INTRODUCTION Thank you for considering SelectHealth℠. This packet has been designed to help you choose the individual health plan coverage that's right for you.

Please read all of the materials carefully and follow the Enrollment Guidelines summarized on the next page before submitting your application to us.

We realize that choosing health plan coverage can seem difficult. We want to help make the process as easy as possible. If you have any questions about the information in this packet, please call us at 801-442-6293 (Salt Lake area) or 800-442-3125 (option 1). You may also contact your SelectHealth-appointed insurance agent. If you need help finding an agent, give us a call.

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Enrollment Guidelines

Following these guidelines will help make it easier for you to select and apply for your individual plan.

REVIEW

Carefully review all of the materials in this packet. Your agent can provide you with additional information regarding these plans, help you determine which plan and options are best for your particular needs, and assist you with the enrollment process. **However, your agent does not have the authority to waive any enrollment requirements or to approve or modify any coverage.** To help you better understand your coverage, a Glossary of Terms is provided on page 36.

SELECT YOUR PLAN AND BENEFIT OPTIONS

The following selections must be made as you enroll for coverage:

- Plan option – HMO/Plus product or HealthSave℠ product
- Provider network – Select Value℠, Select Med Plus℠, or Select Care Plus℠

Before submitting your application, make sure you have completed the "Plan Information" section on the Individual Plans Application Form.

COMPLETE AND SIGN YOUR APPLICATION

The application must be completed and signed by the oldest family member. Your spouse's signature is also required if he or she is applying for coverage.

When completing the application, please read and answer each question or section. Incomplete applications will delay the approval process.

CALCULATE YOUR PREMIUM

Calculate your first month's premium. Refer to the appropriate Premium Calculation Worksheet and Premium Rates. Premiums are based on the age of the applicant (oldest family member applying for coverage).

SELECT YOUR METHOD OF PAYMENT

There are two methods you can choose from to submit your monthly premium: 1) the preauthorized banking withdrawal method, which automatically withdraws the premium from your checking account; or 2) the electronic billing and payment method where you receive your monthly statement by e-mail and make your payment by electronic check or credit card. Make your payment selection by completing the Payment Selection Form attached to the application.

NOTE: *Please keep the Payment Selection Form attached to your application when you submit it to your agent or SelectHealth.*

MAIL

Send the following forms to your agent or mail them to us at the address listed below:

SelectHealth
Individual Plans Dept., N1-765
P.O. Box 30192
Salt Lake City, UT 84130-0192

1. **Completed Application**
2. **Certificate(s) of Creditable Coverage**
   This certificate is provided by your previous health insurance carrier and must be submitted to receive credit for you and your family members' pre-existing condition waiting period. This is not necessary if you are currently covered with SelectHealth.
3. **Completed Payment Selection Form**
   If you have selected the preauthorized banking withdrawal method, be sure to include a voided check or savings account information. You do not need to submit the first month's premium with the application. All premiums will be drafted from your authorized bank account upon approval of your application. If you have selected the electronic billing and payment method, be sure to include your credit card information or a personal check made payable to SelectHealth for your first month's premium.

Your employer cannot pay any portion of your premium either directly or through reimbursement. Please submit personal checks or personal credit card information only.

IMPORTANT NOTE: *Coverage is not in effect until your application is approved and an effective date is determined by SelectHealth. We strongly suggest that you carefully consider the impact of changing coverage, and do not cancel any current coverage until you are officially notified by us of approval. We reserve the right to decline coverage for any individual. Payment does not guarantee acceptance of coverage. If your application is declined for coverage, your original check will be promptly returned to you.*

Plan and Network Options

When selecting individual plan coverage, you have a choice of plan products and provider networks. We want to help you understand your options.

PLAN OPTIONS

We offer two plan designs for individuals: 1) Standard HMO/Plus products; and 2) a High Deductible Health Plan (HDHP) called HealthSave, which is designed to be used with a Health Savings Account (HSA). Both plan designs use the same provider and facility networks and cover the same medical services. However, there are important differences between the two products and they are outlined below.

HMO/PLUS

- Deductible options start as low as $250.
- You can select from additional copay and coinsurance options.
- Maternity and adoption services are covered after a separate $5,000 deductible.
- Additional benefit levels are available, which allows you the option to waive the deductible for office visits and prescription drugs.

For more information on HMO/Plus plans, please see page 5.

HEALTHSAVE

- Deductible options start at $1,500 for single coverage and $3,000 for family coverage.
- One deductible applies to all family members; the entire family deductible must be met before benefits are paid.
- One deductible applies to all covered medical, Rx, and mental health services.
- Higher deductible amounts allow you to save premium dollars.
- These products are designed to use with an HSA, so you can save tax-free money for qualified medical expenses.

For more information on HealthSave plans, please see page 14.

PROVIDER NETWORK OPTIONS

You may choose from one of three provider networks based on your ZIP code. Select the network that best meets the healthcare needs of you and your family. Note that by selecting a larger provider network, you will pay a higher monthly premium.

HMO plans such as Select Value require the use of participating providers (unless there is an emergency). A participating provider is a provider or facility that is contracted under a SelectHealth network.

Select Med Plus and Select Care Plus are HMO plans with a point-of-service feature. This means that you may use both participating and nonparticipating providers (i.e., go out of network) for most services. Coverage is different for nonparticipating services. Please refer to the HMO/Plus Benefit Summary on page 6 for detailed benefit information.

TURN THE PAGE *for our* NETWORK OPTIONS

PROVIDER NETWORK OPTIONS

select:value.

19 PARTICIPATING HOSPITALS

1,000+ PARTICIPATING PHYSICIANS

COUNTIES:
Davis, Salt Lake, Weber, and parts of Summit and Utah

EXCLUDED ZIP CODES WITHIN THE ABOVE COUNTIES:

84017	84024	84033	84036
84055	84061	84013	84626
84633	84651	84653	84655
84660			

select:med+

28 PARTICIPATING HOSPITALS

2,700+ PARTICIPATING PHYSICIANS

COUNTIES:
Cache, Davis, Duchesne, Iron, Juab, Millard, Morgan, Salt Lake, Sanpete, Sevier, Summit, Utah, Wasatch, Washington, Weber, and parts of Box Elder, Garfield, Piute, Tooele, Uintah, and Wayne

EXCLUDED ZIP CODES WITHIN THE ABOVE COUNTIES:

84008	84034	84035	84078
84079	84083	84313	84329
84712	84716	84717	84718
84723	84726	84734	84736
84759	84764	84776	

select:care+

34 PARTICIPATING HOSPITALS

3,500+ PARTICIPATING PHYSICIANS

COUNTIES:
Beaver, Cache, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Uintah, Utah, Wasatch, Washington, Wayne, Weber, and parts of Box Elder and Tooele

EXCLUDED ZIP CODES WITHIN THE ABOVE COUNTIES:
84034 84083 84313 84329

ACCESS

COST

Selecting an HMO/Plus Plan

Follow these simple steps to create the HMO/Plus plan that's right for you:

STEP 1. SELECT YOUR PROVIDER NETWORK *(see page 4 for detailed descriptions)*

select:value.

select:med+

select:care+

NOTE:

If you choose the Select Med or Select Care networks, your plan automatically has a point-of-service feature otherwise known as a 'Plus' plan. This means you can use both participating and nonparticipating providers. Please refer to the Benefit Summary on the following page for benefit details.

STEP 2. SELECT YOUR PLAN LEVEL

Base-Level Plan: The medical and Rx deductible applies to all services. Available medical deductibles under this option are $250, $500, $1,000, and $2,500. Each medical deductible has a separate Rx deductible.

Mid-Level Plan: The mid-level plan offers the same coverage as the base-level plan with one enhancement: the deductible waiver option. This means the medical deductible is waived for participating provider office visits, Intermountain InstaCare℠/urgent care visits, Intermountain KidsCare℠ vists, or Intermountain ExpressCare℠ visits. Available medical deductibles under this option are $250 and $500. Each medical deductible has a separate Rx deductible.

High-Level Plan: The high-level plan includes the medical deductible waiver as well as Rx deductible waiver. Available medical deductibles under this option are $250, $500, and $1,000.

STEP 3. SELECT YOUR ANNUAL DEDUCTIBLES AND CORRESPONDING OUT-OF-POCKET MAXIMUMS

Deductibles are based on a calendar year. The deductible applies to all services before any copay or coinsurance applies, unless you select a mid- or high-level plan. Be sure that the deductible you select is listed as available for your benefit level. Out-of-pocket maximums include your annual deductible amount.

$250 deductible (available with base-, mid- or high-level plans)
$500 deductible (available with base-, mid- or high-level plans)
$1,000 deductible (available with base- or high-level plans)
$2,500 deductible (available with base-level plan)

STEP 4. SELECT YOUR COINSURANCE/COPAY AMOUNT

20% coinsurance, $15/$25 copay
30% coinsurance, $25/$35 copay

STEP 5. CALCULATE YOUR PREMIUM

Now that you have created your plan, use the HMO Premium Calculation Worksheet on page 7 to calculate your monthly premium. Begin by turning to the rate page listing the coinsurance option and plan level you have selected. Next, refer to your provider network and deductible. Your rate will be based on the age of the applicant (oldest family member applying for coverage) and your coverage tier (single, two-party, or family).

HMO/Plus Benefit Summary

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary that you will receive upon approval of your application for detailed benefit information.

	PARTICIPATING BENEFITS *HMO & Plus plans*				NONPARTICIPATING BENEFITS *Plus plans only*		
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM OPTIONS	**Medical Deductible Single/Family**	**Medical Out-of-Pocket Single/Family**	**Rx Deductible Single**	**Rx Out-of-Pocket Single**	**Medical Deductible Single/Family**	**Medical Out-of-Pocket Single/Family**	**Rx Deductible & Out-of-Pocket Single**
Deductible included in the out-of-pocket maximum	$250/$750	$2,500/$5,000	$100[2]	$4,000	$500/$1,500	$4,500/$9,000	See "Participating Benefits"
	$500/$1,000	$3,000/$6,000	$200[2]	$4,000	$750/$2,250	$5,000/$10,000	See "Participating Benefits"
	$1,000/$2,500	$3,500/$7,000	$400[2]	$4,000	$1,500/$3,500	$5,500/$11,000	See "Participating Benefits"
	$2,500/$5,000	$4,000/$8,000	$1,000[2]	$4,000	$3,000/$6,000	$6,000/$12,000	See "Participating Benefits"

COINSURANCE AND COPAY OPTIONS		
80/20 Coinsurance Option		
Coinsurance (e.g., inpatient, outpatient)[4]	20% after deductible	40% after deductible
Office Visit (PCP/SCP)[3]	$15/$25 after deductible[1]	40% after deductible
Participating Emergency Room Visit	$100 after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	$200 after deductible	See "Participating Benefits"
70/30 Coinsurance Option		
Coinsurance (e.g., inpatient, outpatient)[4]	30% after deductible	50% after deductible
Office Visit (PCP/SCP)[3]	$25/$35 after deductible[1]	50% after deductible
Participating Emergency Room Visit	$125 after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	$250 after deductible	See "Participating Benefits"
STANDARD BENEFITS		
Lifetime Maximum Plan Payment	$2,500,000	$1,000,000
Maximum Annual Out-of-Network Payment	N/A	$500,000
Pre-Existing Conditions		
Waived (entirely or partly) for qualifying pre-existing condition credit	Not covered for first 12 months	Not covered for first 12 months
Professional Services		
Adult and Pediatric Immunizations	Covered 100%	Not covered
Elective Immunizations	Participating coinsurance	Not covered
Outpatient Services		
Intermountain InstaCare℠/Urgent Care	SCP copay amount, after deductible[1]	Nonparticipating coinsurance, after deductible
Intermountain KidsCare℠	PCP copay amount, after deductible[1]	Not applicable
Intermountain ExpressCare℠	PCP copay amount, after deductible[1]	Not applicable
Diagnostic Tests, Minor	Covered 100%, after deductible[1]	Nonparticipating coinsurance, after deductible
Diagnostic Tests, Major	Participating coinsurance, after deductible	Nonparticipating coinsurance, after deductible
Physical, Speech, and Occupational Therapy 20 visits per calendar year	SCP copay amount, after deductible	Nonparticipating coinsurance, after deductible
Mental Health and Chemical Dependency		
Not applied to the out-of-pocket maximum Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	50% after deductible	50% after deductible
Supplemental Accident (per person/calendar year)	First $1,000 covered at 100%	
Miscellaneous Services		
Maternity and Adoption (not applied to out-of-pocket)	Covered at 100%, after $5,000 calendar year maternity deductible	Not covered
Infertility (limited to $1500/calendar year; $5,000/lifetime)	50% after deductible	Not covered
Chiropractic	Not covered	Not covered
Prescription Drugs		
Up to a 30-day supply for covered medications; generic substitution required; same benefit applies to 90-day maintenance home delivery	Tier 1: $10 after Rx deductible[2] Tier 2: 25% after Rx deductible[2] Tier 3: 50% after Rx deductible[2]	Tier 1: $10 after Rx deductible[2] Tier 2: 25% after Rx deductible[2] Tier 3: 50% after Rx deductible[2]

1. Medical deductible waived when you select a mid- or high-level plan.
2. Rx deductible also waived when you select a high-level plan.
3. PCP (Primary Care Provider); SCP (Secondary Care Provider).
4. Coinsurance applies to inpatient and outpatient services, ambulance, home health, durable medical equipment, injectable drugs, and allergy treatment.

HMO/Plus Premium Calculation Worksheet

STEP 1. MONTHLY PREMIUM OF PLAN AND OPTIONS SELECTED

(Write down the options you have selected as described on page 5)

Provider Network (Select Value, Select Med Plus, Select Care Plus) _____

Plan Level (base, mid, high) _____

Deductible (applicable to the plan level selected) _____

Coinsurance/Copay (80%/20%-$15/$25 or 70%/30%-$25/$35) _____

Based on your selections, turn to the applicable rate page and find the rate associated with the age of the applicant, which must be the oldest family member, and the tier (single, two-party, family) ENTER RATE ..... $ _____

+

STEP 2. FAMILY SIZE ADJUSTMENT

If your family size is seven to 11: add ten percent ENTER HERE ..... $ _____

Family sizes 12+: determined by underwriting

=

STEP 3. TOTAL MONTHLY PREMIUM AMOUNT

If you choose the electronic billing payment method, send a personal check in this amount for the first month's premium with your application ENTER AMOUNT HERE ..... $ _____

If you choose to pay with the preauthorized banking withdrawal method, you do not need to submit the first month's premium with your application. All premiums will be drafted from your authorized bank account upon approval of your coverage.

NOTE:

- Premium rates are based on the age of the applicant (oldest family member applying for coverage). The application must be written with the oldest family member as the applicant. Initial premium increases may be assessed based on underwriting review.
- Premiums under these plans are subject to adjustment each January 1 (if your original effective date is January 1 through June 30) or each July 1 (if your original effective date is July 1 through December 31).
- Premiums will increase on the first of the month following the birthday on which a subscriber moves from one age band to another. Refer to "Major Medical Outline of Coverage," "Premiums" section on page 29 for information on age bands.
- Premium rates are effective January 1, 2007. If you are age 65 or older and are not eligible for Medicare, contact us for premiums.

80%/20% Coinsurance Option HMO/Plus Base-Level Premium Rates

Deductible applies to all services first.

select:value.

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	82	147	216	73	130	191	66	118	173	58	104	152
20 - 24	87	167	232	77	147	205	70	133	186	61	117	164
25 - 29	100	189	288	89	168	255	80	152	230	71	134	203
30 - 34	115	217	350	101	192	310	92	173	280	81	153	247
35 - 39	124	221	400	110	195	354	99	176	320	87	155	282
40 - 44	142	260	468	126	230	414	114	208	374	100	183	330
45 - 49	165	309	529	146	273	468	132	247	423	116	218	373
50 - 54	189	367	559	167	324	494	151	293	447	133	258	394
55 - 59	226	450	610	200	398	540	180	360	488	159	317	430
60 - 64	275	556	711	243	492	629	220	445	569	194	392	501

select:med+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	89	160	235	79	142	208	71	128	188	63	113	165
20 - 24	94	181	252	84	160	223	76	145	202	67	128	178
25 - 29	109	206	313	96	182	277	87	165	251	77	145	221
30 - 34	125	236	381	110	208	337	100	188	304	88	166	268
35 - 39	135	240	435	119	212	385	108	192	348	95	169	307
40 - 44	154	282	509	137	250	450	123	226	407	109	199	359
45 - 49	179	336	574	158	297	508	143	268	460	126	237	405
50 - 54	206	398	607	182	353	537	164	319	486	145	281	428
55 - 59	245	489	663	217	433	587	196	391	530	173	345	467
60 - 64	298	604	773	264	535	684	239	483	618	210	426	545

select:care+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	98	176	258	87	156	228	79	141	206	69	124	182
20 - 24	104	199	277	92	176	245	83	159	222	73	140	196
25 - 29	120	227	344	106	201	305	96	181	276	85	160	243
30 - 34	137	259	419	121	229	370	110	207	335	97	183	295
35 - 39	148	264	479	131	233	424	118	211	383	104	186	337
40 - 44	170	310	559	150	275	495	136	248	448	120	219	394
45 - 49	197	369	632	174	327	559	157	295	506	139	260	446
50 - 54	226	438	668	200	388	591	181	351	534	159	309	471
55 - 59	270	538	729	239	476	645	216	430	583	190	379	514
60 - 64	328	665	850	291	588	753	263	532	680	231	469	600

80%/20% Coinsurance Option HMO/Plus Mid-Level Premium Rates

No deductible for office visits. Deductible applies to Rx.

select:value.

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	93	167	245	85	151	222
20 - 24	99	189	263	89	171	239
25 - 29	114	215	327	103	195	296
30 - 34	130	246	397	118	223	360
35 - 39	140	250	454	127	227	412
40 - 44	161	295	531	146	267	482
45 - 49	187	350	600	169	318	544
50 - 54	215	416	634	195	377	575
55 - 59	256	510	692	232	463	628
60 - 64	312	631	807	283	572	732

select:med+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	100	179	263	92	165	242
20 - 24	106	203	283	98	187	260
25 - 29	122	231	351	113	213	323
30 - 34	140	264	427	129	243	393
35 - 39	151	269	488	139	248	449
40 - 44	173	316	570	159	291	525
45 - 49	201	376	644	185	347	593
50 - 54	230	447	680	212	411	627
55 - 59	275	548	743	253	505	684
60 - 64	334	677	866	308	624	798

select:care+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	111	199	292	100	180	264
20 - 24	117	225	314	106	204	284
25 - 29	135	256	389	123	232	352
30 - 34	155	293	473	140	265	428
35 - 39	167	298	541	151	270	489
40 - 44	192	351	632	174	317	572
45 - 49	222	417	714	201	377	646
50 - 54	256	495	755	231	448	683
55 - 59	305	608	824	276	550	745
60 - 64	371	751	961	336	680	869

80%/20% Coinsurance Option HMO/Plus High-Level Premium Rates

No deductible for office visits. No deductible for Rx.

select:value.

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	104	187	274	95	169	248	89	159	233
20 - 24	110	211	294	100	192	267	94	180	250
25 - 29	127	240	365	115	218	332	108	205	311
30 - 34	145	275	444	132	249	403	124	234	378
35 - 39	157	280	508	142	254	461	134	238	432
40 - 44	180	329	593	163	299	539	153	280	505
45 - 49	209	391	670	189	355	608	178	333	571
50 - 54	240	465	708	218	422	643	204	396	603
55 - 59	286	570	773	260	518	702	244	486	659
60 - 64	348	705	902	316	640	819	296	600	768

select:med+

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	112	200	294	103	185	271	95	170	249
20 - 24	118	227	316	109	209	291	100	192	268
25 - 29	136	258	392	126	238	362	116	219	332
30 - 34	156	295	477	144	272	440	132	250	404
35 - 39	168	300	545	155	277	503	143	255	462
40 - 44	193	353	637	178	326	587	164	300	540
45 - 49	224	420	719	207	388	663	190	356	610
50 - 54	257	499	760	237	460	701	218	423	645
55 - 59	307	612	830	283	565	766	260	519	704
60 - 64	374	757	968	345	698	893	317	642	821

select:care+

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	124	222	326	112	201	295	104	187	274
20 - 24	131	252	350	119	228	317	110	211	295
25 - 29	151	286	435	137	259	394	127	241	366
30 - 34	173	327	529	157	296	479	146	275	445
35 - 39	187	333	605	169	302	547	157	280	508
40 - 44	214	392	707	194	355	640	180	330	594
45 - 49	249	466	798	225	422	723	209	392	671
50 - 54	286	554	844	259	501	764	240	465	709
55 - 59	341	680	921	308	615	834	286	571	774
60 - 64	415	840	1,074	375	760	972	349	706	903

70%/30% Coinsurance Option HMO/Plus Base-Level Premium Rates

Deductible applies to all services first.

select:value.

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	79	141	206	70	126	185	64	114	168	57	102	149
20 - 24	83	159	222	74	143	199	68	130	180	60	115	160
25 - 29	96	181	275	86	162	247	78	147	224	69	131	199
30 - 34	110	207	335	98	185	300	89	168	272	79	150	242
35 - 39	118	211	383	106	189	343	96	171	311	86	152	277
40 - 44	136	248	447	122	222	401	110	202	364	98	179	323
45 - 49	157	295	505	141	264	453	128	240	411	114	213	365
50 - 54	181	350	534	162	314	478	147	285	434	131	253	386
55 - 59	216	430	583	193	385	522	175	350	474	156	311	422
60 - 64	262	531	680	235	476	609	213	432	553	190	384	492

select:med+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	85	153	224	76	137	201	69	124	182	62	111	162
20 - 24	90	173	241	81	155	216	73	141	196	65	125	174
25 - 29	104	197	299	93	176	268	85	160	243	75	142	216
30 - 34	119	225	364	107	202	326	97	183	296	86	163	263
35 - 39	129	229	416	115	205	373	105	186	338	93	166	301
40 - 44	147	270	486	132	242	435	120	219	395	107	195	352
45 - 49	171	321	549	153	287	492	139	261	447	124	232	397
50 - 54	196	381	580	176	341	520	160	310	472	142	275	420
55 - 59	234	467	633	210	419	568	191	380	515	169	338	458
60 - 64	285	577	739	255	517	662	232	470	601	206	418	534

select:care+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX			$1,000 MEDICAL/$400 RX			$2,500 MEDICAL/$1,000 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	94	168	247	84	151	221	76	137	201	68	122	178
20 - 24	99	190	265	89	171	237	81	155	216	72	138	192
25 - 29	115	216	329	103	194	295	93	176	268	83	157	238
30 - 34	131	248	400	117	222	358	107	201	326	95	179	289
35 - 39	141	252	457	127	226	410	115	205	372	102	182	331
40 - 44	162	297	535	145	266	479	132	241	435	117	215	387
45 - 49	188	353	604	168	316	541	153	287	491	136	255	437
50 - 54	216	419	638	194	375	572	176	341	519	156	303	462
55 - 59	258	514	697	231	461	624	210	418	567	186	372	504
60 - 64	314	635	813	281	569	728	255	517	661	227	459	588

70%/30% Coinsurance Option HMO/Plus Mid-Level Premium Rates

No deductible for office visits. Deductible applies to Rx.

select:value.

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	88	158	232	80	143	210
20 - 24	93	179	249	85	162	226
25 - 29	108	203	309	98	184	280
30 - 34	123	232	376	112	211	341
35 - 39	133	237	430	120	215	390
40 - 44	152	279	502	138	253	455
45 - 49	177	331	567	160	300	514
50 - 54	203	393	599	184	357	544
55 - 59	242	483	654	219	438	593
60 - 64	295	596	763	267	541	692

select:med+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	95	170	249	87	156	229
20 - 24	100	192	267	92	177	246
25 - 29	115	218	332	106	201	306
30 - 34	132	250	403	122	230	372
35 - 39	143	254	461	131	234	425
40 - 44	164	299	539	151	276	497
45 - 49	190	356	609	175	328	561
50 - 54	218	422	643	201	389	593
55 - 59	260	518	702	239	478	647
60 - 64	316	640	819	291	590	755

select:care+

	$250 MEDICAL/$100 RX			$500 MEDICAL/$200 RX		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	105	188	276	95	170	249
20 - 24	111	213	296	100	193	268
25 - 29	128	242	368	116	219	333
30 - 34	147	277	447	133	250	405
35 - 39	158	282	512	143	255	463
40 - 44	181	332	598	164	300	541
45 - 49	210	395	675	190	357	611
50 - 54	242	468	714	219	424	646
55 - 59	288	575	779	261	520	705
60 - 64	351	710	909	317	643	822

70%/30% Coinsurance Option HMO/Plus High-Level Premium Rates

No deductible for office visits. No deductible for Rx.

select:value.

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	98	176	259	89	160	235	84	150	220
20 - 24	104	200	278	95	181	252	89	170	237
25 - 29	120	227	345	109	206	314	102	193	294
30 - 34	137	260	420	125	236	381	117	221	358
35 - 39	148	264	480	135	240	436	126	225	409
40 - 44	170	311	561	155	283	509	145	265	478
45 - 49	197	370	634	179	336	575	168	315	540
50 - 54	227	439	670	206	399	608	193	374	570
55 - 59	270	539	731	245	490	664	230	459	623
60 - 64	329	666	853	299	605	774	280	568	726

select:med+

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	106	189	278	98	175	256	90	161	236
20 - 24	112	214	299	103	198	275	95	182	253
25 - 29	129	244	371	119	225	342	109	207	314
30 - 34	148	279	451	136	257	416	125	236	382
35 - 39	159	284	515	147	262	475	135	241	437
40 - 44	183	334	602	169	308	555	155	283	511
45 - 49	212	397	680	195	367	627	180	337	577
50 - 54	243	472	719	224	435	663	206	400	610
55 - 59	290	579	785	268	534	724	246	491	666
60 - 64	353	715	915	326	660	844	300	607	776

select:care+

	$250 MEDICAL			$500 MEDICAL			$1,000 MEDICAL		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	117	210	308	106	190	279	99	177	259
20 - 24	124	238	331	112	215	300	104	200	278
25 - 29	143	271	411	130	245	372	120	227	346
30 - 34	164	309	500	148	280	453	138	260	420
35 - 39	177	315	572	160	285	518	149	265	481
40 - 44	203	371	668	184	336	605	170	312	562
45 - 49	235	441	755	213	399	683	198	371	634
50 - 54	270	523	798	244	474	722	227	440	671
55 - 59	322	643	871	292	582	789	271	540	732
60 - 64	392	794	1,016	355	719	920	330	667	854

4646 West Lake Park Boulevard
Salt Lake City, UT 84120-8212
1-801-442-5038 / 1-800-538-5038
www.selecthealth.org

selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

Individual Plans
Application Form

Please use ink and print legibly

I. APPLICANT INFORMATION (Must be oldest family member)

Last Name _____ First Name _____ Middle Initial _____
Mailing Address _____ Unit# _____ Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced
City _____ State _____ ZIP _____
Street Address (If different) _____
City _____ State _____ ZIP _____
Your Occupation _____ Your Spouse's Occupation _____
E-mail Address _____ Home Ph# ( ) _____ Work Ph# ( ) _____
Please check one of the following boxes: ❑ New Application ❑ Dependent Addition ❑ Re-apply
Payment Option: ❑ Preauthorized Banking Withdrawal ❑ Electronic Billing and Payment (See Payment Selection Form, p. 7)

II. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SOCIAL SECURITY# (FOR INTERNAL USE ONLY)	SEX	BIRTH DATE (MM/DD/YY)	AGE
Self		*			
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

*APPLICANT SOCIAL SECURITY# REQUIRED WHEN APPLYING FOR HEALTHSAVE PLAN

1. If you are **adding your spouse**, he or she may be deleted from your coverage only under the following circumstances:
   - When your spouse agrees to be deleted from coverage by signing an Individual Plans Change Form; or
   - When proof of a legal divorce or annulment is given (first and last page of the divorce decree and any page in between specifying coverage responsibilities for dependent children if you have elected family coverage).
2. To be eligible for coverage, **children must be under the age of 26, unmarried, and dependent upon you** for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

III. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefit purposes, indicate each individual who will **also be covered** by other medical insurance **while coverage with SelectHealth is in force.** Please do not complete this section if other coverage will be terminated once the SelectHealth coverage is in force.

RELATIONSHIP	NAME OF INDIVIDUALS COVERED BY OTHER INSURANCE	CARRIER NAME	CARRIER PH#	POLICY NUMBER	EFFECTIVE DATE

SELECTHEALTH USE ONLY

Class# _____ **Plan** _____ **Agent/Broker** _____ **Agent/Broker#** _____

Effective Date _____ **Rate Adjustment Percent** _____ **Monthly Payment $** _____

PEC Start Date _____ **PEC Credit** _____
Notes **HSA ❑ Yes ❑ No**

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

IV. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: NETWORK, PLAN OPTION, AND ASSOCIATED BENEFIT SECTION

Network	❑ Select Value℠	❑ Select Med Plus℠	❑ Select Care Plus℠	**Select one network**
Plan Option	❑ HMO/Plus Plan	❑ HealthSave℠		**Select one plan option and complete associated Benefit Section below**

HMO/PLUS BENEFIT SECTION

For HMO/Plus Plan option, complete this section

BENEFIT AND DEDUCTIBLE *Select one benefit level (Base, Mid, or High) and one deductible*

❑ **Base-Level Plan**

Deductible applies to all services first

- ❑ $250 Medical Deductible ($100 Rx Ded)
- ❑ $500 Medical Deductible ($200 Rx Ded)
- ❑ $1,000 Medical Deductible ($400 Rx Ded)
- ❑ $2,500 Medical Deductible ($1,000 Rx Ded)

❑ **Mid-Level Plan**

No deductible for office visits with deductible for Rx

- ❑ $250 Medical Deductible ($100 Rx Ded)
- ❑ $500 Medical Deductible ($200 Rx Ded)

❑ **High-Level Plan**

No deductible for office visits, no deductible for Rx

- ❑ $250 Medical Deductible
- ❑ $500 Medical Deductible
- ❑ $1,000 Medical Deductible

COINSURANCE/COPAY *Select one coinsurance/copay amount*

- ❑ 70%/30%—$25/$35
- ❑ 80%/20%—$15/$25

HEALTHSAVE BENEFIT SECTION

For HealthSave option, complete this section

DEDUCTIBLE *Select one deductible either under Single or Family (Deductible applies to all services **except preventive care**)*

❑ **Single (One person)**

- ❑ $1,500 Deductible (You pay 20% coinsurance after deductible)
- ❑ $2,700 Deductible (You pay 20% coinsurance after deductible)
- ❑ $5,000 Deductible (Covered 100% after deductible)

❑ **Family (Two or more)**

- ❑ $3,000 Deductible (You pay 20% coinsurance after deductible)
- ❑ $5,400 Deductible (You pay 20% coinsurance after deductible)
- ❑ $10,000 Deductible (Covered 100% after deductible)

SelectHealth has made a concerted effort to design the HealthSave coverage in compliance with the requirements for a High Deducible 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 HSA-compatible 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.

HEALTH SAVINGS ACCOUNT VENDOR

SelectHealth's preferred HSA vendor is HealthEquity®. A health savings account will automatically be established for you with HealthEquity, unless you choose to decline this option (see check box below). An administrative fee is included in your premium amount, regardless of whether you choose to use the preferred HSA vendor. As with most HSA vendors, a nominal fee will also be charged if you choose to terminate the account once it has been established.

❑ **I choose to decline the HSA account with HealthEquity**

selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

Authorization to Disclose Health Information to SelectHealth for Pre-Enrollment Underwriting Purposes

NOTICE: By signing this form, you give SelectHealth the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). SelectHealth typically gathers both paper and electronic records. This information helps SelectHealth make an educated decision about insuring you and your dependents.

I. AUTHORIZATION

I authorize any health plan and any healthcare provider (including any pharmacy) to disclose medical information about me to SelectHealth for purposes of determining my eligibility for health insurance coverage as requested in the application dated _____ . The medical information I authorize to be disclosed includes any medical information related to my insurability, except for any genetic test results about me or a blood relative of mine.*

*Utah law prohibits insurers from using genetic results for underwriting purposes.

II. INFORMATION FOR APPLICANT AND DEPENDENTS

I understand the following information:

1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in SelectHealth by sending my written request to SelectHealth; however, if I do so SelectHealth may refuse to enroll me;
2. A healthcare provider may not condition my treatment on signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. I understand that the information that SelectHealth receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information.
5. If SelectHealth does not enroll me, it may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law (if SelectHealth denies insurance coverage because of an individual's health condition, Utah law requires SelectHealth to tell the applicant specifically what this health condition is);
6. If SelectHealth does enroll me, it will only use information disclosed under this Authorization for purposes described in its notice of privacy practices;
7. Unless revoked, this Authorization will remain in effect for underwriting purposes until 60 calendar days from the date SelectHealth has approved or rejected my application.

III. IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT AND DEPENDENTS

Applicant	Date of Birth	Applicant signature*	Date Signed
Spouse	Date of Birth	Spouse signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a spouse and children over 18 years of age must sign for themselves.

V. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections VI and VII for each "Yes" (Y) answer.

1. Is anyone currently receiving medical treatment? ..... **Y** **N**

2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other healthcare provider within the past **THREE YEARS**? ..... **Y** **N**

3. Is any family member currently pregnant, or do they have reason to suspect they might be pregnant? ..... **Y** **N**

4. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? ..... **Y** **N**

5. Do you have any family members who are **not** applying for coverage? If yes, complete **(a)** below ..... **Y** **N**

a) List the reason(s) why any family members are <u>not</u> applying for coverage, and describe their health status and where they are currently covered.

6. Has anyone ever chewed or smoked tobacco? ..... **Y** **N**

7. Has anyone taken any medication, drugs, shots, or remedies in the past **TWELVE MONTHS**? If yes, complete Section VII. ..... **Y** **N**

8. Within the past **FIVE YEARS** has any proposed member:

a) Been advised to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s), **but has not done so**? ..... **Y** **N**

b) Been evaluated for fertility, is infertile, or had a miscarriage or complication(s) of pregnancy? ..... **Y** **N**

c) Had gallbladder problems, ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, or other digestive problems? ..... **Y** **N**

d) Had urinary problems or urinary incontinence? ..... **Y** **N**

e) Had irregular bleeding, abnormal Pap smears/test, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease, or any disorder of the reproductive system? ..... **Y** **N**

f) Had migraines, been unconscious, or had epilepsy, seizures, or convulsions? ..... **Y** **N**

g) Received any mental health counseling, psychotherapy, or had a mental or nervous disorder, depression, stress, or anxiety that required consultation or medication? ..... **Y** **N**

h) Had cysts, growths (except for warts), breast lumps, augmentation, or reduction? ..... **Y** **N**

i) Had a skin disorder that required medical attention? ..... **Y** **N**

j) Had a thyroid disorder or a disorder of the lymph nodes or lymph system? ..... **Y** **N**

k) Been treated for chest pain, high blood pressure, or high cholesterol? ..... **Y** **N**

l) Had any disorder of the eyes, ears, nose, or throat that required treatment? ..... **Y** **N**

m) Had any back, neck, or spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities? ..... **Y** **N**

n) Had a problem for which they **have not** sought medical advice or treatment? ..... **Y** **N**

9. Within the past **TEN YEARS,** has any proposed member:

a) Been hospitalized or had surgery? ..... **Y** **N**

b) Had hepatitis, colitis, a colectomy or ileostomy, rectal disease, spleen problems, jaundice, or other digestive problems? ..... **Y** **N**

c) Had gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement? ..... **Y** **N**

d) Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to, ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis? ..... **Y** **N**

e) Had any surgery or treatments for obesity, bulimia, anorexia, weight control, stomach stapling, or gastric bypass? ..... **Y** **N**

f) Had tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system? ..... **Y** **N**

g) Been treated for alcohol use or attended Alcoholics Anonymous® for their own alcohol consumption? ..... **Y** **N**

h) Been treated for drug dependency, abuse, or reaction? **Y** **N**

i) Been a user of any drug not prescribed, such as: opiates, stimulants, depressants, and/or hallucinogens? **Y** **N**

10. Has any proposed member **EVER** had any indication of, diagnosis of, or treatment for:

a) Any birth defect, developmental or learning disability, physical, neurological, neuromuscular, or mental impairment(s)? ..... **Y** **N**

b) Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders? ..... **Y** **N**

c) A kidney disorder, liver problems, cirrhosis, or pancreatic problems? ..... **Y** **N**

d) Cancer or tumors? ..... **Y** **N**

e) Diabetes? ..... **Y** **N**

f) Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder? ..... **Y** **N**

g) Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV), or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system? ..... **Y** **N**

h) Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem? ..... **Y** **N**

11. Has anyone been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)? ..... **Y** **N**

12. Does anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? ..... **Y** **N**

13. To your knowledge, has anyone been denied for other health or life insurance or been issued a modified or rated policy? ..... **Y** **N**

14. List the applicant's and the applicant's spouse's height and weight below. List weight as it is now and as it was **ONE YEAR** ago**.**

a) **Applicant's Height:** _____ ft. _____ in.
Applicant's Weight: _____ now; _____ one year ago

b) **Spouse's Height:** _____ ft. _____ in.
Spouse's Weight: _____ now; _____ one year ago

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

VI. ADDITIONAL INFORMATION

QUESTION#	FIRST NAME OF INDIVIDUAL	DIAGNOSIS OF ILLINESS, INJURY, TREATMENT, TESTING, OR MEDICAL ATTENTION	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PHONE# OF PHYSICIAN OR HOSPITAL

VII. PRESCRIPTION MEDICATION INFORMATION

FIRST NAME OF INDIVIDUAL	NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PHONE# OF PRESCRIBING PHYSICIAN

VIII. GENERAL INFORMATION

1. Is any employer reimbursing or paying for any portion of this plan? ..... Y N
2. Are you self-employed? ..... Y N
   2a. If self-employed, do you have any full- or part-time employees? ..... Y N
3. Does any listed proposed member live, reside, work, or attend school outside the state of Utah at any time during the year? ... Y N

Please explain "yes" answers to the above questions _____

IX. PRIOR COVERAGE INFORMATION

Have you had health insurance coverage within the past 63 days? ❑ **Yes** ❑ **No** **If "Yes," list carrier information below.**

If you answered "No," when was the last date you were insured? _____

Have you EVER been covered under SelectHealth (formerly IHC Health Plans)? ❑ **Yes** ❑ **No**

If "Yes," list Policy#: _____ **and Policyholder's Name:** _____

If you have had continuous health care coverage not separated by a break in coverage of 63 days or more, your Pre-Existing Condition Waiting Period limitation may be partially or completely waived. To determine if this applies to you, **you must enclose proof of prior coverage**. This could include the following: Certificate of Creditable Coverage from your previous carrier; an Explanation of Benefits (EOB) or other correspondence from a plan or issuer indicating coverage; pay stubs showing payroll deduction for health coverage; a health insurance ID Card; a certificate of coverage under a group health policy; records from medical care providers indicating health coverage; third-party statements verifying periods of coverage; any other relevant documents that evidence periods of health coverage; or a telephone call from the Plan or provider to the Plan verifying Creditable Coverage. **You must also provide the following information:**

Policyholder's Name _____ Name of Carrier _____

Policy Number _____ Effective Date _____ Termination Date _____

Carrier's Address _____ Carrier's Phone Number _____

If you were previously insured on a group plan, have you exhausted your COBRA rights? ❑ **Yes** ❑ **No** ❑ **Not Available**
(COBRA rights are your rights to continue coverage for 18 to 36 months after terminating employment.)
If "Yes," please list dates: Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? ❑ **Yes** ❑ **No** ❑ **Not Available**
(Utah mini-COBRA rights are your rights to continue group health coverage.)
If "Yes," please list dates: Date Started _____ Date Ended

Have you ever been or are you currently insured through the Utah Comprehensive Health Insurance Pool (HIPUtah)? ❑ **Yes** ❑ **No**
If "Yes," please list dates: Date Started _____ Date Ended _____

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in an automatic 12-month Pre-existing Condition Waiting Period.

X. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with SelectHealth. When incorporated with the Contract, this Application and the Member Payment Summary become part of the Contract. Once fully signed and executed, Plan and I agree to terms set forth in the Contract. In connection with both this Application and any Plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. Further, in dealing with SelectHealth, I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by SelectHealth, that no benefits will be provided for any services which begin before the coverage is effective, and that except as expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

Consent at enrollment. I understand that no agent or Plan representative is allowed to permit me to answer any question inaccurately, untruthful, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the Plan changes in the eligibility of any applicants who become members.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of healthcare providers whose services will be covered may be restricted by the Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Contract may be denied coverage. I understand the coverage for which I am applying may limit or exclude certain conditions and may exclude conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date, according to the pre-existing conditions limitation provisions of the Contract. I understand that this Application will become part of the Contract.

Notice to applicant regarding replacement of accident and sickness insurance. According to information furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by SelectHealth. Your new policy provides ten days within which you may decide without cost whether you desire to keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new plan.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present policy or plan.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical or health history.
4. Failure to include all material medical information on an application may provide a basis for the Plan to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this Application, including the health information on pages four and five of this Application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this Application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this Application, I agree to provide that additional information promptly to SelectHealth.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

XI. SIGNATURE OF APPLICANT AND SPOUSE

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

Signature

Please type your signature in the box below.	Please verify your signature by typing it again.	Date Signed.

Spouse's Signature

Please type your signature in the box below.	Please verify your signature by typing it again.	Date Signed.

(Required if applying for coverage)

XII. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant;
2. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of SelectHealth, or b) waive any of the terms of conditions of the Contract.
4. I have no authority to assign effective dates or to affect member changes.
5. Cancellation of this Health Care Agreement by either the subscriber or SelectHealth will terminate this Agency Agreement.

Date application received at SelectHealth, Inc.

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

Agent/Broker Name Michael Oliphant Agency Benefits Manager Phone 1-888-310-9623

Agent Signature

Please type your signature in the box below.	Please verify your signature by typing it again.	Date Signed.
Michael Oliphant	Michael Oliphant	

Requested Effective Date_____

Coverage is not in force until your application is approved and effective date is determined by SelectHealth.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

Individual Plans
Payment Selection Form

Applicant's Name _____ **Applicant's Social Security# OR Subscriber ID** (for internal use only)_____

A. PAYMENT SELECTION

Please select one of the two available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

❑ **Preauthorized Banking Withdrawal**
(Complete section B)

❑ **Electronic Billing and Payment**
(Complete Section C. You must include a check for the first month's premium)

B. PREAUTHORIZED BANKING WITHDRAWAL

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

I (we) authorize SelectHealth to initiate debit entries to my (our): ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name_____ **Account Number** _____

Financial Institution _____ **Routing & Transit Number** _____

I (we) understand that debit entries will be submitted to my (our) account on or about the tenth of each month, regardless of the policy effective date. I (we) understand that a **$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason. I understand and agree that by typing in my name and/or clicking on the button that says "I agree," I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

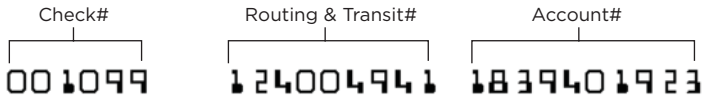
Account Holder's Signature

Please type your signature in the box below.	Please verify your signature by typing it again.	Date Signed.

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.



C. ELECTRONIC BILLING AND PAYMENT

If you have selected the Electronic Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by e-mail. This e-mail will link you to a Web site where you can make your monthly payment by electronic check or by credit card.

This method of payment requires that you submit the first month's premium using a check or credit card with your application. Premium payments are due on the first day of each month.

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

Applicant's Signature **Applicant's Phone#** _____

Please type your signature in the box below.	Please verify your signature by typing it again.	Date Signed.

Applicant's E-mail Address _____ **Applicant's Date of Birth**_____

Application Checkoff List

BEFORE YOU SUBMIT YOUR APPLICATION FORM, DID YOU REMEMBER TO...

- ☐ **Complete Sections I to XI**
- ☐ **Read Section X —** Authorization and Acknowledgement
- ☐ **Sign Section XI —** Signature of Applicant and Spouse
- ☐ **Sign the Payment Selection Form**
- ☐ **Include the first month's premium** (applies to the Electronic Billing and Payment option)
- ☐ **Attach a voided check for Preauthorized Banking Withdrawal**

selecthealth℠

4646 West Lake Park Boulevard
Salt Lake City, UT 84120
P.O. Box 30192
Salt Lake City, UT 84130

HealthSave

Consumers are increasingly interested in plans that allow them more control over their healthcare dollars. High Deductible Health Plans (HDHP), used in conjunction with a Health Savings Account (HSA), are at the forefront of the consumer driven healthcare movement. Over three million Americans have already switched to HSA-based health coverage. With HSA plans, you combine comprehensive healthcare coverage with the ability to develop equity through a tax-advantaged savings account.

The purpose of this section is to help you become familiar with HealthSave, SelectHealth's HDHP, and how it works with an HSA.

THE BASICS

There are two components required for you to create an HSA-based health coverage plan: a qualified HDHP and an HSA.

High Deductible Health Plan

Your HealthSave plan is the HDHP insurance component of this arrangement. In order for you to properly set up an HSA, your health plan has to be a "qualified" HDHP that includes, but is not limited to, the following characteristics:

- A minimum deductible amount set by the US Treasury Department for single or family coverage. This amount may vary from one year to the next.
- A maximum out-of-pocket limit set by the US Treasury Department for single or family coverage. This amount may vary from one year to the next.
- One deductible applies to all services including medical, mental health, and prescription drug coverage.
- Deductible can be waived for preventive care.

As the name implies, deductibles for qualified HDHPs are higher than many other plans. If you have unexpectedly high medical expenses during the year, your HDHP will be a safety net to provide medical coverage for you and your family.

Health Savings Account

The HSA is a tax-advantaged account used to pay medical expenses funded by contributions from you on a pre-tax basis. Money can be withdrawn from the HSA to pay for qualified medical expenses.

By selecting HealthSave, subscribers are eligible to set up an HSA provided they meet the following qualifications:

- Not also covered by any other health plan that is not an HDHP (with exceptions for plans providing certain limited types of coverage such as accident or specific disease policies, etc) and;
- Not entitled to benefits under Medicare and;
- May not be claimed as a dependent on another person's tax return.

HOW HEALTHSAVE WORKS WITH YOUR HSA

Here are some of the key components for using your HSA.

General

- Set up an HSA with your HSA vendor.
- Contribute to your HSA up to specified limits on a pre-tax basis.
- The money in the HSA account can be used to pay your share of the deductible or coinsurance amounts until you reach your out-of-pocket maximum.
- If you do not use the money in the account, it rolls over to the next year and continues to build.
- This is your money to use as you wish. However, if this money is not used for qualified medical expenses, it will be subject to income tax plus a ten percent penalty before the age of 65. After age 65, this money is treated as retirement income and if not used for qualified medical expenses, is only subject to income tax without the penalty.

When you need to fill a prescription

- Present your SelectHealth ID Card at the pharmacy.
- The pharmacist will charge you the discounted purchase price.
- If you have money in your HSA, you can pay for your prescription by swiping your HSA debit card.

- The pharmacy sends SelectHealth the claim to be applied toward the deductible or coinsurance that you owe, if any.
- If you do not have money in your HSA, you need to pay for your prescription using another form of payment. Hold onto the receipt. When you do have funds in your HSA in the future, contact your HSA vendor for reimbursement.

When you go to the doctor

- Present your SelectHealth insurance card for proof of insurance.
- You may use your HSA debit card if the doctor charges a copay for the visit.
- The doctor sends the bill to SelectHealth.
- SelectHealth processes your claim showing your responsibility, if any.
- If you have money in your HSA, pay the bill from your account. There are several methods to choose from, including payment via the Internet, automatic payment by the HSA vendor directly from your account, HSA vendor-supplied debit card, and other methods through conventional mail.
- If you don't have money in your HSA, you need to pay your provider directly.
- You can be reimbursed later when you have the funds available in your HSA.

HealthEquity®

HealthEquity is SelectHealth's preferred HSA vendor. Although HealthSave can be used with any qualified vendor, consider what HealthEquity has to offer before you decide.

HSA SERVICES

HealthEquity has many tools available online and by phone, including the following:

- 24 hours, seven days a week HSA customer service line
- 24 hours, seven days a week HSA customer nurse hotline
- Internet resources:
    - HSA balance information
    - Transaction history
    - Reimbursement requests
    - Pricing of basic medical procedures
    - Medical self-diagnostic tools, medical library

Enrollment is quick and easy with this vendor. An HSA account will automatically be set up for you with HealthEquity unless you check the box on page two of your Application indicating that you wish to decline this option. Keep in mind that an administrative fee for HealthEquity is included in your premium regardless of whether you choose to use this vendor.

Selecting a HealthSave Plan

Follow these steps to create the HealthSave plan that's right for you:

STEP 1. SELECT YOUR PROVIDER NETWORK *(see page 4 for detailed descriptions)*

select:value.

select:med+

select:care+

NOTE:

If you choose the Select Med or Select Care networks, your plan automatically has a point-of-service feature otherwise known as a 'Plus' plan. This means you can use both participating and nonparticipating providers. Please refer to the Benefit Summary on the following page for benefit details.

STEP 2. SELECT YOUR ANNUAL DEDUCTIBLES AND CORRESPONDING OUT-OF-POCKET MAXIMUMS

$1,500 Single/$3,000 Family
$2,700 Single/$5,400 Family
$5,000 Single/$10,000 Family

If you are insuring only yourself, you will enroll on a "single" plan. If you are insuring yourself and one or more family members, you will enroll on a "family" plan. The HealthSave feature has one deductible for all medical, pharmacy, and mental health services.

The deductible must be met each calendar year before benefits are paid. On a family plan, the entire family deductible must be met before benefits are paid for any family member. There is no per-person deductible on the family plan.* All out-of-pocket expenses for covered services will apply to the out-of-pocket maximum.

***PREVENTIVE CARE: Covered preventive care services (e.g., immunizations, well-baby care) are eligible for plan benefits before the deductible is met.**

STEP 3. DETERMINE HSA VENDOR

SelectHealth's preferred HSA vendor is HealthEquity. You may choose to utilize this vendor; however, you are not required to do so. An administrative fee is included in your premium amount regardless of whether you choose to use the preferred vendor. As with most HSA vendors, a nominal fee will also be charged if you choose to terminate the account once it has been established. This option is located on page two of the Individual Plans Application Form. Please refer to this page for further information.

STEP 4. CALCULATE YOUR PREMIUM

Now that you have created your plan, use the HealthSave Premium Calculation Worksheet on page 20 to calculate your monthly premium. Begin by turning to the rate page listing the deductible level you have selected. Next refer to your provider network. Your rate will be based on the age of the applicant (the oldest family member applying for coverage) and your coverage tier (single, two-party or family).

HealthSave Benefit Summary – 80%/20% Coinsurance Plans

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary for detailed benefit information.

BENEFITS	PARTICIPATING BENEFITS *HMO & Plus plans*	NONPARTICIPATING BENEFITS[1,2] *Plus plans only*
LIFETIME MAXIMUM PLAN PAYMENT	$2,500,000	$1,000,000
PRE-EXISTING CONDITIONS Waived (entirely or partly) for qualifying pre-existing condition credit	Not covered for first 12 months	Not covered for first 12 months
DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS Deductible included in the out-of-pocket maximum	**Opt. 1** — **Deductible** — **Out-of-Pocket Maximum** **Single:** $1,500 — $5,000 **Family:** $3,000 — $10,000 **Opt. 2** **Single:** $2,700 — $5,000 **Family:** $5,400 — $10,000	**Opt. 1** — **Deductible** — **Out-of-Pocket Maximum** **Single:** $2,000 — $7,000 **Family:** $4,000 — $14,000 **Opt. 2** **Single:** $3,200 — $7,000 **Family:** $6,400 — $14,000
INPATIENT SERVICES Medical, Surgical, Emergency Admissions, Hospice Skilled Nursing Facility Physical, Speech, and Occupational Therapy	You pay 20% after deductible	You pay 40% after deductible
PROFESSIONAL SERVICES Office Visits–PCP[3] Office Visits–SCP[3] Immunizations Elective Immunizations	 You pay $15 after deductible You pay $25 after deductible Covered 100% You pay 20%	 You pay 40% after deductible ($15 min copay) You pay 40% after deductible ($25 min copay) Not covered Not covered
PREVENTIVE CARE (Deductible waived) Office Visits–PCP[3] Office Visits–SCP[3]	 You pay $15 You pay $25	 Not covered Not covered
OUTPATIENT SERVICES Participating Emergency Room Visit Nonparticipating Emergency Room Visit Intermountain InstaCare Facility/Urgent Care Intermountain KidsCare & ExpressCare Facilities (See preventive care if services are preventive) Diagnostic Tests, Minor Diagnostic Tests, Major Physical, Speech, and Occupational Therapy	 You pay $100 after deductible You pay $200 after deductible You pay $25 after deductible You pay $15 after deductible Covered 100% after deductible You pay 20% after deductible You pay $25 after deductible	 See “Participating Benefits” See “Participating Benefits” You pay 40% after deductible Not available You pay 40% after deductible You pay 40% after deductible You pay 40% after deductible ($25 min. copay)
MENTAL HEALTH & CHEMICAL DEPENDENCY Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	You pay 50% after deductible	You pay 50% after deductible
MISCELLANEOUS SERVICES Infertility (limited to $1,500/calendar year; $5,000/lifetime) Maternity and Adoption Chiropractic	 You pay 50% after deductible Not covered Not covered	 Not covered Not covered Not covered
SUPPLEMENTAL ACCIDENT	Not available	Not available
PRESCRIPTION DRUGS Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply	Tier 1: You pay $10 after deductible Tier 2: You pay 25% after deductible Tier 3: You pay 50% after deductible	Tier 1: You pay $10 after deductible Tier 2: You pay 25% after deductible Tier 3: You pay 50% after deductible

BENEFIT SUMMARY FOOTNOTES:

1. **Precertification for nonparticipating providers is required for all inpatient services, durable medical equipment with purchase price of more than $750, home health nursing services, and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to the out-of-pocket maximum.**
2. **The following services are not covered when provided by a nonparticipating provider: preventive care, immunizations, infertility, allergy tests, and allergy treatments.**
3. **PCP (Primary Care Provider); SCP (Secondary Care Provider).**

HealthSave Benefit Summary – 100% Plans

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary for detailed benefit information.

BENEFITS	PARTICIPATING BENEFITS *HMO & Plus plans*	NONPARTICIPATING BENEFITS[1,2] *Plus plans only*
LIFETIME MAXIMUM PLAN PAYMENT	$2,500,000	$1,000,000
PRE-EXISTING CONDITIONS Waived (entirely or partly) for qualifying pre-existing condition credit	Not covered for first 12 months	Not covered for first 12 months
DEDUCTIBLE & OUT-OF-POCKET MAXIMUMS Deductible included in the out-of-pocket maximum	**Deductible / Out-of-Pocket Maximum** **Single:** $5,000 / $5,000 **Family:** $10,000 / $10,000	**Deductible / Out-of-Pocket Maximum** **Single:** $7,500 / $7,500 **Family:** $15,000 / $15,000
INPATIENT SERVICES Medical, Surgical, Emergency Admissions, Hospice Skilled Nursing Facility Physical, Speech, and Occupational Therapy	Covered 100% after deductible	Covered 100% after deductible
PROFESSIONAL SERVICES		
Office Visits–PCP[3]	Covered 100% after deductible	Covered 100% after deductible
Office Visits–SCP[3]	Covered 100% after deductible	Covered 100% after deductible
Immunizations	Covered 100%	Not covered
Elective Immunizations	Covered 100%	Not covered
PREVENTIVE CARE (Deductible waived)		
Office Visits–PCP[3]	You pay $15	Not covered
Office Visits–SCP[3]	You pay $25	Not covered
OUTPATIENT SERVICES		
Participating Emergency Room Visit	Covered 100% after deductible	See "Participating Benefits"
Nonparticipating Emergency Room Visit	Covered 100% after deductible	See "Participating Benefits"
Intermountain InstaCare Facility/Urgent Care	Covered 100% after deductible	Covered 100% after deductible
Intermountain KidsCare & ExpressCare Facilities (See preventive care if services are preventive)	Covered 100% after deductible	Not available
Diagnostic Tests, Minor	Covered 100% after deductible	Covered 100% after deductible
Diagnostic Tests, Major	Covered 100% after deductible	Covered 100% after deductible
Physical, Speech, and Occupational Therapy	Covered 100% after deductible	Covered 100% after deductible
MENTAL HEALTH & CHEMICAL DEPENDENCY Inpatient limited to 10 days/calendar year Outpatient limited to 25 visits/calendar year	Covered 100% after deductible	Covered 100% after deductible
MISCELLANEOUS SERVICES		
Infertility (limited to $1,500/calendar year; $5,000/lifetime)	Covered 100% after deductible	Not covered
Maternity and Adoption	Not covered	Not covered
Chiropractic	Not covered	Not covered
SUPPLEMENTAL ACCIDENT	Not available	Not available
PRESCRIPTION DRUGS Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply	Tier 1: Covered 100% after deductible Tier 2: Covered 100% after deductible Tier 3: Covered 100% after deductible	Tier 1: Covered 100% after deductible Tier 2: Covered 100% after deductible Tier 3: Covered 100% after deductible

BENEFIT SUMMARY FOOTNOTES:

1. Precertification for nonparticipating providers is required for all inpatient services, durable medical equipment with purchase price of more than $750, home health nursing services, and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to the out-of-pocket maximum.
2. The following services are not covered when provided by a nonparticipating provider: preventive care, immunizations, infertility, allergy tests, and allergy treatments.
3. PCP (Primary Care Provider); SCP (Secondary Care Provider).

HealthSave Premium Calculation Worksheet

STEP 1. MONTHLY PREMIUM OF PLAN AND OPTIONS SELECTED

(Write down the options you have selected as described on page 17)

Provider Network (Select Value, Select Med Plus, Select Care Plus) _____

Deductible ($1,500/$3,000, $2,700/$5,400, $5,000/$10,000) _____

Based on your selections, turn to the applicable rate page and find the rate associated with the age of the applicant, which must be the oldest family member, and the tier (single, two-party, family) ENTER RATE ..... $ _____

+

STEP 2. FAMILY SIZE ADJUSTMENT

If your family size is seven to 11; add ten percent ENTER HERE ..... $ _____

Family sizes 12+: determined by underwriting

=

STEP 3. TOTAL MONTHLY PREMIUM AMOUNT

If you choose the electronic billing payment method, send a personal check in this amount for the first month's premium with your application ENTER AMOUNT HERE ..... $ _____

If you choose to pay with the preauthorized banking withdrawal method, you do not need to submit the first month's premium with your application. All premiums will be drafted from your authorized bank account upon approval of your coverage.

NOTE:

- Premium rates are based on the age of the applicant (oldest family member applying for coverage). Initial premium increases may be assessed based on underwriting review.
- Premiums under these plans are subject to adjustment each January 1 (if your original effective date is January 1 through June 30) or each July 1 (if your original effective date is July 1 through December 31).
- Premiums will increase on the first of the month following the birthday on which a subscriber moves from one age band to another. Refer to "Major Medical Outline of Coverage," "Premiums" section on page 29 for information on age bands.
- Premium rates are effective January 1, 2007. If you are age 65 or older and are not eligible for Medicare, contact us for premiums.

HealthSave Plan Premium Rates

Deductible applies to all services except preventive care.

select:value HEALTHSAVE

	$1,500 SINGLE/$3,000 FAMILY			$2,700 SINGLE/$5,400 FAMILY			$5,000 SINGLE/$10,000 FAMILY		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	63	102	157	57	89	146	49	69	132
20 - 24	67	115	168	60	100	156	51	78	142
25 - 29	76	130	208	69	113	193	58	88	175
30 - 34	86	148	251	78	129	233	66	100	212
35 - 39	93	151	287	84	131	266	71	102	241
40 - 44	106	176	334	96	153	310	81	119	281
45 - 49	122	209	377	110	182	350	93	140	317
50 - 54	139	247	398	126	215	369	106	166	335
55 - 59	165	302	434	149	262	403	125	202	365
60 - 64	200	372	506	180	323	469	151	249	425

select:med+ HEALTHSAVE

	$1,500 SINGLE/$3,000 FAMILY			$2,700 SINGLE/$5,400 FAMILY			$5,000 SINGLE/$10,000 FAMILY		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	68	111	170	62	96	158	53	75	143
20 - 24	72	125	182	65	109	169	55	84	154
25 - 29	82	141	225	75	123	209	63	95	190
30 - 34	93	161	273	84	140	253	71	108	230
35 - 39	101	163	311	91	142	289	77	110	262
40 - 44	115	191	363	103	166	337	87	129	305
45 - 49	132	227	409	119	197	380	100	152	344
50 - 54	151	268	432	136	233	401	115	180	363
55 - 59	179	328	472	161	285	437	136	219	396
60 - 64	217	404	549	195	351	509	164	270	461

select:care+ HEALTHSAVE

	$1,500 SINGLE/$3,000 FAMILY			$2,700 SINGLE/$5,400 FAMILY			$5,000 SINGLE/$10,000 FAMILY		
AGE	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY	SINGLE	2-PARTY	FAMILY
0 - 19	75	121	187	68	106	173	57	82	157
20 - 24	79	137	200	71	119	186	60	92	169
25 - 29	90	155	247	81	135	230	69	104	208
30 - 34	102	176	300	92	153	278	78	119	252
35 - 39	110	179	342	99	156	317	84	121	288
40 - 44	126	210	399	113	182	370	96	141	335
45 - 49	145	249	450	131	216	417	110	167	378
50 - 54	166	295	475	149	256	440	126	197	399
55 - 59	197	360	518	177	313	480	149	241	435
60 - 64	238	444	604	215	385	559	180	296	507

General Information

CARRY YOUR ID CARD and use participating providers and facilities. If you do not, your claims will be denied. You are encouraged to maintain a relationship with a participating physician who focuses on primary care services (Primary Care Provider).

See your plan's Provider & Facility Directory for a list of participating providers or visit www.selecthealth.org. If you need help finding a provider, call Member Advocates at 801-442-4993 (Salt Lake area) or 800-515-2220.

EMERGENCY CARE

If you have an emergency, call 911 or go to the nearest hospital. You will pay a lower copay at a participating emergency room. You will pay a higher copay at a nonparticipating emergency room.

URGENT CARE

If you have an illness or injury that is not life-threatening but needs medical attention within 24 hours, call a participating provider. If the provider is unavailable, you may use one of the following services:

- Call Member Advocates at 801-442-4993 (Salt Lake area) or 800-515-2220. They can help you get an immediate appointment with another provider;
- Go to an Intermountain InstaCare facility;
- Go to an Intermountain ExpressCare clinic (located in select Smith's grocery stores);
- Call an Intermountain KidsCare facility to schedule a same-day appointment; or
- If you are outside of the service area and need urgent care, go to any provider or hospital. You can save money on out-of-area services by using a Beech Street provider. To find one, call 800-937-2277 or visit www.beechstreet.com.

PRENOTIFICATION

Participating providers will prenotify certain medical services on your behalf by calling us directly.

GENERAL PROVISIONS

These plans are designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided through participating providers for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care. Coverage is subject to any deductible, copay provisions, or other limitations which may be set forth in the Contract.

Please refer to the "Benefit Summaries," "General Limitations & Exclusions," and "General Information" sections within this packet for more information. After you receive the Contract (after you are enrolled), you will have ten days to review it before acceptance. If you decide to cancel within the ten-day review period, you may do so by notifying us in writing. You will receive a full refund of your premium. No premium refunds are available after the ten-day review period. If your premium is refunded, the Contract shall be void as if no coverage had been issued.

ELIGIBILITY

You and your dependents may apply for coverage if you are a full-time resident of Utah, and you are not eligible for Medicare. Plans are not sold on a temporary or short-term basis. If your employer is paying any portion of your premium either directly or through reimbursement, it constitutes a group plan, and you are not eligible for coverage.

GUARANTEED ISSUE GUIDELINES

You are guaranteed coverage* with no pre-existing condition exclusion if you have met the following requirements:

- Satisfy all other eligibility and continuation requirements under your contract;
- Have an aggregate of 18 months of creditable coverage, the most recent of which was under a group, governmental, or church plan;
- Were eligible for COBRA or a similar state program, and you elected and exhausted such coverage;
- Are not eligible for coverage under a group health plan, Medicare, or Medicaid and do not have other coverage; or
- Were not terminated from your most recent coverage for nonpayment of premium or fraud.

**Coverage is guaranteed after you are certified as insurable by the Utah State Health Insurance Pool. Such coverage may or may not be with SelectHealth.*

ELIGIBLE FAMILY DEPENDENTS

Eligible family dependents include your spouse (who is not legally separated from you), and your unmarried child(ren), stepchild(ren), legally adopted child(ren), or child placed for adoption, from birth to 26 years of age, provided that they are dependent upon you for at least 50 percent of their financial support. (Financial dependency is not required for otherwise eligible children up to the age of 19.) Newborns, legal adoptees, or children placed with you for adoption must be enrolled within 31 days of birth, adoption, or placement for adoption.

RATING METHODOLOGY

Premiums are based on an adjusted community rate methodology and vary depending on age and family status. Medical underwriters will make an initial evaluation of the health status of individuals and dependents to determine whether any surcharge to published premiums is necessary. Once that initial evaluation is made, subsequent adverse claims experience or deterioration of health of an individual or dependent will have a negligible impact on premiums during renewal periods as experience will be pooled with all individual plan members. Coverage may be declined on a particular individual or dependent at the time of initial evaluation. Certain industries and occupations may have an additional rate increase.

EFFECTIVE DATE OF COVERAGE

Coverage for you and your family dependents listed on the application will become effective on the first or sixteenth of the month as determined by our underwriting department.

RENEWALS

Premiums under these plans are subject to adjustment effective each January 1 (if your original effective date is January 1 through June 30) or July 1 (if your original effective date is July 1 through December 31). You will be notified at least 30 days prior to any adjustment. These plans are guaranteed renewable based on the terms stated in your Contract.

PLAN AND DEDUCTIBLE CHANGES

To request changes to your plan, follow the instructions on your Individual Plans Change Form (Change Form). This form is included in your Contract folder. All requests for plan changes are subject to underwriting approval. The effective date of any change will be determined by our underwriting department.

TERMINATION

Your coverage will not terminate for health reasons; however, your coverage will terminate automatically for any of the following:

- Nonpayment of premiums;
- Commission of fraud or intentional misrepresentation of material fact;
- You no longer reside, live, or work in the service area; or
- You are on a plan we terminate.

If we do not receive your premium or we are unable to collect premiums from your checking or savings account, you will be notified.

You may cancel your Contract during the ten-day examination period. If you wish to cancel your Contract after the examination period, you must give us 30 days advance written notice.

Why Select Us?

AT SELECTHEALTH, we know you have many options when choosing a health coverage partner. Here are just some of the reasons why we may be your best option.

NCQA ACCREDITATION

SelectHealth was the first commercial health plan in Utah to receive "Excellent" Accreditation status by the National Committee for Quality Assurance (NCQA†).

In rating a health plan, NCQA examines how well a plan helps its members do the following:

- Stay healthy
- Get better
- Manage chronic illness
- Access qualified providers
- Receive care and service when needed

Results show that NCQA-accredited plans like SelectHealth outperform non-accredited plans in all measures of clinical care and member satisfaction. Our "Excellent" Accreditation status illustrates our commitment to helping members stay healthy and to providing the highest quality care when they are sick.

EXCEPTIONAL SERVICE

We're here to respond to your questions and concerns.

Member Services

To contact Member Services, call 801-442-5038 (Salt Lake area) or 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., or Saturdays, from 9:00 a.m. to 2:00 p.m.

Representatives help members understand their benefit plan and resolve their concerns.

Member Advocates℠

To contact Member Advocates, call 801-442-4993 (Salt Lake area) or 800-515-2220 weekdays from 8:00 a.m. to 6:00 p.m.

- Member Advocates help members find the right doctor for their needs
- Assist with appointment scheduling–including urgent conditions
- Help members find the closest facility or doctor with the nearest available appointment

Behavioral Health Advocates℠

To contact Behavioral Health Advocates, call 801-442-1989 (Salt Lake area) or 800-876-1989 weekdays from 7:00 a.m. to 6:00 p.m.

Representatives help members find the most appropriate mental health provider for their needs.

FLEXIBILITY IN OFFERINGS

You want choices. SelectHealth offers them. Our wide variety of networks, products, and features allow you to create a truly customized plan that will work for you.

INTEGRATED APPROACH OF SELECTHEALTH AND INTERMOUNTAIN HEALTHCARE

You can be part of what *Modern Healthcare* magazine recognized as one of "the nation's top integrated health systems."* Our integration with Intermountain Healthcare allows us to focus on improving the quality of care while striving to reduce overall medical costs.

OUT-OF-AREA COVERAGE

When you're traveling, it's nice to know you're covered. SelectHealth offers the Beech Street network for members when they travel outside of Utah.

†**NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare.**

***A study was conducted by Verispan, announced in the January 2006 issue of *Modern Healthcare* magazine.**

Select Living

WE WANT OUR MEMBERS TO LIVE WELL, so we provide a number of wellness resources to supplement our health plan benefits. From health-related discounts to other wellness resources, the Select Living program is designed to help our members maintain and enjoy a healthy, happy lifestyle. It's our goal to help them prevent unnecessary health problems and manage existing chronic conditions.

For more information on the following programs and services, visit www.selecthealth.org/wellness or call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

MEMBER DISCOUNTS

We know our members are more likely to embrace a healthy lifestyle when it costs less. The following table outlines discounts we offer to members through partnerships with numerous vendors:

Eyewear	Up to 35 percent off
Health Clubs and Fitness Centers	Various discounts throughout the state
Vitamins and Nutritional Supplements	Up to 40 percent off
Chiropractic Services, Massage Therapy, Acupuncture Services	Up to 25 percent off
Hearing Aids	Up to 15 percent off
Drug Education Materials	Up to $30 off

To receive the discounts mentioned above, members simply present their ID Card. For more detailed information about these discounts or to find participating locations, visit www.selecthealth.org/discounts.

DISEASE MANAGEMENT

Helping our members maintain healthy lives is a top priority. We're especially concerned about members with chronic health conditions. With our disease management program, members can receive access to a care management nurse, educational classes, and newsletters mailed to their homes. We want them to know they're not alone. The program covers the following areas:

- Allergies and Rhinitis
- Asthma
- Cholesterol
- Congestive Heart Failure
- Depression
- Diabetes
- Hepatitis C
- Hypertension
- Migraines
- Oncology

SELECTHEALTH HEALTHY BEGINNINGS℠

Pregnancy is a special time. Our prenatal program provides support and resources for expectant mothers. The program includes a risk assessment screening and provides case management, as well as pregnancy education materials.

SMOKING CESSATION PROGRAMS

Quitting smoking is one of the most significant things a person can do to improve overall health. We offer two programs to help members quit smoking. Free & Clear® allows members to progress at their own pace from home. A counselor is available to talk with participants over the phone. SmokeBreakers℠ is a group program offered at several Intermountain Healthcare hospitals.

ADDITIONAL WELLNESS RESOURCES

We would like our members to have important health information at their fingertips. We provide online education centers, health newsletters, a health topic calendar, and several other resources. To access these materials, visit www.selecthealth.org.

Major Medical Outline of Coverage

SelectHealth
4646 W. Lake Park Blvd.
P.O. Box 30192
Salt Lake City, UT 84130-0192

READ YOUR CONTRACT

Read your Contract carefully. This outline of coverage provides a very brief description of the important features of your Contract. This is not the Contract, and only the actual Contract provisions will control.

The Contract sets forth in detail the rights and obligations of both you and SelectHealth. It is, therefore, very important that you read your Contract carefully.

If you are approved for coverage, you will receive an ID Card and a Contract, which will explain benefits, limitations, exclusions, and managed care provisions in detail. Please refer to your Contract for your covered benefits listed on a Member Payment Summary.

MAJOR MEDICAL EXPENSE COVERAGE

Contracts of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductible, copay provisions, or other limitations, which may be set forth in the Contract.

SUMMARY OF BENEFITS

Benefits are subject to all of the applicable exclusions, limitations and requirements of the Contract.

Daily Hospital Room and Board, Miscellaneous Hospital Services, Surgical Services, Anesthesia Services, and In-hospital Medical Services

- Coinsurance exists for individual plan members. SelectHealth pays the remaining percent after the medical deductible.

Professional Office Visits

- The member pays a copay after the medical deductible.

Maximum Dollar Amount for Covered Charges

- The lifetime maximum plan payment is listed on your Member Payment Summary. A separate maximum payment applies for infertility services.

OTHER BENEFITS OF THE CONTRACT FOR A COVERED MEMBER

Facility Services to Include the Following:

- Medical, surgical, emergency, detoxification, and skilled nursing facility services.

Inpatient Services to Include the Following:

- Medical, surgical, and emergency admissions, maternity services (limited), and skilled nursing facilities.

Outpatient Services to Include the Following:

- Outpatient and ambulatory surgical facility; emergency room (ER); Intermountain InstaCare facilities; and other services, such as chemotherapy, radiation therapy, dialysis, and diagnostic testing (major and minor).

Professional Services to Include the Following:

- Office services; provider office visits and minor surgery; major surgery; infertility (selected services); other professional services, such as medical, surgical, and anesthesiology; psychiatric; and rehabilitation therapy.

Miscellaneous Services to Include the Following:

- Ambulance (ground and air); durable medical equipment; home health, hospice care, injectible drugs; outpatient private nurse; miscellaneous medical supplies; allergy tests, allergy treatment; preventive care; and prescription drugs.

For benefit coverage levels, see your Member Payment Summary, which is included as part of your Contract. All eligible charges must be incurred while the Contract is in force.

GENERAL LIMITATIONS AND EXCLUSIONS

Accepted Medical Practice

Services determined by SelectHealth to be inconsistent with accepted medical practice or services that are illegal are excluded. This includes any service which is not generally recognized by the U.S. medical community as conforming to accepted medical practice, and any service for which required governmental approval has not been granted at the time the service is provided, including services which are investigational, experimental, or research in nature. Procedures, devices, drugs, or "biologics" for which there is insufficient evidence to determine their likely effects on patients' health outcomes are also excluded.

Calendar Year

Unless otherwise noted on your Member Payment Summary, plan benefits are calculated on a calendar year basis regardless of when you are enrolled. Out-of-pocket maximums and limited benefits start over on January 1.

Claims After One Year

Claims are denied if submitted to SelectHealth more than one year after services were rendered unless you can show that notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims are denied if submitted to SelectHealth more than one year after claims were first processed unless you can show that the additional information relating to the claim was filed as soon as reasonably possible. Where SelectHealth is secondary coverage, coordination of benefit's claims will be denied if submitted to SelectHealth more than three years after the date the claim was first processed by the primary carrier unless you show that notice was given or proof of loss was filed as soon as reasonably possible. If it is discovered that SelectHealth is primary, when they were believed to be secondary, and claims were submitted within the filing deadline to the other carrier first, SelectHealth will consider claims up to three years from the date of service.

Excess Charges

Amounts exceeding eligible charges are excluded. You are not responsible for excess charges for covered services from participating providers and facilities. Excess charges paid to nonparticipating providers do not apply to your out-of-pocket maximum.

Limited Benefits

Normally covered services that exceed benefit limits specified on the Member Payment Summary (e.g., dollars, days, visits, etc.) are excluded and not applied to the out-of-pocket maximum, including, but not limited to, services exceeding benefit limits for skilled nursing facilities, rehabilitation therapy, psychiatric services, etc.

Medical Necessity

Services, equipment, and supplies that are not medically necessary are not covered.

Noncovered Services and Complications

All related expenses, accommodations, materials, or care for noncovered services are excluded, including complications resulting directly from a noncovered service. When a noncovered procedure is performed as part of the same operation or process as a covered service, then only eligible charges relating to the covered service will be eligible for benefits. Eligible charges may be calculated to exclude any charges related to the noncovered service.

No Presumption of Coverage

There is no presumption of coverage. Services not specified as covered are excluded.

Excluded Services

Unless otherwise noted in your Member Payment Summary, the following services are excluded:

Abortions, elective
Acupuncture and Acupressure
Administrative Charges, Administrative Examinations and Services, for non-medical purposes
Allergy Tests, Treatment, and Services, selected types of
Appointments Not Kept, charges for
Axillary Hyperhidrosis
Biofeedback
Birthing Centers and Home Childbirth
Cancer Therapy, when investigational or experimental
Chiropractic
Complementary and Alternative Medicine
Cosmetic Procedures
Custodial Care, Long-term Care
Dental, Mouth, and Jaw, including TMJ
Developmental Delay
Dietary Products
Drugs, Medications, and Injections, selected types of

Durable Medical Equipment (DME), selected types of
General Anesthesia, in a doctor's office
Educational and Nutritional Training, selected types of
Evaluation Visits, for noncovered diagnoses
Experimental or Investigational Treatments and Services
Eye Surgery, refractive
Felony, Riot, Insurrection
Fitness Training
Gastric Bypass
Gene Therapy
Genetic Testing, except when criteria is met
Habilitation Therapy Services
Hearing Aids
Home Health Aides and Services
Illegal Activities, injuries while committing
Infertility Services, selected types of
Injections and Immunizations, selected types of
Maternity
Miscellaneous Medical Supplies (MMS), selected types of
Nonparticipating Providers, charges for (except for emergencies and out-of-area urgent conditions)
Obesity, selected related services
Organ Transplants/Implants, selected types of
Orthotics
Osteoporosis Screening
Pre-existing Conditions, during waiting periods
Provider Household Services
Psychiatric, Mental Health, or Alcohol/Substance Abuse, over and above coverage limitations noted on the Member Payment Summary
Rehabilitation Therapy Services, selected types of
Respite Care
Sexual Dysfunction, benefits for
Shipping and Handling
Sterilization Procedures, from nonparticipating providers
Telephone Consultations
Terrorism or Nuclear Release
Transportation Services, medically unnecessary
Unproven Interventions and Therapies
Vision Aids, selected types of
War, related services

PRE-EXISTING CONDITIONS (PEC)

Limited Coverage of Pre-existing Conditions

Pre-existing conditions, if applicable, or sickness or injury directly resulting from or related to such pre-existing conditions are not covered until you have been covered by SelectHealth for 12 months. See the Contract for details. Acceptance under these plans does not imply any waiver of pre-existing condition waiting periods.

Definition of Pre-Existing Condition

A pre-existing condition is a condition occurring or present in the six-month period prior to a member's enrollment date of coverage for which medical advice, diagnosis, care, or treatment (including prescription and over-the-counter drugs) was either received from or recommended by a provider.

NOTE: *If medical records or claims for you and/or your dependents document the presence of a pre-existing condition that was not fully disclosed on the health questionnaire, your coverage may be altered or terminated.*

Pre-Existing Condition Waiting Period

If you or your dependents are considered newly covered, the first 12 months of coverage is referred to as a pre-existing condition waiting period. You may receive credit for any portion of your pre-existing condition waiting period which was satisfied by your previous healthcare coverage. This credit may be used in satisfying all or part of your pre-existing condition waiting period requirement. Pre-existing condition waiting period credit will not apply, however, under the following circumstances:

- The previous healthcare coverage was terminated more than 63 days prior to the member's effective date of coverage with SelectHealth; or
- The benefits or services were not covered by previous healthcare coverage.

Limited Coverage of Selected Services

Services for the following lists of selected diagnoses and procedures are always denied during the first 12 months of coverage unless determined by SelectHealth to be a medically necessary emergency. However, if a member qualifies for pre-existing condition waiting period credit, this credit will also apply to the following services:

Diagnoses
Amenorrhea
Cataracts
Congenital Deformities (except as required in Utah Code Section 31A-22-610)
Cystocele
Dymenorrhea
Enterocele

Infertility
Rectocele
Sleep Problems/Disorders
Urethrocele
Uterine Prolapse
Varicose Veins

Procedures

Allergy Testing and Treatment, in cases of seasonal allergies
Bunionectomy
Carpal Tunnel Surgery
Hysterectomy, except in cases of malignancy
Joint Replacement
Mammoplasty, reduction
Morton's Neuroma, surgical treatment of
Myringotomy/Tympanotomy, with or without tubes insertion
Nasal Septal Repair, except injuries after effective date of coverage
Retained Hardware Removal
Sleep Studies
Sterilization
Tonsillectomy/Adenoidectomy

RENEWAL

Subject and in addition to all terms and conditions of your Contract, your Contract is issued by SelectHealth for the term stated on your application. Unless either formally terminated or otherwise renegotiated, the Contract will be renewed automatically on or about January 1 or July 1 of each year, subject to termination by either party upon 30 days written notice after the term. SelectHealth may only terminate your coverage for the reasons stated on the cover page of your Contract. SelectHealth may exercise specifically reserved rights under the Contract to change the benefits, exclusions, limitations, and/or services set forth in the Contract upon renewal with 30 days written notice.

PREMIUMS

Subject to the provisions of your Contract, the premiums will remain the same until the end of the term specified on the application. If federal or state law or regulations mandate that SelectHealth modify benefits under this Contract, SelectHealth may modify the premiums accordingly. SelectHealth may unilaterally modify the premiums after the term upon 30 days advance written notice to you.

If you have a birthday that moves you into the next age band, you will experience a rate increase the following month. The age bands are as follows: 0 to 19 years, 20 to 24 years, 25 to 29 years, 30 to 34 years, 35 to 39 years, 40 to 44 years, 45 to 49 years, 50 to 54 years, 55 to 59 years, 60 to 64 years, 65 to 69 years, 70 to 74 years, 75 to 79 years, 80 to 84 years, and 85 years of age or older.

Premiums are due and payable on the first day of each month at our office in Salt Lake City, Utah.

Notice of Privacy Statement

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

ABOUT THIS NOTICE

This notice describes the privacy practices of SelectHealth, Inc., and SelectHealth Benefit Assurance Co., Inc., (collectively "SelectHealth"). This notice is intended for our health plan members. SelectHealth is part of Intermountain Healthcare, which is a healthcare delivery system, consisting of hospitals, health plans, doctors, and other practitioners that work together to provide healthcare. Each part of the healthcare system performs a different role in the delivery of healthcare.

For the purposes of this notice, we have defined the following terms:

- "Intermountain" refers to SelectHealth, Inc., SelectHealth Benefit Assurance Co., Inc., and Intermountain Health Services, Inc.
- "SelectHealth" or "we" refers to all coverage plans offered by SelectHealth, Inc., and SelectHealth Benefit Assurance Co., Inc., but does not include plans offered by other companies that contract to use the SelectHealth panel of providers.
- "Intermountain Health Services" means the hospitals, clinics, doctor offices, and other healthcare facilities owned and operated by Intermountain Health Services, Inc., as well as the individuals employed by Intermountain Health Services at these facilities.
- "Affiliated Providers" are doctors and other healthcare practitioners who are not employed by Intermountain Health Services but either have a contractual relationship with SelectHealth or are credentialed to admit patients to an Intermountain hospital.
- "Personal Information" means your personal medical information that describes your physical or mental health or the payment for the provision of your healthcare as well as any other financial information that we may have collected about you.
- "Personal Representative" means an individual who has authority under law to make healthcare decisions on behalf of another person, e.g., a parent for a minor child.

In some situations, Intermountain Health Services and Affiliated Providers have different privacy practices than SelectHealth because of the type of services they provide. As a result, if you are a patient of Intermountain Health Services or an Affiliated Provider, you may receive a separate notice of their privacy practices. To request a copy of the privacy notices of Intermountain Health Services, please call 800-442-4845. To receive a copy of the privacy notices of Affiliated Providers, please contact those providers directly.

SELECTHEALTH'S PRIVACY RESPONSIBILITIES

We are committed to protecting your privacy as described in this document. In addition, certain laws require that we maintain the privacy of your Personal Information and provide you with this notice. This notice describes our legal duties and privacy practices with respect to Personal Information. When we use or disclose Personal Information, we must abide by the terms of this notice (or other notice in effect at the time of the use or disclosure).

COLLECTION OF PERSONAL INFORMATION

We may collect Personal Information from you, healthcare providers, and other payers of healthcare. We may also collect Personal Information from governmental agencies, legal proceedings, and consumer reporting agencies.

USES AND DISCLOSURES WITH AN AUTHORIZATION

An authorization is a written document signed by you or your Personal Representative that gives us permission to use your Personal Information for a specific purpose. We will only use your Personal Information without an authorization in ways described in the next section of this notice entitled "Uses and Disclosures Permitted by Law Without an Authorization." You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

USES AND DISCLOSURES PERMITTED BY LAW WITHOUT AN AUTHORIZATION

Use or Disclosure by SelectHealth for Payment or Healthcare Operations

SelectHealth uses Personal Information for the following routine purposes:

Payment

SelectHealth uses and discloses Personal Information for payment of health coverage premiums and to determine and fulfill its responsibility to provide you benefits—for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have. SelectHealth may also disclose Personal Information to consumer reporting agencies as part of its payment activities.

Finally, SelectHealth will disclose Personal Information about any dependent on a policy to the subscriber, his or her spouse, or the authorized representative of either of these people. This is limited to information necessary to understand how a claim was processed. We disclose this information to allow the subscriber and his or her spouse to manage the policy effectively. You may have rights to limit these disclosures. See the subsection "Your Right to Receive Special Communication" in the "Your Individual Rights" section.

Healthcare Operations

SelectHealth uses and discloses Personal Information for its Healthcare Operations, which includes internal administration, planning, and various activities that improve the quality of the healthcare that we pay for. For example, we may use your Personal Information to assess insurance rates and to evaluate how many of the children on our plans have received the recommended immunizations. SelectHealth may disclose Personal Information to individuals or companies that assist with Payment and Healthcare Operations. However, such disclosures are only made if the person or company agrees to safeguard Personal Information as required by SelectHealth's privacy policy.

In addition, SelectHealth may disclose Personal Information as follows:

- To another healthcare entity for its healthcare operations or payment activities.
- To Affiliated Providers and Intermountain Health Services to improve the overall Intermountain system as well as to help them better manage your care. For example, Intermountain has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma, and as part of these programs, we share information with Affiliated Providers and Intermountain Health Services to facilitate improved coordination of the care members receive for these conditions.

We may use Personal Information to identify health-related services and products that may be beneficial to your health and then contact you about these services and products. However, unless we have an Authorization from you, we will not disclose Personal Information to individuals or organizations outside of Intermountain for the marketing of products or services that are not paid for or provided by Intermountain.

Treatment

SelectHealth may disclose Personal Information to healthcare providers to support them in providing treatment.

Special Protections for Certain Types of Information

SelectHealth may request Personal Information for underwriting purposes. If the health insurance is not placed with us, we will not use or disclose this information for any other purpose. We may request an HIV/AIDS test for underwriting purposes, but only if we provide proper notice and follow other requirements of state law. If we do require an HIV/AIDS test, we will not release the results of this test unless we have specific written permission to do so. Additionally, we will not request private genetic information from asymptomatic individuals for underwriting purposes. However, we may request private genetic information in certain circumstances to determine our obligation to pay for healthcare services.

Public Health Activities

We may disclose Personal Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability as required by law and public health concerns; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; and (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk for contracting or spreading a disease or condition.

Disclosure to Relatives and Close Friends

We may use or disclose Personal Information to a family member, other relative, a close personal friend, or any other person identified by you when you are either present for or otherwise available prior to the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your healthcare.

Victims of Abuse, Neglect, or Domestic Violence

If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose your Personal Information to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities

We may disclose Personal Information to a health oversight agency that oversees the healthcare system and ensures compliance with the rules of government health programs, such as Medicare or Medicaid.

Judicial and Administrative Proceedings

We may disclose Personal Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials

We may disclose Personal Information to the police or other law enforcement officials as required by law or in compliance with a court order.

Health or Safety

We may use and disclose Personal Information to prevent or lessen a serious and imminent threat to an individual's or the public's health or safety.

Specialized Government Functions

We may disclose to military authorities the personal and health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials personal and health information required for lawful intelligence, counterintelligence, and other national security activities.

Workers' Compensation

We may disclose Personal Information as necessary to comply with workers' compensation laws.

Research

We may use or disclose Personal Information without your consent or authorization for purposes of research if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

An Institutional Review Board or a Privacy Board is responsible for reviewing research that involves human subjects and for reviewing the effect of the research on the subjects' privacy rights. Either board must have at least one member on the board not affiliated with Intermountain.

Required by Law

We may use or disclose Personal Information to the extent that:

- Such use or disclosure is required by law; and
- The use or disclosure complies with and is limited to the relevant requirements of such law.

YOUR INDIVIDUAL RIGHTS

For More Information; Complaints

If you would like more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to Personal Information, you may contact our Privacy Office. Please see the last section of this notice, entitled "Privacy Office," for information on contacting our Privacy Office. You may also file written complaints with the Director of the Office of Civil Rights in the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not take action against you if you file a complaint with us or the Director.

Right to Request Additional Restrictions

You may request restrictions on our use and disclosure of Personal Information (1) for payment and healthcare operations or (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

Right to Inspect and Copy Your Health Information

You may request access to our records which (1) we use for decision-making purposes; and (2) contain your Personal Information, including your enrollment, payment, claims adjudication, case, medical management records, and your billing records. You may request access in order to inspect and ask for copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you request a copy or copies of your record, you will be charged a cost-based fee for each copy. If you wish to access the Personal Information maintained by an Affiliated Provider or by Intermountain Health Services, please contact them directly.

Right to Request Amendment to Your Records

You have the right to request an amendment to your Personal Information that SelectHealth created and used for decision-making purposes. SelectHealth will comply with your request unless we are not the originator of the information, or we believe that the information that would be amended is accurate and complete, or other special circumstances apply. If you wish to amend the Personal Information maintained by an Affiliated Provider or by Intermountain Health Services, please contact them directly.

Right to Receive an Accounting of Disclosures

Upon request, you may obtain a written summary of certain disclosures of your Personal Information made by us. Your request must state a time period, which may not exceed the six years prior to the date of your request and may not include dates before April 14, 2003.

If you request an accounting more than once during a twelve month period, we will charge you a reasonable fee for each additional accounting statement.

Right to Receive Special Communications

In certain circumstances, we will agree to any reasonable request for you to receive your Personal Information by alternative means of communication or at alternative locations.

Right to Receive a Paper Copy of This Notice

If you have not already received one, you have the right to receive a paper copy of this notice. To request a paper copy of this notice, please contact our Privacy Office.

NOTE: *Any Personal Representative of yours can exercise these rights related to your Personal Information.*

MAINTAINING THE PRIVACY OF PERSONAL INFORMATION

We guard Personal Information by limiting access to this information to those who need it to perform assigned tasks and through physical safeguards (e.g., locked filing cabinets and password-protected computer systems).

In addition, when you or someone else acting on your behalf calls our Member Services department, the Member Services representative may need to limit the Personal Information disclosed. This is done to help safeguard your Personal Information. The representative may ask for information to verify the identity of the caller before disclosing any Personal Information. The amount and type of Personal Information that we can release depends on several factors:

- Who is requesting the Personal Information
- What that person's relationship is to the subject of the Personal Information
- For what purpose the Personal Information is being requested
- If the Personal Information relates to the treatment of certain conditions

We realize that these restrictions may at times seem inconvenient, but the restrictions help us maintain the privacy of your Personal Information.

OPT OUTS

As part of our legal duties to protect your Personal Information, we are required to allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a company that is not affiliated with SelectHealth so that company can market its products or services to you. We don't make such disclosures, so it isn't necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

EFFECTIVE DATE AND DURATION OF THIS NOTICE

Effective Date

This notice describes the privacy practices of SelectHealth as of January 1, 2005.

Right to Change Terms of This Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all Personal Information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post the new notice on our Web site at www.selecthealth.org and will distribute it via our Membership Guide and member newsletter. You may also obtain any new notice by contacting the Privacy Office.

PRIVACY OFFICE

You may contact the Privacy Office at
Intermountain Privacy Office
4646 West Lake Park Blvd.
Salt Lake City, UT 84120
800-442-4845

E-mail: webfeedback@selecthealth.org

Provider Directory Information

FOR A COMPLETE and current directory of participating Primary, Secondary, and Ancillary providers, as well as pharmacies and facilities, please visit www.selecthealth.org.

You may also contact your SelectHealth-appointed broker for participating provider information.

As a SelectHealth member, you will receive a complete Provider & Facility Directory that contains all participating physicians, facilities, and providers for the plan you have selected.

Glossary of Terms

Coinsurance The percentage of eligible charges payable by the member directly to a provider for covered services. Coinsurance percentages are specified on the Benefit Summary/Member Payment Summary.

Copay A fixed dollar amount payable by the member directly to a provider at the time covered services are rendered. Copay amounts are specified on the Benefit Summary/Member Payment Summary.

Deductible The portion of eligible charges payable by the member each year directly to providers for covered services before benefits are paid. Any deductible amounts paid will apply to the out-of-pocket maximum.

Diagnostic Test, Major A test that is determined to be a major diagnostic test based on several different considerations such as invasiveness, complexity, and the place of service where the test is commonly performed. Major diagnostic tests include, but are not limited to, imaging studies such as MRIs, CT scans, and PET scans; neurologic studies, such as EMGs and nerve conduction studies; cardiovascular procedures, such as coronary angiograms; gastrointestinal procedures, such as EGDs, ERCPs, and colonoscopies, and gene base testing and genetic testing.

Diagnostic Test, Minor A test that does not meet the definition of a major diagnostic test. Examples of common minor diagnostic tests include routine blood and urine tests; simple X-rays, such as chest and long bone X-rays; EKGs; echocardiograms; and sigmoidoscopies.

Excess Charges Charges from providers and facilities that exceed SelectHealth's fee schedule for covered services. The member is responsible to pay for excess charges from nonparticipating providers and facilities. These charges do not apply to the member's out-of-pocket maximum.

Lifetime Maximum The maximum dollar amount SelectHealth will pay for covered services during the member's lifetime. The limit includes all amounts paid on behalf of the member under any SelectHealth plan or affiliated company. The lifetime maximum is specified on the Benefit Summary/Member Payment Summary.

Out-of-Pocket Maximum The maximum dollar amount per year of eligible medical charges payable by the member directly to providers as deductibles, copays, and coinsurance. Except where otherwise noted on the Benefit Summary/Member Payment Summary, SelectHealth will pay 100 percent of eligible medical charges during the remainder of the year once the medical out-of-pocket maximum is satisfied.

Preventive Care Services such as annual physical exams with associated tests, well-child visits, immunizations, and cancer screenings. Care provided for the diagnosis or monitoring of illness based on symptoms the member is experiencing is not considered preventive care and will apply to the appropriate medical benefit.

Primary Care Provider (PCP) A general practitioner who attends to the member's common medical problems and provides preventive care and health maintenance. A PCP is someone who practices internal medicine, family medicine, pediatrics, or obstetrics and gynecology.

Secondary Care Provider (SCP) A provider who specializes in a specific area of care (e.g., orthopedics, cardiology). Any provider who is not identified as a PCP is an SCP.