

# 2008 MEDICAL PLAN COMPARISON CHART



Insurance Company	SelectHealth <small>(formerly known as IHC)</small>			Regence BlueCross BlueShield of Utah			
	Plan Name	Select: Med	Select: Care+	HealthWise	BlueChoices HealthWise		Traditional
		In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network
<b>Dependent Age Maximum</b>	26	23		26	23		23
<b>New Hire Waiting Period</b>	90 Days From Contract Hire Date	90 Days From Contract Hire Date		90 Days From Contract Hire Date	90 Days From Contract Hire Date		90 Days From Contract Hire Date
<b>Pre-Existing Conditions ①</b>	12 months	12 Months		12 Months	12 Months		12 months
<b>Annual Deductible</b>	\$500 per person	\$500 per person	\$800 per person	\$500 per person	\$500 per person	\$600 per person	\$750 per person
<b>Deductible Toward</b>	3 Deductible Max. (\$1500)	3 Deductible Max. (\$1500)	3 Deductible Max. (\$2400)	3 Deductible Max. (\$1500)	3 Deductible Max. (\$1500)	6 Deductible Max. (\$3600)	6 Deductible Max. (\$4500)
<b>Out-of-Pocket Maximum</b>	DOES count toward OOP Maximum	DOES count toward OOP Maximum	DOES count toward OOP Maximum	DOES NOT count toward OOP Maximum	DOES NOT count toward OOP Maximum	DOES NOT count toward OOP Maximum	DOES NOT count toward OOP Maximum
<b>Out-of-Pocket Maximum</b>	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500	Employee \$2000 Employee & 1 \$4000 Employee & 2+ \$4500	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500	Employee \$1000 Employee & 1 \$2000 Employee & 2+ \$2500
<b>Lifetime Maximum</b>	\$2,500,000	None	None	None	\$1,000,000	\$1,000,000	\$1,000,000
<b>Office Visits</b>							
Office Visit	\$15 copay per visit	\$20 copay per visit	70% after deductible	\$15 copay per visit	\$20 copay per visit	80% after deductible	70% after deductible
X-Ray/Lab Tests - Minor	Included in copay	Included in copay	70% after deductible	Included in copay	Included in copay	80% after deductible	70% after deductible
X-Rab/Lab Test - Major	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
<b>Preventative Services</b>							
Annual Maximum	None	None	Not Applicable	None	None	Not Applicable	Not Applicable
Routine Physical (1 per yr)	\$15 copay then 100%	\$20 copay then 100%	Not Covered	\$15 copay then 100%	\$20 copay then 100%	Not Covered	Not Covered
Pap Office Visit	\$15 copay then 100%	\$20 copay then 100%	Not Covered	\$15 copay then 100%	\$20 copay then 100%	Not Covered	Not Covered
Mammogram/Lab Tests	Covered in copay	Covered in copay	Not Covered	Covered in copay	Covered in copay	Not Covered	Not Covered
Well Child Care	\$15 copay then 100%	\$20 copay then 100%	Not Covered	\$15 copay then 100%	\$20 copay then 100%	Not Covered	Not Covered
Immunizations ②	\$15 copay then 100%	\$20 copay then 100%	Not Covered	\$15 copay then 100%	\$20 copay then 100%	Not Covered	Not Covered
Eye Exam	\$15 copay then 100%	\$20 copay then 100%	Not Covered	\$15 copay then 100%	\$20 copay then 100%	Not Covered	Not Covered
Eyewear	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program
<b>Maternity Care</b>							
Initial Prenatal Office Visit	\$15 copay (1st visit only)	\$20 copay (1st office visit)	70% after deductible	\$15 copay (1st visit only)	\$20 copay (1st visit only)	80% after deductible	70% after deductible
Care/Delivery/Profess. Fees ③	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Newborn Adoption Benefit ④	Subject to maternity care benefit; not to exceed \$4,000	Subject to maternity care benefit; not to exceed \$4,000	Subject to maternity care benefit; not to exceed \$4,000	Subject to maternity care benefit; not to exceed \$4000	Subject to maternity care benefit; not to exceed \$4,000	Subject to maternity care benefit; not to exceed \$4,000	Subject to maternity care benefit; not to exceed \$4,000
<b>Inpatient Services ⑤</b>							
Medical-Surgical Admission	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Skilled Nursing Facility ⑥	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Rehabilitation Services ⑦	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Professional Fees	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
<b>Outpatient Services</b>							
Facility Charges	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Surgical Fees	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Rehabilitation Services	\$15 copay after deductible	\$20 copay after deductible	70% after deductible	\$15 copay after deductible	\$20 copay after deductible	80% after deductible	70% after deductible
Home Health / Hospice	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Chemo/Radiation/Dialysis	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
<b>Emergency Services</b>							
Emergency Room	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Ground Ambulance	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
Air Ambulance	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible

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	Plan Name	Select: Med	Select: Care+	HealthWise	BlueChoices HealthWise	HealthWise	Traditional
Dependent Age Maximum	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	No Defined Network
<b>Durable Medical Equipment</b> ③							
Inpatient or Outpatient	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible
<b>Chiropractic Care</b> ④							
Office Visit	Not Covered	Not Covered	30% after deductible	Not Covered	\$20 copay per visit	80% after deductible	70% after deductible
<b>Mental Health</b> ⑤⑥⑦							
Inpatient Visit ⑤⑥	80%	80%	50% after deductible	80%	70%	50% after deductible	50% after deductible
Outpatient Visit ⑤⑥	\$15 copay then 100%	\$20 copay then 100%	50% after deductible	\$15 copay then 100%	50%	50% after deductible	50% after deductible
<b>Prescription Drugs</b> ⑥⑦							
<b>Retail</b>	<b>Up to a 30-Day Supply</b>	<b>Up to a 30-Day Supply</b>		<b>Up to a 30-Day Supply</b>	<b>Up to a 30-Day Supply</b>	<b>Up to a 30-Day Supply</b>	<b>Up to a 30-Day Supply</b>
Generic/Tier 1	\$7.00 per prescription	\$7.00 per prescription		\$7.00 per prescription	\$7.00 per prescription	\$7.00 per prescription	\$7.00 per prescription
Preferred/Tier 2 ⑧	\$20.00 per prescription	\$20.00 per prescription		\$20.00 per prescription	\$20.00 per prescription	\$20.00 per prescription	\$20.00 per prescription
Non-Preferred/Tier 3	\$35.00 per prescription	\$35.00 per prescription		\$35.00 per prescription	\$35.00 per prescription	\$35.00 per prescription	\$35.00 per prescription
<b>Mail Order</b>	<b>Up to a 90-Day Supply</b>	<b>Up to a 90-Day Supply</b>		<b>Up to a 90-Day Supply</b>	<b>Up to a 90-Day Supply</b>	<b>Up to a 90-Day Supply</b>	<b>Up to a 90-Day Supply</b>
Generic/Tier 1	\$14.00 per prescription	\$14.00 per prescription		\$14.00 per prescription	\$14.00 per prescription	\$14.00 per prescription	\$14.00 per prescription
Preferred/Tier 2 ⑧	\$40.00 per prescription	\$40.00 per prescription		\$40.00 per prescription	\$40.00 per prescription	\$40.00 per prescription	\$40.00 per prescription
Non-Preferred/Tier 3	\$70.00 per prescription	\$70.00 per prescription		\$70.00 per prescription	\$70.00 per prescription	\$70.00 per prescription	\$70.00 per prescription
<b>Injectable Drugs</b> ③							
Received at Pharmacy	90% after deductible	90% after deductible	70% after deductible	Subject to pharmacy tiers	Subject to pharmacy tiers	Subject to pharmacy tiers	Subject to pharmacy tiers
Received via Home Health	90% after deductible	90% after deductible	70% after deductible	90% after deductible	90% after deductible	80% after deductible	70% after deductible

## HOW TO FIND A PARTICIPATING PHYSICIAN OR FACILITY

Insurance Company	SelectHealth <small>(formerly known as IHC)</small>		Regence BlueCross BlueShield of Utah		
	Plan Name	Select: Med	Select: Care+	HealthWise	BlueChoices HealthWise
<b>Member Services</b>	442-5038	442-5038	333-2100	333-2100	333-2100
<b>Web Site Address</b>	www.selecthealth.org	www.selecthealth.org	www.ut.regence.com	www.ut.regence.com	www.ut.regence.com
<b>Provider Network Lookup</b>	Select Med	Select Care Plus	HealthWise	HealthWise	BlueCross BlueShield

- ① It is the responsibility of the enrollee seeking credit for Creditable Coverage to obtain and provide the Plan with applicable certification(s) of coverage from prior Creditable plans within a timely manner.
- ② Specified immunizations only.
- ③ Preauthorization is required on the following: inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; DME with purchase price of more than \$750; home health nursing services; certain injectable and prescription drugs; and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to your out-of-pocket max.
- ④ Allowable adoption amount as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
- ⑤ Limited number of visits per calendar year. Refer to the Summary Plan Description(s).
- ⑥ Not applied toward annual out-of-pocket maximum.
- ⑦ Mandatory generic substitution enforced when a generic drug is available or you must pay the the preferred or nonpreferred copay plus the difference in cost between name brand and generic drug.
- ⑧ There are differences in the prescription preferred drug formularies between SelectHealth and Regence. You are encouraged to study the formularies when selecting participation in a medical plan.

### THE BENEFITS LISTED ARE IN SUMMARY FORM ONLY

They are for illustrative purposes only and should not be construed to be complete in and of themselves. In case of conflict, the respective legal plan documents will apply. All deductible/copay/coinsurance amounts and plan payments are based on eligible charges only and not the provider's billed or other charges. You are responsible to pay for extra charges in excess of eligible charges for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Payment percentages listed will be paid according to the respective carrier's fee schedule.