatment, diagnostic studies or follow-up that has not been performed?
- Has any person to be covered been declined for health coverage within the last three years?

I/We hereby apply for coverage with Blue Cross and Blue Shield of Montana. I/We certify and understand the following:

- I/We am/are resident(s) of Montana.
- I/We personally completed the medical questions on this form, filling in all requested information.
- The responses and information I/We have provided in this application and are complete, accurate and current. I/We understand that even if BCBSMT has accepted any dues or premium payment, BCBSMT may decline to issue coverage or may cancel any coverage issued from its beginning based upon any misrepresentation, omission, concealment of facts, or incorrect statement: (a) that is fraudulent; (b) that is material to the acceptance of the risk assumed by BCBSMT; or (c) with respect to which, had the true facts been made known to BCBSMT, BCBSMT would not have issued any policy, would not have issued the particular policy, would have issued a policy only with one or more elimination riders, or would have issued a policy with a different dues or premium amount.
- All of the statements made are true and complete for me and for each person applying for coverage.
- This is an application only. No right is conferred to me or any person listed on this application until Blue Cross and Blue Shield of Montana accepts me/us and dues are paid and processed.
- I/We understand preexisting conditions are excluded.
- I/We understand creditable coverage will not apply to this policy.
- I/We, the undersigned, am/are applying for membership with Blue Cross and Blue Shield of Montana. I/We agree to the terms and conditions of any contract issued to me/us by Blue Cross and Blue Shield of Montana.
- I/We understand that Blue Cross and Blue Shield of Montana maintains contracts with certain providers of medical services. I/We understand Blue Cross and Blue Shield of Montana will directly pay those providers and any other provider it chooses.
- I/We have received the Notice of Privacy Practices.

### Signatures (DO NOT PRINT)

### Signature Date

Applicant	Applicant Telephone Number	MM	DD	YY
Spouse	Dependent (18 and over)			
Dependent (18 and over)	Dependent (18 and over)			
Dependent (18 and over)				

Representative Name: \_\_\_\_\_ Representative Number: \_\_\_\_\_