SelectHealth - New Plan Design

State: UT

citi **Benefits 2009**

		In-Network Coverage
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	$100 (individual) / $200 (family max)*
	Out-of-pocket maximum (includes deductible)	$2,000 (individual) / $4,000 (family max) per calendar year*
	Office visits	Covered at 90% after deductible*
	Maternity care prenatal office visits	Covered at 90% after deductible*
	Inpatient hospitalization	Covered at 90% after deductible*
	Outpatient surgical care	Covered at 90% after deductible*
	Outpatient lab and X-ray	Covered at 90% after deductible*
	Emergency room care	Covered at 90% after deductible*
	Urgent care facility	Covered at 90% after deductible*
Your prescription drug expenses	Retail	$10 copay (tier 1), $25 copay (tier 2), $45 copay (tier 3) per prescription up to 30-day supply (if generic avail., copay plus cost diff. applies) after $50 individual deductible. Copays do not apply to the out-of-pocket maximum*
	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 individual deductible. Copays do not apply to the out-of-pocket maximum*
Preventive care	Routine physical and GYN	Covered at 100%, no deductible. Limit 1 visit per year*
	Routine vision exam	Covered at 100%, no deductible. Limit 1 exam per 12 months*
	Well-child care and immunizations	Covered at 100%, no deductible. Limits apply*
	Routine mammography	Covered at 100%, no deductible. Limits apply*
Mental health	Inpatient	Covered at 90% after separate $100 (individual) / $200 (family) MH/SA deductible. Unlimited days. Precertification required*
	Outpatient	Covered at 90% after separate $100 (individual) / $200 (family) MH/SA deductible. Unlimited days. Precertification required*
Substance abuse	Inpatient detoxification	Covered at 90% after separate $100 (individual) / $200 (family) Medical deductible. Unlimited days. Precertification required*
	Inpatient rehabilitation	Covered at 90% after separate $100 (individual) / $200 (family) MH/SA deductible. Unlimited days. Precertification required*
	Outpatient detoxification	Covered at 90% after separate $100 (individual) / $200 (family) Medical deductible. Unlimited days. Precertification required*
	Outpatient rehabilitation	Covered at 90% after separate $100 (individual) / $200 (family) MH/SA deductible. Unlimited days. Precertification required*
Other professional care	Outpatient physical/speech/ occupational therapy	Covered at 90% after deductible. Limit 20 visits per year for each type of therapy*
	Chiropractic care	$10 copay per visit. Limit 20 visits per year*
	Infertility	Select services covered at 50% after deductible. Contact plan for details
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 specialist:	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.