BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 POLICY YEAR				
UTSELECT Medical Benefits - Employee Medical Plan			**AcademicBlue - Student Health Insurance Plan (UTSHIP)**	
Network Provider: BCBS			**Network Provider: BCBS**	
In-Area Coverage (TX,NM, DC)	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Annual Deductible	$350 Individual/$1,050 Family	$750 Individual/$2,250 Family	$350 Student/$1,050 Family	$700 Student/$2,100 Family
Annual Medical Coinsurance Maximum	$2,150 Individual $6,450 Family (does not include deductible)	Unlimited	No specific coinsurance maximum. Coinsurance contributions after deductible will cap at out-of-pocket maximum.	
Annual Out-of-pocket Maximum	$8,150 (was $7,900) Individual $16,300 (was $15,800) Family Includes medical and prescription cost	Unlimited	$6,600 Student $12,700 Family Per covered person, per policy year	$13,200 Student $37,500 Family
Pre-existing Condition Limitation	None	None	None	None
Lifetime Maximum Benefit	No Limit	No Limit	No Limit	No Limit
OFFICE SERVICES			**OFFICE SERVICES - ALL SERVICES COMPLETED IN THE STUDENT HEALTH CENTER ARE PAID AT 100%**	
Preventive Care	Plan pays 100% = no copay	60% Plan/40% Member	Plan pays 100% = no copay	60% Plan/ 40% Member
Diagnostic Office Visit	Family Care Physician (FCP) $30 Copay Specialist $35 Copay	60% Plan/40% Member	Family Care Physician (FCP) $20 Copay - deductible does not apply Specialist $40 Copay-deductible does not apply Urgent Care $35 Copay-deductible does not apply	60% Plan/ 40% Member 60% Plan/ 40% Member 60% Plan/ 40% Member
Diagnostic Lab and X-Ray	Included in Office Visit FCP $30 Copay Specialist $35 Copay	60% Plan/40% Member	80% of allowable amount	60% Plan/ 40% Member
Other Diagnostic Tests	Included in Office Visit FCP $30 Copay Specialist $35 Copay	60% Plan/40% Member	80% of allowable amount	60% Plan/ 40% Member
Allergy Testing	FCP $30 Copay Specialist $35 Copay	60% Plan/40% Member	80% of allowable amount	60% Plan/ 40% Member
Allergy Serum/Injecxtions (if no office visit billed)	Plan pays 100% = no copay	60% Plan/40% Member	80% of allowable amount	60% Plan/ 40% Member
EMERGENCY CARE			**EMERGENCY CARE**	
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member	80% of allowable amount	80% of allowable amount
Hospital Emergency Room	$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services	$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services	80% of allowable after $150 copay	
Emergency Physician Services	80% Plan/20% Member	80% Plan/20% Member	80% of allowable	
OUTPATIENT CARE			**OUTPATIENT CARE**	
Observation	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Surgery – Facility	$100 Copay	60% Plan/40% Member	80% of allowable amount after $150	60% of allowable amount after $150

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UTSELECT Medical Benefits - Employee Medical Plan			AcademicBlue - Student Health Insurance Plan (UTSHIP)	
Network Provider: BCBS			Network Provider: BCBS	
In-Area Coverage (TX,NM, DC)	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Surgery – Facility	then 80% Plan/20% Member	60% Plan/40% Member	copay	copay
Surgery – Physician	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Diagnostic Lab and X-Ray	100% covered	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
MRI/CT Scans	$100 Copay/Service (copay waived if member calls Benefits Value Advisor/BVA prior to service)	$100 Copay/Service, then 40% Member (copay waived if member calls Benefits Value Advisor/BVA prior to service)	80% of allowable amount	60% of allowable amount
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
INPATIENT CARE			**INPATIENT CARE**	
Hospital - Semi private Room and Board	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Hospital Inpatient Surgery	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Physician	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
OBSTETRICAL CARE			**OBSTETRICAL CARE**	
Prenatal and Postnatal Care Office Visits	FCP $30 Copay Specialist $35 Copay (initial visit only)	60% Plan/40% Member	$20 Copay/visit (applies to first prenatal visit per pregnacy)	60% of allowable amount
Delivery – Facility/Inpatient Care	$100 Copay ($500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Obstetrical Care and Delivery - Physician	80% Plan/20% Member	60% Plan/40% Member		
THERAPY			**THERAPY**	
Physical Therapy/Chiropractic Care	$35 Copay/Visit - max 30 visits	60% Plan/40% Member	80% of allowable amt up to 35 visits	60% of allowable amt up to 35 visits
Occupational Therapy	$35 Copay/Visit - max 30 visits/year/condition	60% Plan/40% Member	80% of allowable amt up to 35 visits	60% of allowable amt up to 35 visits
Speech and Hearing Therapy	$35 Copay/Visit - max 60 visits/year/condition	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
EXTENDED CARE			**EXTENDED CARE**	
Skilled Nursing/Convalescent Facility	80% Plan/20% Member Maximum 180 visits	60% Plan/40% Member	80% of allowabble up to 25 visits	60% of allowabble up to 25 visits
Home Health Care Services	80% Plan/20% Member Maximum 120 visits	60% Plan/40% Member	80% of allowable up to maximum	80% of allowabble up to 25 visits
Hospice Care Services	80% Plan/20% Member	60% Plan/40% Member	No Benefit Period Visit Maximum	
Home Infusion Therapy	80% Plan/20% Member	60% Plan/40% Member		
BEHAVIORAL HEALTH			**BEHAVIORAL HEALTH**	
Coverage	BCBS In-Network	BCBS Out-of-Network*	Paid as any other covered illness	Paid as any other covered illness
Serious Mental Illness – Office Visit	$35 Copay	60% Plan/40% Member	$20 copay/office visit	60% of allowable amount
Serious Mental Illness – Outpatient	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount

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Network Provider: BCBS			**Network Provider: BCBS**	
In-Area Coverage (TX,NM, DC)	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Serious Mental Illness – Inpatient	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Mental Illness – Office	$35 Copay No Limit on visits	60% Plan/40% Member	$20 copay/office visit	60% of allowable amount
Mental Illness – Outpatient	80% Plan/20% Member No Limit	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Mental Illness – Inpatient (Other than Serious Mental Illness; max. 30 days/year)	$100 Copay/Day with $500 max/admission, then 80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Chemical Dependency – Office	$35 Copay No Limit on visits	60% Plan/40% Member	$20 copay/office visit	60% of allowable amount
Chemical Dependency – Outpatient Treatment	80% Plan/20% Member No maximum visits	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Chemical Dependency – Inpatient Treatment	$100 Copay/Day with $500 max/admission, then 80% Plan/20% Member No maximum treatment	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
OTHER SERVICES			**OTHER SERVICES**	
Durable Medical Equipment	80% Plan/20% Member	60% Plan/40% Member	80% of allowable amount	60% of allowable amount
Hearing Aids	80% Plan/20% Member ($1,000 per ear, once every 3 years)		80% of allowable amount - limited to 1 hearing aid per ear per 36 month period	60% of allowable amount - limited to 1 hearing aid per ear per 36 month period
Bariatric Surgery (pre-determination recommended)	$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum); must be covered for three years prior to surgery.		Non-covered service/excluded from coverage.	
PRESCRIPTION DRUGS BENEFITS (Express Scripts)			***PRESCRIPTION DRUG BENEFITS (Prime Therapudics)**	
		Retail Pharmacy Copayment (up to 30 day supply at retail, 90 at UT pharmacy or Walgreens)	**Network Provider Copay**	**Out-of-Network Provider Coinsurance**
Deductible per person per plan year		$100	Deductible does not apply	
Generic Drug		$10, $20	$15	60% of allowable plus $15 copay
Preferred Brand Name Drug		$35, $87.50	$30	60% of allowable plus the $30 copay
Non-Preferred Brand Name Drug		$50, $125	$50	60% plus the $50 copay
Specialty Drug		May Involve Exclusive Accredo	80% of allowable amount	60% of allowable amount
Mail Order Pharmacy - 90 day supply		$20, $87.50, $125	$40 generic; $75 preferred; $125 non-preferred	
UTSELECT MEDICAL PLAN PREMIUMS			**UTSHIP PREMIUMS**	*PRESCRIPTION FILLED AT SHC:$100% of allowable amount after copay
Tier Level	**Monthly Cost Part-time**	**Monthly Cost Graduate Student Employees (more than part time)**	**Monthly Cost (based on annual/12, see website for available payment plans)**	
Employee/Student Only			**$ 254.67**	
Employee/Student + Spouse			**$ 508.83**	

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Network Provider: BCBS			Network Provider: BCBS	
In-Area Coverage (TX,NM, DC)	**In-Network Provider**	**Out-of-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Employee/Student + Child			$ 662.00	
Employee/Student + Family			$ 916.42	
Cost Comparison Per Year-12 Months	**UTSelect Medical Employee Plan Cost**		**UTSHIP Cost**	
Tier Level	**Monthly Cost Part-time**	**Yearly (12 months)**	**Monthly Cost (based on annual/12, see website for available payment options)**	**Yearly (12 Months)**
Employee/Student Only	$ 314.02	$ 3,768.24	$ 254.67	$ 3,056.00
Employee/Student + Spouse	$ 749.04	$ 8,988.48	$ 508.83	$ 6,106.00
Employee/Student + Child	$ 702.16	$ 8,425.92	$ 662.00	$ 7,944.00
Employee/Student + Family	$ 1,117.46	$ 13,409.52	$ 916.42	$ 10,997.00
UT SELECT Plan Year	**9/1 through 8/31**		**UT Student Academic Plan Year**	**Varies by Institution**
This outline is intended as a summary only. If any of the information provided conflicts with the insurance contracts and policies, the contracts and policy information will prevail.				
UT SELECT Customer Service Number	**1-866-882-2034**		**AHP Customer Service Number**	**1-855-267-0214**
UT SELECT Group Policy Number	**71778**		**Academic Health Plan Policy Number**	**239939**