

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2023-2024 POLICY YEAR				
UTSELECT Medical - Employee Medical Plan			AcademicBlue - Student Health Insurance Plan (UTSHIP)	
Network Provider: BCBS			Network Provider: BCBS	
In-Area (TX, NM, DC) Plan Component	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$600 Individual / \$1,800 Family	\$1,800 Individual / \$5,400 Family	\$350 Individual / \$1,050 Family	\$700 Individual / \$2,100 Family
<b>Annual Medical Coinsurance Maximum</b>	\$3,500 Individual	Unlimited	No annual coinsurance maximum. You will continue to pay coinsurance costs until you reach the annual out-of-pocket maximum.	
<b>Annual Out-of-pocket Maximum</b>	\$8,700 Individual / \$17,400 Family	Unlimited	\$8,700 Individual / \$17,400 Family	\$17,400 Individual / \$34,800 Family
<b>Pre-existing Condition Limitation</b>	None	None	None	None
<b>Lifetime Maximum Benefit</b>	None	None	None	None
OFFICE SERVICES			OFFICE SERVICES	
<b>Student Health Center Visit</b>	\$10 Copay	N/A	Plan pays 100% (no copay required)	N/A
<b>Virtual Visit</b>	Plan pays 100% (no copay required) if using MD Live	40% Coinsurance	Plan pays 100% (no copay required) if using Academic Live Care	40% Coinsurance
<b>Preventative Care</b>	Plan pays 100% (no copay required)	40% Coinsurance	Plan pays 100% (no copay required)	40% Coinsurance
<b>Family Care Physician (FCP) Office Visit</b>	\$30 Copay	40% Coinsurance	\$30 Copay	40% Coinsurance
<b>Specialist Office Visit</b>	\$50 Copay	40% Coinsurance	\$35 Copay	40% Coinsurance
<b>Urgent Care</b>	\$50 Copay	40% Coinsurance	\$35 Copay	40% Coinsurance
<b>Diagnostic Lab and X-Ray</b>	Included in Office Visit Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Allergy Testing</b>	FCP - \$30 Copay / Specialist - \$50 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Allergy Serum/Injections (if no office visit billed)</b>	Plan pays 100% (no copay required)	40% Coinsurance	20% Coinsurance	40% Coinsurance
EMERGENCY CARE			EMERGENCY CARE	
<b>Ambulance Service (if transported)</b>	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
<b>Hospital Emergency Room</b>	\$500 Copay / Visit All Inclusive	\$500 Copay / Visit All Inclusive	\$150 Copay/Visit, then 20% Coinsurance (no deductible; copay waived if admitted); Non-emergency use of ER is \$150 copay plus deductible and 20% coinsurance.	
<b>Emergency Physician Services</b>	Included in hospital ER copay	Included in hospital ER copay	20% Coinsurance	20% Coinsurance

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<b>OUTPATIENT CARE</b>			<b>OUTPATIENT CARE</b>	
Observation	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Surgery – Facility	\$200 Copay; then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Surgery – Physician	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Diagnostic Lab and X-Ray	100% covered (except when billed with surgery; then 20% Coinsurance)	40% Coinsurance	20% Coinsurance	40% Coinsurance
MRI/CT Scans	\$150 Copay/Service	\$150 Copay/Service, then 40% Coinsurance	20% Coinsurance	40% Coinsurance
Other Diagnostic Tests	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Outpatient Procedures	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>INPATIENT CARE</b>			<b>INPATIENT CARE</b>	
Hospital - Semi-Private Room and Board	\$200 Copay/Day (\$1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Hospital Inpatient Surgery	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Physician	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>OBSTETRICAL CARE</b>			<b>OBSTETRICAL CARE</b>	
Prenatal and Postnatal Care Office Visits	FCP - \$30 Copay / Specialist - \$50 Copay (initial visit only)	40% Coinsurance	\$30 Copay (initial visit only)	40% Coinsurance
Delivery – Facility/Inpatient Care	\$200 Copay/Day (1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Obstetrical Care and Delivery - Physician	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>THERAPY</b>			<b>THERAPY</b>	
Physical Therapy/Chiropractic Care	\$50 Copay/Visit (max 30 visits/year/condition)	40% Coinsurance	20% Coinsurance (max 35 visits/year for all types of therapy combined)	40% Coinsurance (max 35 visits/year for all types of therapy combined)
Occupational Therapy	\$50 Copay/Visit (max 30 visits/year/condition)	40% Coinsurance	20% Coinsurance (max 35 visits/year for all types of therapy combined)	40% Coinsurance (max 35 visits/year for all types of therapy combined)
Speech and Hearing Therapy	\$50 Copay/Visit (max 60 visits/year/condition)	40% Coinsurance	20% Coinsurance (max 35 visits/year for all types of therapy combined)	40% Coinsurance (max 35 visits/year for all types of therapy combined)
<b>EXTENDED CARE</b>			<b>EXTENDED CARE</b>	
Skilled Nursing/Convalescent Facility	20% Coinsurance (max 180 visits/year)	40% Coinsurance	20% Coinsurance (max 25 visits/year)	40% Coinsurance (max 25 visits/year)
Home Health Care Services	20% Coinsurance (max 120 visits/year)	40% Coinsurance	20% Coinsurance (max 60 visits/year)	40% Coinsurance (max 60 visits/year)
Hospice Care Services	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Home Infusion Therapy	20% Coinsurance	40% Coinsurance		

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<b>BEHAVIORAL HEALTH</b>			<b>BEHAVIORAL HEALTH</b>	
<b>Serious Mental Illness – Office Visit</b>	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
<b>Serious Mental Illness – Outpatient</b>	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Serious Mental Illness – Inpatient</b>	\$200 Copay/Day (\$1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Mental Illness – Office</b>	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
<b>Mental Illness – Outpatient</b>	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Mental Illness – Inpatient (Other than Serious Mental Illness; max. 30 days/year)</b>	\$100 Copay/Day (\$500 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Chemical Dependency – Office</b>	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
<b>Chemical Dependency – Outpatient Treatment</b>	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Chemical Dependency – Inpatient Treatment</b>	\$200 Copay/Day (\$1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>OTHER SERVICES</b>			<b>OTHER SERVICES</b>	
<b>Durable Medical Equipment</b>	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
<b>Hearing Aids</b>	20% Coinsurance (\$1,000 per ear, once every 3 years)		20% Coinsurance - limited to 1 hearing aid per ear per 36 month period	40% Coinsurance - limited to 1 hearing aid per ear per 36 month period
<b>Bariatric Surgery (pre-determination recommended)</b>	\$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.	Non-covered service/excluded from coverage.
<b>Fertility Benefits</b>	\$750 / Quarter Cycle, \$3,000 / Full Cycle; Max 2 Cycles / Lifetime; must be enrolled in plan for 12 continuous months prior to treatment	Non-covered service/excluded from coverage.	Non-covered service/excluded from coverage.	Non-covered service/excluded from coverage.

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PRESCRIPTION DRUGS BENEFITS (Express Scripts)			*PRESCRIPTION DRUG BENEFITS (Prime Therapeutics)	
		Retail Pharmacy Copayment for up to 30 day supply at retail (90 supply at UT pharmacy or Walgreens)	Network Provider Copay	Out-of-Network Provider Coinsurance
Deductible per person per plan year		\$200	Deductible does not apply	
Generic Drug		\$10 (\$20)	\$15	40% Coinsurance plus \$15 copay
Preferred Brand Name Drug		\$35 (\$87.50)	\$30	40% Coinsurance plus the \$30 copay
Non-Preferred Brand Name Drug		\$60 (\$150)	\$50	40% Coinsurance the \$50 copay
Specialty Drug		May Involve Exclusive Accredo	20% Coinsurance	40% Coinsurance
Mail Order Pharmacy - 90 day supply		\$20 generic, \$87.50 preferred, \$150 non-preferred	\$40 generic; \$75 preferred; \$125 non-preferred	\$40 generic; \$75 preferred; \$125 non-preferred
	UTSELECT MEDICAL PLAN PREMIUMS		UTSHIP PREMIUMS	
Tier Level	Monthly Cost for Part-Time Benefits Eligible Grad Student Employees	Monthly Cost for Full-Time Benefits Eligible Grad Student Employees	Monthly Cost for All Benefits Eligible Grad Student Employees	
Grad Student Employee Only	\$362.90	\$0.00	\$0.00	
Grad Student Employee + Spouse	\$865.62	\$312.50	\$143.25	
Grad Student Employee + Child	\$811.44	\$326.84	\$229.80	
Grad Student Employee + Family	\$1,291.36	\$615.40	\$373.05	
	UTSELECT MEDICAL PLAN PREMIUMS		UTSHIP PREMIUMS	
Tier Level	Monthly Cost for Non-Employee Fellows	Annual Cost for Non-Employee Fellows	Monthly Cost for Non-Employee Fellows	Annual Cost for Non-Employee Fellows
Non-Employee Fellow Only	\$725.80	\$8,709.60	\$286.50	\$3,438.00
Non-Employee Fellow + Spouse	\$1,418.74	\$17,024.88	\$573.00	\$6,876.00
Non-Employee Fellow + Child	\$1,296.06	\$15,552.72	\$746.08	\$8,953.00
Non-Employee Fellow + Family	\$1,967.34	\$23,608.08	\$1,032.58	\$12,391.00
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