UT System
Benefit Plan Design Comparison

Coverage	UT SELECT	UT CONNECT
Premium:		
Employee Only	$0	$0
Employee/Spouse	$257.53	$231.78
Employee/Child(ren)	$269.34	$242.41
Employee/Family	$507.15	$456.44
Annual ***Deductible*** (applicable when ***coinsurance*** is required)	$350/person $1,050/family	$250/person $750/family
Coinsurance Maximum	$2,150/person $6,450/family	NA
Annual ***Out-Of-Pocket Maximum***	$7,350/person $14,700/family (includes medical and prescription drug deductibles, copayments and coinsurance)	$7,350/person $14,700/family (includes medical and prescription drug deductibles, copayments and coinsurance)
Pre-existing Condition Limitation	None	
Lifetime Maximum Benefit	No Limit	
OFFICE SERVICES		
Preventive Care	Plan pays 100% (no copayment required)	Plan pays 100% (no copayment required)
Diagnostic Office Visit – Office Setting Family Care Physician (PCP) Internal Medicine OB/GYN Pediatrics	PCP $30	PCP $15 NOTE: First PCP Copay Waived per patient, thereafter copay is applicable
Specialist Office Visit	$35 Copay	$25 Copay
Urgent Care	$35 Copay	$35 Copay
Diagnostic Lab and X-Ray	Included in Office Visit Copay	Included in Office Visit Copay
Other Diagnostic Tests	PCP $30 Copay; Specialist $35 Copay	PCP $15 Copay; Specialist $25 Copay
Allergy Testing	PCP $30 Copay; Specialist $35 Copay	PCP $15 Copay; Specialist $25 Copay
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	Plan pays 100% (no copayment required)
EMERGENCY CARE		
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member
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
Emergency Physician Services	80% Plan/20% Member	80% Plan/20% Member
OUTPATIENT CARE		
Observation	80% Plan/20% Member	80% Plan/20% Member
Surgery – Facility	$100 Copay; Then 80% Plan/20% Member	$50 Copay; Then 80% Plan/20% Member
Surgery – Physician	80% Plan/20% Member	80% Plan/20% Member
Diagnostic Lab and X-Ray	100% covered (except when billed with surgery; then 80% Plan/20% Member	100% covered (except when billed with surgery; then 80% Plan/20% Member
MRI/CT Scans	$100 Copay/Service (copay waived if member calls ***Benefits Value Advisor/BVA*** prior to service) Note: For related services, such as contrast materials or injections, 80% Plan/20% Member	$100 Copay NOTE: For related services, such as contrast materials or injections, 80% Plan/20% Member
Other Diagnostic Tests	80% Plan/20% Member	80% Plan/20% Member
Outpatient Procedures	80% Plan/20% Member	80% Plan/20% Member

Coverage	UT SELECT	UT CONNECT
INPATIENT CARE		
Hospital – Semi private Room and Board**	$100 Copay/Day ($500 max/admission); then 80% Plan/20% Member	Deductible then 80% Plan/20% Member
Hospital Inpatient Surgery**	80% Plan/20% Member	80% Plan/20% Member
Physician	80% Plan/20% Member	80% Plan/20% Member
OBSTETRICAL CARE		
Prenatal and Postnatal Care Office Visits	PCP $30 Copay; Specialist $35 Copay (initial visit only)	PCP $15 Copay; Specialist $25 Copay (initial visit only)
Delivery – Facility/Inpatient Care**	$100 Copay ($500 max/admission); then 80% Plan/20% Member	Deductible then 80% Plan/20% Member
Obstetrical Care and Delivery – Physician	80% Plan/20% Member	80% Plan/20% Member
THERAPY		
Physical Therapy/Chiropractic Care (max. 20 visits/year/condition)	$35 Copay	$25 Copay
Occupational Therapy (max. 20 visits/year/condition)	$35 Copay	$25 Copay
Speech and Hearing Therapy (max. 60 visits/year/therapy)	$35 Copay	$25 Copay
EXTENDED CARE		
Skilled Nursing/Convalescent Facility** (max. 180 visits)	80% Plan/20% Member	80% Plan/20% Member
Home Health Services** Home Health Services** (max 120 visits)	80% Plan/20% Member	80% Plan/20% Member
Hospice Care Services**	80% Plan/20% Member	80% Plan/20% Member
Home Infusion Therapy**	80% Plan/20% Member	80% Plan/20% Member
BEHAVIORAL HEALTH		
Serious Mental Illness – Office Visit	PCP $30 Copay; Specialist $35	PCP $15 Copay; Specialist $25
Serious Mental Illness – Outpatient**	80% Plan/20% Member	80% Plan/20% Member
Serious Mental Illness – Inpatient**	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	Deductible then 80% Plan/20% Member
Mental Illness – Office	PCP $30 Copay; Specialist $35	PCP $15 Copay; Specialist $25
Mental Illness – Outpatient**	80% Plan/20% Member	80% Plan/20% Member
Mental Illness – Inpatient**	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	Deductible then 80% Plan/20% Member
Chemical Dependency – Office	PCP $30 Copay; Specialist $35	PCP $15 Copay; Specialist $25
Chemical Dependency – Outpatient Treatment**	80% Plan/20% Member	80% Plan/20% Member
Chemical Dependency – Inpatient Treatment**	$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member	Deductible then 80% Plan/20% Member
OTHER SERVICES		
Durable Medical Equipment**	80% Plan/20% Member	80% Plan/20% Member
Prosthetic Devices	80% Plan/20% Member	80% Plan/20% Member
Hearing Aids ($1000 per ear; once every 3 years)	80% Plan/20% Member	
Bariatric Surgery (pre-determination recommended)	$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. (For non-network providers, after $3,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount). Individual must be enrolled in the UT SELECT plan for 36 continuous months prior to the date of the surgery to receive benefits	

**These services require preauthorization to establish medical necessity