UT SELECT Plan Highlights

Effective September 1, 2014

UT Benefits

	Network	Non-Network
Deductible (per plan year)	$350 per individual $1,050 per family	$750 per individual $2,250 per family
Out-of-Pocket Maximum	$2,500 per individual $7,500 per family (deductible and coinsurance) $6,350 per individual $12,700 per family (deductible, coinsurance and copays)	$5,000 per individual $15,000 per family
Coinsurance Plan pays (up to the allowable amount) Participant pays (after deductible)	80% 20%	60% 40%
Office Visit Copay Participant pays	$30 for primary $35 for specialist	40% after deductible
Preventive Care See reverse side for a list of covered services	No copay *(plan pays 100%)*	40% after deductible
Inpatient Hospital *(facility charges)* Participant pays	$100 copay per day, plus 20% after deductible *($500 maximum copay per admission)*	40% after deductible
Inpatient Hospital *(physician charges)* Participant pays	20% after deductible	40% after deductible
Emergency Room Participant pays	$150 copay *(copay waived if admitted)*	$150 copay *(copay waived if admitted)*
Outpatient Lab and X-Ray Participant pays	No copay *(plan pays 100%)*	40% after deductible
MRI/CT Participant pays	$100 copay per procedure (copay waived if member calls Benefits Value Advisor **prior to** service)	40% after deductible
Outpatient Surgery *(facility charges)* Participant pays	$100 copay per visit plus 20% after deductible	40% after deductible
Outpatient Surgery *(physician charges)* Participant pays	20% after deductible	40% after deductible

Questions? Call Customer Service at **1-866-882-2034** from 8 a.m. to 6 p.m. (CT) Monday through Friday.

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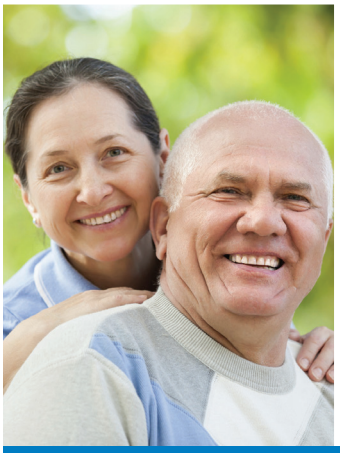
UT SELECT - Preventive Care

Preventive Care Services	Network Benefits When Using Network Providers (Provider must bill services as "preventive care")
Evidence–based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. Evidence–informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents. Additional preventive care and screenings for women, not described above, as provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. Examples of covered services included are routine annual physicals (one per year); immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); smoking cessation counseling services and healthy diet counseling; and obesity screening/counseling. Examples of covered services for women with reproductive capacity are female sterilization procedures and specified FDA approved contraception methods with a written prescription by a health care practitioner, including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Express Scripts. To determine if a specific contraceptive drug or device is included in this benefit, contact Customer Service at 1-800-818-0155. The list may change as FDA guidelines are modified.	Plan pays 100% (no copay required)



UT SELECT
Plan Highlights

Please visit **healthcare.gov** for additional information on preventive care services.