BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2021-2022 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	$350 Individual / $1,050 Family	$750 Individual / $2,250 Family	$350 Individual / $1,050 Family	$700 Individual / $2,100 Family
Annual Medical Coinsurance Maximum	$2,150 Individual / $6,450 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	$8,550 Individual / $17,100 Family	Unlimited	$6,600 Individual / $12,700 Family	$13,200 Individual / $37,500 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 with MD Live	Plan pays 100% (no copay required)	Plan pays 100% (no copay required)	$20 Copay	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	$20 Copay	40% Coinsurance
Specialist Office Visit	$35 Copay	40% Coinsurance	$40 Copay	40% Coinsurance
Urgent Care	$35 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 - $35 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	$150 Copay/Visit, then 20% Coinsurance (no deductible; copay waived if admitted)		$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	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance

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In-Area (TX, NM, DC) Plan Component	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
OUTPATIENT CARE			**OUTPATIENT CARE**	
Observation	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Surgery – Facility	$100 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	$100 Copay/Service (copay waived if member calls health advocate prior to service)	$100 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	$100 Copay/Day ($500 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 - $35 Copay (initial visit only)	40% Coinsurance	$20 Copay (initial visit only)	40% Coinsurance
Delivery – Facility/Inpatient Care	$100 Copay/Day ($500 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	$35 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	$35 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	$35 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	$35 Copay	40% Coinsurance	$20 Copay	40% Coinsurance
Serious Mental Illness – Outpatient	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Serious Mental Illness – Inpatient	$100 Copay/Day ($500 max/admission); then 20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Mental Illness – Office	$35 Copay	40% Coinsurance	$20 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	$35 Copay	40% Coinsurance	$20 copay/office visit	40% Coinsurance
Chemical Dependency – Outpatient Treatment	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Chemical Dependency – Inpatient Treatment	$100 Copay/Day ($500 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.

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In-Area (TX, NM, DC) Plan Component	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
PRESCRIPTION DRUGS BENEFITS (Express Scripts)			***PRESCRIPTION DRUG BENEFITS (Prime Therapuetics)**	
		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		$100	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		$50 ($125)	$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, $125 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	$314.02	$0.00	$0.00	
Grad Student Employee + Spouse	$749.04	$270.42	$133.00	
Grad Student Employee + Child	$702.16	$282.82	$213.00	
Grad Student Employee + Family	$1,117.46	$532.52	$346.00	
	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	$628.06	$7,536.72	$266.00	$3,190.00
Non-Employee Fellow + Spouse	$1,227.68	$14,732.16	$532.00	$6,380.00
Non-Employee Fellow + Child	$1,121.52	$13,458.24	$692.00	$8,300.00
Non-Employee Fellow + Family	$1,702.40	$20,428.80	$958.00	$11,490.00
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**