BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 POLICY YEAR					
UT SELECT Medical Benefits - Employee Medical Plan BCBS			UT Connect Medical (In-Network Only Coverage)	Academic Health Plan - Student Health Insurance Plan (SHIP) BCBS	
In-Area Coverage (TX,NM, DC)	**BCBS In-Network Provider**	**BCBS Out-of-Network Provider***	**In-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
Annual Deductible	$350 Individual/$1,050 Family	$750 Individual/$2,250 Family	$250 Individual/$750 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	$2,150 Individual $6,450 Family (does not include deductible)	No specific coinsurance maximum. Coinsurance contributions after deductible will cap at out-of-pocket maximum.	
Annual Out-of-pocket Maximum	$7,900 Individual $15,800 Family Includes medical and prescription cost	Unlimited	$7,900 Individual $15,800 Family (does not include deductible)	$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	None
Lifetime Maximum Benefit	No Limit	No Limit	None	No Limit	No Limit
OFFICE SERVICES				**OFFICE SERVICES**	
Preventive Care	Plan pays 100% = no copay	60% Plan/40% Member	100% of allowable charges	Plan pays 100% = no copay	60% Plan/ 40% Member
Diagnostic Office Visit	FCP $30 Copay; Specialist $35 Copay	60% Plan/40% Member	FCP $15 Copay; Specialist $25 Copay	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	Included in Office Visit FCP $15 Copay; Specialist $25 Copay	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	Included in Office Visit FCP $15 Copay; Specialist $25 Copay	80% of allowable amount	60% Plan/ 40% Member
Allergy Testing	FCP $30 Copay; Specialist $35 Copay	60% Plan/40% Member	FCP $15 Copay; Specialist $25 Copay	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	Plan pays 100% = no copay	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% 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	$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% Plan/20% Member	80% of allowable	

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UT SELECT Medical Benefits - Employee Medical Plan BCBS			UT Connect Medical (In-Network Only Coverage)	Academic Health Plan - Student Health Insurance Plan (SHIP) BCBS	
In-Area Coverage (TX,NM, DC)	BCBS In-Network Provider	BCBS Out-of-Network Provider*	In-Network Provider	In-Network Provider	Out-of-Network Provider
OUTPATIENT CARE				**OUTPATIENT CARE**	
Observation	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Surgery – Facility	$100 Copay; then 80% Plan/20% Member	60% Plan/40% Member	$50 Copay; then 80% Plan/20% Member	80% of allowable amount after $150 copay	60% of allowable amount after $150 copay
Surgery – Physician	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Diagnostic Lab and X-Ray	100% covered, then 80% Plan/20% Member	60% Plan/40% Member	100% covered	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)	$100 Copay/Service NOTE: For related services, such as contrast materials or injections, 80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% 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	Deductible; $0 Copay 80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Hospital Inpatient Surgery**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Physician	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% 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	FCP $15 Copay; Specialist $25 Copay (initial visit only)	$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	Deductible; $0 Copay then 80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Obstetrical Care and Delivery - Physician	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member		
THERAPY				**THERAPY**	
Physical Therapy/Chiropractic Care	$35 Copay/Visit - max 20 visits	60% Plan/40% Member	$25 Copay/Visit - max 20 visits	80% of allowable amt up to 35 visits	60% of allowable amt up to 35 visits
Occupational Therapy	$35 Copay/Visit - max 20 visits/year/condition	60% Plan/40% Member	$25 Copay/Visit - max 20 visits/year/condition	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	$25 Copay/Visit - max 60 visits/year/condition	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% Plan/20% Member Maximum 180 visits	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% Plan/20% Member Maximum 120 visits	80% of allowable up to maximum	80% of allowabble up to 25 visits
Hospice Care Services**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	No Benefit Period Visit Maximum	
Home Infusion Therapy**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member		

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UT SELECT Medical Benefits - Employee Medical Plan			UT Connect Medical (In-Network Only Coverage)	Academic Health Plan - Student Health Insurance Plan (SHIP)	
BCBS				BCBS	
In-Area Coverage (TX,NM, DC)	BCBS In-Network Provider	BCBS Out-of-Network Provider*	In-Network Provider	In-Network Provider	Out-of-Network Provider
BEHAVIORAL HEALTH				BEHAVIORAL HEALTH	
Coverage	BCBS In-Network	BCBS Out-of-Network*	BCBS In-Network	Paid as any other covered illness	Paid as any other covered illness
Serious Mental Illness – Office Visit	$35 Copay	60% Plan/40% Member	PCP $15 Copay/ Specialist $25 Copay	$20 copay/office visit	60% of allowable amount
Serious Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Serious Mental Illness – Inpatient**	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	Deductible; $0 Copay then 80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Mental Illness – Office	$35 Copay No Limit on visits	60% Plan/40% Member	PCP $15 Copay/ Specialist $25 Copay	$20 copay/office visit	60% of allowable amount
Mental Illness – Outpatient**	80% Plan/20% Member No Limit	60% Plan/40% Member	80% Plan/20% Member No Limit	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	Deductible; $0 Copay, then 80% Plan/20% Member	80% of allowable amount	60% of allowable amount
Chemical Dependency – Office	$35 Copay No Limit on visits	60% Plan/40% Member	PCP $15 Copay/ Specialist $25 Copay No Limit on visits	$20 copay/office visit	60% of allowable amount
Chemical Dependency – Outpatient Treatment**	80% Plan/20% Member No maximum visits	60% Plan/40% Member	80% Plan/20% Member No maximum visits	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	Deductible; $0 Copay then 80% Plan/20% 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% Plan/20% Member	80% of allowable amount	60% of allowable amount
Prosthetic Devices	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member		
Hearing Aids	80% Plan/20% Member ($1,000 per ear, once every 3 years)		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. After $3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. (For non-network providers, after $3,000 deductible, plan pays the non-network allowable amount; member pays charges exceeding the allowable amount).		$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After $3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. NOTE: Individual must be enrolled in the UT SELECT plan for 36 continuous months prior to the date of the surgery to receive benefits.	Non-covered service/excluded from coverage.	

BENEFITS SUMMARY COMPARISON - UT SELECT PLAN VS. STUDENT HEALTH INSURANCE PLAN for 2020-2021 POLICY YEAR					
UT SELECT Medical Benefits - Employee Medical Plan			UT Connect Medical	Academic Health Plan - Student Health Insurance Plan (SHIP)	
BCBS			(In-Network Only Coverage)	BCBS	
In-Area Coverage (TX,NM, DC)	**BCBS In-Network Provider**	**BCBS Out-of-Network Provider***	**In-Network Provider**	**In-Network Provider**	**Out-of-Network Provider**
PRESCRIPTION DRUGS BENEFITS				***PRESCRIPTION DRUG BENEFITS (Review Details Online)**	
		Retail Pharmacy Copayment (up to 30 day supply)	**Mail Service Copayment (up to 90 day supply)**	**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				80% of allowable amount	60% of allowable amount
UT SELECT MEDICAL PLAN PREMIUMS			**UT Connect Medical Plan Premiums**	**SHIP Plan Cost**	Prescription filled at the SHC: $100% of allowable amount after copay 90 Day supply may be purchased through the Prime Therapeutics Network Mail at $40 generic; $75 preferred;$125 non-preferred brand
Tier Level	**Monthly Cost Part-time**	**Tobacco Program Premiums**	**Monthly Cost Part-time**	**Monthly Cost (based on annual/12)**	
Employee/Student Only	$ 314.02	$ 30.00	$ 314.02	$ 232.42	
Employee/Student + Spouse	$ 749.04	$ 60.00	$ 749.04	$ 464.83	
Employee/Student + Child	$ 702.16	$ 60.00	$ 702.16	$ 604.92	
Employee/Student + Family	$ 1,117.45	$ 90.00	$ 1,117.45	$ 837.33	
				***The Annual Deductible is waived when you use the UTD Student health Center; includes campus pharmacy**	
Cost Comparison Per Year-12 Months	**UT Select & UT Connect Medical Employee Plan Cost**			**Student Health Insurance Plan Cost**	
Tier Level	**Monthly Cost Part-time**	**Yearly (12 months)**	**Yearly (12 months)**	**Monthly Cost (based on annual/12)**	**Yearly (12 Months)**
Employee/Student Only	$ 314.02	$ 3,768.24	$ 3,768.24	$ 254.42	$ 3,053.00
Employee/Student + Spouse	$ 749.04	$ 8,988.48	$ 8,988.48	$ 508.83	$ 6,106.00
Employee/Student + Child	$ 702.16	$ 8,425.92	$ 8,425.92	$ 662.00	$ 7,944.00
Employee/Student + Family	$ 1,117.45	$ 13,409.40	$ 13,409.40	$ 916.42	$ 10,997.00
UT Select Plan Year	**9/1 through 8/31**			**UT Student Academic Plan Year**	**8/1 through 7/31**
Tier Level	**UT Select or UT Connect vs SHIP**	**Dental, Vision & AD&D Cost***	**Total Savings Through SHIP**	**Note: Student employees need to consider the coverage level needed and the financial impact to them in selecting the coverage that meets their need.**	
Employee/Student Only	$ 715.24	$ 72.91	$ 788.15		
Employee/Student + Spouse	$ 2,882.48	$ 134.45	$ 3,016.93		
Employee/Student + Child	$ 481.92	$ 146.39	$ 628.31		
Employee/Student + Family*	$ 2,412.40	$ 109.91	$ 2,522.31		

***Premium Sharing allowed if students waives the the UT Select or UT Connect Medical Plan. Family coverage reflects UT Select Dental Plan so that the cost will not exceed the $157.01. The AD&D coverage is based on $18,000 annual salary with maximum $180,000 employee coverage, $10,000 child coverage and $90,000 spouse coverage.**

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**	**UT Connect Customer Svc. No.**	**1-888-372-3398**	**AHP Customer Service Number**	**1-855-267-0214**
UT Select Group Policy Number	**71778**	**UT Connect Group Policy No.**	**241132**	**Academic Health Plan Policy Number**	**239939**
Prepared by: Marita M. Yancey, Sr. Director of Benefits and Wellness				**Date: June 22, 2020**	