

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 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	\$8,150 Individual / \$16,300 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/Injections (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

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 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
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	Non-covered service/excluded from coverage.	Non-covered service/excluded from coverage.

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 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
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.

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 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
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		\$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 Grad Student Fellows	Yearly (12 months)	Monthly Cost (based on annual/12, see website for available payment options)	Yearly (12 Months)
Employee/Student Only	\$ 628.06	\$ 7,536.72	\$ 254.67	\$ 3,056.00
Employee/Student + Spouse	\$ 1,227.68	\$ 14,732.16	\$ 508.83	\$ 6,106.00
Employee/Student + Child	\$ 1,121.52	\$ 13,458.24	\$ 662.00	\$ 7,944.00
Employee/Student + Family	\$ 1,702.40	\$ 20,428.80	\$ 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