Welcome to Your Benefits

2021 Murray School District

LARGE EMPLOYER - UTAH

selecthealth®

BENEFIT SUMMARIES

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VALUE NETWORK

MEMBER PAYMENT SUMMARY
IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column. Services from Out-of-Network Providers are not covered (except emergencies).

CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	None
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	plan Year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per plan Year	
Deductible	$1,000
Out-of-Pocket Maximum	$3,000
Family Coverage, 2 or more enrolled - per plan Year	
Deductible - per person/family	$1000/$3000
Out-of-Pocket Maximum - per person/family	$3000/$6000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)	
INPATIENT SERVICES	**IN-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per plan Year	20% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible
Up to 40 days per plan Year for all therapy types combined	
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	$30
Secondary Care Provider (SCP)[1]	$40
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20%
Major Surgery	20%
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%
Secondary Care Provider (SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**IN-NETWORK**
Preventive Eye Exams	Covered 100%
All Other Eye Exams	$40
OUTPATIENT SERVICES[4]	**IN-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible
Emergency Room - *(In-Network facility)*	$250 after Deductible
Emergency Room - *(Out-of-Network facility)*	$250 after Deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45
Intermountain KidsCare® Facilities	$30
Intermountain Connect Care®	Covered 100%
Chemotherapy, Radiation and Dialysis	20% after Deductible
Diagnostic Tests: Minor[2]	Covered 100%
Diagnostic Tests: Major[2]	20% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible
Outpatient Cardiac Rehab	Covered 100%
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$40 after Deductible

See other side for additional benefits

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VALUE NETWORK

MEMBER PAYMENT SUMMARY

IN-NETWORK

MISCELLANEOUS SERVICES	IN-NETWORK
Durable Medical Equipment (DME)[4]	20% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Select Services*	50% after Deductible
Donor Fees for Covered Organ Transplants[4]	20% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	**IN-NETWORK**
Mental Health and Chemical Dependency[4]	
Office Visits	$30
Inpatient	20% after Deductible
Outpatient	20%
Residential Treatment[2]	20% after Deductible
Injectable Drugs and Specialty Medications[4]	20% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per plan Year	$250
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]	
Tier 1	$20
Tier 2	$40 after pharmacy Deductible
Tier 3	$60 after pharmacy Deductible
Tier 4	$100 after pharmacy Deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]	
Tier 1	$20
Tier 2	$80 after pharmacy Deductible
Tier 3	$180 after pharmacy Deductible
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic

1 Refer to **selecthealth.org/findadoctor** to identify whether a Provider is a primary or secondary care Provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the allowed amounts and not on the Providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

7 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical Out-of-Pocket Maximum.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

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MED NETWORK

MEMBER PAYMENT SUMMARY	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	OUT-OF-NETWORK When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan Year	
Maximum Annual Out-of-Network Payment - (per plan Year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan Year		
Deductible	$1,000	$2,000
Out-of-Pocket Maximum	$3,000	$5,000
Family Coverage, 2 or more enrolled - per plan Year		
Deductible - per person/family	$1000/$3000	$2000/$6000
Out-of-Pocket Maximum - per person/family	$3000/$6000	$5000/$10000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	40% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per plan Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible	40% after Deductible
Up to 40 days per plan Year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$30	40% after Deductible
Secondary Care Provider (SCP)[1]	$40	40% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$40	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$250 after Deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$250 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45	40% after Deductible
Intermountain KidsCare® Facilities	$30	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Chemotherapy, Radiation and Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100%	40% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100%	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$40 after Deductible	40% after Deductible

See other side for additional benefits

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MED NETWORK

MEMBER PAYMENT SUMMARY	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$30	40% after Deductible
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20%	40% after Deductible
Residential Treatment[2]	20% after Deductible	40% after Deductible
Injectable Drugs and Specialty Medications[4]	20% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per plan Year	$250	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$20	
Tier 2	$40 after pharmacy Deductible	
Tier 3	$60 after pharmacy Deductible	
Tier 4	$100 after pharmacy Deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	$20	
Tier 2	$80 after pharmacy Deductible	
Tier 3	$180 after pharmacy Deductible	
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	

1 Refer to **selecthealth.org/findadoctor** to identify whether a Provider is a primary or secondary care Provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the allowed amounts and not on the Providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

7 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical Out-of-Pocket Maximum.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

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MED NETWORK / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan Year	
Maximum Annual Out-of-Network Payment - (per plan Year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan Year		
Deductible	$3,000	$4,000
Out-of-Pocket Maximum	$4,000	$5,500
Family Coverage, 2 or more enrolled - per plan Year		
Deductible	$6,000	$8,000
Out-of-Pocket Maximum - per person/family	$4000/$8000	$5500/$11000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	40% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per plan Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after Deductible	40% after Deductible
Up to 40 days per plan Year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$15 after Deductible	40% after Deductible
Secondary Care Provider (SCP)[1]	$25 after Deductible	40% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20% after Deductible	Not Covered
Major Surgery	20% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$25 after Deductible	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$75 after Deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$75 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$35 after Deductible	40% after Deductible
Intermountain KidsCare® Facilities	$15 after Deductible	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Chemotherapy, Radiation and Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$25 after Deductible	40% after Deductible

See other side for additional benefits

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MED NETWORK / HSA QUALIFIED

MEMBER PAYMENT SUMMARY	
IN-NETWORK	**OUT-OF-NETWORK**

MISCELLANEOUS SERVICES	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME)[4]	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$15 after Deductible	40% after Deductible
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20% after Deductible	40% after Deductible
Residential Treatment[2]	20% after Deductible	40% after Deductible
Injectable Drugs and Specialty Medications[4]	20% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$7 after In-Network Deductible	
Tier 2	$21 after In-Network Deductible	
Tier 3	$42 after In-Network Deductible	
Tier 4	$100 after In-Network Deductible	
Maintenance Drugs-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]		
Tier 1	$7 after In-Network Deductible	
Tier 2	$42 after In-Network Deductible	
Tier 3	$126 after In-Network Deductible	
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	

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2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

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5 All Deductible/Copay/Coinsurance amounts are based on the allowed amounts and not on the Providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

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To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

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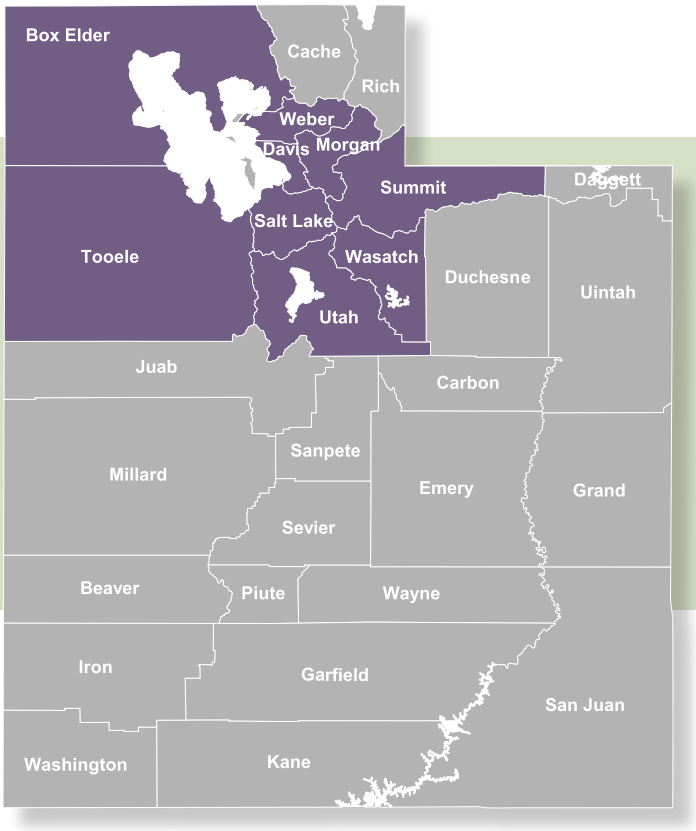
SelectHealth Value®

If you live or work in one of the shaded counties below, SelectHealth Value may be a good option. It is our most affordable network and includes all Intermountain Healthcare® doctors, facilities, clinics, and InstaCare/ KidsCare locations—that's 24 hospitals, 160 clinics, and more than 5,500 doctors, including specialists who you can see without a referral. This network also includes access to dozens of clinics and providers who aren't affiliated with Intermountain Healthcare.

Additionally, you'll have urgent care telehealth visits through Intermountain Connect Care, our free mental health hotline **(833-442-2211)**, and our Health Answers nurse line **(844-501-6600)**.

It's robust coverage that gives you what you want and need in a network.

Wondering whether your current doctor or neighborhood clinic is part of the SelectHealth Value network? To find out, visit **selecthealth.org/providers**. Remember to filter your results by choosing SelectHealth Value from the network drop-down menu.



PRIMARY CARE PROVIDERS

A Primary Care Provider (PCP) sees patients for common medical problems, performs routine exams, and helps prevent or treat illness. You can trust a PCP to know your health history, be your partner in preventive care, and help you find other doctors when you need them.

SPECIALISTS

When you need more than your PCP, our network of specialists and surgeons can help—and there are thousands to choose from.

LOCAL CLINICS

Intermountain community clinics and contracted clinics are in your area, so you never have to drive far to get the care you need. Plus, some clinics have extended hours!

HOSPITALS

Our hospitals span Utah, offering great care and services. Think heart care, cancer treatment, transplant services, women and newborns, and much more—you name it, they can treat it.

INTERMOUNTAIN INSTACARE®

What's open late and costs less than the ER? Our InstaCare® and KidsCare® clinics. If you need urgent care, these are great options.

INTERMOUNTAIN CONNECT CARE®

Visit a provider 24/7 via live online video. Most plans cover this service for a $0 copay. Check your ID card or member materials for coverage information.

INTERMOUNTAIN HEALTH ANSWERS®

Our free nurse line is available 24/7 to ease your mind. Call **844-501-6600** about any condition.

EMERGENCY CARE

If you have an emergency, call 911 or go to the nearest hospital—we've got you covered anywhere you are.

SelectHealth Med®

PLUS OUT-OF-NETWORK BENEFITS

SelectHealth Med plus out-of-network benefits includes all Intermountain Healthcare® facilities, clinics, and doctors and key speciality facilities such as the Huntsman Cancer Hospital and Moran Eye Center. SelectHealth Med includes nearly 40 participating hospitals and over 200 clinics with more than 7,200 doctors, including specialists who you can see without a referral. Plus, with this plan, you can use out-of-network doctors and facilities for covered services.

Finally, you'll have in-network benefits throughout the U.S. Use the table below to find in-network providers wherever you are in the country.

STATE	NETWORK
Utah	SelectHealth Med
Idaho	St. Luke's Health Partner's, Brightpath, & the SelectHealth Network
Nevada	SelectHealth Value
All Other States	UnitedHealthcare Options PPO

Visit **selecthealth.org/provider** or use our mobile app to search for in-network doctors and facilities. Remember to choose the right network from the drop down.

PRIMARY CARE PROVIDERS

A Primary Care Provider (PCP) sees patients for common medical problems, performs routine exams, and helps prevent or treat illness. You can trust a PCP to know your health history, be your partner in preventive care, and help you find other doctors when you need them.

SPECIALISTS

When you need more than your PCP, our network of specialists and surgeons can help—and there are thousands to choose from.

LOCAL CLINICS

Intermountain community clinics and contracted clinics are in your area, so you never have to drive far to get the care you need. Plus, some clinics have extended hours!

HOSPITALS

Our hospitals span Utah, offering great care and services. Think heart care, cancer treatment, transplant services, women and newborns, and much more—you name it, they can treat it.

INTERMOUNTAIN INSTACARE®

What's open late and costs less than the ER? Our InstaCare® and KidsCare® clinics. If you need urgent care, these are great options.

INTERMOUNTAIN CONNECT CARE®

Visit a provider 24/7 via live online video. Most plans cover this service for a $0 copay. Check your ID card or member materials for coverage information.

INTERMOUNTAIN HEALTH ANSWERS®

Our free nurse line is available 24/7 to ease your mind. Call **844-501-6600** about any condition.

EMERGENCY CARE

If you have an emergency, call 911 or go to the nearest hospital—we've got you covered anywhere you are, even outside of the country.

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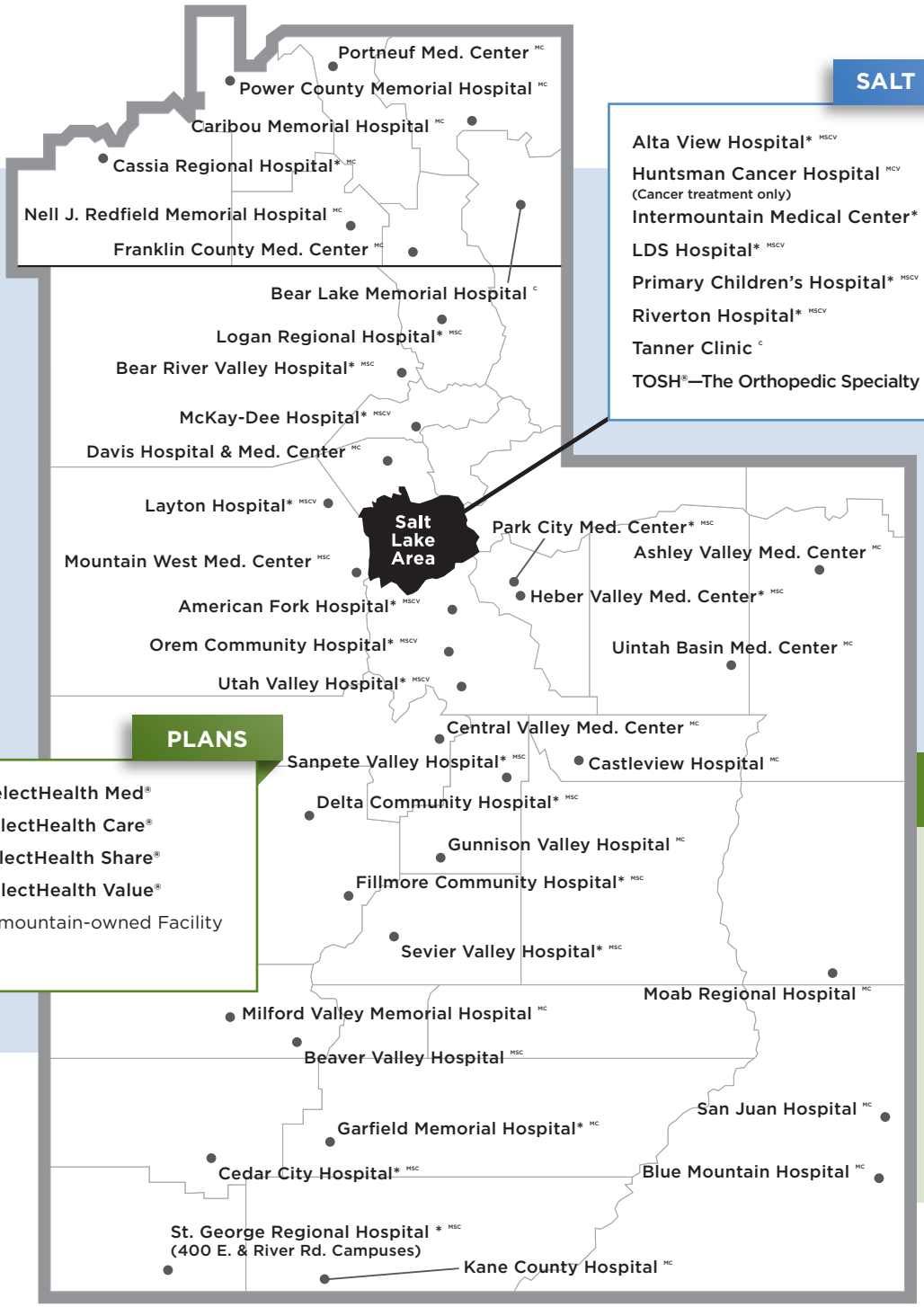
Facility Map

Use the map and key below to determine which hospitals are participating on your SelectHealth® plan.



SALT LAKE AREA

- Alta View Hospital* MSCV
- Huntsman Cancer Hospital MCV
  (Cancer treatment only)
- Intermountain Medical Center* MSCV
- LDS Hospital* MSCV
- Primary Children's Hospital* MSCV
- Riverton Hospital* MSCV
- Tanner Clinic C
- TOSH®—The Orthopedic Specialty Hospital *MSCV

PLANS

M—SelectHealth Med®
C—SelectHealth Care®
S—SelectHealth Share®
V—SelectHealth Value®
*Intermountain-owned Facility

NEED MORE INFORMATION?

WEB
selecthealth.org/facilities

PHONE
800-538-5038

YOUR
HEALTHCARE

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Seven Tips to Keep Healthcare Costs Low

We know healthcare can be expensive, but by using the tips below, you can keep your costs lower.

TIP 1

GET CARE IN THE RIGHT PLACE. Make sure you choose the most appropriate place for your healthcare needs. Besides helping you save money, this helps you stay healthy and safeguard your benefits. If you're not sure where to go, you can always call us at **800-515-2220**. And remember, save that trip to the emergency room for only true emergencies.

TIP 2

USE GENERIC DRUGS WHENEVER POSSIBLE. Talk to your doctor and pharmacist about options for using generic drugs—they can help you get effective medication at the best price.

TIP 3

STAY HEALTHY. The number one influence on your health is you. Take the time to take care of yourself and your family. Fact: The healthier you are, the less you spend on healthcare.

TIP 4

GET PREVENTIVE CARE. Preventive care is covered 100% by most plans when you use in-network providers. Preventive care can help you stay healthy in the long run.

TIP 5

SEE IN-NETWORK PROVIDERS. We've said it many times, but it's worth saying again. If you go to doctors and facilities in your network, your insurance will pay more and you will usually pay less for the care you receive. And if you go out-of-network, you will likely pay more out-of-pocket.

TIP 6

USE AN FSA OR AN HSA. Sign up for a plan that pairs with a Flexible Spending Account (FSA) or Health Savings Account (HSA) to pay for your out-of-pocket health expenses (if offered by your employer). Remember only certain plans pair with an HSA, and other limits may apply.

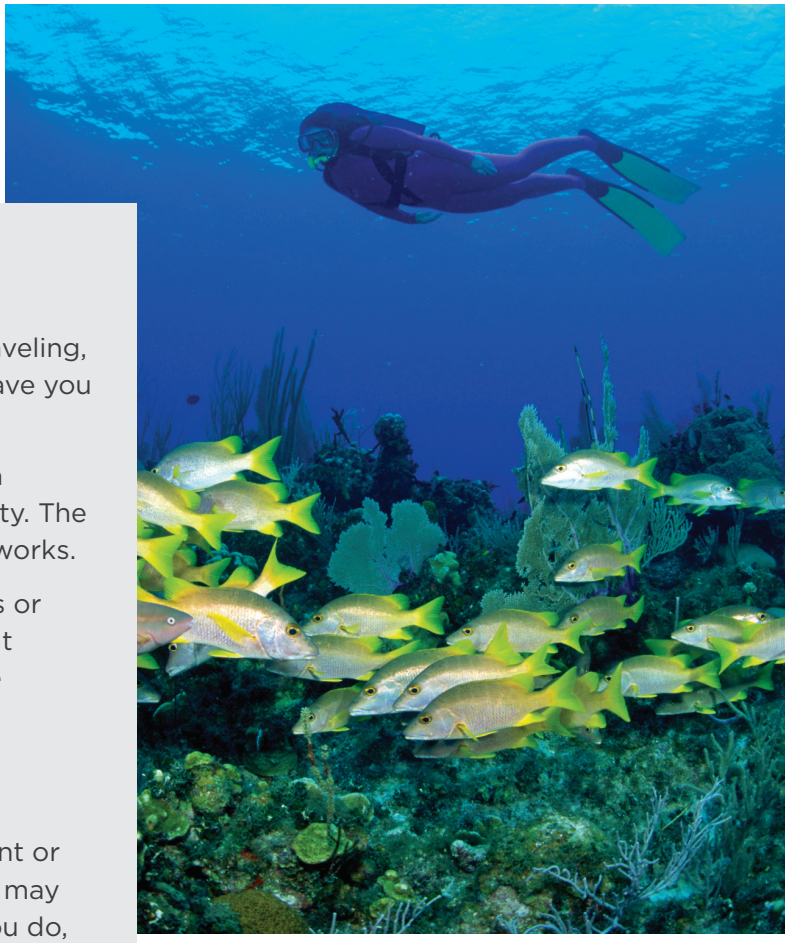
TIP 7

MANAGE YOUR CHRONIC ILLNESS. The Care Management team can coordinate care and find the best way to meet your needs. Current programs include asthma, cancer, COPD, diabetes, depression, heart disease, high-risk pregnancy, mental health concerns, and substance abuse. To speak with a care manager, call **800-442-5305**.

On the Move?

OUTSIDE OF YOUR SERVICE AREA

In-network benefits apply when you receive services for urgent or emergency conditions, no matter where you are.



SAVE MONEY WHEN TRAVELING

To reduce your medical out-of-pocket expenses while traveling, using the UnitedHealthcare Options PPO network may save you money for urgent and emergency care.

Remember: Always present your ID card when you visit a UnitedHealthcare Options PPO network provider or facility. The logos on the back of the card give you access to the networks.

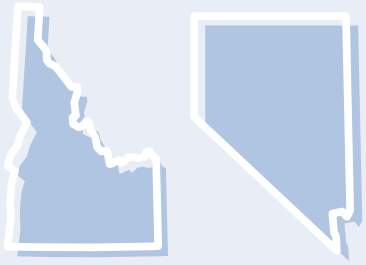
To find UnitedHealthcare Options PPO network providers or facilities, call Member Services at **800-538-5038** or visit **selecthealth.org/providers** and select "UnitedHealthcare Options PPO" from the network drop down..

OUTSIDE OF THE COUNTRY

If you are traveling outside of the country and need urgent or emergency care, visit the nearest doctor or hospital. You may need to pay for the treatment at the time of service. If you do, keep your receipt and submit it along with a *Claim Reimbursement Form*, which can be found on **selecthealth.org/forms**.

OUT-OF-AREA DEPENDENTS

Enrolled dependents who live outside of your service area (maybe they're going to college or living with another family member) can receive in-network benefits for covered services. To qualify for this coverage, you need to submit a Dependent Address Change form, which can be found at **selecthealth.org/forms**. The form contains important instructions about which networks your enrolled dependents can use when living outside your service area—please read it carefully.



IDAHO AND NEVADA

SelectHealth Med® and SelectHealth Care® plans also include in-network benefits in Idaho through the Brightpath and St. Luke's Health Partners networks, and in Nevada through the SelectHealth Value network.

selecthealth

We're Here to Help You

MEMBER SERVICES

We want to help you understand your insurance plan—so, when you have a question, give us a call. We also realize that life doesn't always happen between nine and five, so we're here late.

7 a.m. to 8 p.m., weekdays
9 a.m. to 2 p.m., Saturdays

800-538-5038

ONLINE CUSTOMER SERVICES

No time for a call? Log in to your SelectHealth member account and chat with us or request a call back at a time that's convenient for you.

selecthealth.org

MEMBER ADVOCATES℠

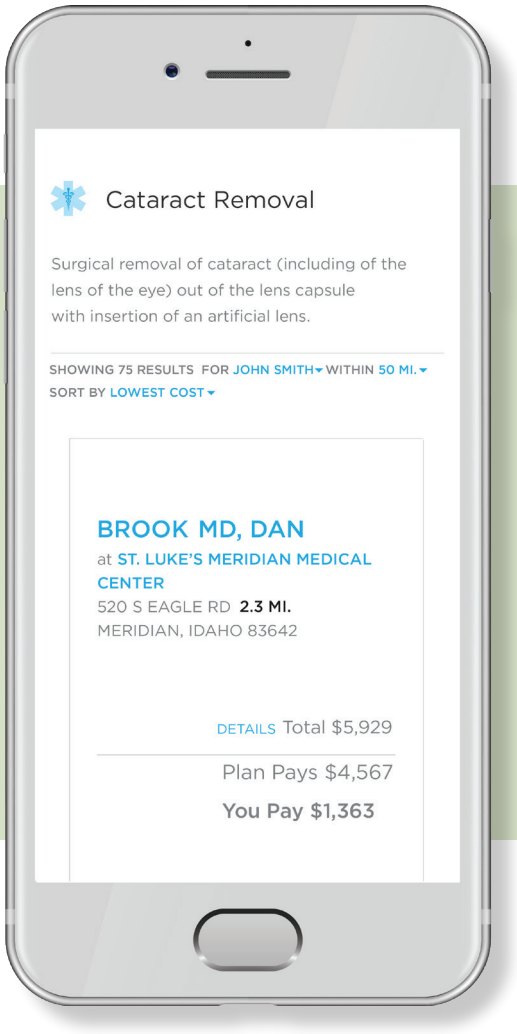
We can help you find the right doctor for your needs. We'll find the closest facility or doctor with the nearest available appointment, schedule appointments for you, and help you understand and maximize your benefits.

800-515-2220

Health insurance doesn't have to be complicated. We can help you with everything from understanding your benefits to finding the right doctor. Our customer service teams are dedicated to providing exceptional service.

Superior Tech for You

Your secure online member account is your one-stop shop for information about your healthcare. Your member account can be accessed from your mobile device or computer by visiting **selecthealth.org**.



MEDICAL COST ESTIMATOR

We can use your benefits to estimate the cost of many healthcare services. For example, we can estimate the cost of cataract removal, including charges for the facility, provider, and anesthesiologist. Bundling these numbers together, we'll estimate how much your plan will cover and what you will pay.

ID CARDS

Lost your ID card? No worries—you can view and print copies of your card on your SelectHealth member account.

REQUEST A CALL

Use our call request feature to schedule a call back from our Member Services team at a set time that's convenient for you.

CHAT WITH US

No time for a phone call? Use our secure chat feature to talk with Member Services online. If you need to know whether your medication will be covered or how much a doctor's bill was, chat can help.

HEALTHCARE INFORMATION

View your benefits, claims, and deductible levels.

Many contracted providers and facilities receive secure messages and will even upload lab results, imaging reports, and other health information on your Intermountain Healthcare *My Health+* account. To access information from your providers, click the blue *My Health+* button in the right corner of your SelectHealth dashboard.

MyHealth+

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SelectHealth Healthy Beginnings®

HOW WE CAN HELP

Our Healthy Beginnings℠ program is designed to help you have the healthiest pregnancy possible. This prenatal program is available to you at no extra cost, and nurse care managers can offer:

- Support and education during your pregnancy
- Help with claims and benefit questions
- Community resources, such as Women, Infants, and Children (WIC) and food and transportation programs, etc.
- Education about childbirth, breastfeeding, and more
- Access to needed care

EXTRA PERKS

- Cash incentives for prenatal and postnatal care*
- Free online education through Intermountain Healthcare®
- Prenatal booklet and a free book of your choice
- Help getting a breast pump after delivery

HOW TO ENROLL

Call us at **866-442-5052**, Monday through Friday, from 8:00 a.m. to 5:00 p.m. If calling after hours, please leave a message with a phone number and best time to reach you.

*based on plan type

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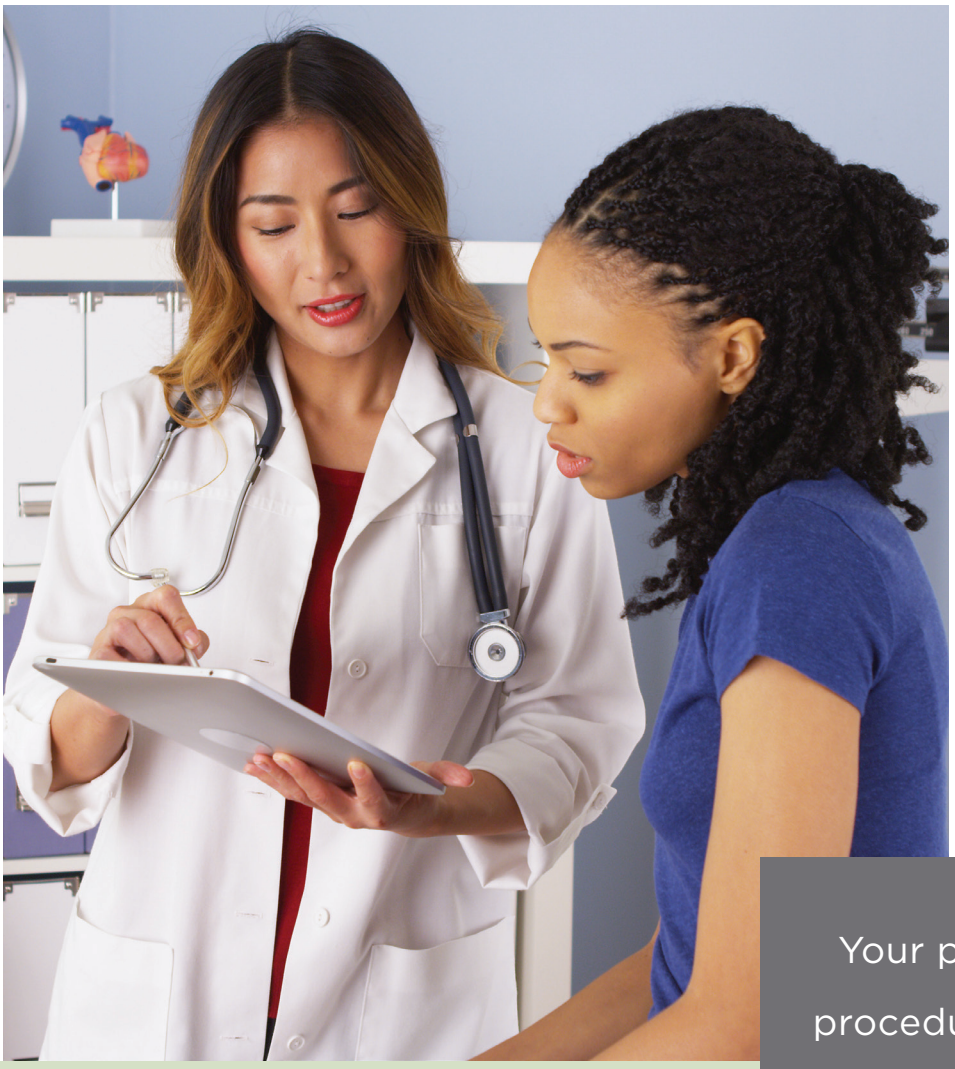
Preventive Care



DID YOU KNOW?

Your plan covers many procedures, services, and preventive screenings at no out-of-pocket cost to you. With 100% coverage, you can get the preventive care you need.

For services to be covered as preventive, your doctor must submit claims with preventive codes. If a preventive service identifies a condition that needs further testing or treatment, regular copays, coinsurance, or deductibles may apply. Unless otherwise indicated, these services are generally covered once every 12 months.

This information is subject to change at any time and additional limitations may apply. To verify if your service or supply is considered preventive, call Member Services at **800-538-5038**.

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Zero Out-of-Pocket Cost

Adult Preventive Services (ages 18 and older)

Laboratory Tests

- Complete Blood Count (CBC)
- Prostate Cancer Screening (PSA)
- Diabetes Screening
- Cholesterol Screening
- Gonorrhea Screening
- Human Papillomavirus (HPV) Testing (once every 3 years for women ages 21-65)
- Chlamydia Screening
- Human Immunodeficiency Virus (HIV) Screening
- Syphilis Screening
- Tuberculosis (TB) Testing
- Lead Screening
- BRCA 1 & 2 Testing (covered once per lifetime for high-risk individuals who meet criteria)
- Hepatitis B Virus (HBV) Screening (covered for high-risk individuals who meet criteria)
- Hepatitis C Virus (HCV) Screening (once per lifetime for individuals over age 50)

Procedures

- Pap Test
- Lung Cancer Screening (between ages 55 and 80)
- Screening Mammogram
- Colon Cancer Screening
- Abdominal Aortic Aneurysm Screening (males only, once between ages 65 and 75)
- Bone Density/DEXA (once every two years in women ages 60 and older)
- Certain Sterilization Procedures (such as tubal ligation)

Examinations/Counseling

- Physical Exam
- Tobacco Use Counseling
- Alcohol Misuse Screening and Counseling
- Hearing Screening (ages 65 and older)
- Glaucoma Screening (Every 12 months)
- Sexually Transmitted Infections Counseling
- Dietary Counseling (only for certain diet-related chronic diseases)

Immunizations

- Influenza
- Tetanus or Tetanus, Diphtheria, and Pertussis (Td, Tdap)
- Pneumococcal
- Hepatitis A
- Meningitis
- Zoster (ages 50 and older OR ages 59 and older)
- Human Papillomavirus (HPV) (ages 9 to 25)

Contraception

Most contraceptives are covered as a preventive service under your pharmacy benefits.

- Cervical Cap with Spermicide
- Diaphragm with Spermicide
- Emergency Contraception (Ella, Plan B)
- Female Condom
- Implantable Rod
- IUDs
- Generic Oral Contraceptives (Combined Pill, Progestin Only, or Extended/ Continuous Use)
- Patch
- Shot/Injection (Depo-Provera)
- Spermicide
- Sponge with Spermicide
- Surgical Sterilization for Women (Tubal Ligation)
- Surgical Sterilization Implant for Women
- Vaginal Contraceptive Ring

Pediatric Preventive Services (younger than age 18)

Procedures/Counseling

- Well-Child Visit (preventive when billed on the following schedule: birth; 2 to 4 days; 2 to 4 weeks; 2, 4, 6, 9, 12, 15, and 18 months; ages 2, 2 1/2; once a year from ages 3 to 18)
- Eye Exam
- Developmental Testing
- Newborn Hearing Screening (once per lifetime)
- Hearing Screening (ages 10 and younger)
- Application of Fluoride Varnish (younger than age 5)

Laboratory Tests

- Newborn Metabolic Screening (younger than age 1)
- Human Immunodeficiency Virus (HIV) Screening
- PKU Screening (younger than age 1)
- Thyroid (younger than age 1)
- Sickle Cell Disease Screening (younger than age 1)

Immunizations

(As recommended by the CDC/ACIP)

- Measles, Mumps, Rubella (MMR)
- Diphtheria, Tetanus, Pertussis (Dtap, DT, DTP)
- Haemophilus Infuenzae Type B (Hib, DtaP-Hib-IPV, DTP-Hib, Dtap-Hib)
- Polio (OPV, IPV, DtaP-Hep-LPV)
- Influenza
- Pneumococcal
- Hepatitis A
- Hepatitis B
- Meningitis
- Varicella (including MMVR)
- Rotavirus
- Human Papillomavirus (HPV) (ages 9 to 25)

Obstetrical Preventive Services

These are specific to pregnant women. To determine which additional non-obstetrical services may be considered preventive, please refer to the Adult or Pediatric Preventive Services lists.

Laboratory Tests

- Iron Deficiency Anemia Screening
- Diabetes Screening
- Urine Study to Detect Asymptomatic Bacteriuria (first prenatal visit or at 12 to 16 weeks gestation)
- Rubella Screening
- Rh(D) Incompatibility Screening
- Hepatitis B Infection Screening (at first prenatal visit)
- Gonorrhea Screening
- Chlamydia Screening
- Syphilis Screening

Breast-feeding Supplies and Support

- Breast Pump, Electronic AC or DC (one per birth)
- Lactation Class (one per birth at a SelectHealth-approved facility)

This information is subject to change at any time and additional limitations may apply. To verify if your service or supply is considered preventive, call Member Services at **800-538-5038**.

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Helping You Manage Your Health

Care managers are specially trained registered nurses who assist members with long-term chronic diseases and help them recover from surgeries and short-term illnesses. They have years of healthcare experience, with extensive knowledge about facilities, providers, and services. If you qualify for care management, a care manager will work with you and your doctor to make sure you get the most appropriate care and receive help with your benefits and claims.

In addition to one-on-one support, we provide educational materials and follow-up phone calls to help you manage your condition. Care management is available for members with the conditions, surgeries, or illnesses listed here. Please call us to learn more.

- **Asthma**
- **Cancer**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Complex joint replacements**
- **Diabetes**
- **Heart disease**
- **Depression/Anxiety**
- **High-risk pregnancy**
- **HIV and other blood conditions**
- **Some surgeries**

NEED MORE INFORMATION?

WEB
selecthealth.org/caremanagement

PHONE
800-442-5305

Helping You Quit

TOBACCO CESSATION

If you smoke, Quit for Life® can help. It's a private program that you follow at your own pace from home. You receive a Quit Kit and access to a toll-free Quit Line. If you participate, a trained smoking cessation counselor will call you and provide one-on-one coaching and support over the phone for one year.

The Quit for Life program is covered 100%—no copay or coinsurance required. Call **866-QUIT-4-LIFE** or visit **quitnow.net** for more information or to enroll.

The Quit For Life program is brought to you by the American Cancer Society® and Optum. The two organizations have 35 years of combined experience in tobacco cessation coaching and have helped more than one million tobacco users. Together, they will help millions more make a plan to quit, realizing the American Cancer Society's mission to save lives and create a world with more birthdays.

NICOTINE REPLACEMENT THERAPY

Most SelectHealth plans include 100% coverage for Nicotine Replacement Therapy (NRT), which includes prescription drugs or patches that can help curb nicotine cravings. Check your benefits to make sure you have coverage, but most of our plans allow two 90-day courses of nicotine replacement medication each year. For more information about prescribed medication that may increase your chances to quit smoking, talk to your doctor.

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Know Before You Fill

COMPARE DRUG PRICES

Log in to your SelectHealth member account to search for covered medications, compare drug prices, and see other information about your prescriptions and benefits. Your member account also has information about any special requirements, like step therapy or preauthorization, which you and/or your doctor may need to complete before you can fill a prescription. If you ever have questions about drugs with special requirements, call Member Services at **800-538-5038**.

SAVE MONEY WITH LOWER-TIER DRUGS

The list of drugs covered by your plan will be either RxSelect® or RxCore®. Your member materials and ID card indicate which drug list you have, and searchable versions of these two drug lists are available on our website.

Your drug list will have three or four tiers of coverage and each tier corresponds to a copay or coinsurance amount (the amount you pay when you get drugs at the pharmacy). Look for generics and lower-tier alternatives to pay less for equally effective medications.

$	**Tier 1**	Lowest Cost (mostly generic drugs)
$$	**Tier 2**	Higher Cost (generic and brand-name drugs)
$$$	**Tier 3**	Highest Cost (mostly brand-name drugs)
$$$$	**Tier 4**	Injectable Drugs and Specialty Medications

CONVENIENT PHARMACY ACCESS

INTERMOUNTAIN HOME DELIVERY PHARMACY

Get your prescriptions delivered for FREE. Register online at **intermountainrx.org** or call **855-779-3960**.

INTERMOUNTAIN SPECIALTY PHARMACY

Get your specialty drugs or self-injectables delivered for FREE.

Ask your doctor to send prescriptions or call **877-284-1114**.

RETAIL 90®

Get a 90-day supply of your maintenance medications at a participating Retail 90 pharmacy—and pay less in most cases.

YOUR LOCAL PHARMACY

From major national chains to the corner drug store, you can get your prescriptions filled pretty much anywhere. Search for participating pharmacies at **selecthealth.org**.

selecthealth

Stay Home, Stay Safe, Get Healthcare

WE'VE EXPANDED OUR TELEHEALTH COVERAGE!

ON-DEMAND HEALTHCARE

Our plans (including high deductible health plans) have $0 copays/coinsurance before deductible for Connect Care℠ urgent care video visits.

The average wait time is under 10 minutes, and you can save more than $400 a visit when compared with the ER.*

Download the Connect Care app or go to **intermountainconnectcare.org** to get started. The service is available 24/7, and you can see a doctor virtually at no out-of-pocket cost to you.

WHAT IS URGENT CARE?

When you can't see your regular doctor, use Connect Care for:

- > Stuffy and runny nose
- > Allergies
- > Sore throat
- > Eye infections
- > Cough
- > Painful urination
- > Lower back pain
- > Joint pain or strains
- > Minor skin problems

For emergencies, call 911 or go to the ER.

* Data based on internal SelectHealth and Intermountain Healthcare claims and wait time data

$0 OUT-OF-POCKET PSYCHIATRIC CARE FROM ANYWHERE IN UTAH OR IDAHO.

Receive the same quality care for mild-to-moderate conditions through the convenience of a video visit.

Schedule an appointment by calling: **833-442-2670 OR** Schedule through MyHealth+

1. Download the MyHealth+ App or use the web version: **intermountainhealthcare.org/MyHealth**.
2. In the app select "Get Care," then "Appointments," the "Behavioral Health-Connect Care" specialty
3. Book an appointment.

TREATING MILD-TO-MODERATE:

- > Anger or Mood Swings
- > Anxiety
- > Attention Deficit
- > Bipolar
- > Depression
- > Insomnia
- > Panic Attacks
- > PTSD
- > Stress
- > Substance Abuse/Misuse

VISIT INTERMOUNTAINHEALTHCARE.ORG/CCBH FOR MORE INFORMATION.

THROUGH THE COVID-19 (NOVEL CORONAVIRUS) PANDEMIC, YOU WILL HAVE COVERAGE* FOR:

SCHEDULED VIDEO VISITS

A scheduled video visit is a non-urgent care visit with your doctor or specialist (including mental health providers) using Intermountain Video Visits or other approved platform. This is covered under the same benefit as a normal doctor's office or specialist visit.

ASYNCHRONOUS (DELAYED RESPONSE) VISITS

These visits include emails or other secure communications with your doctor (through My Health+ or other platform) that are used to diagnose or treat health conditions. These communications, if billed, are also covered under the same benefit as a doctor's office or specialist visit.

* Expanded telehealth coverage will continue during the "public health emergency period" as defined by federal law. These benefits follow the member's office visit benefit and cost-sharing may apply.

SAVING FOR TODAY AND TOMORROW WITH A

Health Savings Account (HSA) from HealthEquity®

An HSA is an untaxed medical savings account you can use to pay for medical-related expenses. There are a few requirements, but it is a great way to build savings for today and for your future. Why? Because unlike a Flexible Savings Account (FSA), whatever you do not spend year-to-year rolls over. To get started:

STEP 1

SELECT AN HSA-QUALIFIED HEALTH PLAN

Enroll in an HSA-qualified SelectHealth plan. These plans typically cost less than traditional plans and provide tax-saving opportunities. Our HSA provider, HealthEquity, will work with your employer and SelectHealth to automatically set up your account and send you a HealthEquity Visa® Health Account Card[1] to conveniently pay for eligible medical expenses.

STEP 2

ADD MONEY TO YOUR HSA

Fund your HSA through pre-tax payroll deductions or transfer money into your account through the HealthEquity member portal. Your employer can help you make pre-tax payroll deductions.

To make tax-free[2] contributions to an HSA, the IRS requires that:

- > You are covered by an HSA-qualified health plan.
- > You have no other health coverage (such as another health plan, Medicare, military health benefits, or medical FSA).
- > You are not Medicare-eligible.
- > You cannot be claimed as a dependent on another person's tax return.

To see how you can personally benefit from an HSA, visit **healthequity.com/me**.

1 This card is issued by The Bancorp Bank, pursuant to a license from U.S.A., Inc. and can be used for qualified expenses. See Cardholder Agreement for complete usage instructions.

2 HSAs are not taxed at the federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor if you have questions.

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Member Discounts

NEED MORE INFORMATION?

WEB
selecthealth.org/discounts

PHONE
800-538-5038

Plan Information

CARE AND COST MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. We review things such as the appropriateness of the care setting, medical necessity, and appropriateness of hospital lengths of stay. This helps reduce unnecessary medical expenses and keeps premiums as low as possible. For more information about how we help manage healthcare, including information about services that require preauthorization or to know how to file an appeal, please visit **selecthealth.org/policy.**

PROTECTING YOUR PRIVACY

We understand the importance and sensitivity of your personal health information, and we have security measures in place to protect it. For more information about how we protect your privacy, including our complete Notice of Privacy Practices, please visit **selecthealth.org/policy**.

EXCLUSIONS AND LIMITATIONS

Unless otherwise noted on your Member Payment Summary, there are some healthcare services that SelectHealth does not cover. Please visit **selecthealth.org/policy** to learn more about some of the services that are not covered or have coverage limitations. You can also read more about exclusions and limitations in your Member Materials.

MEMBER RIGHTS AND RESPONSIBILITIES

We want you to be an active part of your healthcare. Visit **selecthealth.org/policy** to view your member rights and responsibilities.

FAIR TREATMENT NOTICE

SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats upon request.

PRINTED VERSIONS AVAILABLE

If you would like to request a printed copy of any or all of these notices, call Member Services at **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

FORMS AND OTHER DOCUMENTS

P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 **selecthealth.org**

Enrollment Form and Instructions Large Employer

You must read all instructions before completing and signing the Enrollment Form because it contains terms for agreement. If you need help, contact a Human Resources/Personnel representative at your place of employment or call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**.

SECTION A. EMPLOYEE INFORMATION

Complete this section with all of the requested information about yourself (the employee applying for coverage).

SECTION B. EMPLOYER USE ONLY

An authorized representative of the employer group must complete this section.

- Group Name, Subgroup Name, and Class Name – This information can be provided by your agent or sales representative.
- Employee's Payroll Status – Indicates the current employment classification of the subscriber. For example, please indicate if he or she is an active employee, on an approved leave of absence, or retired.
- Comments – This section may be used to communicate any other pertinent information to SelectHealth/SelectHealth Benefit Assurance Company.
- Employer's Signature – An authorized representative of the employer must sign and date this section to validate the form.

SECTION C. WAIVER OF COVERAGE

Complete and sign this section if you wish to waive healthcare coverage at this time.

You and your dependents may not be eligible to enroll again until the next open enrollment period established by your employer and SelectHealth/SelectHealth BAC, unless you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (special enrollment event), you may be able to enroll yourself, your spouse, and the new dependent(s) if you request enrollment within 31 days of the special enrollment event.

SECTION D. DEPENDENT INFORMATION

Complete this section with all of the requested information about you and your dependent(s).

- If your dependent child is older than the age limit specified in the agreement with SelectHealth/SelectHealth BAC and your employer, but still eligible for coverage because of a physical or mental disability, you must attach proof of the dependent's disability to this form.
- If you or your eligible dependents have other health or dental (if applicable) insurance, you must complete the Secondary Medical Coverage Form (COB) to facilitate accurate coordination of benefits with other carriers.

If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:

- During your employer's next open enrollment period;
- When proof of a legal divorce or annulment is given to SelectHealth/SelectHealth BAC; or
- When your spouse agrees by signing the Employee Change Form (if allowed by your employer's eligibility rules).

SECTION E. EMPLOYEE AGREEMENT AND SIGNATURE

You must read and understand the following information. After you have read and agreed to the following terms of this form, sign under "Section E. Employee Agreement and Signature." Otherwise, this application and enrollment may not be valid.

- I hereby apply for membership in SelectHealth/SelectHealth BAC for the persons listed on this application (herein referred to as applicants) and agree to submit premiums as required by SelectHealth/SelectHealth BAC or authorize my employer to deduct from my earnings the necessary contributions, if any, required of me. I accept the terms of the group agreement between my employer and SelectHealth/SelectHealth BAC and appoint my employer to act as an agent on my behalf. I understand that said agreement is on file with the employer and SelectHealth/SelectHealth BAC and is available for my inspection. I understand that any intentional material misrepresentation in answering the questions on this application or nonpayment of premiums may result in recision or cancellation of my coverage and that of my dependents.

Enrollment Form (See reverse side for instructions)

I am (Please check one):

❑ A new enrollee ❑ Switching from another SelectHealth plan (list plan) _____ ❑ Switching from another carrier (list carrier) _____

Please make selection(s) below (Form is not complete unless a box is checked)

❑ SelectHealth Med Plus®

❑ SelectHealth Value®

❑ SelectHealth Med Plus® HealthSave

❑ HealthEquity Health Savings Account (HSA)

A. EMPLOYEE INFORMATION (Please print legibly)

LEGAL NAME (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY) SOCIAL SECURITY NUMBER

MAILING ADDRESS

CITY STATE ZIP

STREET ADDRESS (if different)

CITY STATE ZIP

HOME PHONE CELL PHONE E-MAIL ADDRESS

SEX
❑ Male ❑ Female

Please select your preferrred language / Seleccione el idioma de su preferencia / Aah shoodi, heedigi sha'a saad ninii ziin?
❑ English ❑ Spanish ❑ Navajo ❑ Other

MARITAL STATUS
❑ Single ❑ Legally Married

If you are enrolling due to a special event, check all that apply:
❑ Birth/adoption ❑ Marriage ❑ Loss of other coverage

EMPLOYEE'S PRIOR COVERAGE You must give proof of prior coverage to SelectHealth/SelectHealth BAC as soon as reasonably possible.

CARRIER _____ DATE COVERAGE ENDED _____ /_____ /_____

B. EMPLOYER USE ONLY (Employer, please provide the following information where applicable to this employee.)

GROUP NAME _____ GROUP # _____

SUBGROUP NAME _____ SUBGROUP # _____

CLASS NAME _____ CLASS ID # _____

HIRE DATE (MM/DD/YYYY) _____ /_____ /_____ EMPLOYEE'S MEDICAL PLAN EFFECTIVE DATE (MM/DD/YYYY) _____ /_____ /_____

EMPLOYEE'S PAYROLL STATUS _____

Comments _____

Employer Signature _____ Date _____ /_____ /_____

C. WAIVER OF COVERAGE

I have been given the opportunity to enroll and choose to waive such coverage. I have read the information in "Section C" on the first page of this Enrollment Form and understand the consequences of my choice to waive coverage. Reason for waiving (check one box):

❑ I already have health insurance through ______________________________.
INSURANCE COMPANY NAME

❑ I do not want to buy health insurance at this time.

❑ I already have dental insurance through ______________________________.
INSURANCE COMPANY NAME

❑ I do not want to buy dental insurance at this time.

Employee Signature ______________________________ Date ______ /______ /______

D. DEPENDENT INFORMATION

Complete this section in full. List all eligible dependents (spouse and children) whom you wish to be covered and elect the coverage desired. List children in order of age. List the relationship of all children and dependents to the employee in the "Relationship" column. If you need more space, use another Enrollment Form (available from SelectHealth).

NUMBER OF DEPENDENTS YOU ARE ENROLLING ______________________

COVERAGE

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Spouse ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

Are you and/or your ex-spouse required by a divorce decree to pay the medical expenses of your dependent(s)? ❑ Yes ❑ No

If yes, you must attach a copy of the divorce decree to this Enrollment Form. Include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

Are you adding a dependent because of a court or administrative order? ❑ Yes ❑ No
If yes, please attach a copy of the notice with this form.

Will you or any of your dependent(s) have other health or dental insurance in addition to this plan? ❑ Yes ❑ No If yes, complete COB Form.

E. EMPLOYEE AGREEMENT AND SIGNATURE

This section requires that you turn to the first page of this form and read the information in "Section E. Employee Agreement and Signature." I hereby certify that I have read, understand, and agree to the terms outlined in "Section E. Employee Agreement and Signature" on the first page of this Enrollment Form. After your employer has approved this form, please keep a copy for your records.

Employee Signature ______________________________ Date ______ /______ /______

P.O. Box 30192, Salt Lake City, UT 84130-0192 800-538-5038 **selecthealth.org**

Health Savings Account (HSA) Enrollment and Authorization to Disclose Health Information to HealthEquity®

Complete this form if you have chosen a HealthSave℠ plan with HealthEquity as your HSA administrator. (See your application/enrollment form.) Please fax your completed form to SelectHealth Enrollment at 801.442.5798. If you have the ability to send secure e-mails, you can e-mail your completed form to enrollment@selecthealth.org. If you have chosen a HealthSave plan and you don't complete and send this form, an HSA will not be set up for you. However, failure to complete and send this form will not affect your HealthSave insurance coverage.

Policyholder's Last Name _____ First Name _____ Middle Initial _____

Social Security# _____ Birth Date _____

Name of Employer _____

A. HSA ENROLLMENT

This Enrollment Form will open an HSA that is used to accumulate assets for the payment of qualified healthcare expenses. Your HSA is your financial asset even if you change employers or health plans. To open an HSA, you must meet three criteria:

1. You must be covered by a qualified High Deductible Health Plan (HDHP) (your HealthSave plan is a qualified HDHP);
2. You generally cannot be covered by another health plan, including Medicare; and
3. You cannot be claimed as a dependent on another individual's tax return.

These criteria are explained in more detail in the HSA Custodial Agreement available at **healthequity.com**.

I understand the following about HSA enrollment:

1. By signing this form, I have requested an HSA to be set up in my name with HealthEquity;
2. I have read, understand, and accept my obligations under the HSA Custodial Agreement; and
3. I certify that I am eligible to open and contribute to an HSA.

B. AUTHORIZATION

I authorize SelectHealth to disclose medical and dental claims information about me to HealthEquity, as the administrator of my HSA, for purposes of administering and coordinating reimbursements under my account.

C. IMPORTANT PRIVACY INFORMATION

I understand the following information:

1. SelectHealth will not condition payment, enrollment, or eligibility for health plan benefits on my signing this Authorization;
2. This Authorization will apply to all claims incurred while this Authorization is in effect;
3. I may refuse to sign this Authorization, or I may revoke it at any time for any reason, except to the extent that: a) SelectHealth has already made disclosures in reliance on this Authorization; or b) claims have already been incurred before the revocation. However, if I do so, it will limit HealthEquity's ability to provide me account administration services;
4. I may revoke this Authorization by sending a written request to SelectHealth;
5. Once SelectHealth discloses information according to this Authorization, SelectHealth cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information; and
6. Unless revoked, this Authorization will remain in effect until the earlier of: a) the end of my eligibility as a SelectHealth member; or b) the date that HealthEquity no longer administers my account.

D. IDENTIFYING INFORMATION/SIGNATURES FOR THE EMPLOYEE/APPLICANT AND DEPENDENTS

NOTICE: By signing this form, you give SelectHealth the right to disclose health information to HealthEquity about you and your dependents for whom you have legal authority to sign (e.g., a minor child). You do not need to list dependents for whom you have legal authority to sign. Generally, a spouse and children older than age 18 must sign for themselves.

Applicant	Date of Birth (MM/DD/YY)	Applicant Signature	Date Signed (MM/DD/YY)
Spouse	Date of Birth (MM/DD/YY)	Spouse Signature or Representative with Legal Authority	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)

P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-5038/800-538-5038
selecthealth.org

selecthealth.

Change Form Large Employer

Employee Name ______________________ Date of Birth ______________

Subscriber# ______________________ Social Security# ______________

A. EMPLOYEE INFORMATION CHANGE

New Mailing Address and Phone#

Street Address ______________ City ______________

State ________ ZIP ________ Ph#(_____) ______________

Name Change

From ______________

To ______________

B. ADDITION OR DELETION OF FAMILY MEMBERS

	CHANGE	PLAN	NAME (LAST, FIRST, MIDDLE INITIAL)	SEX M/F	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER*	REASON
Spouse	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change Signature required (see section C) ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage ❑ Marriage ❑ Divorce[1] ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage ❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage ❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage ❑ Marriage ❑ Newborn ❑ Adoption ❑ Death

NOTES: You must give proof of prior coverage to SelectHealth within 60 days.

1. If you are making a change because of a divorce, you must attach a copy of the divorce decree with this Change Form. You should include the first page of the decree, the signature page, and any other portion(s) that specifies responsibility for dependent coverage.
2. If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
3. If you are making a change because of a loss of other coverage, complete the information below:

Carrier ______________ Date Coverage Began ________ Date Coverage Ended ________

*Federal law section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires SelectHealth to gather this information.

C. DISCONTINUANCE OF BENEFITS

I wish to discontinue **my** benefits. Check all that apply: ❑ **Medical** ❑ **Dental** ❑ **Eyewear** ❑ **HSA**

Reason for Discontinuance ______________ Date of Discontinuance ________

I wish to discontinue my **spouse** or **ex-spouse's** benefits. Check all that apply: ❑ **Medical** ❑ **Dental** ❑ **Eyewear** ❑ **HSA**

The spouse's or Ex-Spouse's signature is required below, unless the divorce decree is attached (see Note 1 above) for divorce situations.

Subscriber's Spouse or Ex-Spouse's Signature ______________ Date ________

D. EMPLOYEE SIGNATURE

Employee Signature ______________ **Date** ________

E. EMPLOYER USE

Employer Authorization ______________ Date ________

Company Name ______________ Group# ________

Comments ______________

Discontinuance of Medical Benefits

❑ Date of Termination ______________

Term Reason: ❑ Voluntary ❑ Part Time ❑ Employment Termination

❑ Date of Loss of Eligibility Status ______________

❑ Transfer Date From ________ To ________

❑ Date of Retirement ______________

❑ Date of Death ______________

Leave of Absence

❑ Leaving for Active Military Service ______________

Coverage to Remain Active ❑ Yes ❑ No

❑ Taking a Leave of Absence Date ________ Expected Return Date ________

Coverage to Remain Active ❑ Yes ❑ No

❑ Return from a Leave of Absence/Military Service

Date ______________

Retiring? Have a child dependent who is turning 26? If you're shopping for a health plan, call our experts at

855-442-0220.

selecthealth®

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800-538-5038 • **selecthealth.org**