# SelectHealth – New Plan Design

**State: UT**

citi **Benefits 2010**

| | | 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 | $500 (individual) / $1,000 (family max)* | | |
| | Out-of-pocket maximum (includes deductible) | $3,000 (individual) / $6,000 (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. Rx deductible and 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. Rx deductible and 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 deductible* | | |
| | Outpatient | Covered at 90% after deductible* | | |
| ***Substance abuse*** | Inpatient detoxification | Covered at 90% after deductible* | | |
| | Inpatient rehabilitation | Covered at 90% after deductible* | | |
| | Outpatient detoxification | Covered at 90% after deductible* | | |
| | Outpatient rehabilitation | Covered at 90% after deductible* | | |
| ***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. Copays do not apply to out-of-pocket maximum | | |
| | Infertility | Select diagnosis and treatment 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: | Select Med | | |

*** Indicates a benefit change**

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