



Individual Plans Idaho Supplemental Application Form

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

Is this policy intended to replace any other accident and healthcare insurance presently in force? Yes No (internal use only)

Are you self-employed?

Is your employer reimbursing or paying for any portion of this policy?

If yes, are contributions made through a qualified Health Reimbursement Arrangement (HRA)? Are you self-employed?

DEMOGRAPHICS

Cell Phone #* _____ Email Address _____

Preferred Language** English 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 (for internal informational purposes only)

* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels

** By notifying us of your preferred language, we are not agreeing to send your materials in that language (for translation assistance, please call Member Services 800-538-5038)

PLAN OPTIONS

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

Network Options Select Health St. Luke's Health Patners (SLHP) Select Health BrightPath
 Select Health Saint Alphonsus Health Alliance (SAHA) Select Health Med

SELECT HEALTH® PLANS

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS

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

- Silver 4500** – \$4,500 Medical Deductible (\$2,500 Rx Deductible)
- Gold 1500** – \$1,500 Medical Deductible (\$400 Rx Deductible)
- Silver 3000** – \$3,000 Medical Deductible (\$1,500 Rx Deductible)
- Silver 4000** – \$4,000 Medical Deductible (\$1,500 Rx Deductible)
- Expanded Bronze 9200** – \$9,200 Medical and Rx Deductible Combined
- Expanded Bronze 6000** – \$6,000 Medical Deductible (\$2,000 Rx Deductible)
- Gold 1000** – \$1,000 Medical Deductible (\$500 Rx Deductible)

\$0 DEDUCTIBLE COPAY PLANS

- Silver Copay Plan** – \$0 Medical Deductible (\$3,500 Rx Deductible)

TRADITIONAL DEDUCTIBLE PLANS

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

- Bronze 8000** – \$8,000 Medical Deductible (\$1,700 Rx Deductible)
- Expanded Bronze 4500** – \$4,500 Medical Deductible (\$1,700 Rx Deductible)

SELECT HEALTH HEALTHSAVE®

HSA-QUALIFIED PLANS*

The deductible applies to all covered care except preventive care

- Expanded Bronze 7900 (HSA Qualified)** – \$7,900 Medical Deductible and Rx Deductible Combined

Select Health 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, Select Health makes no representations or warranties about the legal adequacy of this coverage as a Health Savings Account (HSA)-compatible plan. Select Health 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 Select Health 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 regardless of whether 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.**

PEDIATRIC DENTAL DISCLOSURE

The policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent or Your Health Idaho if you wish to purchase a stand-alone dental care product.

Application Checkoff List

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

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

Once you receive notification that your application has been approved, please call us at 855-442-0220 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.

- Your employer cannot pay any portion of your premium either directly or through reimbursement unless contributions are made through a qualified Health Reimbursement Arrangement (HRA)
- Select Health will only accept third-party premium payments when required by state or federal law

SEP Addendum

Applicant's Name _____

Applicant's Social Security OR Date of Birth _____

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

Are you enrolling: During the annual open enrollment period? Outside of annual open enrollment period?

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 Select Health? Yes No

If yes, enter policy number _____

eSignature _____ Date _____