UT SELECT Benefit Summary Chart

SEPTEMBER 1, 2017 - AUGUST 31, 2018

IN-AREA PLAN

In-Area Benefits apply to any eligible Employees, Retirees, and their dependents whose residence of record is in the State of Texas, New Mexico, or Washington, D.C.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	**$350/individual** **$1,050/family**	**$750/individual** **$2,250/family**
ANNUAL MEDICAL COINSURANCE MAXIMUM	**$2,150/individual** **$6,450/family** (does not include deductible)	**N/A**
ANNUAL OUT-OF-POCKET MAXIMUM	**$7,150/individual** **$14,300/family** (All member medical and prescription drug allowed cost share)	**N/A**
OFFICE SERVICES		
PREVENTIVE CARE	**Plan pays 100%** (no copayment required)	**60% Plan/40% Member**
DIAGNOSTIC OFFICE VISIT (FAMILY CARE PHYSICIAN (FCP) IS FAMILY PRACTICE INTERNAL MEDICINE OB/GYN PEDIATRICS IN AN OFFICE SETTING)	**FCP $30 Copay;** **Specialist $35 Copay**	**60% Plan /40% Member**
URGENT CARE	**$35**	**60% Plan /40% Member**
EMERGENCY CARE		
AMBULANCE SERVICE (IF TRANSPORTED)	**80% Plan/20% Member**	
HOSPITAL EMERGENCY ROOM	**$150 Copay plus** **20% coinsurance** (copay waived if admitted)	
OUTPATIENT CARE		
OUTPATIENT FACILITY SERVICES	**$100 Copay;** **then 80% Plan /20% Member**	**60% Plan/40% Member**
NON-EMERGENCY MRI/CT SCANS	**$100 Copay** (may be waived by contacting the BVA before services) Note: For related services, such as contrast materials or injections, 80% Plan/20% Member	**$100 Copay plus** **60% Plan/40% Member** (copay may be waived by contacting the BVA before services)
INPATIENT CARE		
SEMI PRIVATE ROOM AND BOARD**	**$100 Copay/Day** **($500 max/admission);** **then 80% Plan/20% Member**	**60% Plan/40% Member**
THERAPY		
PHYSICAL THERAPY/CHIROPRACTIC CARE, OCCUPATIONAL THERAPY (MAX. 20 VISITS/YR)	**$35 Copay**	**60% Plan/40% Member**
SPEECH AND HEARING THERAPY (MAX. 60 VISITS/YR)		

BEHAVIORAL HEALTH		
OFFICE VISIT	**$35 Copay**	**60% Plan/40% Member**
OUTPATIENT**	**80% Plan /20% Member**	**60% Plan/40% Member**
INPATIENT**	**$100 Copay/Day ($500 max/admission) then 80% Plan/20% Member**	**60% Plan/40% Member**
OTHER SERVICES		
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.	**$3,000 deductible** (does not apply to plan year deductible or out-of-pocket maximum). After $3,000 bariatric surgery deductible, plan pays 100% up to the allowable amount. The member pays charges exceeding the allowable amount which can be a significant difference.

* Any charges over the allowable amount are the patient's responsibility.

**These services require preauthorization to establish medical necessity.

NEW! UT HEALTH NETWORK

A new benefit tier known as the UT Health Network offers an enhanced plan design for UT SELECT Medical participants receiving services from certain UT physicians and certain UT medical facilities. You will pay lower copays and coinsurance when seeing a participating UT physician at a participating UT-owned facility, and you can also save on physician charges when treatment is received from a participating UT physician at a non-UT-owned facility. Benefits of the new UT Health Network along with several claims examples are illustrated below.

	NEW! UT HEALTH NETWORK BENEFIT	STANDARD UT SELECT IN-NETWORK BENEFIT
PRIMARY CARE	**$20 copay**	**$30 copay**
SPECIALIST	**$25 copay**	**$35 copay**
EMPLOYEE CLINIC*	**$10 copay**	**$30 copay**
DEDUCTIBLE	**$350**	**$350**
COINSURANCE	**10%**	**20%**
INPATIENT COPAY*	**$0 / day**	**$100 / day (max $500)**

Current points of service for the UT Health Network include:

- UT Medical Branch Galveston facilities & providers;
- UT Health Northeast (Tyler) facilities & providers; and
- UT Austin, UT Health Houston, and UT Health San Antonio Employee & Nursing Clinics.

The UT Health Network benefit is not available at this time for services received from UT Rio Grande Valley, UT Southwestern, or UT MD Anderson Cancer Center physicians or facilities. Your regular UT SELECT Medical in-network benefits apply for these providers and locations.

For additional information, including details about available Employee & Nursing Clinics, please see the individual city links under "UT Health Network" in the navigation menu of the OEB website. You can also log into Blue Access for Members to access the Provider Finder specific to UT SELECT Medical, where participating providers and facilities are clearly marked as being part of the UT Health Network. You must be logged in to see the "UT Health Network" designation.

BENEFITS EXAMPLES

- Your UT Health Network benefit applies depending on the status of the provider and facility as shown below.
- Visit to a Participating Employee or Nursing Clinic: Member pays $10 copay.
- Office Visit with a UT Provider (at any Facility): Member pays office visit copay of $20 or $25.
- Inpatient or Outpatient Services with a UT Provider at a participating UT Facility: Member pays regular $350 deductible, 10% coinsurance on provider and facility charges, and a $0 inpatient/$100 outpatient copay.
- Inpatient or Outpatient Services with a UT Provider at a non-participating Facility: Member pays regular $350 deductible, 10% coinsurance on provider charges, 20% coinsurance on facility charges, and $100 facility copay per day.

OUT-OF-AREA PLAN

Out-of-Area benefits apply to any eligible Employees, Retirees, and their dependents whose residence of record is outside of the State of Texas, New Mexico, or Washington, D.C. The Out-of-Area plan covers the same services as the In-Area Plan, and the prescription drug plan benefits are the same.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	**$350 / individual** **$1,050 / family**	**$750 / individual** **$2,250 / family**
ANNUAL MEDICAL COINSURANCE MAXIMUM	**$2,150 / individual** **$6,450 / family** (does not include deductible)	**$4,250 / individual** **$12,750 / family** (does not include deductible)
ANNUAL OUT-OF-POCKET MAXIMUM	**$7,150 / individual** **$14,300 / family** (All member medical and prescription drug allowed cost share)	**N/A**
PREVENTIVE CARE	**Plan pays 100%** (no copayment required)	**60% Plan / 40% Member**
OTHER COVERED MEDICAL SERVICES	**75% Plan / 25% Member**	**60% Plan / 40% 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.	**$3,000 deductible** (does not apply to plan year deductible or out-of-pocket maximum). After $3,000 bariatric surgery deductible, plan pays 100% up to the allowable amount. The member pays charges exceeding the allowable amount which can be a significant difference.

KEY TERMS AND EXAMPLES

Allowed Amount – Maximum amount on which payment is based for covered health care services. Sometimes, this is referred to as "eligible expense", "payment allowance", or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference (balance billing) which can be significant. In-Network providers agree to the allowed amount for covered services and do not balance bill.

Annual Deductible – The amount of out-of-pocket expense the member pays in a plan year (September 1 – August 31) for health care services before the plan begins to pay. The deductible does not apply to all services, and copayments are not applied to the deductible met.

Annual Out-of-Pocket Maximum – The amount of out-of-pocket expense the member pays for eligible expenses in a plan year (September 1 – August 31). This limit never includes your premium, balance-billed charges or health care the plan doesn't cover. The bariatric expenses also do not count toward this limit.

The $2,150/$6,450 limit includes medical coinsurance only (no copayments or prescription plan costs). There's an additional limit including copayments and prescription costs such that in no case will the eligible in-network out-of-pocket expenses including medical and prescription deductible, coinsurance, and copayments be greater than $7,150 for employee only coverage or $14,300 for employee plus dependent coverage (Subscriber plus spouse, subscriber plus child(ren), or subscriber plus family).

Benefits Value Advisor (BVA) – A Benefits Value Advisor is a health care expert who uses data, cost estimators, provider-finders and other tools to provide consumers with choices that allow them to maximize their health care benefits. Contact the BVA at 1-866-882-2034. Calling this number prior to a non-emergency office or outpatient MRI or CT Scan will allow the $100 copayment to be waived.

FCP – Family Care Physician; Includes Family Practice, Internal Medicine, OB/GYN, and Pediatrics in an office setting.

YOUR HEALTH CARE BENEFITS TRAVEL WITH YOU

You and your covered dependents have access to Blue Cross and Blue Shield network providers throughout the United States and around the world. To receive the network (highest) level of benefits when you need to seek care, please call 1-800-810-BLUE (2583) printed on your Medical ID card.

TRANSITIONAL BENEFITS

If you or a covered dependent are being treated for certain chronic or ongoing medical conditions at the time you enroll in UT SELECT, and your doctor is not in the UT SELECT PPO network, ongoing care with your current doctor for up to three months may be requested.

Transitional benefits are subject to approval. To request transitional benefits, complete a "Transitional Benefits Form" available from your institution's Benefits Office or online at **www.bcbstx.com/ut**.