Fair Treatment Notice

SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

> Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).

> Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call SelectHealth Member Services at **800-538-5038** or SelectHealth Advantage Member Services at **855-442-9900** (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.

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。

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

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth. 번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'd ,''ę'ęt'áá jiik'eh, éí ná hólǫ ,'kojį' hódíílnih SelectHealth.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth.

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. まで、お電話にてご連絡ください。

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። SelectHealth ን ያናግሩ።

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте SelectHealth.

تنبيه: إذا كنت تتحدث عربى، فستتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بـ SelectHealth.

توجه: اگر به زبان را وارد کنی صحبت می‌کنید، خدمات کمک زبانی، بصورت رایگان در اختیار شماست. با SelectHealth تماس بگیرید.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ SelectHealth

SelectHealth: 1-800-538-5038
SelectHealth Advantage: 1-855-442-9900

selecthealth.

SelectHealth, Inc.
P.O. Box 30192
Salt Lake City, UT 84130-0192
855-442-0220
selecthealth.org

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Individual Plans Utah Supplemental Application Form

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

Cell Phone #*_____

A. DEMOGRAPHICS

Cell Phone #* _____

Preferred (non-English) Language** ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Navajo ☐ Nepali ☐ Tongan ☐ Serbo-Croatian ☐ Tagalog ☐ German ☐ Russian ☐ Arabic ☐ French ☐ Japanese ☐ Mon-Khmer, Cambodian ☐ Other _____

Race ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Citizenship ☐ United States Citizen ☐ Lawful Permanent Resident ☐ Temporary Visitor ☐ Undocumented Immigrant

* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels
** By notifyiing us of your preferred language, we are not agreeing to send your materials in that language (for translation asistance, please call Member Services 800-538-5038)

B. MEDICAL PLAN INFORMATION

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

Network Options ☐ SelectHealth Value ☐ SelectHealth Med ☐ SelectHealth Signature

For more information, visit selecthealth.org/individualplans.

SELECTHEALTH® PLANS

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS

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

☐ Expanded Bronze 6900 – $6,900 Medical Deductible ($1,500 Rx Deductible)*

☐ Expanded Bronze 5900 Copay Plan – $5,900 Medical Deductible ($2,500 Rx Deductible)

☐ Silver 5500 (Off-Exchange Only) – $5,500 Medical Deductible ($1,500 Rx Deductible)

☐ Gold 1500 – $1,500 Medical Deductible ($250 Rx Deductible)*

☐ Benchmark Silver 6300 – $6,300 Medical Deductible ($1,300 Rx Deductible)*

☐ Silver 6500 Diabetes Support Plan - $6,500 Medical Deductible ($2,000 Rx Deductible)*

TRADITIONAL DEDUCTIBLE PLAN

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

☐ Silver 3000 – $3,000 Medical Deductible ($1,000 Rx Deductible)*

PLANS WITH COMBINE PHARMACY AND MEDICAL DEDUCTIBLE

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

☐ Benchmark Bronze 9100 – $9,100 Medical and Rx Deductible Combined*

PLANS WITH $0 DEDUCTIBLES

☐ Benchmark Silver 0 Copay Plan – $0 Medical Deductible ($3,500 Rx Deductible)*

☐ Benchmark Expanded Bronze 0 Copay plan – $0 Medical Deductible ($3,500 Rx Deductible)

☐ Benchmark Platinum 0 - $0 Medical Deductible ($0 Rx Deductible)*

☐ Benchmark Gold 0 - $0 Medical Deductible (250 Rx Deductible)*

SELECTHEALTH HSA QUALIFIED

The deductible applies to all covered care except preventive care.

☐ Expanded Bronze 7500 (HSA Qualified) – $7,500 Medical and Rx Deductible Combined

☐ Benchmark Silver 3750 (HAS Qualified) – $3750 Medical and Rx Deductible Combined (off exchange only)*

SelectHealth designed the HSA-eligible 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.

* Can be paired with the Signature Network

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

STANDARDIZED PLANS

- ☐ Benchmark Silver 0 Standardized Plan – $5800 Combined Medical and Pharmacy Deductible
- ☐ Benchmark Expanded Bronze Standardized Plan – $7500 Combined Medical and Pharmacy Deductible
- ☐ Benchmark Platinum Standardized Plan - $0 Combined Medical and Pharmacy Deductible
- ☐ Benchmark Gold Standardized Plan - $2000 Combined Medical and Pharmacy Deductible

C. SELECTHEALTH DENTAL® PLAN INFORMATION

TRADITIONAL PLANS

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

Network Options ☐ *Classic* ☐ *Prime** ☐ *Fundamental**

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

☐ *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% (only available for the $1,500 Annual Maximum plan)*

Individual Plans Payment Selection Form

Applicant's Name _____ Applicant's Social Security# OR Date of Birth _____

(internal use only)

D. 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**
(Complete Section "B.")

☐ **Online Billing and Payment**
(Complete Section "C.")

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E. 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# _____

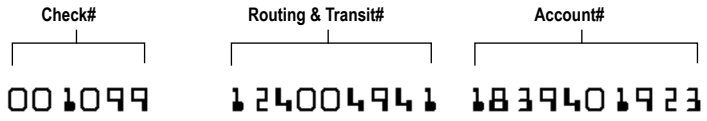
I understand that debit withdrawals will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a **$25.00 service charge** *may be applied if the premium amount cannot be deducted from my account for any reason.*

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.



F. 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

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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** _____