MetroHealth Select Direct

Individual Membership Application

Please print clearly and return the completed application(s) and signed membership agreement to:

MetroHealth Select Direct
2500 MetroHealth Drive, M141
Cleveland, OH 44109

If you have additional questions, please contact us at (216) 778-2055 or select@metrohealth.org

Required Applicant Information	
First Name	
Middle Name	
Last Name	
Date of Birth (mm/dd/yyyy)	
Gender	
Email Address	
Phone (xxx) xxx-xxxx	
Street Address	
City	
State	
Zip	

If the applicant has insurance coverage, please provide information below.

Insurance Information		
Insurance Company	Group ID	Member ID

MetroHealth Select Direct

Select Direct Membership Information	
Coverage Level – Preferred, Premium, Platinum	
Desired Effective Date (1st or 15th of a month) – (mm/dd/yyyy)	
Payment Frequency (Monthly, Quarterly, Annually)	
Desired Payment Method (Cash, Check, Debit/ACH, Credit Card) *	

Membership Fee Calculation	
One-time Registration	$99.00
Recurring Membership Fee (based on the age of the applying member, coverage level and payment frequency)	+ $ _____
Total Due Prior to Effective Date	$

*If paying by check, please make payable to: **The MetroHealth System**. If paying electronically, a MetroHealth Select Direct representative will contact you upon receipt of this application to process the payment over the phone.

Adding additional members to your membership? (circle one) Yes / No

If you would like to add additional members to this membership account, please complete and attach the application for those individuals and submit at the same time. Any additional members must be enrolled at the SAME level of membership (Preferred, Premium, Platinum).

MetroHealth Select Direct Primary Care Agreement

Patient Name: _____ DOB: _____

Address: _____

The following terms and conditions govern this MetroHealth Select Direct Primary Care Agreement ("Membership Agreement") between The MetroHealth System (dba MetroHealth Select) and the above named patient ("Patient"). This Membership Agreement commences on the 1st or 15th day of the month following confirmation of your account registration by MetroHealth Select (for example, if MetroHealth Select confirms your account registration on January 10th, your membership will become active to seek Covered Services, as defined herein, on January 15th) ("Effective Date").

Membership Effective Date: _____

The Patient acknowledges and understands that this Membership Agreement does NOT provide comprehensive health insurance coverage, nor is it a contract of insurance.

1. **Membership.** Patient agrees the he or she is enrolling as a member in the MetroHealth Select Direct Primary Care Program ("Membership Program") beginning on the Effective Date noted above for a twelve (12) month period ("Initial Term"). At the end of the Initial Term, this Membership Agreement shall renew for successive one-year periods (each a "Renewal Term"). Patient may terminate this Membership Agreement by notifying MetroHealth Select in writing at least thirty (30) days prior to the beginning of the next Renewal Term of Patient's desire to terminate his or her membership. The Initial Term and any subsequent Renewal Term shall collectively be referred to as the "Term".

   As a member of the Membership Program, Patient shall be eligible to receive basic primary care, laboratory and radiology services as outlined in the attached Exhibit A ("Covered Services") for the level of membership selected below. Membership in the Membership Program includes only the Covered Services specifically described in Exhibit A.

   Please mark the desired level of membership:

   ☐ Preferred Membership

   ☐ Premium Membership

   ☐ Platinum Membership

2. **Registration and Membership Fees.** Patient agrees to pay a one-time registration fee in the amount of Ninety-Nine Dollars ($99.00). The one-time registration fee is due on or prior to the Effective Date.

   Patient agrees to pay a membership fee ("Membership Fee") in accordance with the recurring Membership Fee calculation shown on Patient's application form. The Membership Fee may be paid on a monthly, quarterly, or annual basis as selected by Patient ("Invoice Period"). The Membership Fee is based on the age of the Patient, coverage level of membership and payment frequency. The Membership Fee is due on or prior to the beginning of each Invoice Period. Patient understands that he or she is obligated to pay the full Membership Fee (equivalent to twelve (12) monthly installments, four (4) quarterly installments, or one (1) annual installment) for the Term of this Membership Agreement even if Patient does not seek Covered Services available under this Membership Agreement or terminates the Membership Agreement in accordance with Section 5. Any fees or charges that are not included in the Membership Fee (i.e. fees for non-covered services) will be due at the time of service.

   A. **Late Fee.** If Patient pays the Membership Fee in monthly or quarterly installments and fails to pay the full Membership Fee installment on-time (no later than 7 days after the Invoice Period), Patient shall be charged a late fee of Ten Dollars ($10.00). If Patient fails to pay the monthly installment on time for two consecutive Invoice Periods or if Patient fails to pay a quarterly installment within sixty (30) days of the Invoice Period, MetroHealth Select may terminate this Membership Agreement.

   B. **Changes to Membership Fee Schedule.** MetroHealth Select may amend the Membership Fee schedule at any time, in its sole discretion, by providing Patient at least sixty (60) days advance written notice. Any changes to the Membership Fee schedule shall become effective as to Patient at his or her next Renewal Term.

3. **Non-covered Services.** Patient understands and acknowledges that Patient is responsible for any charges incurred for health care services outside of this Membership Agreement, including, but not limited to, emergency room visits, hospital and specialist care, as well as other services that are not identified in Exhibit A as Covered Services.

4. **MetroHealth Select Direct is Not Insurance.** Patient acknowledges and understands that this Membership Agreement is not a contract for health insurance coverage and that MetroHealth Select is not an insurance company or providing insurance. Further, the Covered Services provided under this Membership Agreement do not qualify as "Minimum Essential Coverage" under the Affordable Care Act.

   A. **Insurance Claims.** Patient acknowledges and understands that MetroHealth Select will not bill insurance carriers on Patient's behalf for Covered Services provided to Patient and MetroHealth Select will not bill any health care plan of which the Patient

may be a subscriber or beneficiary for Membership Fees due and owing to MetroHealth Select under this Membership Agreement

B. **Tax-Advantaged Medical Savings Accounts.** The Membership Fees described in Section 2 of this Membership Agreement may not constitute eligible medical expenses that are payable or reimbursable under a tax advantaged savings account such as a health savings account ("HSA"), medical savings account ("MSA"), flexible spending arrangement ("FSA") or health reimbursement account ("HRA"). Every health plan is unique and Patient should consult with his or her health benefits advisor regarding whether Membership Fees may be paid using these aforementioned funds.

C. **High Deductible Health Plans.** Third party payors may not count Membership Fees incurred pursuant to this Membership Agreement toward any deductible. Every plan is unique and Patient should consult with their health benefits advisor regarding whether Membership Fees may be counted towards the Patient's deductible under a high deductible plan.

D. **Medicare.** Medicare cannot be billed for any Covered Services listed in Exhibit A performed by MetroHealth Select under this Membership Agreement. Patient agrees not to make any attempt to collect reimbursement from Medicare for Covered Services listed in Exhibit A.

5. Termination. Termination of this Membership Agreement shall cause the termination of Patient's membership in the Membership Program described herein.

A. **Termination by MetroHealth Select.** Notwithstanding any other termination rights within this Membership Agreement, MetroHealth Select may terminate this Membership Agreement at any time and for any reason by providing Patient sixty (60) days advanced written notice. Any pre-paid monthly or quarterly Membership Fees will be returned to Patient on a pro-rated basis based on the termination date within thirty (30) days.

B. Termination by Patient. Patient may terminate this Membership Agreement at any time and for any reason, upon thirty (30) day advance written notice to MetroHealth Select. Such termination shall be effective at the end of the Patient's current Term. Patient may continue to seek Covered Services under this Membership Agreement until the termination date.

6. Reinstatement. In the event Patient terminates this Membership Agreement, Patient shall be ineligible for membership in the Membership Program for a period of three (3) months following the effective date of termination unless Patient pays a reinstatement fee in the amount of Three Hundred Dollars ($300.00) ("Early Reinstatement Fee") to MetroHealth Select. Following this three (3) month period of ineligibility, if Patient desires to rejoin

Membership Program in the future, Patient will be subject to any registration fees associated with new membership.

7. **Policies, Procedures and Amendments.** MetroHealth Select may from time to time develop policies and procedures in connection with the operation or administration of the Membership Program. MetroHealth Select may also amend the Membership Program, including the listing of Covered Services within Exhibit A and Membership Fees, from time to time and in its sole discretion. Patient shall receive notice of any such policies, procedures and amendment and shall be bound by such.

8. **Entire Agreement.** This Membership Agreement constitutes the entire understanding between parties hereto relating to the matters herein contained and shall not be modified or amended except in a writing signed by both parties hereto.

9. **Waiver.** The waiver of either MetroHealth Select or Patient of a breach of any provisions of this Membership Agreement must be in writing and signed by the waiving party to be effective and shall not operate or be construed as a waiver of any subsequent breach by either MetroHealth Select or Patient.

10. **Notices.** All notices, consents, approvals, requests and communications required under this Membership Agreement or the Membership Program shall be in writing and shall be deemed to have been given when delivered by first class mail, postage prepaid, or by hand delivery to Patient at the most recent address shown in our records and to MetroHealth Select at the address shown below:

    The MetroHealth System
    MetroHealth Select Direct
    2500 MetroHealth Drive
    M141
    Cleveland, OH 44109

    If Patient has provided an email address at the time of registration, Patient acknowledges and agrees that MetroHealth Select may provide requisite notice to Patient by email.

11. **Assignment.** This Membership Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.

12. **Governing Law.** This Agreement will be governed by the laws of the State of Ohio and the venue for any disputes shall be the state and federal courts located in Cuyahoga County, Ohio.

13. **Regulatory Compliance.** It is the intent of MetroHealth Select that the Membership Program comply in all respects with all applicable federal, state and local laws,

regulations, rules and interpretive case decisions and MetroHealth Select has structured it with that specific intent. However, both parties understand that such laws, regulations and case decisions are complicated and in a state of flux. Therefore, in the event that any provision of this Membership Agreement is rendered invalid or unenforceable by a court of competent jurisdiction, or the applicable laws and regulations are altered by any legislative or regulatory body, or Patient is notified in writing of MetroHealth Select's reasonable belief that these terms and conditions or any of its provisions may be declared null, void, unenforceable, or in violation of applicable laws or regulations, the remaining provisions, if any, of these terms and conditions will nevertheless continue in full force and effect.

I acknowledge that I have read and agree to the above terms of this Membership Agreement.

_____

Patient Signature

Print Patient Name:_____

Date: _____

MetroHealth Select Direct

Exhibit A

Membership Program Covered Services

	Preferred	Premium	Platinum
Primary Care Visits – Internal Medicine, Pediatrics, Med/Peds, Family Med, Express Care, Retail (Drug Mart)	Up to 3 ^	Up to 3 ^	Up to 4 ^
Routine age-appropriate immunizations and vaccines ^	Covered	Covered	Covered
Screening Mammogram including Tomosynthesis #	Covered	Covered	Covered
Cervical Cancer Screen* #	Covered	Covered	Covered
Complete Blood Count	Annually	Annually	Annually
Lipid Panel	Annually	Annually	Annually
Basic Metabolic Panel	Annually	Annually	Annually
Thyroid Panel	Annually	Annually	Annually
Hepatic Function Panel	Annually	Annually	Annually
Hemoglobin A1c	Up to 2	Up to 2	Up to 2
Iron level	Annually	Annually	Annually
Prostate specific antigen (PSA) #	Annually	Annually	Annually
Vitamin D level	Annually	Annually	Annually
Urinalysis	Annually	Annually	Annually
Hepatitis C Screening #	Covered	Covered	Covered
Sexually-transmitted disease screening	Covered	Covered	Covered
Lead Screening (in children) #	Covered	Covered	Covered
Venipuncture (required for screening services)	Included	Included	Included
Bone Density Scan #	Not Covered	Included	Included
Screening Colonoscopy #	Not Covered	Covered	Covered
Basic X-ray	Not Covered	1	3

^ For members under 2 years old, well-child visits will be covered according to the American Academy of Pediatrics guidelines. Therefore, these members may have up to 6 visits covered in the Preferred and Premium tiers, and up to 8 visits in the Platinum tier.

** Cervical cancer screens done by a gynecologist will be covered as long as performed during a coded preventive visit.*

 # Indicated by age appropriate guidelines and testing frequencies. For more information, visit www.cdc.gov/vaccines/index/html

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Other diagnostic services, not listed above, including imaging and pathology, will not be covered under this plan but will be provided at preferred discount pricing.

Pending other insurance coverage, additional services needed will be provided at preferred discount pricing. Some notable excluded services: emergency medicine, maternity care, specialty providers, surgical services, physical/occupational therapy, speech therapy, dental care, and inpatient services.