



INTRODUCTION Welcome to SelectHealth. Our primary objective is to deliver quality care and services to you and your employees. To assist you and your staff, we have prepared this manual to outline plan benefits and explain the policies and procedures for each plan in which you participate. Use this manual as your guide to enrollment, changes in employee status, and billing. Included are descriptions of the various forms and member materials, as well as basic instructions on how they are used. In addition to this manual, your sales representative will continue to be an invaluable resource in all aspects of managing your plan.

If you have questions about your group health plan, please contact your sales representative or Member Services at 801-442-5038 (Salt Lake area) or 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.

<p>TABLE</p> <p>— of —</p> <p>CONTENTS</p>	<p>INTRODUCTION 1</p> <p>IMPORTANT NUMBERS..... 2</p> <p>MEMBER SERVICE PROGRAMS..... 3</p> <p>SELECTHEALTH WELLNESS 4</p> <p>YOUR HEALTH PLAN BENEFITS 5</p> <p>NEW ENROLLMENT..... 7</p> <p>ANNUAL RENEWAL..... 8</p> <p>FORMS 9</p> <p>MEMBER MATERIALS 10</p> <p>BILLING INFORMATION 12</p>
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Important Numbers

MEMBER SERVICES

Salt Lake Area801-442-5038
Toll-Free 800-538-5038
Fax 801-442-5610

ENROLLMENT SERVICES

Salt Lake Area 801-442-7839
Continental U.S.A. 800-538-5038
Fax 801-442-5798

LARGE EMPLOYER SALES

Salt Lake Area 801-442-4908
Toll-Free 800-442-3125
Fax 801-442-0983

BILLING DEPARTMENT

Salt Lake Area 801-442-4350 opt. 1
Toll Free 800-442-3125 opt. 4

SELECTHEALTH HEALTHY BEGINNINGS®

Education, one-on-one support, and resources for expectant mothers
Salt Lake Area801-442-5052
Continental U.S.A. 866-442-5052

SMOKING CESSATION PROGRAMS

Quit for Life® 866-QUIT-4-LIFE

MEMBER ADVOCATESSM

Salt Lake Area 442-4993
Toll-Free 800-515-2220

BEHAVIORAL HEALTH ADVOCATES

Salt Lake Area 442-1989
Toll-Free 800-876-1989

HSA VENDOR - HEALTHEQUITY®

24-Hour Member Service . 866-346-5800
Fax 1-801-642-0505
www.healthequity.com

MAILING ADDRESS

SelectHealth
PO Box 30192
Salt Lake City, UT 84130-01

PHYSICAL ADDRESS

5381 Green St.
Murray, Utah 84123

HOME DELIVERY PRESCRIPTION DRUG PROGRAM

Medco by Mail 800-875-3146
www.medcohealth.com



Member Service Programs

MEMBER SERVICES

Your group has been assigned to a Member Services team that is specifically trained to help large employers and their employees with their health plan questions. Call Member Services to verify information about your plan and benefit options, to check a claim, or to verify a claim has been processed correctly.

Member Services is available to help weekdays, from 7:00 a.m. to 8:00 p.m. and Saturdays, from 9:00 a.m. to 2:00 p.m. Call 801-442-5038 (Salt Lake area) or 800-538-5038.

MEMBER ADVOCATES® AND BEHAVIORAL HEALTH ADVOCATESSM

SelectHealth Member Advocates® and Behavioral Health Advocates are teams of service representatives available to help your employees find a provider when needed. These teams help your employees with the following:

- Find a doctor who is accepting new patients;
- Schedule an appointment for annual exams, immunizations, and checkups;
- Learn about a doctor, such as where he or she went to medical school;
- Find a doctor who speaks a particular language;
- Schedule an appointment to see a specialist; and
- Schedule an appointment for urgent care when their regular doctor is unavailable.

To contact Member Advocates, call 801-442-4993 (Salt Lake area) or 800-515-2220, weekdays, from 7:00 a.m. to 8:00 p.m. and Saturdays, from 9:00 a.m. to 2:00 p.m. To contact Behavioral Health Advocates, call 801-442-1989 (Salt Lake area) or 800-879-1989, weekdays, from 8:00 a.m. to 6:00 p.m.

ONLINE SERVICES

At www.selecthealth.org, members can access information regarding their health plan and their personal insurance information. They can view a current Provider & Facility Directory, access claims information, or download and print an Explanation of Benefits (EOB). Members can also download forms and view educational materials related to pregnancy, parenting, safety, preventive care, and more.

PROVIDER & FACILITY DIRECTORY

Members can visit our Web site at www.selecthealth.org/providers to search the online provider directory for participating providers. To locate a facility, visit www.selecthealth.org/facility. You and your employees can search for facilities by facility type, geographic region, or panel participation. To order a hard copy of the Provider & Facility Directory, employees should call Member Services.



SelectHealth WellnessSM

WE WANT OUR MEMBERS TO LIVE WELL, so we provide a number of wellness resources to supplement our health plan benefits. From member discounts to work site health programs, the Select Living program is designed to help you maintain and enjoy a healthy, happy lifestyle. For more information on the following programs and services, visit www.selecthealth.org/wellness or call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

MEMBER DISCOUNTS

Getting in shape is easier when it costs less. SelectHealth members receive discounts on the following services and products:

- > Fitness centers
- > Personal training
- > Vision correction
- > Acupuncture
- > Massage therapy
- > Nutritional supplements
- > Eyewear

CARE MANAGEMENT

In addition to one-on-one support with registered nurses, we provide educational materials, online and community resources, and follow-up phone calls to help members manage their medical conditions. Care management services are available to all SelectHealth members and can help with the following:

- > Allergies and Rhinitis
- > Depression
- > Asthma
- > Diabetes
- > Cancer
- > Hepatitis C
- > High Cholesterol
- > High-Risk Pregnancy
- > Congestive Heart Failure
- > High Blood Pressure
- > COPD
- > Migraines

SELECTHEALTH HEALTHY BEGINNINGS[®]

Our prenatal program provides support and resources for expectant mothers. In addition to pregnancy education materials, the program includes a risk assessment screening and provides high-risk case management when needed.

SMOKING CESSATION PROGRAM

One of the most significant things a person can do to improve overall health is to quit smoking. We offer a program that can help. Quit for Life[®] allows members to progress at their own pace from home. SelectHealth members have 100 percent coverage; no copay or coinsurance is required.

PREVENTIVE CARE

Regular preventive care exams can help members maintain optimal health and detect and treat concerns early. We provide information, schedules, and reminder calls and mailings to help members seek the appropriate examinations and immunizations.

WORK SITE PROGRAMS

Looking for ways to promote productivity, reduce health risks, and encourage healthy habits at the workplace? We've already done the work for you. The following programs can help motivate your employees throughout the year:

- > Catch A FlightSM
- > Get FitSM
- > Holiday Weigh InSM
- > Summer Slim DownSM
- > The Weigh to Health[®]
- > Walk A DaySM
- > Walking TrailsSM
- > Wellness Week

ONLINE WELLNESS RESOURCES

We want members to have important health information at their fingertips. *My Health*, our secure Web site, allows members to manage their health information in one location. *My Health* gives members access to the following:

- > Personalized benefits summary
- > Prescription drug cost comparison
- > Personal health assessments
- > Health management centers
- > Online health coaching for nutrition, fitness, weight loss, and smoking cessation
- > Paperless claims and year-to-date totals
- > Personal Intermountain medical records



Your Health Plan Benefits

This section presents a condensed explanation of the benefits provided for each of your company's plans. Your participating employees will receive this same information on the Member Payment Summary included with their Certificate of Coverage. For answers to any questions regarding these benefits, please contact your sales representative or Member Services.

Note: A complete description of the policies and procedures related to your plan(s) can be found in the Master Group Contract.

1 PLAN OPTIONS

Refer to this area to determine if your benefits include one or two levels of coverage. You are required to see participating providers with one level of coverage. Two levels of coverage will allow you to also see nonparticipating providers, but at a lower benefit.

2 BENEFIT ACCUMULATOR PERIOD

Refer to this line to determine if your benefits apply to a calendar or plan year. Benefits are calculated on a yearly basis. For calendar year plans, the out-of-pocket maximums and limited benefits start over on January 1. For plan year plans, the out-of-pocket maximums and limited benefits start over on your group renewal date.

3 ANNUAL OUT-OF-NETWORK MAXIMUM

The maximum dollar amount that SelectHealth will pay per member per year for services from nonparticipating providers covered as a nonparticipating benefit. Dollar amounts applied to the annual out-of-network maximum are also applied to the lifetime maximum.

select:care+	MEMBER PAYMENT SUMMARY	
	PARTICIPATING <i>(In-Network)</i> <small>When using participating providers, you are responsible to pay the amounts in this column.</small>	NONPARTICIPATING <i>(Out-of-Network)</i> <small>When using nonparticipating providers, you are responsible to pay the amounts in this column.</small>
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - Per Person	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar year	
Maximum Annual Out-of-Network Payment - (per calendar year)	None	\$1,000,000
MEDICAL DEDUCTIBLE AND MEDICAL, OUT-OF-POCKET		
Deductible - Per Person/Family (per calendar year)	\$250/\$500	\$500/\$1000
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	\$2000/\$4000	\$4000/\$8000
INPATIENT SERVICES		
Medical, Surgical, Hospice, and Emergency Admissions	20% after deductible	40% after deductible with preauth
Maternity and Adoption	20% after deductible	40% after deductible with preauth
Skilled Nursing Facility - Up to 60 days per calendar year	20% after deductible	40% after deductible with preauth
Inpatient Rehab Therapy: Physical, Speech, Occupational <small>Up to 40 days per calendar year for all therapy types combined</small>	20% after deductible	40% after deductible with preauth
PROFESSIONAL SERVICES		
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)	\$20	40% after deductible
Secondary Care Provider (SCP)	\$30	40% after deductible
Preventive Care		
Primary Care Provider (PCP)	\$20	Not Covered
Secondary Care Provider (SCP)	\$30	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	20%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Office Surgery <i>(Surgical and Endoscopic Services Over \$350)</i>	20%	40% after deductible
Physician's Fees - <i>(Medical, Surgical, Maternity, Anesthesia)</i>	20% after deductible	40% after deductible with preauth
OUTPATIENT SERVICES		
Outpatient Facility and Ambulatory Surgical - <i>(all related services)</i>	20% after deductible	40% after deductible with preauth
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20% after deductible	See Participating Benefit
Emergency Room - <i>(Participating facility) - Includes all services rendered in conjunction with the ER</i>	\$100 after deductible	See Participating Benefit
Emergency Room - <i>(Nonparticipating facility) - Includes all services rendered in conjunction with the ER</i>	\$150 after deductible	See Participating Benefit
Intermountain InstaCare SM Facilities, Urgent Care Facilities	\$40	40% after deductible
Intermountain KidsCare SM Facilities	\$20	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor	Covered 100%	40% after deductible
Diagnostic Tests: Major	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible with preauth
Outpatient Rehab Therapy: Physical, Speech, Occupational <small>Up to 20 visits per calendar year for each therapy type</small>	\$30 after deductible	40% after deductible

4 DEDUCTIBLE

An amount that you must pay each year for covered services before SelectHealth makes any payment. Some categories of benefits may be subject to separate deductibles.

5 OUT-OF-POCKET MAXIMUM

The maximum amount that you must pay each year to providers and/or facilities as deductibles, copays and coinsurance.



7 PHARMACY DEDUCTIBLE

An amount that you must pay each year before SelectHealth makes any payment for covered prescription drugs.

COPAY

A fixed amount that you must pay for covered services to a provider or facility.

COINSURANCE

A percentage of the allowed amount that you must pay for covered services to the provider and/or facility.

NONPARTICIPATING

Nonparticipating benefits allow you the flexibility to use nonparticipating providers and facilities at a lesser benefit.

PARTICIPATING

Participating benefits apply when you receive covered services from participating providers.

select:care+	MEMBER PAYMENT SUMMARY	
	PARTICIPATING <i>(In-Network)</i>	NONPARTICIPATING <i>(Out-of-Network)</i>
MISCELLANEOUS SERVICES	PARTICIPATING	NONPARTICIPATING
Durable Medical Equipment (DME) ⁴	20% after deductible	40% after deductible with preauth
Infertility - Selected Services <i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	*50% after deductible	Not Covered
Miscellaneous Medical Supplies (MMS)	20% after deductible	40% after deductible
Other Plan Payment Maximums		
Cochlear Implants - <i>Up to \$35,000 lifetime</i>	20% after deductible	40% after deductible with preauth
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000 lifetime</i>	20% after deductible	40% after deductible with preauth
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	20% after deductible	40% after deductible with preauth
BENEFIT RIDERS	PARTICIPATING	NONPARTICIPATING
Mental Health and Chemical Dependency ¹		
Mental Health Office Visits	\$20	40% after deductible
Inpatient	20% after deductible	40% after deductible with preauth
Outpatient	20% after deductible	40% after deductible
Residential Treatment ²	Not Covered	Not Covered
Injectable Drugs and Specialty Medications ³	20% after deductible	40% after deductible with preauth
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per calendar year		7 ^*\$50
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> ⁴		
Tier 1		^^*\$10
Tier 2		^^*\$25
Tier 3		^^*\$45
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail ⁹⁰) ⁵ -selected drugs ⁶		
Tier 1		^^*\$10
Tier 2		^^*\$50
Tier 3		^^*\$135
Generic Substitution Required		Generic required or must pay copay plus cost difference between name brand and generic

1 SelectHealth provides an allowable adoption amount of \$4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.
3 Refer to your Certificate of Coverage for more information.
4 Certain DME items require preauthorization for coverage. Refer to your Certificate of Coverage, or contact SelectHealth Member Services for more information.
5 Preauthorization is required for all the following: inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; home health nursing services; and pain management/pain clinic services. If you fail to preauthorize these services when using a nonparticipating provider, your benefits are reduced to 50 percent and will not be applied to your out-of-pocket maximum.
6 Dollar amount applied to the Maximum Annual Out-Of-Network Payment is also applied to the Lifetime Maximum Benefit.
7 All mental health and chemical dependency services require preauthorization with the exception of office visits.
+ Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your Certificate of Coverage for more information.
* Not applied to Medical out-of-pocket maximum. ^ After Pharmacy Deductible.

All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of allowed amounts for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Contract, Certificate of Coverage, or Provider & Facility Directory for more information.



New Enrollment

We suggest you establish an open enrollment period to help your employees select a health plan and to assist them in completing the necessary forms. Copies of all forms mentioned in this manual can be obtained from your sales representative or on www.selecthealth.org.

EMPLOYEES ELIGIBLE FOR BENEFIT COVERAGE

Any employee who is eligible* for health benefit coverage may enroll. This includes:

- New or other employees who have not previously enrolled in a plan but are eligible for coverage;
- Eligible employees who missed previous enrollment deadlines;
- Employees who wish to switch from a previously selected alternate health benefit program (either through SelectHealth or another carrier); or
- Employees who are currently enrolled in the plan and wish to re-enroll.

**You are responsible to notify employees upon eligibility. Eligibility guidelines are employer-established and reflected in the Master Group Contract.*

THE OPEN ENROLLMENT PROCESS

SelectHealth team members are available to participate in open enrollment sessions to explain plan designs and answer questions for your employees. We will also provide you with the necessary literature pertaining to the plans you are offering. Contact your sales representative with any questions.

The open enrollment period, typically a minimum of ten working days, should be announced to all employees in advance. The enrollment period should be concluded and enrollment materials be submitted to SelectHealth at least thirty days prior to your effective or renewal date. A delay in submitting enrollment materials to SelectHealth may delay the processing and distribution of ID Cards and information to your employees.

Initial Enrollment Checklist

To complete an initial enrollment for your employees, submit the following enrollment materials to your sales representative or broker/agent:

- Completed Enrollment Forms for all employees (including those waiving coverage). All Enrollment Forms must be completed and signed by you and your employees.
- COBRA Forms: COBRA subscribers must complete a SelectHealth COBRA Form. This form must be signed by you and your employees.
- First month's premium payment: Your first month's premium payment will be based on an estimated premium. Once your enrollment is processed, an actual premium will be determined, and any difference will be adjusted on the following (second month's) billing statement.

Upon receipt, sign and send back:

- Signed Execution Section of Master Group Contract: The Execution Section is your formal application for coverage and will be provided to you by SelectHealth. Once signed by a company officer, this application initiates the Master Group Contract between your company and SelectHealth.

If you would prefer to submit your eligibility electronically, please contact your sales representative to obtain plan data values and to schedule file data testing.



Annual Renewal

THE RENEWAL PROCESS

Your SelectHealth sales representative or broker/agent will contact you 60 days prior to your contract expiration date with a new proposal packet, including your renewal rates and plan options. After accepting the proposal, you will receive a new Execution Section of the Master Group Contract to sign.

At this time, you may also discuss plans for any open enrollment meetings (i.e., when they will be held, what plan materials will be needed, and if you would like a SelectHealth representative to be present).

To complete the renewal process, you must return the following re-enrollment materials to your sales representative:

- Completed Employee Change Forms
- Completed New Enrollment Forms
- Signed Execution Section of Master Group Contract

RE-ENROLLING MEMBERS

To expedite the re-enrollment of employees currently on a SelectHealth plan during the renewal period, we will provide re-enrollment materials.

Your employees who do not wish to make any changes in coverage, whose information is listed correctly, and who do not have dependents over the regular age limit do not need to take any action. If we have not received information to make changes for the employee by the effective re-enrollment date, we will automatically re-enroll them.

If changes are necessary (i.e., address changes, marital status changes, coverage changes, addition or deletion of dependent coverage, etc.), the subscriber must request such changes by submitting an Employee Change Form. The completed form must be submitted to your Human Resource or Personnel department. You should then forward all forms to the appropriate SelectHealth department. If you need clarification, call your sales representative.

Making Changes in Enrollment Information

Changes in enrollment information are requested by submitting an Employee Change Form. Most changes, except the addition of dependents, may be made either at open enrollment or at anytime during the year.

The following is a list of possible changes:

- Addition of Dependents
- Deletion of Dependents
- Deletion of a Spouse
- Address or Telephone Change
- Name Change
- Marital Status Change
- Employment Status Change
- Discontinuance of Medical Benefits



Forms

This section provides details about our most commonly used forms and includes information about when to use each form and how to complete it.

The forms can be found at www.selecthealth.org/leforms. All forms are in a printable format and are ready to use. If you have any problems or questions, please contact your sales representative.

ENROLLMENT FORM

Your employees must complete the Enrollment Form to enroll on a plan or to transfer from their current plan. Enrollment Forms may be submitted during open enrollment from any eligible employee. Enrollment Forms will be accepted from new employees within 30 days of the date they become eligible.

EMPLOYEE CHANGE FORM

Employees should use the Employee Change Form to make any changes in personal data, including an address or telephone change, name or marital status, additions or deletions of family members, coverage status change, or discontinuance of medical benefits. You should use the Employee Change Form to notify us of changes in employment status. You must authorize the Change Forms by completing the bottom section.

COBRA FORM

COBRA applies to employers of 20 or more employees who sponsor a group health plan. Such employees and/or their covered dependents (Qualified Beneficiaries), who experience a loss of coverage associated with a set list of qualifying events are guaranteed the right to continue coverage under the former employer's group plan for 18 , 29, or 36 months depending upon the qualifying event.

As part of administering COBRA, an employer has various notification responsibilities. The employer must notify employees of their rights when they first become eligible for COBRA, when a qualifying event occurs, and at other times as specified by law. These notifications have timelines associated with them. SelectHealth reserves the right to refuse to offer COBRA coverage to Qualified Beneficiaries when the employer does not comply with its own COBRA responsibilities.



Enrollment Materials

Enrollment Guides must be ordered through your sales representative. ID Cards and Certificate of Coverage will automatically be sent after an employee enrolls on a plan.

We will provide the following plan information for employees during open enrollment periods and for new employees during the year:

ENROLLMENT GUIDE

Includes information about SelectHealth, descriptions of plan guidelines, Member Payment Summary, Provider & Facility Directory, and an Enrollment Form.

MEMBER PAYMENT SUMMARY

Highlights medical services covered through their specific plan and the employee's portion of the costs for those services.

PROVIDER & FACILITY DIRECTORY

This directory lists providers participating with SelectHealth, including physicians, specialists, pharmacies, and plan facilities.

ENROLLMENT FORM

This form is to be completed by employees choosing to enroll in the SelectHealth plan. (See "Forms" section.)

DENTAL PAYMENT SUMMARY

Also for subscribers with a dental plan, this summarizes dental services covered through the dental plan and the portion of the costs for those services to be paid by their plan and the employee.

VISION PAYMENT SUMMARY

Also for subscribers with an eyewear plan, this summarizes eyewear services covered through the plan and the portion of the costs for those services to be paid by their plan and the employee.

Member Materials

SelectHealth will send the following materials after the enrollment process is completed:

MEMBER ID CARDS

After an employee is enrolled on a SelectHealth plan, two ID Cards will automatically be mailed to his or her home. If an employee needs additional cards, they should call Member Services.

CERTIFICATE OF COVERAGE

This booklet provides an excellent reference on how the plan works, coverage provided, procedures which must be followed, and a Member Payment Summary. Each employee will receive their Certificate of Coverage a few weeks after they receive their ID Cards. Additional copies of the Certificate of Coverage can be requested by contacting Member Services. For answers to questions about your employees' plan, please refer to the Certificate of Coverage, the Master Group Contract, or call Member Services.



Member ID Cards

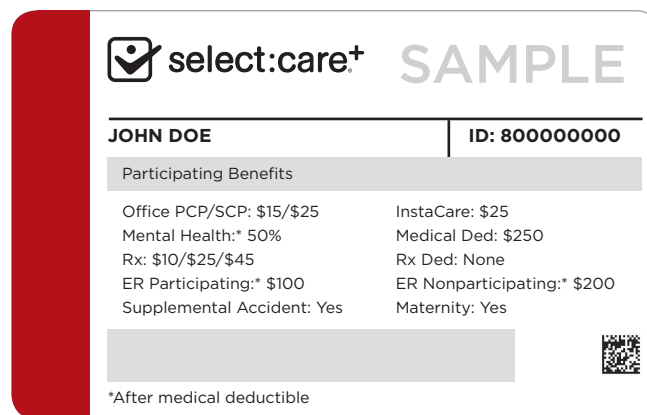
Each employee with coverage will receive two ID Cards in the name of the subscriber. Additional ID Cards may be requested from SelectHealth.

When to Use

Your employees must show their ID Card each time they receive healthcare services. It identifies the employee as a SelectHealth member and helps the provider's office register the patient quickly and accurately.

Information on the ID Card

The example below shows the information included on the plan ID Card. This card is a sample only and may not reflect the exact language that is on your employees' ID Cards.



BEECH STREET

Beech Street provides your employees with a lower-cost option when they need urgent and emergency services while traveling outside of the service area. SelectHealth members will not have to pay excess charges as long as they use Beech Street providers and facilities. They will, however, still be responsible to pay applicable deductibles, copays, and coinsurance. Members need to show the Beech Street logo on the back of their ID Card in order to receive the benefits of this arrangement. Call Beech Street at 800-937-2277 or visit www.beechstreet.com/beechplus/slh/ to find a participating provider or facility.





Understanding Your Billing Statement

Each month, you will receive a billing statement showing a list of your employees covered by SelectHealth and their total monthly premium. You should receive your billing statement approximately 13 days before the beginning of the coverage period. (For example, your billing statement for July should reach your office by June 17.)

Payment is due on the first day of each month. If payment is not received on the due date, your group's account will fall into its 30-day grace period, as stated in the Master Group Contract. If payment is not received by the last working day of the month in which premiums are due, your group's policy will be terminated for nonpayment.

Please include a copy of the monthly Billing Reconciliation Form when remitting payment to ensure that your changes are made in a timely fashion. Also include new Enrollment Forms, Employee Change Forms, and any other forms necessary for coverage additions, deletions, or changes applicable to the billing reconciliation. Groups are allowed a 60-day retro period for deletions. Any deletions going past the 60-day window will not be honored.

If you have questions concerning the billing process, please contact the billing department at 801-442-4350, option 1.

PAPERWORK NEEDED FOR CHANGES

Below are the forms and procedures needed to make changes to your employees' enrollment. Please remember normal enrollment guidelines, such as time frames to add dependents to coverage, still apply. If you or your employee completed and submitted the proper forms, and the change was not reflected on your billing statement, contact your sales representative or Member Services.

- Termination of entire family/dependents – Submit an Employee Change Form listing the covered employee and dependents. Remember to note the last day of coverage.
- New employee – Submit an Enrollment Form listing the new employee and dependents to be enrolled.
- Addition of dependents – Submit an Employee Change Form listing the new dependents.
- Termination of spouse – Submit an Employee Change Form with the spouse's signature noting the last day of coverage.
- COBRA – When someone is eligible for COBRA, the employee must first be terminated from active status. Submit an Employee Change Form noting the last day of coverage.
- Certification of Over Age Dependents – When someone is eligible for COBRA, the employee must first be terminated from active status. Submit an Employee Change Form noting the last day of coverage.

How to Reconcile the Billing Statement

It is important to keep your account accurate and complete. Upon receipt of your billing statement each month, please do the following to reconcile your account:

- Review your bill for accuracy; and
- Complete the Billing Reconciliation Form to review any new enrollments, changes in eligibility, or terminations.

You will notice the Billing Reconciliation Form explains two ways to reconcile your billing statement:

- **Option 1** – This first option is the method we prefer you use. You will find this method will save you both time and effort in reconciling your statement, as we will adjust for any coverage changes on your next billing statement.
- **Option 2** – You may use this method if it is necessary for you to balance exactly with your company's monthly records. Under this option, you calculate the adjustments for any coverage changes.



OPTION 1 (PREFERRED)

1. New Enrollments: Compare your list of employees with the billing statement. Use the Billing Reconciliation Form to list those employees who should be covered but who are not listed on the statement. Please fill in the subscriber's ID number or Social Security number and effective dates. If the employee is being enrolled under a COBRA option, please mark the "check if COBRA" box.
2. Changes: List those employees who have changed from one status to another (i.e., family to single, two-party to family, etc.) and whose status has not been updated on the billing statement. Please fill in the subscriber's ID number or Social Security number and indicate the change in coverage(s) and dates these changes become effective.
3. Terminations: List those employees who are shown on the statement who should be terminated. Please fill in the subscriber's ID number or Social Security number, the last day of coverage for the employee, and check the box indicating whether the employee is terminating from COBRA or has left employment with your company. If neither of these apply, please check "other." If they have enrolled under a COBRA option, you must notify SelectHealth to terminate them from an active status. Terminations must be reported within 31 days of an employee's last day of employment.
4. List all of the above items on the Billing Reconciliation Form as changes that SelectHealth should reflect on the next billing statement.
5. Find the last subscriber name listed on your billing statement. After this name, you will find the amount due for the monthly billing. Make sure this amount reflects your last payment made to SelectHealth. You can verify this by looking on the front page of the billing to see if your last check has been posted to your account. If your last check has been posted to your account, you can remit payment for the amount due. If your last check has been sent to SelectHealth but has not been credited to your account, simply deduct the prior payment amount from your amount due and remit the difference. Send SelectHealth a copy of the Billing Reconciliation Form with your payment.
6. It is not necessary to adjust the amount due for the coverage changes you submit. The adjustments for the changes you are currently requesting will be automatically calculated on your next month's billing.
7. Please double check your records to make sure the proper paperwork has been sent to SelectHealth to implement the changes you are requesting. This will help ensure the changes are made as quickly as possible.

OPTION 2

1. Follow the same steps as for Option 1, except adjust the amount due based on the coverage changes you listed in steps 1 through 3.
2. Find the amount due, which appears on the billing statement after your last employee's name. This number should reflect the difference between the amount due on your prior billing statement and the amount you paid plus the current month's premium charges. This must be your starting amount before you begin adjusting for changes.
3. Please complete the following to adjust the payment due:
 - Add premiums to the amount billed for the employees who are not on the billing statement but should be active;
 - Either add or subtract premium dollars for employees who have changed their coverage status (i.e., family to single) and whose coverage has not been updated on the billing statement;
 - Subtract premiums for those employees who are on the billing statement who are no longer covered. Please use the column on the right side of the Billing Reconciliation Form to help you compute the correct adjusted payment due;
 - Please make sure you have sent SelectHealth all of the paperwork that is needed to implement the changes for which you are adjusting the amount due along with a copy of the Billing Reconciliation Form.



Premium Proration

Most employer groups use one of two methods in dealing with effective dates and termination dates. These are outlined below:

1. The eligibility (start) date for coverage always begins on the first day of the month, and termination always becomes effective the last day of the month. In these cases, there will be no prorated premiums, as the employee will be covered for a full month. If an addition to an individual's coverage occurs within the month (i.e., newborn or new spouse), the premium will be prorated. Please refer to the proration method below.
2. The eligibility (start) date for coverage, or the termination of benefits may occur on any day of the month. In this case, premiums will be prorated, as the employee will be covered for a partial month. Please refer to the proration method below.

PRORATION SCHEDULE

For the purpose of premium proration, the month is divided into two parts. Premiums are prorated according to the portion of the month in which the coverage begins, ends, or changes.

	DAY OF MONTH
PRORATION OF NEW ENROLLMENTS	
100% OF MONTHLY PREMIUM	1 ST to 15 TH
NO PREMIUM DUE	16 TH to LAST
PRORATION OF TERMINATIONS	
NO PREMIUM DUE	1 ST to 15 TH
100% OF MONTHLY PREMIUM	16 TH to LAST
PRORATION OF ADDITIONS CAUSING A CHANGE IN STATUS	
100% OF NEW STATUS PREMIUM	1 ST to 15 TH
100% OF OLD STATUS PREMIUM	16 TH to LAST
PRORATION OF DELETIONS CAUSING A CHANGE IN STATUS	
100% OF NEW STATUS PREMIUM	1 ST to 15 TH
100% OF OLD STATUS PREMIUM	16 TH to LAST