

UTAH COMPREHENSIVE HEALTH INSURANCE POOL

outline of
coverage

January
2011

hiputah





The Utah Comprehensive Health Insurance Pool (HIPUtah)

In 1991, the state established the Utah Comprehensive Health Insurance Pool (HIPUtah) to specifically address the problem of people with serious medical conditions, such as cancer, diabetes, heart disease, and other chronic illnesses that made them unable to obtain health insurance at any price.

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Coverage in HIPUtah is not guaranteed. Each application will be carefully reviewed to assure that all eligibility requirements are met. If an applicant is eligible for coverage in the private market, he or she is not eligible for HIPUtah, unless HIPAA (the Federal Health Insurance Portability and Accountability Act of 1996) eligible.

The benefits and features of HIPUtah are described briefly in this document. This document is not an insurance policy, and the information provided is governed by the specific terms and conditions of the HIPUtah Enrollee Agreement issued to enrollees.

If you have any questions about the information in this packet, please call 801-442-6660 (Salt Lake Area) or 800-705-9173.

PRODUCER REFERRAL FEE

HIPUtah offers a one-time \$50 referral fee to Producers, who help an individual complete an application for the HIPUtah program. The referral fee will be paid after the new enrollee's first premium payment is processed by SelectHealth.

The Producer section of the application must be completed in order to receive the referral fee. The Utah Insurance Department will verify the Insurance License Number provided on the application, send payment directly to the Producer and issue a 1099 at year end.

Please note that payment can only be made to an individual Producer, not an agency.

Plan Options

HIPUtah offers three standard Health Maintenance Organization (HMO)-type products and a High Deductible Health Plan (HDHP), which is designed to be used with a Health Savings Account (HSA). The HDHP plan uses the same provider and facility network and covers the same medical services. The major differences between these plan options are outlined below.

HMO

- Medical deductible options are \$500, \$1,000, and \$2,500
- Once the deductibles are met, enrollees are responsible for 20% coinsurance for covered medical services
- Deductible doesn't apply to preventive care services
- Separate pharmacy deductibles apply (\$150, \$250, and \$500) with each of these plan options

HDHP

- The deductible is \$5,000
- One deductible applies to both medical and pharmacy
- The entire deductible must be met before any benefits are paid with the exception of preventive care services
- This plan option is designed for use with an HSA if you choose; an HSA can save money tax free for qualified medical expenses
HIPUtah is partnered with HealthEquity, a Utah based Health Savings Account (HSA) Administrator, to administer your Health Savings Account for \$3.95 per month. If you choose to use HealthEquity, complete the HSA Enrollment and Authorization form as well as the HSAContribution form and submit it with your HIPUtah Application.

IMPORTANT: *Enrollees can only switch to higher deductible plan options. In other words, once you enroll on the HDHP plan, you cannot switch to a lower deductible plan option.*



Eligibility

WHO IS ELIGIBLE?

A person is eligible for HIPUtah coverage if he or she meets the following criteria:

1. Has resided in Utah for 12 consecutive months immediately preceding the date of application for HIPUtah (the 12 month requirement can be waived if moving from another state's high risk pool);
2. Pays the established premium;
3. Meets the required health underwriting criteria established by the State of Utah; and
4. Does not fall into the ineligible categories listed later in this outline.

OR

A person is eligible for HIPUtah coverage if he or she pays the established premium and meets the following criteria:

1. Is HIPAA eligible and has at least 18 months of prior coverage, the most recent prior coverage being under a group health plan, government plan or church plan, and has elected and exhausted COBRA or state continuation plan where available;
2. Applies for HIPUtah coverage within 63 days of termination from prior coverage; and
3. Does not fall into the ineligible categories listed later in this outline.

WHO IS NOT ELIGIBLE?

A person is not eligible for HIPUtah coverage if any one of the following is true:

1. The person is eligible for benefits under Medicaid or Medicare except for a person who has a spend down as provided in Utah Code Ann. §31A-29-112;
2. HIPUtah coverage has been terminated within the last 12 months unless the person demonstrates that continuous other coverage has been involuntarily terminated for any reason other than nonpayment of premium, unless the person is HIPAA eligible;
3. The person has exhausted the maximum lifetime benefits offered by HIPUtah;
4. The person is an inmate of a public institution;
5. The person is eligible for a public health plan through which medical care is provided;
6. The person is eligible for a group health benefit plan through an employer plan;
7. The person is covered under any other health benefit plan;
8. The person's health condition does not meet the health underwriting criteria established by the State of Utah, unless the person is HIPAA eligible; or
9. The person has not resided in Utah for 12 consecutive months, unless HIPAA eligible.
10. The person's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

Are You HIPAA Eligible?

Under a federal law known as HIPAA, which stands for the Health Insurance Portability and Accountability Act, if you are an “eligible individual” who has recently lost their employer- or union-sponsored group health plan, you have a right to purchase individual health coverage through HIPUtah, without a preexisting condition exclusion.

In order to be HIPAA eligible, all of the following must apply:

- Your last healthcare coverage must have been under a group plan, governmental plan, or church plan, including COBRA or state continuation coverage, for an aggregate of at least 18 months during which there was no break of 63 or more complete days in a row. This prior health coverage is referred to as “creditable coverage.”
- You are not eligible under a group health plan, Medicare, Medicaid, and/or do not have other health insurance coverage.
- You did not lose your latest health coverage due to nonpayment of premium or fraud.
- If you qualify for COBRA or state continuation coverage, you must accept the coverage and continue the coverage for the maximum time period allowed. Note: When an employer terminates its group health plan entirely, COBRA coverage ends and is considered exhausted.

Once COBRA or state continuation coverage has been exhausted, you have 63 days to file an application to get a policy through HIPUtah as a HIPAA eligible individual. If you accept a conversion policy or a short-term policy after exhausting COBRA, you give up your HIPAA eligibility. It is important to know that a conversion policy is not a HIPAA policy.

When applying for the high-risk pool you can present a Certificate of Creditable Coverage from your insurance company or health plan showing that you have a total of 18 months of creditable coverage as part of applying for coverage under HIPUtah. If a Certificate of Creditable Coverage is not available, you may document your prior health coverage by other means, including by telephone.

Just remember, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Coverage Guidelines

The following guidelines apply to the HIPUtah Plan:

HIPUTAH PROVIDER NETWORK

The HIPUtah Provider Network is comprised of the Select CareSM network and the University of Utah (U of U) providers, facilities, and pharmacies. For the most current HIPUtah Provider & Facility Directory, visit selecthealth.org/hiputah.

Enrollees must always use participating providers; otherwise, services will not be covered. An exception is emergency services obtained from the closest available facility (including out of state), regardless of whether that facility is under contract with the HIPUtah Network. SelectHealth reserves the right to review all emergency claims to determine whether such claims satisfy the requirements for emergency services.

MANAGED CARE

HIPUtah will apply a care management program, which helps ensure that services enrollees receive are medically necessary, appropriate, and consistent with current medical practice. The program has three methods of reviewing the healthcare received: prenotification, precertification, and case management. It is the enrollee's responsibility to verify prenotification/precertification is obtained by a provider.

WHAT IS NOT COVERED

The following is a brief summary of services not eligible for coverage by HIPUtah. The HIPUtah Enrollee Agreement contains a complete list of exclusions.

- All non-medically necessary services
- All nonapproved services
- Injuries that occurred at work
- Cosmetic procedures
- Custodial care
- Dental services (unless required because of accidental injury)
- Chiropractic and naturopathic services
- Organ transplants (only limited coverage)
- Infertility treatment and services
- Routine foot care
- Abortion, except in cases of rape, incest, or to save the life of the mother
- Services provided or ordered to treat complications of a non-covered service such as gastric bypass or cosmetic procedures

Exclusion Periods

A medical condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day, is known as a pre-existing condition. HIPUtah will not cover services for a pre-existing pregnancy for the first ten months following the effective date of coverage. Other pre-existing conditions will not be covered by HIPUtah for the first six months following the effective date of coverage except when any of the following apply to an individual:

- HIPAA eligible; or
- Transferring from an out-of-state high-risk pool within established time regulations; or
- Involuntarily terminated from either individual or group coverage and has no other option for coverage.

Application Instructions

Enclosed in this packet is the application for coverage under HIPUtah. Please complete this form and submit it along with copies of medical records and proof of former insurance to the following address: HIPUtah P.O. Box 30192, Salt Lake City, Utah 84130-0192. For questions please call **801-442-6660** (Salt Lake area) or **800-705-9173**.

PLEASE NOTE THE FOLLOWING:

- All applicants must submit medical records or a doctor's letter showing diagnosis and prognosis of medical condition(s). Applicants are responsible for obtaining medical records and paying for any costs incurred.
- Provide documentation of prior creditable coverage by submitting copies of any insurance letters or other applicable information showing any previous insurance coverage for the last 18 months and an expiration date.
- If you are coming off 18 months of prior group coverage, including exhausting COBRA or a state continuation plan, you have 63 days to apply for continuous coverage. If you are coming off individual insurance and have been involuntarily terminated, you have 63 days to apply for continuous coverage.
- Before you allow your current health insurance coverage to lapse, contact a HIPUtah representative at 801-442-6660 (Salt Lake area) or 800-705-9173.
- Please be aware that some pre-existing conditions are not covered due to specific exclusions under the policy.

All information must be provided. If there is information missing on the application or if required medical records are missing, your application will be returned to you. Please check the completeness of your application before mailing. Please do not include a premium payment. You will be notified by mail whether or not you have been accepted. Once you have been accepted, HIPUtah requires that you contact a HIPUtah representative to complete the final enrollment steps.

How to Apply for Coverage

To apply for coverage under HIPUtah, each applicant must submit a completed application and medical records. All information on the application and attachments will be reviewed and relied upon by the HIPUtah Administrator for issuance of HIPUtah coverage. Once accepted and before coverage can become effective, the applicant must contact a HIPUtah representative and complete the final enrollment steps within 90 days, unless HIPAA eligible. Coverage will not be effective until contact with a HIPUtah representative is made, approval is given, and a HIPUtah Enrollee Agreement and ID Card have been issued.

FOLLOW THESE STEPS TO APPLY FOR HIPUTAH COVERAGE:

Step 1 – Complete the application. Please be sure to answer **ALL** questions and provide accurate information.

Step 2 – Submit documentation of creditable coverage (prior health insurance coverage) if applicable.

Step 3 – Select a doctor. HIPUtah providers are listed at selecthealth.org/hiputah.

Step 4 – Select a deductible and payment plan option.

Step 5 – Submit a copy of your medical records obtained by you from your physician.

Step 6 – Submit documentation providing proof that applicant is lawfully admitted into the United States.

Step 7 – Submit the completed application plus any additional documentation to the HIPUtah Administrator.

Applicants are urged to contact the HIPUtah Administrator at **801-442-6660** (Salt Lake area) or **800-705-9173** for more information about coverage, the application process, and all other requirements necessary to obtain coverage through HIPUtah.

Enrollee Responsibilities

To ensure that continued coverage under HIPUtah is appropriate and to ensure that HIPUtah coverage is provided appropriately for covered services, enrollees are responsible for the following:

- Verifying that prenotification or precertification has been provided before services are received;
- Notifying the Administrator within 72 hours after the receipt of emergency services when outside of Utah;
- Paying all premiums due on or before the due date;
- Notifying the Administrator at the time the enrollee becomes covered by or eligible for Medicaid or Medicare; and
- Notifying the Administrator at the time the enrollee becomes covered by or eligible for any health plan other than HIPUtah.

In addition, we encourage the enrollees to coordinate all care with his or her participating physician.

RENEWAL OR TERMINATION OF COVERAGE

Coverage under HIPUtah is provided on a month-to-month basis.

HIPUtah Monthly Premiums

(EFFECTIVE JANUARY 1, 2011)

HIPUtah is required by Utah law to evaluate premium rates each year for an effective date of January 1 and/or July 1.

Premiums for HIPUtah coverage are calculated based on age and deductible options. The premiums are listed in the following table.

Premium increases due to an age category change are effective the first of the month following the birth date.

Age	OPTION 1 \$500 DEDUCTIBLE \$2,000 OOP*	OPTION 2 \$1,000 DEDUCTIBLE \$3,000 OOP*	OPTION 3 \$2,500 DEDUCTIBLE \$6,000 OOP*	OPTION 4 \$5,000 DEDUCTIBLE \$5,000 OOP*#
Under 21	\$366	\$319	\$245	\$178
21 to 25	\$393	\$342	\$263	\$192
26 to 30	\$455	\$396	\$304	\$222
31 to 35	\$536	\$466	\$361	\$263
36 to 40	\$569	\$497	\$381	\$278
41 to 45	\$610	\$518	\$399	\$289
46 to 50	\$711	\$603	\$464	\$336
51 to 55	\$804	\$683	\$526	\$380
56 to 60	\$944	\$809	\$623	\$478
61 to 64	\$1,041	\$883	\$681	\$535

*Medical Out-of-Pocket Maximum
#Health Savings Account Eligible Plan

HIPUTAH MEMBER PAYMENT SUMMARY

The HIPUtah Member Payment Summary is included in the center section of this document after the application. It shows the benefits and covered services for the HIPUtah plans.

NOTES:

- The deductible must be met before coinsurance applies, with the exception of preventive services.
- Benefit limitations may be applicable to certain services.

Application Guide

Please consider the following when choosing between HIPUtah and Federal-HIPUtah:



HIPUtah Coverage Options

- \$500 Deductible/\$2,000 Out-of-Pocket Maximum
- \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum
- \$2,500 Deductible/\$6,000 Out-of-Pocket Maximum
- \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

Rx Benefits

- Separate Rx deductible applies.
- There is no Rx out-of-pocket maximum.

Prior Coverage

- You may apply for this plan if you are uninsured for any duration.
- Pre-existing conditions may be excluded for the first six months of this plan (maternity is excluded for the first ten months).

Effective Date

- You may request your desired effective date. SelectHealth reserves the right to make the final effective date determination.



Federal-HIPUtah Coverage Options

- \$500 Deductible/\$2,000 Out-of-Pocket Maximum
- \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum
- \$2,500 Deductible/\$4,000 Out-of-Pocket Maximum
- \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

Rx Benefits

- Separate Rx deductible applies.
- Rx out-of-pocket maximums apply.

Prior Coverage

- You may apply for this plan if you are uninsured for six months or more.
- Pre-existing condition exclusions do not apply to this plan.

Effective Date

- Your effective date will be the first day of the month following the month you submit your application.



ADMINISTERED BY
selecthealth.

PARTICIPATING (IN-NETWORK)

You must use participating providers
(except for emergencies).

CONDITIONS and LIMITATIONS

Lifetime Maximum Plan Payment — Per Person	\$1,500,000
Annual Maximum Plan Payment — Per Person ⁴	\$400,000
Pre-Existing Conditions (PEC) and Limitations ¹	Not covered first 6 months
Maternity Pre-Existing Conditions (PEC) and Limitations ¹	Not covered first 10 months

MEDICAL DEDUCTIBLE and MEDICAL OUT-OF-POCKET**You Pay**

Calendar Year Deductible and Out-of-Pocket Amounts		
<i>Deductible is included in the out-of-pocket Maximum</i>	Deductible	Out-of-Pocket
\$500 Deductible	\$500	\$2,000
\$1,000 Deductible	\$1,000	\$3,000
\$2,500 Deductible	\$2,500	\$6,000

INPATIENT SERVICES**You Pay**

Medical, Surgical, and Hospice	20% after deductible
Maternity <i>Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy BeginningsSM program: 866-442-5052</i>	20% after deductible
Skilled Nursing Facility <i>Up to 30 days/calendar year</i>	20% after deductible
Rehab Therapy: Physical, Speech, Occupational <i>Up to 30 days/calendar year for all therapy types combined</i>	20% after deductible

PROFESSIONAL SERVICES**You Pay**

Office Visits and Office Surgeries	
Primary Care Provider (PCP) ²	20% after deductible
Secondary Care Provider (SCP) ²	20% after deductible
Preventive Care	
Office Visits	Covered at 100%
Adult and Pediatric Immunizations	Covered at 100%
Diagnostic Tests, Minor	Covered at 100%
Allergy Tests	See office visits
Allergy Treatment and Serum	20% after deductible
Physician's Fees — <i>Medical, Surgical, Anesthesia</i>	20% after deductible

OUTPATIENT SERVICES**You Pay**

Outpatient and Ambulatory Surgical Facility	20% after deductible
Ambulance (Air) — <i>emergencies only</i>	20% after deductible
Ambulance — <i>emergencies and urgent conditions only</i>	20% after deductible
Emergency Room Participating Facility	20% after deductible
Emergency Room Nonparticipating Facility	20% after deductible
Intermountain InstaCare SM Facilities, Urgent Care Facilities	20% after deductible
Intermountain KidsCare SM Facilities	20% after deductible
Chemotherapy, Radiation, and Dialysis	20% after deductible
Diagnostic Tests, Minor	20% after deductible
Diagnostic Tests, Major ¹	20% after deductible
Home Health, Hospice	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar year for each therapy type</i>	20% after deductible

MISCELLANEOUS SERVICES**You Pay**

Chiropractic Care	Not covered
Durable Medical Equipment (DME) ³	20% after deductible
Infertility	Not covered
Injectable Drugs and Specialty Medications ^{3,4}	20% after deductible
Mental Health and Chemical Dependency ³ <i>Inpatient — Up to 10 days/calendar year</i> <i>Outpatient — Up to 20 visits/calendar year</i>	20% after deductible 20% after deductible
Miscellaneous Medical Supplies	20% after deductible
Cochlear Implants - <i>Unilateral Only</i>	See Professional, Inpatient, or Outpatient Services
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000/transplant</i>	See Professional, Inpatient, or Outpatient Services

PRESCRIPTION DRUGS³**You Pay**

Prescription Drug List (formulary)	RxSelect SM						
If your medical deductible is: Your Rx deductible per person/calendar year is:	<table border="1"> <tr> <td><u>\$500</u></td> <td><u>\$1,000</u></td> <td><u>\$2,500</u></td> </tr> <tr> <td>\$150</td> <td>\$250</td> <td>\$500</td> </tr> </table>	<u>\$500</u>	<u>\$1,000</u>	<u>\$2,500</u>	\$150	\$250	\$500
<u>\$500</u>	<u>\$1,000</u>	<u>\$2,500</u>					
\$150	\$250	\$500					
<i>The Rx Deductible does not apply to medical out-of-pocket amounts</i>							
Tier 1	\$5 after Rx deductible						
Tier 2	25% after Rx deductible						
Tier 3	50% after Rx deductible						
<i>Up to a 30-day supply for covered medications; generic substitution required</i>							
Maintenance Drug Benefit - 90-Day Supply (Medco by Mail or Retail90 SM)							
Tier 1	\$5 after Rx deductible						
Tier 2	25% after Rx deductible						
Tier 3	50% after Rx deductible						

FOOTNOTES

1. Refer to the Enrollee Agreement for more information.
2. Refer to your HIPUtah Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Provider.
3. Preauthorization is required on the following services: (a) certain injectable drugs and specialty medications; (b) certain prescription drugs; (c) certain DME items; (d) certain mental health and chemical dependency services; and (e) all services obtained outside the United States unless for a routine, urgent, or emergent condition. Please refer to your Enrollee Agreement or call Member Services for more information.
4. Injectable drugs are not covered after \$300,000 of the total annual maximum plan payment has been met.
All deductible/copay/coinsurance amounts are based on allowed charges and not on the provider's billed charges. You are responsible to pay for excess charges on covered services from nonparticipating providers and facilities. Excess charges are not applied to the out-of-pocket maximum. Refer to your Enrollee Agreement or Provider & Facility Directory for more information.

Benefits are administered by SelectHealth.

HIPUtah MPS 01/01/11

**PARTICIPATING (IN-NETWORK)**

You must use participating providers
(except for emergencies).

CONDITIONS and LIMITATIONS

Lifetime Maximum Plan Payment — Per Person	\$1,500,000
Annual Maximum Plan Payment — Per Person ⁴	\$400,000
Pre-Existing Conditions (PEC) and Limitations ¹	Not covered first 6 months
Maternity Pre-Existing Conditions (PEC) and Limitations ¹	Not covered first 10 months

DEDUCTIBLE and OUT-OF-POCKET

Calendar Year Deductible and Out-of-Pocket Amounts <i>Deductible is included in the out-of-pocket Maximum</i>	You Pay	
	Deductible	Out-of-Pocket
	\$5,000	\$5,000

INPATIENT SERVICES

	Covered
Medical, Surgical, and Hospice	100% after deductible
Maternity <i>Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy BeginningsSM program: 866-442-5052</i>	100% after deductible
Skilled Nursing Facility <i>Up to 30 days/calendar year</i>	100% after deductible
Rehab Therapy: Physical, Speech, Occupational <i>Up to 30 days/calendar year for all therapy types combined</i>	100% after deductible

PROFESSIONAL SERVICES

	Covered
Office Visits and Office Surgeries	
Primary Care Provider (PCP) ²	100% after deductible
Secondary Care Provider (SCP) ²	100% after deductible
Preventive Care	
Office Visits	Covered at 100%
Adult and Pediatric Immunizations	Covered at 100%
Diagnostic Tests, Minor	Covered at 100%
Allergy Tests	See office visits
Allergy Treatment and Serum	100% after deductible
Physician's Fees — <i>Medical, Surgical, Anesthesia</i>	100% after deductible

OUTPATIENT SERVICES

	Covered
Outpatient and Ambulatory Surgical Facility — <i>Includes all related facility services</i>	100% after deductible
Ambulance (Air) — <i>emergencies only</i>	100% after deductible
Ambulance — <i>emergencies and urgent conditions only</i>	100% after deductible
Emergency Room Participating Facility	100% after deductible
Emergency Room Nonparticipating Facility	100% after deductible
Intermountain InstaCare SM Facilities, Urgent Care Facilities	100% after deductible
Intermountain KidsCare SM Facilities	100% after deductible
Chemotherapy, Radiation, and Dialysis	100% after deductible
Diagnostic Tests, Minor	100% after deductible
Diagnostic Tests, Major ¹	100% after deductible
Home Health, Hospice	100% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits/calendar year for each therapy type</i>	100% after deductible

MISCELLANEOUS SERVICES	Covered
Chiropractic Care	Not covered
Durable Medical Equipment (DME) ³	100% after deductible
Infertility	Not covered
Injectable Drugs and Specialty Medications ^{3,4}	100% after deductible
Mental Health and Chemical Dependency ³ <i>Inpatient — Up to 10 days/calendar year</i> <i>Outpatient — Up to 20 visits/calendar year</i>	100% after deductible 100% after deductible
Miscellaneous Medical Supplies	100% after deductible
Cochlear Implants - <i>Unilateral Only</i>	100% after deductible
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000/transplant</i>	100% after deductible

PRESCRIPTION DRUGS ⁵	Covered
Prescription Drug List (formulary)	RxSelect SM
Tier 1	100% after deductible
Tier 2	100% after deductible
Tier 3	100% after deductible
<i>Up to a 30-day supply for covered medications; generic substitution required</i>	
Maintenance Drug Benefit - 90-Day Supply (Medco by Mail or Retail ^{90SM})	
Tier 1	100% after deductible
Tier 2	100% after deductible
Tier 3	100% after deductible

FOOTNOTES

1. Refer to the Enrollee Agreement for more information.
2. Refer to your HIPUtah Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Provider.
3. Preauthorization is required on the following services: (a) certain injectable drugs and specialty medications; (b) certain prescription drugs; (c) certain DME items; (d) certain mental health and chemical dependency services; and (e) all services obtained outside the United States unless for a routine, urgent, or emergent condition. Please refer to your Enrollee Agreement or call Member Services for more information.
4. Injectable drugs are not covered after \$300,000 of the total annual maximum plan payment has been met.

All deductible/copay/coinsurance amounts are based on allowed charges and not on the provider's billed charges. You are responsible to pay for excess charges on covered services from nonparticipating providers and facilities. Excess charges are not applied to the out-of-pocket maximum. Refer to your Enrollee Agreement or Provider & Facility Directory for more information.



New Enrollee Application Form

Please use dark ink and print legibly. Do not write in shaded areas.

Administered by SelectHealth

A. COVERAGE AND PAYMENT INFORMATION

Plan Type	Coverage	Payment Option
<i>Select one plan type. Refer to the Application Guide for more information.</i>	<i>Select one deductible</i>	
<input type="checkbox"/> HIPUtah	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> Direct Monthly Billing (\$5.00 monthly service fee applies. This option is not available on Federal-HIPUtah plans)
<input type="checkbox"/> Federal-HIPUtah	<input type="checkbox"/> \$1,000 Deductible	<input type="checkbox"/> Preauthorized Banking Withdrawal
Desired Effective Date _____	<input type="checkbox"/> \$2,500 Deductible	<input type="checkbox"/> Online Billing and Payment (See Payment Selection Form)
	<input type="checkbox"/> \$5,000 Deductible	

B. APPLICANT INFORMATION

Note: Every person applying for a policy must complete a separate application, including members of the same family.

Applicant

Last Name _____ First Name _____ Middle Initial _____
Social Security# _____ Date of Birth _____ Sex M F
Street Address _____ Unit# _____
City _____ State _____ ZIP _____
E-mail Address _____ Home Ph# (____) _____ Work Ph# (____) _____
Employer _____ Employer's Medical Insurance _____ Occupation _____
of People in Household _____
Total Annual Income of All Members of Applicant's Household* \$ _____

**Defined as the sum of adjusted gross income from federal tax return for most recent year for all members of applicant's household. Documentation may be requested by HIPUtah to verify household income and is required on application.*

Primary Care Physician Full Name _____ Street Address _____

Responsible Party (to be completed when applicant is a minor younger than age 16 or lacks the legal ability to contract)

Last Name _____ First Name _____ Middle Initial _____
Street Address _____ Unit# _____
City _____ State _____ ZIP _____
Social Security# _____ Date of Birth _____ Relationship to Applicant _____
Employer _____ Employer's Medical Insurance _____ Occupation _____

C. PRIOR HIPUTAH OR FEDERAL-HIPUTAH COVERAGE

Has applicant ever been covered by the HIPUtah or Federal-HIPUtah program before? Yes No
If yes, date coverage terminated _____ Reason for Termination _____
Was the lifetime policy maximum met? Yes No
Has the applicant had coverage similar to HIPUtah or Federal-HIPUtah in another uninsurable risk pool? Yes No
If yes: State _____ Plan Ph# (____) _____ Dates of Coverage _____ to _____
Was the policy dollar maximum of the above coverage met? Yes No
Reason for Termination _____

SELECTHEALTH USE ONLY

Conditional Eligibility _____ State/Federal (circle one) _____
Effective Date _____ Points _____ HIPAA Eligible _____
Final Status Code _____ PEC _____

D. ELIGIBILITY REQUIREMENTS

1. Is the applicant lawfully admitted into or a citizen of the United States? Yes No
If "Yes," please provide documentation such as U.S. Passport, U.S. Birth Certificate, Certificate of Citizenship, I-94 Card, Resident Alien Card, Certificate of Naturalization, etc.
2. Is the applicant a resident of Utah? Yes No
If "Yes," how long has he or she been a continuous Utah resident? _____ years _____ months
3. Is the responsible party a resident of Utah? Yes No
If "Yes," how long has he or she been a continuous Utah resident? _____ years _____ months
4. Is the applicant currently covered by or eligible for Medicare? Yes No
If "Yes," Medicare number _____ Effective Date _____
5. Is the applicant currently covered by or eligible for Medicaid? Yes No
If "Yes," Medicaid number _____ Effective Date _____
6. Is the applicant currently covered by or eligible for any other public health plan? Yes No
If "Yes," program name _____ Effective Date _____
7. Is the applicant currently covered by or eligible for any health insurance? (Including employer-sponsored, state extension, COBRA, or group conversion) Yes No
If "Yes," health insurance carrier name _____ Effective Date _____
8. If enrolled, would any employer reimburse or pay for any portion of this plan? Yes No
9. Has the applicant either voluntarily cancelled health insurance coverage or been involuntarily cancelled by a health insurance company within the last six months? Yes No
If "Yes," please answer the following questions:
 - a. Was the coverage under an employer-sponsored program? Yes No
If yes, what date did your prior coverage end? (MM/DD/YYYY) _____ / _____ / _____
 - b. Was the coverage under COBRA or state extension? Yes No
 - c. Was the COBRA or state extension coverage exhausted? Yes No
 - d. Was the coverage under an individual plan? Yes No
 - e. Was the coverage under a group conversion plan? Yes No
 - f. Was the coverage under a government-sponsored plan (e.g. Medicare, Medicaid, etc.)? Yes No
 - g. Did your employer drop insurance coverage? Yes No
 - h. Were you self-employed? Yes No
 - i. Did you lose employment? Yes No
 - j. Other reasons for loss of coverage _____

If you answered yes to any of the above, please complete section "E".

E. PRIOR/CURRENT COVERAGE INFORMATION

Will the applicant be losing coverage within the next six months for any reason? Yes No

If "Yes," give the dates of current coverage and the reason for termination below.

PRIOR/CURRENT HEALTH INSURANCE COVERAGE INFORMATION

Please complete the following information about your health insurance coverage for the last 18 months, regardless of whether it is still in effect. If you have had coverage through more than one insurance carrier during that time, please include coverage information for each carrier. Failure to complete information on this form could result in no credit toward the pre-existing condition waiting period.

Please include a letter of Creditable Coverage (termination letter) for those policies listed below with this application. The application process will be delayed if it is not included.

The following documentation is also acceptable for submission:

- Explanation of Benefits or other correspondence that indicates coverage
- Health insurance ID card
- Medical record that indicates health coverage
- Pay stubs showing payroll deduction for health coverage
- Certificate of coverage for a group health insurance policy
- Other documentation that shows evidence of health coverage

LIST BELOW ALL CORRESPONDING INSURANCE POLICIES

	CARRIER 1	CARRIER 2	CARRIER 3
1. TYPE(S) OF COVERAGE			
Employer sponsored			
COBRA			
State extension			
Individual			
Group conversion			
Government sponsored			
2. COVERAGE EFFECTIVE DATE			
3. TERMINATION DATE			
4. INSURANCE CARRIER PH#			
5. REASON FOR COVERAGE TERMINATION (e.g., loss of job, overage dependent, COBRA expiration, employer dropped coverage, nonpayment of premiums)			

F. UNINSURABILITY INFORMATION

1. Has the applicant been denied coverage from any other health insurance carrier? Yes No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): _____

Date of Application _____ Date of Denial _____ (Please attach a copy of denial letter)

2. Is an application to any other health insurance coverage currently in process for the applicant? Yes No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): _____

Date of Application _____

3. Does the applicant, spouse or parent, legal guardian or other responsible party work for an employer that offers health insurance benefits? If "Yes," or "Unsure," list the name, address and phone number of each employer. Also list insurance carrier name and reason Applicant is not insured on this program:

Applicant Yes No Unsure _____
Spouse Yes No Unsure _____
Parent, Legal Guardian or other Responsible Party Yes No Unsure _____

4. Please list all current medical condition(s) that have prevented the applicant from obtaining other health insurance.

Note: All applicants must submit with this application copies of medical records or a physician letter documenting the above medical condition(s). Documentation must specifically show date of onset, diagnosis and prognosis of said medical condition(s). It is the applicant's responsibility to obtain these records at his or her expense. Even if disclosed, non-covered procedures/diagnosis and services provided or ordered to treat complications of a non-covered service, including gastric bypass are not covered.

G. AFFIRMATION

I, the applicant (or parent, legal guardian, or responsible party of applicant), affirm that my foregoing answers to questions in Section A through F are complete and correct to the best of my knowledge. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by HIPUtah.

I understand that:

- "Preexisting condition," with respect to a health benefit plan means the following: (a) a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; (b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
- Benefits otherwise payable under the policy will be reduced by all amounts paid or payable through any other health coverage, workers-compensation, motor vehicle coverage, or any state or federal law or program.
- If this application contains fraudulent or intentional misstatements or omissions, HIPUtah may do any or all of the following: (a) cancel the agreement as though it were never effective; (b) deny benefits under the "pre-existing condition" exclusion; or (c) take any other action available to it by law.
- I understand that if I am at least 18 years of age and I am not lawfully admitted to the United States, I am not eligible for HIPUtah.

Any matter in dispute between you and HIPUtah or Federal-HIPUtah may be subject to arbitration as an alternative to court action pursuant to the rules of the Utah Uniform Arbitration Act. Any decision reached by arbitration shall be binding upon both you and HIPUtah or Federal-HIPUtah. The arbitration award may include attorney's fees, if allowed by law, and may be entered as a judgment in any court of proper jurisdiction.

DISCLOSURE AUTHORIZATION

I authorize disclosure of medical record information about me (or about the applicant, if I am other than the Applicant) to HIPUtah or Federal-HIPUtah if needed to (a) determine eligibility for coverage; and/or (b) process claims for benefits.

This authorization takes effect on the date received by the Administrator and remains in effect as follows:

- For information needed to process a claim for benefits, the authorization is effective for the lifetime of the policy or the duration of the timely filing deadline for any claim, whichever is longer.
- For information needed to evaluate the application for coverage, the authorization will be effective for 90 days after the date received by the Administrator.

Signature _____ Date ____/____/____
(Applicant's signature or signature of parent, legal guardian, or responsible party.)

H. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization provides for the release of PHI to the Utah Comprehensive Health Insurance Pool (HIPUtah) through its Administrator. Federal privacy laws require health plans to include certain provisions in any authorization for use or disclosure of medical information, other than uses or disclosures for treatment, payment, healthcare operations, and as otherwise required or expressly permitted by law. If HIPUtah or SelectHealth needs to use, disclose, or receive PHI other than for the purposes set forth herein, I understand that I may be required to sign a separate authorization.

On behalf of myself (or the applicant if I am other than the applicant), I authorize any physician, healthcare provider, hospital, insurance, or reinsurance company, or other insurance information exchange to disclose PHI including alcohol, chemical dependency, mental treatment, genetic testing, or HIV treatment to HIPUtah, SelectHealth, or its representatives. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, SelectHealth on behalf of HIPUtah, may be unable to enroll me for coverage under HIPUtah or Federal-HIPUtah, or to pay claims that were incurred while I had insurance coverage with HIPUtah or Federal-HIPUtah.

I understand that I may cancel this authorization at any time by sending a written request to SelectHealth, Inc. at P.O. Box 30192, Salt Lake City, Utah 84130-0192. Cancellation of this authorization will not affect any action HIPUtah or SelectHealth took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with HIPUtah or Federal-HIPUtah, or 24 months from the date at right, whichever comes first.

Federal law requires HIPUtah or SelectHealth to tell me that if the party to whom HIPUtah

or SelectHealth, Inc. discloses my PHI shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are subject to federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of such information without specific written authorization.

NAME _____
(Please Print)

SIGNATURE* _____ DATE _____

NAME _____
(Please Print)

SIGNATURE* _____ DATE _____

* If signed by a Personal Representative of the member/enrollee, please complete the following:

Personal Representative's Name _____

Relationship to Individual Parent Legal Guardian** Holder of Power of Attorney**

** Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

I. PRODUCER INFORMATION

Producer Name (Last, First, Initial) R. Brent Bennett Social Security# _____

Insurance License# _____ Ph# (801) 327-7205 E-mail Address brent@spectrabenefits.com

Street Address 895 W Baxter City South Jordan State UT ZIP 84095 **17**



Payment Selection Form

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

A. PAYMENT SELECTION

Please select one of the three 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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Preauthorized Banking Withdrawal
Complete section "B" | <input type="checkbox"/> Online Billing and Payment
Complete section "C." You must include a check for the first month's premium
<small>You will receive a premium notice by mail once you are accepted</small> | <input type="checkbox"/> Monthly Statement
\$5 Monthly service fee required,
(Option not available on Federal-HIPUtah plan) |
|--|--|--|

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 authorize SelectHealth to initiate debit entries to my (our) **Checking Account** **Savings Account**

Account Holder's Name _____ Account# _____

Financial Institution _____ Routing & Transit# _____

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

Account Holder's Signature _____ Date _____

PREAUTHORIZED BANKING WITHDRAWAL

Attach a Voided Check Here

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

Check#	Routing & Transit#	Account#
00 1099	1 2400494 1	18 3940 19 23

C. ONLINE BILLING AND PAYMENT

If you have selected the Online 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.

Premium payments are due on the first day of each month.

Applicant's Name _____ Applicant's Signature _____

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

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

- Complete entire application**
- Complete Section B**
Including total annual income for all family members
- Complete Section D**
- Signatures of Applicant and Dates, Sections G and H**
- Include:**
 - Medical records or Physician letter showing diagnosis and prognosis of medical conditions and documentation of lawful admission to the U.S.
 - Health Savings Account Enrollment and Authorization Form, if you choose to establish an HSA with HealthEquity.

We appreciate your cooperation. Failure to complete this information may delay the review of your application and effective date of coverage.

HIPUtah's Premium Assistance Subsidy (PAS) Program

HIPUtah offers a Premium Assistance Subsidy (PAS) Program. You may be eligible for up to a 25 percent discount on your monthly premium depending on your annual income level.

If you believe your income is at or below the amounts shown below, we recommend you complete the "HIPUtah Premium Assistance Subsidy Application" included in this packet.

HIPUTAH PREMIUM ASSISTANCE SUBSIDY CHART	
Household Size	Annual Income
1	\$32,490
2	\$43,710
3	\$54,930
4	\$66,150
5	\$77,370
6	\$88,590
7	\$99,810
8	\$111,030



Administered by SelectHealth

HIPUtah Premium Assistance Subsidy Application

A. APPLICANT INFORMATION

Last Name _____ First _____ Initial _____

Date of Birth ____/____/____ Ph # (____) _____

Street Address _____ City _____ State ____ ZIP _____

Name and Social Security # of Head of Household _____

HIPUtah Premium Assistance Subsidy Chart	
Persons in Family or Household*	Annual Income
1	\$32,490
2	\$43,710
3	\$54,930
4	\$66,150
5	\$77,370
6	\$88,590
7	\$99,810
8	\$111,030

HIPUtah enrollees who have an annual income below certain levels may be eligible for the premium assistance subsidy program. If you believe your income is at or below the amounts shown on the Premium Assistance Subsidy Chart, we recommend you complete this form by answering the questions below, attach the required additional HIPUtah documentation, and submit it with this application. You could receive up to a 25 percent discount on your premiums.

Note: Premium assistance will be offered only as long as funding remains available.

B. INCOME INFORMATION

1. Please list the total number of exemptions claimed on your most recent tax return filed in your household _____
2. Please list the total number of individuals currently in your household _____
3. Please tell us about your yearly household income as reflected on your most recent tax return. If you are married, your spouse lives in your household, and you did not file a joint tax return last year; complete all columns below.

	A	B	C
	Your Return	Spouse's Return	Total
Filed a 1040, the total household income listed on line 22	\$	\$	\$
Filed a 1040, total Social Security income listed on line 20a	\$	\$	\$
Filed a 1040EZ, the adjusted gross income on line 4	\$	\$	\$
Filed a 1040A, the total household income on line 15	\$	\$	\$
Filed a 1040A, total Social Security income listed on line 14a	\$	\$	\$

4. Total combined household income listed above* (amount listed in Column C above) \$ _____
5. What do you believe your yearly household income will be this year? \$ _____

* Your household size is the total number of exemptions claimed on your tax return and is not related to the total number of individuals on a HIPUtah policy or application.

C. SIGNATURE

I certify that the foregoing information and attachments are true and accurate to the best of my knowledge, and I give permission for HIPUtah and its Administrator to make any necessary contacts to verify the income information reported on and attached to this application. I authorize state agencies to release my most recently reported income information to HIPUtah for eligibility verification. This information will be used to confirm applicant eligibility for the HIPUtah Premium Assistance Subsidy Program and may not be disclosed outside of HIPUtah or state agencies. I know that I can be penalized if I knowingly give false information, and I understand that I may be asked to provide additional information.

Applicant Signature _____ **Date** ____/____/____

**Parent or Legal Guardian
Signature if Applicant is under
Age or Legally Incompetent** _____ **Date** ____/____/____

D. REQUIRED DOCUMENTATION

Please attach copies of all of your most recent Federal Tax Forms, including Filing Extension (Form 4868) and send to

**SelectHealth
P.O. Box 30192
Salt Lake City, UT 84130-0192**

If your last year’s household income was more than the amounts listed on the HIPUtah Premium Assistance Subsidy Chart, but has been reduced this year, complete this application and provide one of the following proofs of income for the most recent three-month period:

1. Copy of the two most recent pay stubs, along with a statement or note to explain how often you receive a paycheck. If a pay stub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement, or
2. If self employed, send most recent three months profit and loss statements or other verification of income, along with the Schedule C, K-1, or E from last year’s federal income tax return, or
3. If you have income such as disability or retirement, send copies of award letters or bank statements showing direct deposits from disability or retirement.

NOTE: Failure to submit the required documentation will forfeit your eligibility for the Premium Assistance Subsidy Program.



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

Health Savings Account Enrollment and Authorization to Disclose Health Information to HealthEquity® Form

Complete this form if you have chosen a High Deductible Health Plan (HDHP) plan with HealthEquity as your HSA administrator. (See your application/enrollment form.)

If you have chosen an HDHP plan and you fail to complete this form, an HSA will not be set up for you. However, failure to complete this form will not affect your health insurance coverage under your HDHP plan.

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

Social Security# _____ Birth Date ____/____/____

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 health plans. To open an HSA, you must meet three criteria:

1. You must be covered by a qualified HDHP (your HipUtah 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 www.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 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, HIPUtah's administrator 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 HIPUtah or Federal-HIPUtah Enrollee; or b) the date that HealthEquity no longer administers my account.

D. IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT

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 ____/____/____

Applicant Signature _____ **Date Signed** ____/____/____

SELECTHEALTH USE ONLY

HSA Effective Date ____/____/____

HSA Contribution Form

PERSONAL INFORMATION

Your name: First: _____ Last: _____ Middle Initial: _____

Your address: Street: _____

City: _____ State: _____ Zip: _____

Your contact info: Phone: (____) _____ Email Address: _____

Account Holder Social Security Number: _____

CONTRIBUTIONS TO YOUR HSA

Contribution Tax Year: _____

Contributions for the prior year are accepted until April 15th of the current year. Funds will be applied to the tax year of the date on the attached check if no year is indicated.

How would you like to deposit funds into your HSA?

OPTION 1	OPTION 2	OPTION 3
Check	One Time Electronic Funds Transfer (EFT)	Recurring Monthly Electronic Funds Transfer (EFT)
<p>Include a check (<i>payable to HealthEquity</i>) with this contribution form.</p> <p><i>Mail to:</i> HealthEquity 15 West Scenic Pointe Drive, Suite 400 Draper, UT 84020</p>	<p><i>Fax this form and a voided check to: 801-727-1005</i></p> <p>Amount of deposit: \$ _____</p> <p>Financial Institution: _____</p> <p>City/State: _____</p> <p>Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Routing #: _____</p> <p>Account #: _____</p>	<p><i>Fax this form and a voided check to: 801-727-1005</i></p> <p>Monthly Amount of Deposit: \$ _____</p> <p>Date of First Transfer: _____</p> <p>Financial Institution: _____</p> <p>City/State: _____</p> <p>Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Routing #: _____</p> <p>Account #: _____</p>

AUTHORIZATION

I hereby authorize the deposit of the amount stated above into my Health Savings Account. I understand the eligibility requirements for the type of HSA Deposit I am making and I state that I do qualify to make the deposit.

I assume complete responsibility for:

1. Determining that I am eligible for an HSA each year I make a contribution.
2. Ensuring that all contributions I make are within the limits set forth by the tax laws.
3. The tax consequences of any contribution (including rollover contributions) and distributions.

Account Holder Signature

Date

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.

I. Introduction

The Utah Comprehensive Health Insurance Pool, also known as HIPUtah, is committed to protecting the privacy of your Personal Information and is required by applicable federal and state laws to maintain the privacy of your Personal Information.

As you read this document, please keep in mind that the terms “we,” “us,” and “our” refer to HIPUtah.

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).

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

- “Affiliated Providers” are doctors and other healthcare practitioners who are not employed by Intermountain Healthcare but either have a contractual relationship with SelectHealth or are credentialed to admit patients to an Intermountain hospital.
- “SelectHealth” refers to SelectHealth, Inc. SelectHealth provides administrative services — such as claims processing and care management — on behalf of HIPUtah. When providing these administrative services, SelectHealth will use and disclose your Personal Information as described in this notice.
- “Intermountain Healthcare” means the hospitals, clinics, doctor offices, and other healthcare facilities owned and operated by IHC Health Services, Inc., as well as the individuals employed by Intermountain Healthcare at these facilities.
- “Intermountain” refers to SelectHealth, Inc., SelectHealth Benefit Assurance Co., Inc., and Intermountain Healthcare.
- “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.

Intermountain Healthcare and Affiliated Providers have different privacy practices than HIPUtah. As a result, if you are a patient of Intermountain Healthcare or an Affiliated Provider, you will receive a separate notice of their privacy practices. To request a copy of the privacy notices of Intermountain Healthcare, please contact 1-800-442-4845; to receive a copy of the privacy notices of Affiliated Providers, please contact those providers directly.

II. 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.

III. 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: “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.

IV. Uses and Disclosures Permitted by Law Without an Authorization

A. Use or Disclosure by us for payment or healthcare operations. We use Personal Information for the following routine purposes:

Payment. We use and disclose Personal Information for payment

of health coverage premiums and to determine and fulfill our responsibility to provide you benefits—for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have. We may also disclose Personal Information to consumer reporting agencies, or other individuals or companies that assist with our payment activities.

Finally, we will disclose Personal Information about an unemancipated minor to the minor’s parents who have custody of that minor or their authorized representatives. We limit these disclosures to the information necessary to understand how a claim was processed. We disclose this information for the effective management of the coverage provided by HIPUtah. A minor may have the right to limit these disclosures. See the subsection “Your Right to Receive Confidential Communication” in the “Your Individual Rights” section.

Healthcare Operations. We use and disclose Personal Information for our healthcare operations, which include 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. We may disclose Personal Information to individuals or companies that assist with healthcare operations. However, such disclosures are only made if the person or company agrees to safeguard your Personal Information.

In addition, we may disclose Personal Information as follows:

- To another healthcare entity for its healthcare operations.
- To Affiliated Providers and Intermountain Healthcare to improve the overall healthcare you receive as well as to help them better manage your care. For example, SelectHealth has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma. As part of these programs, we share information with Affiliated Providers and Intermountain Healthcare 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.

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

Special Protections for Certain Types of Information. We 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.

B. 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 to contracting or spreading a disease or condition.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

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

K. 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 HIPUtah.

L. 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.

V. Your Individual Rights

A. 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 SelectHealth's Privacy Office. Please see the last section of this notice, entitled "Privacy Office," for specific contact information. 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, SelectHealth's Privacy Office will provide you with the correct address for the Office of Civil Rights. We will not take action against you if you file a complaint with the Office of Civil Rights or us.

B. 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.

C. Right to Inspect and Copy Your Personal Information.

You may request access to our records which we use for decision-making purposes and contains 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 Healthcare, please contact them directly.

D. Right to Request Amendment to Your Records. You have the right to request an amendment to your Personal Information that we created and used for decision-making purposes. Any such requests should be directed to SelectHealth. 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 Healthcare, please contact them directly.

E. 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.

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.

F. Right to Request Alternative Communications by Alternative Means. You have the right to request communications of your Personal Information by alternative means or at alternative locations if the normal means/locations of disclosure could endanger you. We will accommodate all reasonable written requests.

G. 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 SelectHealth's Privacy Office.

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

VI. 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.

VII. 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 non-affiliated with HIPUtah

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.

VIII. Effective Date and Duration of This Notice

A. Effective Date. This notice describes the privacy practices of HIPUtah as of January 1, 2008.

B. 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. You may also obtain any notice by contacting SelectHealth's Privacy Office.

IX. Privacy Office

SelectHealth answers privacy related questions and complaints as part of the administrative services it provides to HIPUtah. You may contact SelectHealth's Privacy Office at:

Intermountain Privacy Office
P.O. Box 30192
Salt Lake City, UT 84130-0192
1-800-442-4845
E-mail: privacy@imail.org

Effective July 2008

Administered by



P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-6660 / 800-705-9173
www.selecthealth.org/hiputah

