

Fair Treatment Notice

SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

- > Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- > Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** (TTY Users: 711)

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'de'ę', t'áá jiik'eh, éí ná hółq', kojí' hódíílnih SelectHealth: **1-800-538-5038**.

ध्यान दनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमितिभाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

تدعاسملا تامدخ نإف، ةيبرعلا ثدحتت تنك اذا: ةظوحلم
ةكشرشب ل لصتا. ن اجملاب كل رفاوتت ةيوعلل
SelectHealth: **1-800-538-5038**.

សម្ពាសៈ បីសិនជាអ្នកនិយាយ ភាសាខ្មែរ
ស្រីវ៉ាជំនួយជូនកុំភាសា ជាយមិនគិតថ្លៃ
គម្រោងមានសរាប់ អ្នកក៏ សូមទូរស័ព្ទមក
SelectHealth: **1-800-538-5038** ។

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**。まで、お電話にてご連絡ください。

Individual Plans Utah Supplemental Application Form

Applicant's Name _____ Applicant's Social Security # OR Date of Birth _____
(internal use only)

A. MEDICAL PLAN INFORMATION

Select a network, then select one of the following plans, including any associated benefit options.

Network Options SelectHealth Value SelectHealth Med

For more information, visit selecthealth.org/individualplans.

SELECTHEALTH[®] PLANS

PLANS WITH NO DEDUCTIBLE FOR ONE URGENT CARE AND ALL PRIMARY CARE PROVIDER (PCP) AND MENTAL HEALTH (MH) OFFICE VISITS
The deductible is waived for one urgent care and all PCP/MH office visits per year. Each visit is subject to a copay only.

- Expanded Bronze 7800 – \$7,800 Medical Deductible (\$1,500 Rx Deductible)
- Expanded Bronze 4800 Copay Plan – \$4,800 Medical Deductible (\$2,500 Rx Deductible)

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS

The deductible is waived (only the copay applies) for all office visits.

- Expanded Bronze 8150 – \$8,150 Medical and Rx Deductible Combined
- Silver 4000 Copay Plan – \$4,000 Medical Deductible (\$2,500 Rx Deductible)
- Silver 3000 – \$3,000 Medical Deductible (\$1,000 Rx Deductible)
- Silver 3100 (Off-Exchange Only) – \$3,100 Medical Deductible (\$1,000 Rx Deductible)
- Gold 1500 – \$1,500 Medical Deductible (\$250 Rx Deductible)

TRADITIONAL DEDUCTIBLE PLAN

The deductible applies to all covered care except preventive care, which is covered no charge for all plans.

- Silver 2300 – \$2,300 Medical Deductible (\$1,000 Rx Deductible)

BENCHMARK PLANS

The deductible applies to all covered care except preventive care and these plans only cover the Essential Health Benefits required by the Affordable Care Act.

- Benchmark Bronze 8150 – \$8,150 Medical and Rx Deductible Combined
- Benchmark Bronze 6800 – \$6,800 Medical Deductible (\$1,000 Rx Deductible)
- Benchmark Expanded Bronze 3600 – \$3,600 Medical Deductible (\$1,000 Rx Deductible)
- Benchmark Silver 6200 – \$6,200 Medical and Rx Deductible

SELECTHEALTH HEALTHSAVE[®]

HSA QUALIFIED*

The deductible applies to all covered care except preventive care.

- HealthSave Expanded Bronze 6850 (HSA Qualified) – Rewards – \$6,850 Medical and Rx Deductible Combined
- HealthSave Expanded Bronze 4000 (HSA Qualified) – \$4,000 Medical and Rx Deductible Combined
- HealthSave Silver 3250 (HSA Qualified) – \$3,250 Medical and Rx Deductible Combined

SelectHealth designed the HealthSaveSM plans to be in compliance with the requirements for a High-Deductible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code). However, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as an Health Savings Account (HSA)-eligible plan. SelectHealth is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

*HSA-qualified plans have a minimum deductible requirement. Some Cost-Share Reduction (CSR) plans do not meet that requirement.

HSA VENDOR

The SelectHealth preferred HSA vendor is HealthEquity[®]. An HSA will be established for you with HealthEquity if you choose an HDHP unless you opt out (see option below). An administrative fee is included in your premium whether or not you choose to use the preferred HSA vendor. As with most HSA vendors, a nominal fee will be charged if you choose to terminate the account once it has been established.

HealthEquity HSA Opt Out

- I do not plan to open an HSA or I plan to use another administrator.

CATASTROPHIC PLAN

Catastrophic plans are available for those who are under age 30 or those who qualify for a hardship exemption.

Deductible waived for first three PCP, Intermountain KidsCareSM, and/or mental health office visits combined per person per calendar year.

- Catastrophic 8150 – \$8,150 Medical and Rx Deductible Combined

B. SELECTHEALTH DENTAL[®] PLAN INFORMATION

TRADITIONAL PLANS

Select network, then select from one of the following plan options below.

Network Options Classic Prime* Fundamental*

Add out-of-network benefits

Select one plan option. Includes a \$50/\$150 dental deductible

- \$750 Annual Maximum \$1,000 Annual Maximum \$1,500 Annual Maximum

Please select either 100% or 90% for preventive care coverage

- 100% 90%

A dental policy provides dental benefits only. Review your policy carefully.

*Available only in Salt Lake, Davis, Weber, and Utah counties.

Individual Plans Payment Selection Form

Applicant's Name _____ Applicant's Social Security# OR Date of Birth _____
(internal use only)

A. PAYMENT SELECTION

Please select a method of payment for your monthly premium. SelectHealth® will accept third-party premium payments only when required by state or federal law. Please submit only personal account information.

- Preauthorized Banking Withdrawal Online Billing and Payment
(Complete Section "B.") (Complete Section "C.")

B. PREAUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for your monthly premium, your payment will be deducted automatically from your checking/savings account each month. Please complete the information below.

I authorize SelectHealth to initiate withdrawals from my Checking Account Savings Account

Account Holder's Name _____ Account# _____

Financial Institution _____ Routing & Transit# _____

I understand that debit withdrawals will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a \$25.00 service charge may be applied if the premium amount cannot be deducted from my account for any reason.

Account Holder's Signature _____ Date _____

PREAUTHORIZED BANKING WITHDRAWAL

Attach a Voided Check Here

Do not use a checking deposit slip for checking withdrawal.
 Checking deposit slips do not always contain the necessary routing and transit information.

Check#	Routing & Transit#	Account#
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00 1099	1 2400494 1	1839401923

C. ONLINE BILLING AND PAYMENT

Once you receive notification that your application has been approved, please call us at 800-442-0220 to make your first month's payment. After your first payment, all future monthly statements will be sent via email. The statement emails will direct you to a website where you can pay online with a debit or credit card. Premium payments are due on the first of day of each month.

Application Checklist

BEFORE YOU SUBMIT YOUR APPLICATION
FORMS, REMEMBER TO:

- Complete and sign the Utah Individual Health Insurance Application Form
- Complete the Utah Individual Plans Supplemental Application Form
- Sign the Payment Selection Form
- OR visit us at selecthealth.org to apply online

SEP Addendum

Applicant's Name _____

Applicant's Social Security OR Date of Birth _____

Are you: A new applicant? Adding dependents? Changing an existing plan?

If you are enrolling outside of annual open enrollment or adding dependents, what is the reason? (documentation may be required)

- Loss of health plan coverage
- Loss of health plan coverage as result of a divorce
- Permanent move providing access to a new health plan
- Birth or adoption
- Marriage
- Court order
- Loss of Medicaid or CHIP eligibility
- Loss of cost-sharing eligibility tax credit
- Other _____

Date of Event _____

Will this coverage be replacing an existing Individual policy with SelectHealth? Yes No

If yes, enter policy number _____

eSignature _____ Date _____