

UT SELECT Benefit Summary Chart

SEPTEMBER 1, 2015 - AUGUST 31, 2016

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	\$6,600/individual \$13,200/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	FCP \$30 Copay; Specialist \$35 Copay	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)	\$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 SERIOUS MENTAL ILLNESS (NO LIMIT); OTHER MENTAL ILLNESS AND CHEMICAL DEPENDENCY (MAX. 20 VISITS/YR. FOR OUTPATIENT AND OFFICE COMBINED)	\$30 Copay	60% Plan/40% Member