

UT SELECT BENEFIT SUMMARY CHART

September 1, 2013 - August 31, 2014

Coverage	In-Area			Out-of-Area*
	BCBS In-Network	BCBS Out-of-Network *	UTSW Network Pilot Program	
Annual Deductible (applicable when coinsurance is required)	\$350/person \$1,050/family	\$750/person \$2,250/family	Waived except as noted	\$350/person \$1,050/family
Annual Out-of-Pocket Maximum	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family		\$2,500/person \$7,500/family
Pre-existing Condition Limitation	None	None	None	None
Lifetime Maximum Benefit	No Limit	No Limit	No Limit	No Limit
OFFICE SERVICES				
Preventive Care	Plan pays 100% (no copayment required)	60% Plan/40% Member	Plan pays 100% (no copayment required)	Plan pays 100% (no copayment required)
Diagnostic Office Visit	FCP or Behavioral Health Provider \$30 Copay; Specialist \$35 Copay; 100% covered after copay	60% Plan/40% Member	FCP & Specialist \$10 Copay; 100% covered after copay	75% Plan/25% Member
Diagnostic Lab and X-Ray	Included in Office Visit Copay	60% Plan/40% Member	Included in Office Visit Copay	75% Plan/25% Member
Other Diagnostic Tests	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member	FCP & Specialist \$10 Copay	75% Plan/25% Member
Allergy Testing	FCP \$30 Copay Specialist \$35 Copay	60% Plan/40% Member	FCP & Specialist \$10 Copay	75% Plan/25% Member
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	60% Plan/40% Member	Plan pays 100% (no copayment required)	75% Plan/25% Member
EMERGENCY CARE				
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan /20% Member	80% Plan /20% Member	75% Plan/25% Member
Hospital Emergency Room	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	75% Plan/25% Member
Emergency Physician Services	Plan pays 100% (no copayment required)			75% Plan/25% Member
OUTPATIENT CARE				
Observation	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Surgery – Facility	\$100 Copay; then 80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Surgery – Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Diagnostic Lab and X-Ray	100% covered	60% Plan/40% Member	100% covered	75% Plan/25% Member
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member

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	BCBS In-Network	BCBS Out-of-Network *	UTSW Network Pilot Program	
INPATIENT CARE				
Hospital - Semi private Room and Board**	\$100 Copay/Day (\$500 max/admission); then 80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Hospital Inpatient Surgery**	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
OBSTETRICAL CARE				
Prenatal and Postnatal Care Office Visits	FCP \$30 Copay; Specialist \$35 Copay (initial visit only)	60% Plan/40% Member	\$10 Copay (initial visit only)	75% Plan/25% Member
Delivery – Facility/Inpatient Care**	\$100 Copay (\$500 max/admission); then 80% Plan /20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Obstetrical Care and Delivery - Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
THERAPY				
Physical Therapy/ Chiropractic Care (max. 20 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Occupational Therapy (max. 20 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Speech and Hearing Therapy (max. 60 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
Respiratory Therapy	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/25% Member
EXTENDED CARE				
Skilled Nursing/ Convalescent Facility** (max.180 visits)	80% Plan/20% Member	60% Plan/40% Member	N/A	75% Plan/25% Member
Home Health Care Services** (max.120 visits)	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member	75% Plan/25% Member
Hospice Care Services**	80% Plan / 20% Member	60% Plan/40% Member	80% Plan/20% Member	75% Plan/25% Member
Home Infusion Therapy**	80% Plan / 20% Member	60% Plan/40% Member	80% Plan/20% Member	75% Plan/25% Member

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BEHAVIORAL HEALTH				
Serious Mental Illness – Office Visit	\$30 Copay	60% Plan/40% Member	\$10 Copay	75% Plan/ 25% Member
Serious Mental Illness – Outpatient**	80% Plan / 20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
Serious Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
Mental Illness – Office (max. 20 visits/yr. for outpatient and office combined)	\$30 Copay	60% Plan/40% Member	\$10 Copay	75% Plan/ 25% Member
Mental Illness Outpatient** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
Mental Illness – Inpatient** (Other than Serious Mental Illness) Max. 30 days/yr.	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
Chemical Dependency – Office (max. 20 visits/yr. for outpatient and office combined)	\$30 Copay	60% Plan/40% Member	\$10 Copay	75% Plan/ 25% Member
Chemical Dependency – Outpatient Treatment** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
Chemical Dependency - Inpatient Treatment** (max. 30 days/yr.; 3 episodes of treatment per lifetime)	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	100% covered	75% Plan/ 25% Member
OTHER SERVICES				
Durable Medical Equipment**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/ 20% Member	75% Plan/ 25% Member
Prosthetic Devices	80% Plan/20% Member	60% Plan/40% Member	80% Plan/ 20% Member	75% Plan/ 25% Member
Hearing Aids (\$500 per ear; once every 4 years)	80% Plan/20% Member			75% Plan/ 25% Member
Bariatric Surgery (pre-determination recommended)	\$5,000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$5,000 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 \$5,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount).		\$2,500 deductible – Inpatient Only (does not apply to UT SELECT plan year deductible or out-of-pocket maximum)	After \$5,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount.

* For services provided out-of-network and out-of-area, any charges over the allowable amount are the patient’s responsibility.

**These services require preauthorization to establish medical necessity.