UT CONNECT Benefit Summary Chart

SEPTEMBER 1, 2018 - AUGUST 31, 2019

When you need to see a doctor, contact your primary care physician. Your PCP will either treat you or refer you to a network specialist or facility for further care. If you visit a specialist without a referral from your PCP, your care may not be covered — even if it's at a network provider. As your primary care medical home, your PCP will ensure you are receiving the most efficient and effective treatment for all your health care needs.

The plan doesn't cover care received out-of-network, except for medical emergencies. If you receive non-emergency care from a doctor who is not in the network, the plan will not pay benefits for those services.

NETWORK BENEFITS	
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	**$250/individual** **$750/family**
COINSURANCE MAXIMUM	**$2,150/individual** **$6,450/family**
ANNUAL OUT-OF-POCKET MAXIMUM	**$7,350/individual** **$14,700/family** (medical and prescription deductible, coinsurance, and copayments)
PRE-EXISTING CONDITION LIMITATION	**None**
LIFETIME MAXIMUM BENEFIT	**No limit**
OFFICE SERVICES	
PREVENTIVE CARE	**Plan pays 100%** (no copayment required)
DIAGNOSTIC OFFICE VISIT	**PCP $15 Copay; Specialist $25 Copay** **NOTE: First PCP Copay Waived per patient, thereafter copay is applicable**
DIAGNOSTIC LAB AND X-RAY	**Included in Office Visit Copay**
URGENT CARE	**$35 Copay**
OTHER DIAGNOSTIC TESTS	**PCP $15 Copay;** **Specialist $25 Copay**
ALLERGY TESTING	**PCP $15 Copay;** **Specialist $25 Copay**
ALLERGY SERUM/INJECTIONS (IF NO OFFICE VISIT BILLED)	**Plan pays 100%** (no copayment required)
EMERGENCY CARE	
AMBULANCE SERVICE (IF TRANSPORTED)	**80% Plan/20% Member**
HOSPITAL EMERGENCY ROOM	**$150 Copay/then 20% Member coinsurance** (copay waived if admitted) **If admitted, ER services are added to claims for inpatient services**
EMERGENCY PHYSICIAN SERVICES	**80% Plan/20% Member**

OUTPATIENT CARE	
OBSERVATION	80% Plan/20% Member
SURGERY – FACILITY	$50 Copay; then 80% Plan/20% Member
SURGERY – PHYSICIAN	80% Plan/20% Member
DIAGNOSTIC LAB AND X-RAY	100% covered (except when billed with surgery; then 80% Plan/20% Member)
MRI/CT SCANS	$100 Copay NOTE: For related services, such as contrast materials or injections, 80% Plan/20% Member
OTHER DIAGNOSTIC TESTS	80% Plan /20% Member
OUTPATIENT PROCEDURES	80% Plan /20% Member
INPATIENT CARE	
HOSPITAL - SEMI PRIVATE ROOM AND BOARD**	Deductible then 80% Plan/20% Member
HOSPITAL INPATIENT SURGERY**	80% Plan/20% Member
PHYSICIAN	80% Plan/20% Member
OBSTETRICAL CARE	
PRENATAL AND POSTNATAL CARE OFFICE VISITS	PCP $15 Copay; Specialist $25 Copay (initial visit only)
DELIVERY – FACILITY/INPATIENT CARE**	Deductible then 80% Plan/20% Member
OBSTETRICAL CARE AND DELIVERY - PHYSICIAN	80% Plan/20% Member
THERAPY	
PHYSICAL THERAPY/CHIROPRACTIC CARE (MAX. 20 VISITS/YR)	$25 Copay / Visit
OCCUPATIONAL THERAPY (MAX. 20 VISITS/YR)	$25 Copay / Visit
SPEECH AND HEARING THERAPY (MAX. 60 VISITS/YR)	$25 Copay / Visit
EXTENDED CARE	
SKILLED NURSING/CONVALESCENT FACILITY** (MAX. 180 VISITS)	80% Plan/20% Member
HOME HEALTH CARE SERVICES** (MAX. 120 VISITS)	80% Plan/20% Member
HOSPICE CARE SERVICES**	80% Plan/20% Member
HOME INFUSION THERAPY**	80% Plan/20% Member
BEHAVIORAL HEALTH	
SERIOUS MENTAL ILLNESS – OFFICE VISIT	PCP $15 Copay; Specialist $25 Copay
SERIOUS MENTAL ILLNESS – OUTPATIENT**	80% Plan /20% Member
SERIOUS MENTAL ILLNESS – INPATIENT**	Deductible then 80% Plan/20% Member
MENTAL ILLNESS – OFFICE	PCP $15 Copay; Specialist $25 Copay
MENTAL ILLNESS – OUTPATIENT**	80% Plan/20% Member
MENTAL ILLNESS – INPATIENT**	Deductible then 80% Plan/20% Member

CHEMICAL DEPENDENCY – OFFICE	**PCP $15 Copay; Specialist $25 Copay**
CHEMICAL DEPENDENCY – OUTPATIENT TREATMENT**	**80% Plan/20% Member**
CHEMICAL DEPENDENCY – INPATIENT TREATMENT**	**Deductible then 80% Plan/20% Member**
BEHAVIORAL HEALTH	
DURABLE MEDICAL EQUIPMENT**	**80% Plan/20% Member**
PROSTHETIC DEVICES	**80% Plan/20% Member**
HEARING AIDS (ADULT) ($1000 PER EAR; ONCE EVERY 3 YEARS)	**80% Plan/20% Member**
HEARING AIDS (THROUGH AGE 18; 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. NOTE: Individual must be enrolled in the UT SELECT plan for 36 continuous months prior to the date of the surgery to receive benefits.

* The plan doesn't cover care received out-of-network, except for medical emergencies. If you receive non-emergency care from a doctor who is not in the network, the plan will not pay benefits for those services.
**These services require preauthorization to establish medical necessity.

UT CONNECT KEY TERMS

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) including medical and prescription drug deductibles, copayments and coinsurance

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 888-372-3398.

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

EMERGENCY BENEFITS WHILE YOU TRAVEL

In an emergency, go to the nearest facility for care, in or out of the network. Emergency care is always covered in a true emergency situation (e.g., heart attack, broken bones, head injuries, severe pain, severe bleeding, etc.). UT CONNECT uses the same network for international services as UT SELECT.

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" online at www.bcbstx.com/utconnect.