SelectHealth

State: UT

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Benefits 2008

Plan facts	Member services	(800) 538-5038 Annual enrollment information: (800) 538-5038
	Member services hours	Mon-Fri: 7:00 AM-8:00 PM; Sat: 9:00 AM-2:00 PM MT
	Web address	www.selecthealth.org
	Product name	Select Med
Your medical expenses	Annual deductible	$200 (individual) / $400 (family max)*
	Annual out-of-pocket maximum	$1,500 (individual) / $3,000 (family max)
	Office visits	$15 (PCP) or $25 (specialist) copay per visit after deductible*
	Maternity care prenatal office visits	$15 copay after deductible for initial visit, thereafter covered at 100% *
	Inpatient hospitalization	$500 copay per admission after deductible*
	Outpatient surgical care	$25 copay per visit after deductible*
	Outpatient lab and X-ray	Covered at 100% after deductible. $50 copay after deductible for major diagnostic tests*
	Emergency room care	$50 copay/visit after deductible. Out-of-area: $100 copay/visit after deductible (waived if admitted)*
	Urgent care facility	$25 copay/visit after deductible (waived if admitted)*
Your prescription drug expenses	Retail	$10 copay (tier 1), $25 copay (tier 2), $45 copay (tier 3) per prescription up to 31-day supply (if generic avail., copay plus cost diff. applies) after $50 per individual deductible
	Mail order	$10 copay (tier 1), $50 copay (tier 2), $135 copay (tier 3) per prescription up to 90-day supply (if generic avail., copay plus cost diff. applies) after $50 per individual deductible
Preventive care	Routine physical and GYN	$15 copay per visit after deductible. Limit 1 visit per year*
	Routine vision exam	$25 copay per visit after deductible. Limit 1 visit per 12-month period*
	Well-child care and immunizations	Well Child Care: $15 copay per visit after deductible. Limits apply. Immunizations: Covered at 100%*
	Routine mammography	Covered at 100% after deductible. Limits apply. Contact plan for details*
Mental health	Inpatient	$500 copay per admission after separate $200 (ind) /$400 (family) MH/SA deductible; thereafter covered at 80%. Unlimited days. Precert required*
	Outpatient	$25 copay per visit after separate $200 (ind) /$400 (family) MH/SA deductible. Outpatient facility services covered at 80% after MH/SA deductible. Contact plan for details. Unlimited visits. Precert required*
Substance abuse	Inpatient detoxification	$500 copay per admission after annual medical deductible; thereafter covered at 100%. Unlimited days. Precert required*
	Inpatient rehabilitation	$500 copay per admission after separate $200 (ind) /$400 (family) MH/SA deductible; thereafter covered at 80%. Unlimited days. Precert required*
	Outpatient detoxification	$25 copay per visit after annual medical deductible. Outpatient facility services covered at 80% after annual medical deductible. Unlimited visits. Precertification required*
	Outpatient rehabilitation	$25 copay per visit after separate $200 (ind) /$400 (family) MH/SA deductible. Outpatient facility services covered at 80% after MH/SA deductible. Unlimited visits. Precertification required*
Other professional care	Outpatient physical/speech/ occupational therapy	$25 copay per visit after deductible. Limit 20 visits per year for each type of therapy*
	Chiropractic care	$15 copay per visit after deductible. Limit 20 visits per year, not applied to OOP maximum. Precertification required*
Out-of-network coverage	Out-of-network non-emergency care	Not covered

Key facts	NCQA status:	Excellent	Domestic partner coverage available:	Yes
	PCP referral required for	No	Domestic partner children coverage avail.:	Yes
	Lifetime Maximum Benefit:	$2,500,000		
	Provider Network:	See website for details		

*** Indicates a benefit change**

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.