

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2025-2026 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
Annual Deductible	\$600 Individual / \$1,800 Family	\$1,800 Individual / \$5,400 Family	\$350 Individual / \$1,050 Family	\$700 Individual / \$2,100 Family
Annual Medical Coinsurance Maximum	\$5,000 Individual / \$15,000 Family	Unlimited	No annual coinsurance maximum. You will continue to pay coinsurance costs until you reach the annual out-of-pocket maximum.	
Annual Out-of-pocket Maximum	\$9,100 Individual / \$18,200 Family	Unlimited	\$8,700 Individual / \$17,400 Family	\$17,400 Individual / \$34,800 Family
Pre-existing Condition Limitation	None	None	None	None
Lifetime Maximum Benefit	None	None	None	None
OFFICE SERVICES		OFFICE SERVICES		
Student Health Center Visit	\$10 Copay	N/A	Plan pays 100% (no copay required)	N/A
Virtual Visit	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
Preventative Care	Plan pays 100% (no copay required)	40% Coinsurance	Plan pays 100% (no copay required)	40% Coinsurance
Family Care Physician (FCP) Office Visit	\$30 Copay	40% Coinsurance	\$30 Copay	40% Coinsurance
Specialist Office Visit	\$50 Copay	40% Coinsurance	\$35 Copay	40% Coinsurance
Urgent Care	\$50 Copay	40% Coinsurance	\$35 Copay	40% Coinsurance
Diagnostic Lab and X-Ray	Included in Office Visit Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Allergy Testing	FCP - \$30 Copay / Specialist - \$50 Copay	40% Coinsurance	20% Coinsurance	40% Coinsurance
Allergy Serum/Injecxtions (if no office visit billed)	Plan pays 100% (no copay required)	40% Coinsurance	20% Coinsurance	40% Coinsurance
EMERGENCY CARE		EMERGENCY CARE		
Ambulance Service (if transported)	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
Hospital Emergency Room	\$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.	
Emergency Physician Services	Included in hospital ER copay	Included in hospital ER copay	20% Coinsurance	20% Coinsurance

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OUTPATIENT CARE			OUTPATIENT CARE	
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
INPATIENT CARE			INPATIENT CARE	
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
OBSTETRICAL CARE			OBSTETRICAL CARE	
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
THERAPY			THERAPY	
Physical Therapy/Chiropractic Care	\$40 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	\$40 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	\$40 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)
EXTENDED CARE			EXTENDED CARE	
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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BEHAVIORAL HEALTH			BEHAVIORAL HEALTH	
Serious Mental Illness – Office Visit	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
Serious Mental Illness – Outpatient	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Serious Mental Illness – Inpatient	\$200 Copay/Day (\$1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Mental Illness – Office	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
Mental Illness – Outpatient	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Mental Illness – Inpatient (Other than Serious Mental Illness; max. 30 days/year)	\$100 Copay/Day (\$500 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Chemical Dependency – Office	\$30 or \$50 Copay Based on Treatment	40% Coinsurance	\$30 Copay	40% Coinsurance
Chemical Dependency – Outpatient Treatment	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Chemical Dependency – Inpatient Treatment	\$200 Copay/Day (\$1,000 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
OTHER SERVICES			OTHER SERVICES	
Durable Medical Equipment	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Hearing Aids	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
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.	Non-covered service/excluded from coverage.
Fertility Benefits	\$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	\$421.32	\$0.00	\$0.00	
Grad Student Employee + Spouse	\$1,004.98	\$362.82	\$143.25	
Grad Student Employee + Child	\$942.08	\$379.46	\$229.80	
Grad Student Employee + Family	\$1,499.28	\$714.48	\$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	\$842.64	\$10,111.68	\$286.50	\$3,438.00
Non-Employee Fellow + Spouse	\$1,647.16	\$19,765.92	\$573.00	\$6,876.00
Non-Employee Fellow + Child	\$1,504.72	\$18,056.64	\$746.08	\$8,953.00
Non-Employee Fellow + Family	\$2,284.10	\$27,409.20	\$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