



Your **UT SELECT**
Health Benefits

Effective September 1, 2013



**BlueCross BlueShield
of Texas**



THE UNIVERSITY of TEXAS SYSTEM
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Welcome

Meeting Your Health Care Needs

This booklet is a guide to your UT SELECT medical (UT SELECT) benefits administered by Blue Cross and Blue Shield of Texas (BCBSTX) under the direction of The University of Texas System (UT System), Office of Employee Benefits (OEB). It includes definitions of terms you should know and detailed information about your UT SELECT plan. Tips on how to use the plan effectively, answers to frequently asked questions, and a comprehensive table of contents to help you locate information you need are also included. If you have questions, call Customer Service at 1-866-882-2034, refer to the website (www.bcbstx.com/ut), or contact your institution Benefits Office.

This booklet is intended to be an information source only. It is not a contract or a policy.

The terms “you” and “your” as used in this Benefits Booklet refer to the employee or retiree. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise. Underlined words are defined terms. Whenever these terms are used, the meaning is consistent with the definition given. Terms in *italics* may be section headings describing provisions or they may be defined terms.

You are responsible for carefully reading this Benefits Booklet so you will be aware of all the benefits and requirements of UT SELECT, including definitions and limitations and exclusions.

Important Phone Numbers

Customer Service

1-866-882-2034
8 a.m. - 6 p.m. (Central Time)
Monday through Friday

Preauthorization

1-800-441-9188
7:30 a.m. - 6 p.m. (Central Time)
Monday through Friday

Behavioral Health

1-800-528-7264
8 a.m. - 5 p.m. (Central Time)
Monday through Friday

BlueCard PPO Access

1-800-810-BLUE (2583)
24 hours, seven days a week

Blue Care Connection® Condition Management

1-800-462-3275

Special Beginnings® Prenatal Program

1-888-421-7781

24/7 Nurseline

1-888-315-9473

Websites

UT SELECT and Online Provider Directory

www.bcbstx.com/ut

Office of Employee Benefits

www.utsystem.edu/benefits

Wellness Resources

www.livingwell.utsystem.edu

Express Scripts, Inc.

Prescription Drug Program – Customer Service

1-800-818-0155

www.express-scripts.com/ut



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UT SELECT is administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Texas provides claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Identification Cards

The ID card issued to you by Blue Cross and Blue Shield of Texas identifies you as a **participant** in the UT SELECT medical **plan**. (You will receive a separate ID card from Express Scripts for your pharmacy benefits under UT SELECT.) Your ID card contains important information about you, your employer group, and the benefits to which you are entitled.

Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

Any change in family status may require a new ID card be issued to you.

Unauthorized, Fraudulent, Improper, or Abusive Use of ID cards

The unauthorized, fraudulent, improper, or abusive use of ID cards issued to you and your covered family members will include, but not be limited to:

- Use of the ID card prior to your **effective date**
- Use of the ID card after your date of termination of coverage under UT SELECT

*The unauthorized, fraudulent, improper, or abusive use of ID cards by any **participant** can result in, but is not limited to, the following sanctions:*

- Denial of benefits
- Recoupment from you or any of your covered family members of any benefit payments made
- Notice to your institution Benefits Office of potential violations of law or professional ethics

How to Request ID Cards

Blue Cross and Blue Shield of Texas and Express Scripts will issue separate ID cards for the Medical and Prescription Drug plans. The cards will be mailed to your home address on file. There is no charge for ID cards. To request additional cards or to replace lost or damaged cards:

- **Medical:** Call Blue Cross and Blue Shield of Texas Customer Service at 1-866-882-2034, or log onto Blue Access for Members through www.utsystem.edu/benefits or www.bcbstx.com/ut to order Medical ID cards online or print a temporary ID card.
- **Prescription Drug:** Call Express Scripts Customer Service at 1-800-818-0155 or you can print one through the Express Scripts website, www.express-scripts.com. A virtual card is also available through the new Express Scripts app (application) via your mobile phone.

Website Features

You can access helpful information and administrative forms through the UT SELECT website. Go to www.bcbstx.com/ut to find:

- Doctors and Hospitals (Provider Finder)
- Forms
- Benefits Booklet
- Medical Policies
- Healthy Living Information
- Blue Access for Members (view claims)
- Contact Information
- Frequently Asked Questions

Many of the most frequently requested features appear directly on the UT SELECT home page. The website appearance and content are subject to change at any time.

Blue Access for Members (requires registration)

With Blue Access for Members you can:

- Check the status of a claim.
- Confirm who is covered under your *plan*.
- View and print detailed claim history and information (Explanation of Benefits/EOBs). **EOBs are available online. To receive copies by mail, you must log into Blue Access for Members to elect to receive paper copies or call Customer Service for assistance.**
- Locate a physician or other provider in your network that meets your needs.
- Sign up to receive e-mail notifications of new claim activity.
- Request a new or replacement ID card or print a temporary ID card.

How to Find Blue Access for Members

Go to www.bcbstx.com/ut

Select the link for “Blue Access for Members”

To register for Blue Access for Members, you'll need your group and member identification number, found on your UT SELECT ID card. Upon authentication, you'll be asked to create a user name and password that you'll use for all future visits to Blue Access for Members.

Your UT SELECT Medical Benefits

In-Area Summary of Benefits

In-Area Network and Non-Network benefits apply to eligible employees, retirees and their covered dependents residing in Texas, New Mexico or Washington, D.C. Payment for non-network (including *ParPlan*) services is limited to the *allowable amount* as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the *allowable amount*. **Any charges over the *allowable amount* for non-network services are the patient's responsibility and are in addition to *deductible, coinsurance and out-of-pocket maximums*.**

UTSW Network Pilot Program

The UTSW Network benefit is a collaborative pilot program between UT Southwestern and The University of Texas System Office of Employee Benefits providing UT SELECT members a greatly reduced or eliminated out-of-pocket expense when receiving certain services from a UTSW physician or at a UTSW facility. This benefit is available to any UT SELECT member with an address on file with in-area benefits for as long as the pilot program continues. During the pilot program period, many covered services under the UT SELECT plan will have additional benefits under the UTSW Network option when those services are provided by UTSW physicians at UTSW facilities. See the UT SELECT In-Area Summary of Benefits for more details.

All UTSW physicians and facilities are included as long as the service is covered on the UTSW Network. Physician fees for services performed by UTSW physicians at affiliated hospitals are included in this benefit. However, the benefit does not include facility charges for other hospitals (e.g. Children's Medical Center, VA North Texas Health Care System, Parkland Health & Hospital System, Baylor, and Texas Health Resources). For Dallas and surrounding counties, UTSW has a clinically affiliated physician (UTSCAP) program in which UTSW selectively partners with quality internal medicine and family practice community physicians. UTSCAP providers will be included in the UTSW Network.

Note: The UTSW Network is a temporary pilot program. UT System reserves the right to terminate the program at any time without advance notice.

In-Area			
Coverage	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
Annual Out-of-Pocket Maximum	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family	
Pre-existing Condition Limitation	None		
Lifetime Maximum Benefit	No Limit		
OFFICE SERVICES			
Preventive Care	Plan pays 100% (no copayment required)	60% Plan/40% Member	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
Diagnostic Lab and X-Ray	Included in Office Visit Copay	60% Plan/40% Member	Included in Office Visit Copay
Other Diagnostic Tests	FCP \$30 Copay; Specialist \$35 Copay	60% Plan /40% Member	FCP & Specialist \$10 Copay
Allergy Testing	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member	FCP & Specialist \$10 Copay
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	60% Plan/40% Member	Plan pays 100% (no copayment required)

In-Area			
Coverage	BCBS In-Network	BCBS Out-of-Network*	UTSW Network Pilot Program
EMERGENCY CARE			
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member	80% Plan/20% Member
Hospital Emergency Room	\$150 Copay (waived if admitted) If admitted, ER services are added to claims for inpatient services	\$150 Copay (waived if admitted) If admitted, ER services are added to claims for inpatient services	\$150 Copay (waived if admitted)
Emergency Physician Services	Plan pays 100% (no copayment required)		
OUTPATIENT CARE			
Observation	80% Plan/20% Member	60% Plan/40% Member	100% covered
Surgery – Facility	\$100 Copay; then 80% Plan/20% Member	60% Plan/40% Member	100% covered
Surgery – Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered
Diagnostic Lab and X-Ray	100% covered	60% Plan/40% Member	100% covered
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member	100% covered
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member	100% covered
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
Hospital Inpatient Surgery**	80% Plan/20% Member	60% Plan/40% Member	100% covered
Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered
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)
Delivery – Facility/Inpatient Care**	\$100 Copay (\$500 max/admission); then 80% Plan/20% Member	60% Plan/40% Member	100% covered
Obstetrical Care and Delivery - Physician	80% Plan/20% Member	60% Plan/40% Member	100% covered
THERAPY			
Physical Therapy/Chiropractic Care (max. 20 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered
Occupational Therapy (max. 20 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered
Speech and Hearing Therapy (max. 60 visits/yr)	80% Plan/20% Member	60% Plan/40% Member	100% covered
Respiratory Therapy	80% Plan/20% Member	60% Plan/40% Member	100% covered
EXTENDED CARE			
Skilled Nursing/Convalescent Facility** (max.180 visits)	80% Plan/20% Member	60% Plan/40% Member	N/A
Home Health Care Services** (max.120 visits)	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member
Hospice Care Services**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member
Home Infusion Therapy**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member

In-Area			
Coverage	BCBS In-Network	BCBS Out-of-Network*	UTSW Network Pilot Program
BEHAVIORAL HEALTH			
Serious Mental Illness – Office Visit	\$30 Copay	60% Plan/40% Member	\$10 Copay
Serious Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member	100% covered
Serious Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member	100% covered
Mental Illness – Office (max. 20 visits/yr. for outpatient and office combined)	\$30 Copay	60% Plan/40% Member	\$10 Copay
Mental Illness - Outpatient** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	60% Plan/40% Member	100% covered
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
Chemical Dependency – Office (max. 20 visits/yr. for outpatient and office combined)	\$30 Copay	60% Plan/40% Member	\$10 Copay
Chemical Dependency - Outpatient Treatment** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	60% Plan/40% Member	100% covered
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
OTHER SERVICES			
Durable Medical Equipment**	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member
Prosthetic Devices	80% Plan/20% Member	60% Plan/40% Member	80% Plan/20% Member
Hearing Aids (\$500 per ear; once every 4 years)	80% Plan/20% 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)

* 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.

Out-of-Area Summary of Benefits

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. Payment for services is limited to the ***allowable amount*** as determined by Blue Cross and Blue Shield. ***ParPlan*** (Texas) and Traditional Indemnity Network (outside of Texas) providers accept the ***allowable amount***. To maximize your benefits and to avoid charges over the ***allowable amount***, seek care through a BCBS provider when possible. **Any charges over the *allowable amount* are the patient's responsibility and will be in addition to *deductible, coinsurance and out-of-pocket maximums.***

Coverage	Out of Area*
Annual <i>Deductible</i>	\$350/person \$1,050/family (applicable when <i>coinsurance</i> is required)
Annual <i>Out-of-Pocket Maximum</i>	\$2,500/person \$7,500/family
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No Limit
OFFICE SERVICES	
Preventive Care	Plan pays 100% (no copayment required)
Diagnostic Office Visit	75% Plan/25% Member
Diagnostic Lab and X-Ray	75% Plan/25% Member
Other Diagnostic Tests	75% Plan/25% Member
Allergy Testing	75% Plan/25% Member
Allergy Serum/Injections <i>(if no office visit billed)</i>	75% Plan/25% Member
EMERGENCY CARE	
Ambulance Service (if transported)	75% Plan/25% Member
Hospital Emergency Room	75% Plan/25% Member
Emergency Physician Services	75% Plan/25% Member
OUTPATIENT CARE	
Observation	75% Plan/25% Member
Surgery – Facility	75% Plan/25% Member
Surgery – Physician	75% Plan/25% Member
Diagnostic Lab and X-Ray	75% Plan/25% Member
Other Diagnostic Tests	75% Plan/25% Member
Outpatient Procedures	75% Plan/25% Member
INPATIENT CARE	
Hospital - Semi private Room and Board**	75% Plan/25% Member
Hospital Inpatient Surgery**	75% Plan/25% Member
Physician	75% Plan/25% Member
OBSTETRICAL CARE	
Prenatal and Postnatal Care Office Visits	75% Plan/25% Member
Delivery – Facility/Inpatient Care**	75% Plan/25% Member
Obstetrical Care and Delivery - Physician	75% Plan/25% Member
THERAPY	
Physical Therapy/Chiropractic Care (max. 20 visits/yr)	75% Plan/25% Member
Occupational Therapy (max. 20 visits/yr)	75% Plan/25% Member
Speech and Hearing Therapy (max. 60 visits/yr)	75% Plan/25% Member
Respiratory Therapy	75% Plan/25% Member
EXTENDED CARE	
Skilled Nursing/Convalescent Facility** (max.180 visits)	75% Plan/25% Member
Home Health Care Services** (max.120 visits)	75% Plan/25% Member
Hospice Care Services**	75% Plan/25% Member
Home Infusion Therapy**	75% Plan/25% Member

Coverage	Out of Area*
BEHAVIORAL HEALTH	
Serious Mental Illness – Office Visit	75% Plan/25% Member
Serious Mental Illness – Outpatient**	75% Plan/25% Member
Serious Mental Illness – Inpatient**	75% Plan/25% Member
Mental Illness – Office (max. 20 visits/yr. for outpatient and office combined)	75% Plan/25% Member
Mental Illness - Outpatient** (max. 20 visits/yr. for outpatient and office combined)	75% Plan/25% Member
Mental Illness – Inpatient** (Other than Serious Mental Illness) Max. 30 days/yr	75% Plan/25% Member
Chemical Dependency – Office (max. 20 visits/yr. for outpatient and office combined)	75% Plan/25% Member
Chemical Dependency - Outpatient Treatment** (max. 20 visits/yr. for outpatient and office combined)	75% Plan/25% Member
Chemical Dependency - Inpatient Treatment** (max 30 days/yr; 3 episodes of treatment per lifetime)	75% Plan/25% Member
OTHER SERVICES	
Durable Medical Equipment**	75% Plan/25% Member
Prosthetic Devices	75% Plan/25% Member
Hearing Aids (\$500 per ear; once every 4 years)	75% Plan/25% Member
Bariatric Surgery (pre-determination recommended)	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.

How Your UT SELECT Medical Plan Works

Freedom of Choice

Each time you need medical care, you can choose to:

See a Network Provider*	See a Non-Network Provider	
	<u>ParPlan</u> Provider	Non-Network Provider that is not a contracting provider
<ul style="list-style-type: none"> You receive the highest level of benefits (network benefits) You are not required to file claim forms You are not balance billed; network providers will not bill for costs exceeding the BCBSTX <u>allowable amount</u> for covered services Your provider will preauthorize necessary services 	<ul style="list-style-type: none"> You receive the lower level of benefits (non-network benefits) You are not required to file claim forms in most cases; ParPlan providers will usually file claims for you You are not balance billed; ParPlan providers will not bill for costs exceeding the BCBSTX <u>allowable amount</u> for covered services In most cases, ParPlan providers will preauthorize necessary services 	<ul style="list-style-type: none"> You receive non-network benefits (the lowest level of benefits) You are required to file your own claim forms You may be billed for charges exceeding the BCBSTX <u>allowable amount</u> for covered services You must preauthorize necessary services

* This includes the UTSW Network Pilot Program providers.

Network vs. Non-Network Providers

Network*	Non-Network (Including <u>ParPlan</u>)	
You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the <u>allowable amount</u> as determined by BCBSTX. <u>ParPlan</u> providers accept the <u>allowable amount</u> . You are responsible for all charges billed by non- <u>ParPlan</u> providers which exceed the <u>allowable amount</u> .	
If you need to...		
Visit a doctor or specialist <i>A "specialist" is any physician other than a family practitioner, internist, OB/GYN or pediatrician</i>	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the office visit <u>copayment</u> Pay any <u>deductible</u> and <u>coinsurance</u> Your doctor or other provider cannot charge more than the <u>allowable amounts</u> for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the office visit File a claim and get reimbursed for the visit minus any <u>deductible</u> and <u>coinsurance</u> Your costs will be based on <u>allowable amounts</u>; the non-network doctor from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX
Receive preventive care	<ul style="list-style-type: none"> Visit any network doctor or specialist Plan pays 100% for certain age-specific and gender-specific preventive care services; see page 27 Your doctor or other provider cannot charge more than the <u>allowable amounts</u> for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the preventive care visit File a claim and get reimbursed for the visit minus any <u>deductible</u> and <u>coinsurance</u> Your costs will be based on <u>allowable amounts</u>; the non-network doctor from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX

	Network*	Non-Network (Including <i>ParPlan</i>)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the <u>allowable amount</u> as determined by BCBSTX. <i>ParPlan</i> providers accept the <u>allowable amount</u> . You are responsible for all charges billed by non- <i>ParPlan</i> providers which exceed the <u>allowable amount</u> .
If you need to...		
Receive <i>emergency</i> care	<ul style="list-style-type: none"> • Call 911 or go to any <i>hospital</i> or doctor immediately; you will receive network benefits for <u>emergency</u> care • Pay the <u>copayment</u> (waived if admitted) • Pay any <u>deductible</u> and <u>coinsurance</u> (if admitted) (see <i>Emergency Care</i> on page 21) 	
Be admitted to the <i>hospital</i>	<ul style="list-style-type: none"> • Your network doctor will preauthorize your admission • Go to the network <i>hospital</i> • Pay any applicable <u>copayment</u>, <u>deductible</u> and <u>coinsurance</u> 	<ul style="list-style-type: none"> • You, a family member, your doctor or the <i>hospital</i> must preauthorize your admission • Go to any licensed <i>hospital</i> • Pay any <u>deductible</u> and <u>coinsurance</u> each time you are admitted • Your costs will be based on <u>allowable amounts</u>; the non-network doctor/facility from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX
Receive behavioral health or chemical dependency services	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care (see page 13) • See any licensed doctor or other provider, or go to any network <i>hospital</i> or facility • Pay any applicable <u>copayment</u>, <u>deductible</u> and <u>coinsurance</u> 	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care (see page 13) • See any licensed doctor or other provider, or go to any licensed <i>hospital</i> or facility • Pay any <u>deductible</u> and <u>coinsurance</u> • Your costs will be based on <u>allowable amounts</u>; the non-network doctor or other provider from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX
File a claim	Claims will be filed for you	You may need to file the claim yourself

* This includes the UTSW Network Pilot Program providers.

What is a *ParPlan* provider?

ParPlan providers have agreed to accept the Blue Cross and Blue Shield of Texas allowable amount and/or negotiated rates for covered services. When using *ParPlan* providers, benefits for covered services are reimbursed at the lower (non-network) level. In most cases, *ParPlan* providers will file the member's claims and preauthorize necessary services. The member is not responsible for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services when *ParPlan* providers are used.

What happens if care is not available from a network provider?

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider **prior to the visit**, network benefits will be paid. Otherwise, non-network benefits will be paid, and the claim will have to be resubmitted for review and adjustment, if appropriate.

Need to locate a network or *ParPlan* doctor or *hospital*?

Log onto www.bcbstx.com/ut and click on Doctors & Hospitals. You can always call Customer Service at 1-866-882-2034 to confirm network status.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas (a non-contracting provider), you receive non-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the Blue Cross and Blue Shield of Texas non-contracting **allowable amount**, which in most cases is less than the allowable amount applicable for Blue Cross and Blue Shield of Texas contracted providers. The non-contracted provider is not required to accept the Blue Cross and Blue Shield of Texas non-contracting allowable amount as payment in full and may balance bill you for the difference between the Blue Cross and Blue Shield of Texas non-contracting allowable amount and the non-contracting provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under UT SELECT and any applicable deductibles, coinsurance amounts, and copayment amounts.

Allowable Amount

The **allowable amount** is the maximum amount of benefits Blue Cross and Blue Shield of Texas will pay for eligible expenses you incur under UT SELECT. Blue Cross and Blue Shield of Texas has established an **allowable amount** for medically necessary services, supplies and procedures provided by providers that have contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan and providers that have not contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan. When you receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas, you will be responsible for any difference between the Blue Cross and Blue Shield of Texas **allowable amount** and the amount charged by the non-contracting provider. You will also be responsible for charges for services, supplies and procedures limited or not covered under UT SELECT, **copayment** amounts, **deductibles**, any applicable **coinsurance**, and **out-of-pocket maximum** amounts.

How is the **allowable amount** determined?

For hospitals and other facility providers, physicians, and other health care providers contracting with Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan – The allowable amount is based on the terms of the provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For hospitals and other facility providers, physicians, and other health care providers not contracting with Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting allowable amount) – The allowable amount will be the lesser of the provider's billed charges or the Blue Cross and Blue Shield of Texas non-contracting allowable amount. Except for home health care, the non-contracting allowable amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim. The non-contracting allowable amount for home health care is developed from base Medicare national per visit amounts for low utilization payment adjustment, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and shall be updated on a periodic basis. When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the allowable amount for non-contracting providers will represent an average contract rate in aggregate for network providers adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and shall be updated not less than every two years.

BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event BCBSTX does not have any claim edits or rules, BCBSTX may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Texas within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare services, or its successor.

The non-contracting allowable amount does not equate to the provider's billed charges and participants receiving services from a non-contracting provider will be responsible for the difference between the non-contracting allowable amount and the non-contracting provider's billed charge, and this difference may be considerable. To find out the Blue Cross and Blue Shield of Texas non-contracting allowable amount for a particular service, participants may call the toll-free Customer

Service number shown on their UT SELECT ID card.

For multiple surgeries – The allowable amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest allowable amount plus a determined percentage of the allowable amount for each of the other covered procedures performed.

For procedures, services, or supplies provided to Medicare recipients – The allowable amount will not exceed Medicare’s limiting charge.

Predetermination of Benefits

As **participants** in UT SELECT, you and your covered dependents are entitled to a review by the Blue Cross and Blue Shield of Texas Medical Division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if Blue Cross and Blue Shield of Texas considers the service to be medically necessary and, therefore, eligible for benefits. To have a predetermination conducted, have your physician provide a letter of medical necessity and any pertinent medical records supporting this position to Blue Cross and Blue Shield of Texas. After a decision is reached, you and your physician will be notified in writing. **Predetermination is not a guarantee of payment.**

Continuity of Care

In the event a **participant** is under the care of a network provider at the time such provider stops participating in the network and at the time of the network provider’s termination, the **participant** has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Blue Cross and Blue Shield of Texas will continue providing coverage for that provider’s services at the in-network benefit level.

Special circumstances means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the **participant**. *Special circumstances* shall be identified by the treating physician or health care provider, who must request that the **participant** be permitted to continue treatment under the physician’s or provider’s care and agree not to seek payment from the **participant** of any amounts for which the **participant** would not be responsible if the physician or provider were still a network provider.

The continuity of coverage will not extend for more than ninety (90) days, or more than nine (9) months if the **participant** has been diagnosed with a terminal illness, beyond the date the provider’s termination from the network takes effect. However, for **participants** past the 24th week of pregnancy at the time the provider’s termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Transitional Benefits

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in UT SELECT and your provider is **not** in the PPO network, ongoing care with the current provider may be requested for a period of time. Transitional care benefits may be available if being treated for any of the following conditions by a non-network provider:

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care

Transitional care benefits are subject to approval. To request transitional care benefits, complete a **Transitional Benefits Form** available from your institution Benefits Office or at www.utsystem.edu/benefits. Instructions for submitting the request to Blue Cross and Blue Shield of Texas are on the form. If the transitional care request is approved, you or your covered dependent may continue to see the non-network provider and receive the network level of benefits from the UT SELECT **plan**. If the transitional care request is denied, you may still continue to see your current provider, but benefits will be paid at the non-network level.

If your provider is in the network, you do not have to complete a Transitional Benefits Form.

Preauthorization Requirements

UT SELECT requires advance approval (preauthorization) by Blue Cross and Blue Shield of Texas for certain services. Preauthorization establishes in advance the *medical necessity* of certain care and services covered under UT SELECT. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements, such as limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient *hospital admissions*
- Skilled nursing care in a skilled nursing facility
- Home health care
- Hospice care
- Home infusion therapy (in a home setting)
- Motorized and customized wheelchairs and certain other durable medical equipment totaling over \$5,000
- Transplants
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
 - Psychological testing
 - Neuropsychological testing
 - Electroconvulsive therapy, and
 - Intensive outpatient program.

Intensive outpatient program means a freestanding or hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions that are unlikely to benefit from treatment programs that focus solely on mental illness conditions.

Care should also be preauthorized if you or your doctor wants to:

- Extend your *hospital* stay beyond the approved days (you or your doctor must call for an extension before your approved stay ends); or
- Transfer you to another facility or to or from a specialty unit within the facility.

Note: You must request preauthorization to use a non-network provider to receive the network level of benefits. **Preauthorization for *medical necessity* of services does not guarantee the network level of benefits.** Even if approved by Blue Cross and Blue Shield of Texas, non-network providers paid at the network level may bill for charges exceeding the Blue Cross and Blue Shield of Texas *allowable amount* for covered services. You are responsible for these charges, which can be significant.

What happens if services are not preauthorized?

Blue Cross and Blue Shield of Texas will review the *medical necessity* of your treatment prior to the final benefit determination. If Blue Cross and Blue Shield of Texas determines the treatment or service is not medically necessary, benefits will be denied.

How to Preauthorize

To satisfy preauthorization requirements, you, your physician or other provider of services, or a family member must call the toll-free number (1-800-441-9188) on the back of your Medical ID Card. The call for preauthorization should be made between 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your provider's office.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient *hospital admission*, the call for preauthorization should be made at least two working days before you are admitted unless it would delay emergency care. In an *emergency*, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient *hospital admission* is preauthorized, a length of stay is assigned. Your UT SELECT *plan* is required to provide a minimum length of stay in a *hospital* facility for the following:

- Maternity Care
- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Caesarean section
- Treatment of Breast Cancer
- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

If you require a longer stay than was first preauthorized, your provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Note: Your provider will not be required to obtain preauthorization from Blue Cross and Blue Shield of Texas for prescribing a length of stay less than 48 hours (or 96 hours) for *maternity care*. If you require a longer stay, your provider must seek an extension for the additional days by obtaining preauthorization from Blue Cross and Blue Shield of Texas.

Preauthorization for Extended Care Expense and Home Infusion Therapy

Preauthorization for *extended care expense* and home infusion therapy (in a home setting) may be obtained by having the agency or facility providing the services contact Blue Cross and Blue Shield of Texas to request preauthorization. The request should be made:

- Prior to initiating *extended care expense* or home infusion therapy
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

Blue Cross and Blue Shield of Texas will review the information submitted prior to the start of *extended care expense* or home infusion therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If *extended care expense* or home infusion therapy is to take place in less than one week, the agency or facility should call the preauthorization telephone number shown on your ID card (1-800-441-9188). If Blue Cross and Blue Shield of Texas has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Chemical Dependency, Serious Mental Illness, Mental Health Care

- All inpatient and certain outpatient treatment of chemical dependency, serious mental illness and mental health care should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Accessing the BlueCard Program for Health Care Outside Texas



Your benefits travel with you. Your UT SELECT Medical ID Card features the Blue Cross and Blue Shield symbols and the PPO-in-a-suitcase logo telling providers that you are part of the BlueCard program. This means that you and your covered dependents may use Blue Cross and Blue Shield network providers throughout the United States. Follow these steps to receive the network (highest) level of benefits offered under your **plan** while traveling or away from home:

1. If you are outside of Texas and need health care, refer to your UT SELECT Medical ID Card and call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest network doctors and **hospitals**.
2. Although network providers outside of Texas may preauthorize those services that require preauthorization (such as a **hospital admission**), it is ultimately your responsibility to obtain preauthorization by calling the appropriate number on the back of your UT SELECT Medical ID Card.
3. When you arrive at the doctor's office or **hospital**, present your UT SELECT Medical ID Card, and the doctor or **hospital** will verify eligibility and coverage information.
4. After you receive medical attention, the network provider will file claims for you.
5. You will be responsible for paying any applicable **copayment, deductible, or coinsurance** amounts, as well as any charges for non-covered services. BlueCard providers have agreed to accept the Blue Cross and Blue Shield Plan's **allowable amount** for covered services and will not bill you for any costs exceeding the **allowable amount**.

For more information, see the notice on page 65 regarding other Blue Cross and Blue Shield's separate financial arrangements with providers.

Does UT SELECT provide benefits for medical services outside the United States?

Yes. Through the BlueCard Worldwide program, you have access to **hospitals** on almost every continent and to a broad range of medical assistance services when you travel or live outside the United States. BlueCard Worldwide provides the following services:

- Provider location
- Referral information
- Medical monitoring
- Wire transfers/overseas mailing
- Translation
- Coverage verification
- Currency conversion

If you need to locate a doctor, other provider or **hospital**, or need medical assistance, call BlueCard Access at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at BlueCard Worldwide **hospitals**.

In an **emergency**, go directly to the nearest **hospital**.

Call Blue Cross and Blue Shield of Texas for preauthorization, if necessary. (Refer to the phone number on the back of your UT SELECT ID card. The preauthorization phone number is different than the BlueCard Access number.)

In most cases, you will not need to pay for inpatient care at BlueCard Worldwide **hospitals** in advance. The **hospital** should submit your claim. You will, however, be responsible for the usual out-of-pocket expenses (non-covered services, **copayment, deductible, and coinsurance** amounts).

If you do not use a BlueCard Worldwide provider for care, you must pay the provider or **hospital** at the time of service and obtain proof of payment (itemized receipt). Then, you will need to complete and submit an international claim form, along with your proof of payment and send it to the BlueCard Worldwide Service Center to receive any applicable reimbursement for covered expenses. The claim form is available online at www.bcbstx.com/ut. Except for emergency care, non-network benefits will apply towards covered expenses if you are eligible to receive in-area benefits. If you are eligible for out-of-area benefits, the out-of-area benefit level will apply.

Remember that bills from foreign providers differ from billing in the United States. The bills may be missing the provider's name and address, in addition to other critical information. It is very important that you fill out the BlueCard Worldwide claim form completely and attach your bills from the foreign provider. Missing information will delay claims processing.

What the UT SELECT Medical Plan Covers

The following medical expenses are covered by UT SELECT. The descriptions have been alphabetized for quick reference. Covered services may be subject to other *plan* limitations.

Refer to the Benefits Summaries for UT SELECT on pages 4-8 of this booklet for more detailed information, including the applicable *copayment*, *deductible* and *coinsurance*.

Acquired Brain Injury

Benefits for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, UT SELECT includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Note: *Service* means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury. *Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury. Treatment for an acquired brain injury may be provided at a *hospital*, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Note: A new Texas state law affecting *participant* subrogation rights will take effect in 2014. New information on how subrogation works under UT SELECT will replace this section before the new law takes effect.

Allergy Care

Coverage is provided for testing and treatment for *medically necessary* allergy care. Allergy injections are not considered immunizations for purposes of the UT SELECT preventive care benefit.

Ambulance Services

UT SELECT covers ambulance services when medically necessary as outlined below:

- The patient's condition must be such that any other form of transportation would be medically contraindicated.
- The patient is transported to the nearest site with the appropriate facilities for the treatment of the injury or illness involved or in the case of organ transplant, to the approved transplant facility.

Air or sea ambulance services are medically necessary as outlined below:

- The time needed to transport a patient by either basic or advanced life support land ambulance poses a threat to survival
- The point of pick-up is inaccessible by land vehicle
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest *hospital* with appropriate facilities for treatment (e.g. transport of a critically ill patient to an approved transplant facility with a waiting organ)

The following services are **not** medically necessary, as they do not require ambulance transportation:

- Ambulance services when the patient has been legally pronounced dead prior to the ambulance being summoned.
- Services provided by an ambulance crew who do not transport a patient but only render aid. Some examples are:
 - Ambulance dispatched to scene of an accident and crew rendered aid until a helicopter can be sent
 - Ambulance dispatched and patient refuses care or transport; or
 - Ambulance dispatched and only basic first aid is rendered.

Non-emergency transports between medical facilities may be considered medically necessary for a patient who has a medical problem requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. Disabled means the patient's physical condition limits his mobility and is unable to stand and sit unassisted or requires continuous life support systems. Non-emergency transport from a patient's home is not a covered benefit.

Transfers by medical vans or commercial transportation (such as physician owned limousines, public transportation, cab, etc.) are not reimbursable.

What does medical necessity or medically necessary mean?

- Supplies and services are covered only if they are medically necessary. This means that the services and supplies must be:
- Essential to, consistent with, and provided for diagnosis or the direct care or treatment of the condition, sickness, disease, injury, or bodily malfunction
 - Within the standards of generally accepted health care practice as determined by Blue Cross and Blue Shield of Texas
 - Not primarily for the convenience of the *participant*, his physician, the *hospital* or other provider
 - The most economical supplies or levels of service appropriate for safe and effective treatment. When applied to hospitalization, this further means that the *participant* requires acute care as a bed patient due to the nature of the services provided or the *participant's* condition and the *participant* cannot receive safe or adequate care as an outpatient.

Medical necessity is determined by Blue Cross and Blue Shield of Texas, considering the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a physician may have prescribed treatment, such treatment may not be medically necessary within this definition. A determination of medical necessity does not guarantee payment unless the service is covered by the UT SELECT plan.

Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services by a provider, during pregnancy and/or in the post-partum period. Benefits include the purchase or rental of manual, electric, or hospital-grade breast pumps, accessories and supplies as follows:

Pump Type	Coverage Level	Qualifying Source	Limit/Restriction
Manual Breast Pump	Plan pays 100% (no cost-share)	Network or non-network provider, retail	N/A
Electric Breast Pump	Plan pays 100% (no cost-share)	Network provider or contracted durable medical equipment (DME) supplier only	Two per calendar year
Hospital Grade Breast Pump	Plan pays 100% (no cost-share; rental only)	Network or contracted DME supplier only	Rental cost up to the purchase price (\$125-\$150)

You may be required to pay the full amount and submit a claim form to BCBSTX with an itemized receipt for the breast pump, accessories and supplies. Visit the www.bcbstx.com/ut website to obtain a claim form.

Chemical Dependency Treatment (preauthorization required)

Chemical dependency is the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance. All inpatient and certain outpatient treatment (see page 13) for chemical dependency should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

There is a maximum limit of three separate series of chemical dependency treatments (episodes) per lifetime for each covered individual. A series of treatments is a planned, structured, and organized program to promote chemical-free status. A program may include different facilities or modalities, such as inpatient detoxification, inpatient rehabilitation/ treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a *participant* is discharged on medical advice or when a *participant* fails to materially comply with the treatment program for a period of 30 days.

Inpatient treatment of chemical dependency must be provided in a chemical dependency treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a *hospital* will be available on the same basis as any other illness.

Chiropractic Care

UT SELECT pays benefits for services (including occupational therapy and physical therapy) and supplies provided by or under the direction of a licensed Doctor of Chiropractic.

Clinical Trials

Benefits are available for services provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- National Institutes of Health;
- United States Food and Drug Administration;
- United States Department of Defense;
- United States Department of Veterans Affairs; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Condition Management

UT SELECT provides voluntary condition management (also known as disease management) programs designed specifically for *participants* who have been diagnosed with asthma, diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, metabolic syndrome (high blood pressure, high cholesterol), low back pain, cancer, end stage renal disease or any other chronic condition. Lifestyle management programs are also available to address weight management and Tobacco cessation. When you enroll in one of the programs, you'll receive helpful information about your condition, at no cost to you.

The programs work collaboratively with your health *plan*, doctor and you to identify the best way to manage your condition more effectively. Enrolling in a program can help:

- Decrease the intensity and frequency of your symptoms
- Enhance your self-management skills
- Reduce (or decrease) missed days at work
- Enrich your quality of life

Claims, lab results, pharmacy data, preauthorization prior to hospitalization, predictive modeling, health risk assessments, self referrals and/or a physician referral are some of the sources used to determine if you may be a candidate for enrollment in a condition management program. As you know, your physician plays an important role in treating your condition and Blue Cross and Blue Shield of Texas will notify your physician by letter and/or contact you directly to invite you to enroll in one of the programs. Program participation is voluntary.

Each program addresses your specific needs, based on the severity of your condition, complications and risk factors. If the severity of your condition is mild, you will receive:

- Coverage for targeted preventive screenings
- Seasonal mailings with educational materials related to your condition
- Annual contact calls to encourage medication compliance
- Tools to help you better self-manage your condition

If the symptoms of your chronic condition are moderate to severe, your program will be tailored to provide you with:

- Personalized self-management planning
- Regularly scheduled monitoring by a registered nurse
- 24-hour-a-day telephone access to a specialty nurse
- An audio library of topics related to your condition, available by telephone around-the-clock
- Assistance in getting selected condition-specific durable medical equipment for monitoring your chronic condition covered under your health plan
- Home health visits and social service consultation, if needed

Please be assured your health care information is kept confidential and will not be released to your employer.

Blue Cross and Blue Shield of Texas condition management programs are fully compliant with federal and state privacy regulations. Such regulations do permit a health insurer and its contracted business associates (such as a pharmacy benefits manager and a disease management program) to use and disclose individuals' health information for purposes of *health care operations* without a patient authorization, as long as the business associates also agree to keep the information protected and to use it only for the specified purposes. *Health care operations* includes population-based activities relating to improving health or reducing health care costs, plus contacting patients with information about treatment alternatives. Regulators have determined that disease management activities are part of *health care operations*.

To enroll or ask questions about Blue Cross and Blue Shield of Texas condition management programs, call **1-800-462-3275**.

Cosmetic, Reconstructive, or Plastic Surgery

Cosmetic, reconstructive and/or plastic surgery is surgery which can be expected or is intended to improve the physical appearance of a *participant*; or is performed for psychological purposes; or restores form but does not correct or materially restore a bodily function. For cosmetic, reconstructive or plastic surgery, UT SELECT covers only the following services if *medically necessary*:

- Treatment for correction of defects due to accidental injury while covered under UT SELECT.
- Reconstructive surgery following cancer surgery.
- Surgery performed on a newborn child for the treatment or correction of a congenital defect.
- Surgery to correct a congenital defect in a dependent child (other than a newborn child) under age 26 for the treatment or correction of a congenital defect if that child has been covered since birth under a health care plan offered by UT System. This does not include breast surgery.
- Reconstruction of the breast on which a mastectomy has been performed while covered under a health care plan offered by UT System; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses (two per *plan year*) and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Benefits for eligible expenses will be the same as for the treatment of any other sickness as shown on the Benefits Summary. No other cosmetic, reconstructive or plastic surgery is covered unless particularly specified in this Benefits Booklet.

Dental Services and Covered Oral Surgery

General dental services are not covered by UT SELECT. When *medically necessary* as determined by Blue Cross and Blue Shield of Texas and prescribed by your doctor, covered oral surgery is limited to:

- Covered oral surgery, including removal of complete/partial bony impacted teeth (soft tissue wisdom tooth removal is not a covered benefit);
- Services provided to a newborn for treatment or correction of a congenital defect;
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the *participant* is covered by UT SELECT. Services must be received within 24 months of the date of the accident or to the termination date of the UT SELECT *plan*, whichever occurs first. (An injury sustained as a result of biting or chewing is not considered to be an accidental injury); and
- Orthognathic surgery.

Facility and related services, when *medically necessary*, are covered for *participants* who are unable to undergo treatment in a dental office or under local anesthesia due to a documented physical, mental, or medical reason. Preauthorization is required. **The specific dental procedure is not covered under the UT SELECT plan; only the facility and related services are covered.**

What is covered oral surgery?

Covered oral surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts, and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) due to accident, trauma, congenital defects and developmental defects or a pathology.

Diabetic Management Services

UT SELECT covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Covered items include:

Diabetic Equipment

- Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind),
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies) and
- Podiatric appliances, including up to two pairs of therapeutic footwear per *plan year*, for the prevention of complications associated with diabetes.

Diabetic Prescriptions

- Insulin and insulin analog preparations,
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels and
- Glucagon emergency kits

Diabetic Supplies

- Test strips for blood glucose monitors,
- Lancets and lancet devices,
- Visual reading and urine test strips and tablets which test for glucose, ketones and protein,
- Injection aids, including devices used to assist with insulin injection and needleless systems,
- Insulin syringes,
- Biohazard disposable containers,

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), are covered under the prescription drug program, administered by Express Scripts. The specific diabetic management service (supplies or equipment) is payable by either Blue Cross and Blue Shield of Texas or Express Scripts (the Prescription Drug Program administrator; see pages 50 to 54).

Diabetic Management Services/Diabetes Self-Management Training Programs

Includes initial and follow-up instruction concerning:

- The physical cause and process of diabetes;
- Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- Prevention and treatment of special health problems for the diabetic patient;
- Adjustment or lifestyle modifications; and
- Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

Dietary and Nutritional Services

Dietary and nutritional services means the education, counseling, or training of a *participant* (including print material) regarding diet, regulation or management of diet, or the assessment or management of nutrition. Dietary and nutritional services are generally excluded from coverage, except for a nutritional assessment program from diabetic management provided in and by a *hospital* and approved in advance by Blue Cross and Blue Shield of Texas or for diabetic management services. Dietary or nutritional services may also be covered for the following conditions: inborn metabolic disorders, chronic renal failure, chronic liver failure, severe dyslipidemia, lactose deficiency, celiac disease (sprue), severe food allergies or in situations where the prescription for nutritional supplements indicates it is being prescribed as the sole source of nutrition. Also covered are amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein-induced enterocolitis syndromes;
- Eosinophilic disorders, as evidenced by the results of biopsy; and
- Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A prescription order from your health care practitioner is required.

Note: Healthy diet/intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease is covered 100% by UT SELECT when using network providers for preventive care services. (Services must be billed as preventive care.) Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dieticians.

Durable Medical Equipment

UT SELECT covers the rental (or purchase at the discretion of Blue Cross and Blue Shield of Texas of therapeutic supplies and rehabilitative equipment required for therapeutic use, such as a standard wheelchair, crutches, walker, bedside commode, hospital-type bed, suction machine, artificial respirator, or similar equipment. **Note:** Continuous Passive Air Pressure (CPAP) equipment is subject to *deductible* and *coinsurance*, in addition to any office visit *copayment*.

Equipment to alleviate pain or provide patient comfort (for example, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene protection and home air fluidized beds) is **not** covered, even if prescribed by your doctor.

Emergency Care and Treatment of Accidental Injury

Your UT SELECT *plan* covers medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In case of *emergency*, call 911 or go to the nearest emergency room. Whether you require hospitalization or not, you should notify your network physician within 48 hours, or as soon as reasonably possible, of any *emergency* medical treatment so he can recommend the continuation of any necessary medical services.

For in-area *participants*, a *copayment* will be required for facility charges for each outpatient *hospital* emergency room visit. If admitted for the *emergency* condition immediately following the visit, the services apply to the inpatient services and preauthorization of the inpatient *hospital admission* will be required. (For out-of-area *participants*, benefits for *emergency* care and treatment of accidental injury are determined on the same basis as for treatment of any other illness.)

All *emergency* care, whether provided by a network provider or a non-network provider, will be eligible for the network level of benefits. If you continue to be treated by a non-network provider after you receive *emergency* care and you can safely be transferred to the care of a network provider, only non-network benefits will be available. Non-network providers may bill you for any charges exceeding the non-contracting *allowable amount*.

What is an emergency?

Emergency care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement, or

In the case of a pregnant woman, serious jeopardy to the health of the fetus.

24/7 Nurseline

888-315-9473

Available 24 hours a day, seven days a week; bilingual nurses available. The 24/7 Nurseline can help:

- Decide if a situation is an emergency
- Answer health-related questions
- Understand your condition

Eyeglasses or Lenses

Eyeglasses and lenses are covered if the patient has a history of having had cataract surgery. Hard contact lenses are covered for the non-surgical correction of a corneal defect such as keratoconus. Soft contact lenses are covered for a diagnosis of aphakia. Coverage includes one initial lens, one replacement lens for each aphakic eye in the first year and then one replacement lens per each aphakic eye per year thereafter.

Hearing Aids

UT SELECT allows a \$500 maximum benefit per ear every four years for non-disposable hearing aids, fittings, and molds. Blue Cross and Blue Shield of Texas will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the Blue Cross and Blue Shield of Texas *allowable amount* when using network or *ParPlan* providers. If you use a non-contracting provider, Blue Cross and Blue Shield of Texas will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider's billed charges. *Deductibles* do not apply. Hearing aid repair and batteries are not covered.

Savings on Hearing Aids

Blue Cross and Blue Shield of Texas has arranged for a discount program through TruHearing* that offers digital hearing aids at a reduced price. This program allows you to receive discounts of 30% to 60% off of manufacturer suggested retail price for the latest technology digital hearing instruments. The program also includes a free hearing screening, hearing instrument fitting and related services through the TruHearing network of participating providers. As a UT SELECT member, your children, parents and grandparents can also access this discount hearing program.

To access the program, call the TruHearing toll-free phone number, **1-877-882-2020**, during 8 a.m. to 8 p.m., Monday through Friday to locate a provider, schedule an appointment and obtain a referral to the provider. It's that easy! For additional information, you may also visit the program's website at www.TruHearing.com.

*The relationship between Blue Cross and Blue Shield of Texas and TruHearing is that of independent contractors.

Home Health Care (preauthorization required)

UT SELECT covers *medically necessary* services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, speech, and respiratory therapy services provided by licensed therapists, and
- Supplies and equipment routinely provided by the home health agency.

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for *custodial care*.

Home Infusion Therapy (preauthorization required for services in a home setting)

UT SELECT covers the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous (IV) or gastrointestinal (enteral) infusion or by intravenous injection. Home infusion therapy includes:

- Drugs and IV solutions
- Pharmacy compounding and dispensing services
- All equipment and ancillary supplies necessitated by the defined therapy
- Delivery services
- Patient and family education, and
- Nursing services.

Over-the-counter products which do not require a prescription, including standard nutritional formulations used for enteral nutrition therapy, are **not** covered unless it is determined to be the sole source of nutrition.

Hospice Care (preauthorization required)

UT SELECT covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for *home* hospice care:

- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, respiratory, and speech therapy by licensed therapists, and
- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling.

Covered *facility* hospice care includes:

- All usual nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Room and board and all routine services, supplies and equipment provided by the hospice facility
- Physical, speech and respiratory therapy services by licensed therapists, and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

Hospital Admission (preauthorization required)

UT SELECT covers room and board (up to the *hospital's* semiprivate room rate; a private-room rate is allowed only when medically necessary), general nursing care, and other *hospital* services and supplies. It does not cover personal items such as telephones and television rental.

Infertility Services

Testing for problems of infertility is covered.

Note: Services or supplies, including testing such as HSG, provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are **not** covered. See pages 31-33 for additional exclusions.

Lab and X-Ray Services

Medically necessary laboratory and radiographic procedures, services and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered when ordered by a provider.

Network providers are responsible for referring patients to network labs, imaging centers or an outpatient department of a network *hospital* for *medically necessary* lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your *plan* when using network providers.

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider **prior to the visit**, network benefits will be paid. Otherwise, non-network benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. If a non-network provider is used, the *participant* will be responsible for any expenses exceeding the *allowable amount*.

In some situations, a provider or facility will refer the results of lab tests and X-rays to a radiologist or pathologist for a professional interpretation of the results. Since *participants* have little or no control over this referral, all professional interpretations for lab and X-ray will be paid at the network level of benefits whether performed by a network or non-network provider. However, if a non-network provider is used, the *participant* will be responsible for any expenses exceeding the *allowable amount*.

What happens if lab and X-ray work are performed outside the doctor's office, or the lab work and X-rays are sent to another location for interpretation?

Lab and X-ray services, including interpretations, performed outside the doctor's office at a free-standing network facility are paid at 100% of the *allowable amount*. Lab and X-ray services performed in conjunction with an outpatient procedure or inpatient at an in-network facility will be subject to *deductible* and *coinsurance*.

Are non-network specialists such as anesthesiologists, radiologists and pathologists covered at the network level of benefits if the *hospital* or surgeon is in the network?

These services will be paid at the network benefits level. However, payment for non-network services is limited to the Blue Cross and Blue Shield of Texas *allowable amount*, and you are responsible for any charges billed by the provider which exceed the *allowable amount*, except for *emergency* care services (see page 21.)

Male Sexual Dysfunction

Coverage for male sexual dysfunction may be allowed if the patient has a documented disease resulting in impotence. The surgical procedures, supplies, or medications used for treatment of male sexual or erectile dysfunction include, but are not limited to, the following:

- Inflatable or non-inflatable penile implants (protheses)
- Vacuum erection devices
- Intracavernosal injection therapy
- (Trans)urethral suppository method

The use of the procedures, supplies, or medications for treatment of psychologic/psychogenic male sexual or erectile dysfunction/impotence is not eligible for coverage.

Maternity Care

UT SELECT covers maternity-related expenses for employees and covered dependents.

Maternity care includes diagnosis of pregnancy, pre- and post-natal care and delivery (including delivery by Caesarean section). UT SELECT covers inpatient care for the mother and newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Caesarean section.

Inpatient ***hospital*** expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's ***hospital admission*** for the delivery. These charges will be considered expenses of the child and may be subject to the benefit provisions and benefit maximums described in the Benefits Summary.

Note: UT SELECT includes a free voluntary comprehensive prenatal program – Special Beginnings – that helps mothers take better care of themselves and their babies. The program assesses pregnancy risk level and provides close monitoring through a series of calls from an experienced obstetrical nurse from pregnancy through six weeks after delivery. A \$50 reward card is given to women who enroll in the program by the twelfth week of gestation and complete the program after delivery. To enroll or ask questions about the program, call the toll-free number: **1-888-421-7781**.

How are doctor's charges for maternity care covered?

You pay the office visit ***copayment*** for your initial visit. For delivery, you pay your ***coinsurance*** after your ***copayment*** and ***deductible***.

What are complications of pregnancy?

Complications of pregnancy means:

- Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
- Non-elective Caesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Does UT SELECT provide coverage for using a licensed nurse midwife as a practitioner?

UT SELECT will only allow benefits for midwife services provided by an advanced practice nurse (APN). Other common designations that you may encounter include: (1) certified midwife, an individual who has obtained a state issued certificate from the State Midwifery Agency; and (2) certified professional midwife, a professional certification that can be obtained from the National Association of Registered Midwives. UT SELECT does not recognize these or other designations/certifications for midwife services.

How is a newborn child covered under UT SELECT?

UT SELECT automatically provides coverage for a newborn child of a covered employee (or a covered dependent of an employee) for the first 31 days after the date of birth, but this coverage ends at the end of 31 days unless the newborn is added to the employee's coverage. To add coverage for the newborn beyond the first 31 days, you must make the appropriate changes to your benefit designations within the 31-day period after the date of birth. Application for changes must be made through your institution Benefits Office. If you do not finalize the appropriate changes during the 31-day period following the birth, the changes cannot be honored. You may apply for coverage for your dependent during the next annual enrollment period or when a qualified change of status event occurs. Please contact your institution Benefits Office with questions or changes in status.

For grandchildren to be eligible for newborn coverage, the grandchild must be added to the employee's (or retiree's) coverage for benefits within 31 days of the newborn's birth. An eligible grandchild must be a dependent of the employee for federal income tax purposes. Consult your institution Benefits Office for more information about grandchildren as eligible dependents.

Medical-Surgical Expenses

UT SELECT provides coverage for medical-surgical expenses for you and your covered dependents. These include:

- Services of physicians and other professional providers
- Services of a certified registered nurse-anesthetist (CRNA)
- Diagnostic X-ray and laboratory procedures
- Radiation therapy
- Anesthetics and its administration, when performed by someone other than the operating physician or other professional provider
- Oxygen and its administration provided the oxygen is actually used
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the **participant**
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the **participant's effective date** of coverage under UT SELECT, excluding all replacements of such devices other than those necessitated by growth to maturity of the **participant**
- Services or supplies used by the **participant** during an outpatient visit to a **hospital**, a **therapeutic center**, or a chemical dependency treatment center, or scheduled services in the outpatient treatment room of a **hospital**
- Certain diagnostic procedures including, but not limited to, bone scan, cardiac stress test, CT scan, MRI, myelogram, PET Scan
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes
- Injectable drugs, administered by or under the direction or supervision of a physician or other professional provider

Services and supplies for medical-surgical expense must be furnished by or at the direction or prescription of a physician or other professional provider. A service or supply is furnished at the direction of a physician or other professional provider if the listed service or supply is:

- provided by a person employed by the directing physician or other professional provider;
- provided at the usual place of business of the directing physician or other professional provider; and
- billed to the patient by the directing physician or other professional provider

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Mental Health Care (preauthorization required for all inpatient care and certain outpatient care, see page 13)

UT SELECT covers charges for inpatient and outpatient mental health care for:

- Diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used by Blue Cross and Blue Shield of Texas, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin
- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the direction or supervision of a provider, when the eligible expense is:
 - Individual, group, family or conjoint psychotherapy
 - Counseling
 - Psychoanalysis
 - Psychological testing and assessment
 - For administering or monitoring of psychotropic drugs
 - **Hospital** visits or consultations in a facility providing such care
 - Electroconvulsive treatment
 - Psychotropic drugs

All inpatient and outpatient treatment for mental health should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Refer to the Benefits Summary for day or visit limitations that apply.

Medically necessary mental health care in a **psychiatric day treatment facility**, a **crisis stabilization unit** or facility, or a **residential treatment center**, in lieu of hospitalization, will be considered inpatient **hospital** expense at a mental health facility. Each full day of mental health care in a **psychiatric day treatment facility**, **crisis stabilization unit** or facility, or **residential treatment center** will count as a half day of inpatient care when calculating **plan year** limitations.

Obesity

Surgical treatment of morbid obesity may be a covered benefit when:

- It is determined to be medically necessary; and
- It satisfies the criteria established in Blue Cross and Blue Shield of Texas medical policy guidelines.

Contact Blue Cross and Blue Shield of Texas customer service for current medical necessity determination criteria.

Organ and Tissue Transplants (preauthorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if the:

- Transplant is not *experimental/investigational* in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- Recipient or donor is a *participant* under UT SELECT (Benefits are also available to the donor who is not a *participant* under UT SELECT)
- Transplant procedure is preauthorized
- Recipient meets all of the criteria established by Blue Cross and Blue Shield of Texas in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the *hospital* in which the transplant is performed

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Donor search and acceptability testing of potential live donors
- Removal of organs or tissues from deceased donors
- Transportation and storage of donated organs and tissues

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies **not** covered by UT SELECT include:

- Living and/or travel expenses of the recipient or live donor
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species

Orthotics

UT SELECT covers orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom-designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, an orthodontic or other dental appliance (except as allowed for accidental injury under covered oral surgery on page 19); splints or bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings and garter belts.

Note: Foot orthotics are covered for the treatment of diabetes.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the *participant's* responsibility.

Outpatient Facility Services

UT SELECT covers the following services provided through a *hospital* outpatient department or a free-standing facility when *medically necessary*:

- Radiation therapy
- Chemotherapy
- Dialysis
- Rehabilitation services
- Outpatient surgery

Preauthorization for outpatient procedures is not required, but calling customer service to confirm benefits before services are performed is recommended.

Prenatal Genetic and Chromosomal Metabolic Testing

Benefits for eligible expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chronic villus sampling (CVS). These tests are eligible for coverage for the specific conditions listed:

- In pregnancies where the woman will be 35 years of age or over at the expected time of delivery
- When a previous pregnancy has resulted in the birth of a child with a chromosomal (e.g. Down's Syndrome) or genetic abnormality or major malformations
- When a chromosomal or genetic abnormality is present in a parent or there is a history of genetic abnormality in a blood relative
- Where there is a history of multiple (three or more) miscarriages in this union or in a prior relationship of either parent
- When the fetus is at an increased risk for hereditary error of metabolism detectable in vitro.

Preventive Care

UT SELECT encourages preventive care and maintenance of good health. Covered services under this benefit must be billed by the provider as "preventive care." Preventive care benefits will be provided for the following covered services and when using network providers, the services will not be subject to copayment, deductible, coinsurance or dollar maximums:

- 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;
- Evidenced-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; and
- 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. For the most recent list of recommended services, check with your doctor or visit www.healthcare.gov.

Examples of covered services included are routine annual physicals; 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); tobacco cessation counseling services; 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 the toll-free number on your identification card. The list of contraceptive drugs and devices covered under this benefit may change as FDA guidelines, medical management and medical policies are modified.

Covered preventive care services not included in the description above will be subject to applicable copayment, deductible, and coinsurance. Examples include ear exams and early detection tests for cardiovascular disease.

You may find more information about covered preventive care services by visiting healthcare.gov or by contacting Customer Service at the toll-free number on your identification card. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your doctor bills for services that are not preventive.

Covered preventive care services not included in the description above may be subject to applicable copayment, deductible, and coinsurance. Examples include hearing screenings and early detection tests for cardiovascular disease.

You may find more information about covered preventive care services by visiting healthcare.gov or by contacting customer service at the toll-free number on your ID card. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your doctor bills for services that are not preventive.

More about Your Preventive Care Benefits

Benefits for the Prevention and Detection of Osteoporosis

If a **participant** is a *qualified individual*, as defined below, benefits will be determined on the same basis as for any other illness as shown on the *Benefits Summary*. Benefits are provided for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the **participant's** risk of osteoporosis and fractures associated with osteoporosis.

Qualified individual means a **participant** who is:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

Benefits for Certain Tests for Detection of Prostate Cancer

If a male **participant** incurs medical-surgical expenses for diagnostic medical procedures incurred in conducting a medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided for:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk factor.

Benefits for Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are provided as a surgical benefit as referenced in the *Benefits Summary*.

Benefits for Speech and Hearing Services

Benefits as shown on the *Benefits Summary* are available for the services of a physician or other professional provider to restore loss of or correct an impaired speech or hearing function. Any benefit payments made by Blue Cross and Blue Shield of Texas for hearing aids will apply toward the benefit maximum amount indicated on the *Benefits Summary*.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other preventive care services as shown on the *Benefits Summary*, for each woman enrolled in UT SELECT for eligible expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. **Note:** UT SELECT provides coverage for the HPV vaccine.

Childhood Immunizations

Benefits for childhood immunizations will be determined at 100% of the **allowable amount**. Any **copayment**, **deductible**, and **coinsurance** and amounts will not be applicable. Benefits are available for:

- Diphtheria
- Hemophilus influenzae type B
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella
- Any other immunization that is required by law for the child

Doses, recommended ages, and recommended populations vary. See the Advisory Committee on Immunization Practices' website for more information: www.cdc.gov/vaccines/recs/acip/default.htm. Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. Covered services not included in the description above may be subject to applicable copayment, deductible, and coinsurance.

Professional Services

Covered services must be medically necessary as determined by Blue Cross and Blue Shield of Texas and provided by a licensed doctor or by other covered health providers as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Who are covered health providers?

UT SELECT provides benefits for services provided by professional providers:

- Advanced Practice Nurse (APN)
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage Family Therapist (LMFT)
- Licensed Clinical Social Worker
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Licensed Surgical Assistant
- Nurse First Assistant (NFA)
- Physician Assistant (PA)
- Psychological Associates who work under the supervision of a Doctor in Psychology

Prosthetic Devices

UT SELECT provides coverage for prosthetic appliances, including replacements necessitated by growth to maturity of the participant. Coverage is provided for medically necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of:

- An absent body organ (including contiguous tissue), or
- The function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses)

For purposes of this definition, a wig or hairpiece is **not** considered a prosthetic appliance.

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the participant's responsibility.

Rehabilitation Services (Physical, Speech and Occupational Therapies)

UT SELECT covers rehabilitation services and physical, speech and occupational therapies that are *medically necessary*, meet or exceed treatment goals for a *participant*, and are provided on an inpatient or outpatient basis or in the provider's office. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration.

Serious Mental Illness (preauthorization required for all inpatient care and certain outpatient care, see page 13)

Benefits for the treatment of serious mental illness will be provided on the same basis as any other illness. Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*:

- Bipolar disorders (hypomanic, manic, depressive, and mixed)
- Depression in childhood and adolescence
- Major depressive disorders (single episode or recurrent)
- Obsessive-compulsive disorders
- Paranoid and other psychotic disorders
- Schizo-affective disorders (bipolar or depressive)
- Schizophrenia

All inpatient and outpatient treatment for serious mental illness should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Medically necessary care for serious mental illness in a *psychiatric day treatment facility*, a *crisis stabilization unit* or facility, or a *residential treatment center*, in lieu of hospitalization, will be considered inpatient *hospital* expense at a mental health facility. Each full day of mental health care in a *psychiatric day treatment facility*, *crisis stabilization unit* or facility, or *residential treatment center* will count as a half day of inpatient care when calculating *plan year* limitations.

Skilled Nursing Facility (preauthorization required)

UT SELECT covers care in a skilled nursing facility and pays benefits for:

- Room and board
- Routine medical services, supplies, and equipment provided by the skilled nursing facility
- General nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist

What is a skilled nursing facility?

A skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services. A skilled nursing facility is licensed in accordance with state law (where the state law provides for licensing of such facility) and is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care. Skilled nursing facilities are not for individuals convalescing.

What the UT SELECT Medical Plan Does Not Cover

Limitations and Exclusions

In addition to the limitations and exclusions set out in the description of What the Medical Plan Covers, beginning on page 16, UT SELECT does not cover medical expenses for the following:

1. Any services or supplies which are not medically necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any *experimental/investigational* services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the *allowable amount* as determined by Blue Cross and Blue Shield of Texas.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the *participant* for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a *participant* is not required to make payment or for which a *participant* would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the *participant* by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges resulting from the failure to keep a scheduled visit with a physician or other professional provider; or for completion of any insurance forms; or for acquisition of medical records.
10. Room and board charges incurred during a *hospital admission* for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the *participant's* physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a *participant* hereunder or any services or supplies provided after the termination of the *participant's* coverage
12. Any services or supplies provided for dietary and nutritional services, except as may be provided under UT SELECT for an inpatient nutritional assessment program provided in and by a *hospital* and approved by Blue Cross and Blue Shield of Texas, or as listed for covered *dietary and nutritional services* or benefits as described in this Benefits Booklet.
13. Any services or supplies provided for *custodial care*, long term care, respite care (except as specifically mentioned under the hospice care program) and maintenance care.
14. Any services or supplies provided for the non-surgical and/or non-diagnostic treatment of, or related to services to, the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery, as described under *dental services and covered oral surgery*.
15. Any services or supplies incurred for dental care and treatments, dental surgery, or dental appliances, except as provided under *dental services and covered oral surgery* in this Benefits Booklet.
16. Any services or supplies provided for cosmetic, reconstructive, or plastic surgery, except as provided for in this Benefits Booklet.
17. Any services or supplies provided for the correction of vision deficiencies, including, but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, eye refraction, photo reflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in benefits for *eyeglasses and vision services*.

18. Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.
19. Applied behavior analysis.
20. Any services or supplies provided for any medical social services (except as provided as an *extended care expense*), bereavement counseling (except as provided under hospice care), and vocational counseling.
21. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
22. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a physician or other professional provider.
23. Any services or supplies provided primarily for *environmental sensitivity*, *clinical ecology* or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or inpatient allergy testing or treatment.
24. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
25. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions (except as explained in this Benefits Booklet);
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
26. Abortion, unless the *participant's* life would be endangered by continuing the pregnancy, there is a diagnosed fetal anomaly, or the pregnancy is caused by a criminal act such as rape or incest.
27. Any services or supplies in connection with:
 - Routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease, or
 - Foot care for flat feet, fallen arches, and chronic foot strain.
28. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
29. Any services or supplies provided for the following treatment modalities:
 - Acupuncture;
 - Intersegmental traction;
 - Surface EMGs;
 - Spinal manipulation under anesthesia; and
 - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
30. Benefits for any covered services or supplies furnished by a contracting facility for which such facility has not been specifically approved to furnish under a written contract or agreement with Blue Cross and Blue Shield of Texas will be paid at the non-network benefit level.
31. Any services or supplies furnished by a non-contracting facility (except that for accidents, the immediate, initial treatment necessary to stabilize the *participant* furnished by any *hospital*, including a governmental facility) shall be subject to benefits as provided in this booklet.
32. Any services or supplies provided for reduction mammoplasty, except when medically necessary.
33. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages available for purchase over-the-counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. **Note:** This exclusion does not apply to podiatric appliances when provided as diabetic equipment.
34. Any benefits in excess of specified benefits maximums.
35. Any services and supplies provided to a *participant* incurred outside the United States if the *participant* traveled to the location for the purposes of receiving medical services, supplies, or drugs.
36. Replacement prosthetic appliances except those necessitated by growth due to maturity of the *participant*.
37. Inpatient private duty nursing services.
38. Outpatient drugs except as provided under the *plan* by the prescription drug program.
39. Outpatient contraceptive services, drugs and devices, except for contraceptive prescription drugs provided under the Prescription Drug Program portion of this *plan*.

40. Any drugs and medicines purchased for use outside a *hospital* which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a physician or other professional provider.
41. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except: when medically necessary for the treatment of morbid obesity; or, when provided under preventive care for healthy diet/intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
42. The use of the procedures, supplies, or medications for treatment of psychological/psychogenic male sexual or erectile dysfunction/impotence.
43. Over-the-counter contraceptives.
44. Non-covered Durable Medical Equipment includes, but is not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
45. Services or supplies used primarily for patient convenience.
46. Most supplies available for purchase over-the-counter without a doctor's prescription.
47. Any tobacco cessation prescription drug products including, but not limited to, nicotine gum and nicotine patches, except as may be provided under the prescription drug program.
48. Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient.
49. Investigational services and supplies and all related services and supplies, except for routine patient care costs associated with investigational cancer treatment if those services or supplies would otherwise be covered under UT SELECT if not provided in connection with an approved clinical trial program.
50. Long-term care service, respite care service (except as specifically mentioned under hospice care), and maintenance care.
51. Any services or supplies not specifically defined as eligible expenses in this *plan*.

UT SELECT Medical Plan Claims and Appeals

How to File a Medical Claim

You or your provider must submit and Blue Cross and Blue Shield of Texas (BCBSTX) must receive all claims for benefits under UT SELECT within 12 months of the date on which you received the services or supplies. Claims not submitted and received by BCBSTX within this 12-month period will not be considered for payment of benefits.

Who files claims?

When you receive treatment or care from a network provider (or non-network provider who is a ParPlan provider), you will not be required to file claims. The provider will submit the claims directly to BCBSTX for you.

You may be required to file your own claims when you receive treatment or care from a non-network provider who is not a ParPlan provider. At the time services are provided, inquire whether the provider will file claims for you.

Benefit payments will be made directly to network or contracting providers when they bill BCBSTX. Written agreements between BCBSTX of Texas and other providers may require payment directly to them. However, if the benefit payments are for claims from providers with no written agreement with BCBSTX, BCBSTX may choose to pay either you or your provider. If you receive payment from BCBSTX, it will be your responsibility to settle your account with your provider.

If allowed by law, any benefits available to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

To file a medical claim, follow these steps:

1 Get a claim form	Claim forms are available from your institution Benefits Office, or you can download a claim form from the website by logging onto www.bcbstx.com/ut . Use a separate claim form for each individual; do not combine expenses for family members on one claim form.
2 Complete the claim form	Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim. <ul style="list-style-type: none">• Patient's name• Subscriber number, including the alpha prefix (<i>UTS or UZS</i>)• Correct address• Diagnosis (<i>preferably indicated by your provider on an itemized bill</i>)• Date of injury, illness, or pregnancy• Whether the patient has other group health insurance coverage
3 Attach an itemized bill	Attach an itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim: <ul style="list-style-type: none">• Name and address of the provider providing the services or supplies• Date of service• Type of service• Charges for each service• Patient's name• Diagnosis
4 Mail the claim form and itemized bills <i>Keep a copy of the claim form and itemized bills for your records.</i>	Send the claim form and itemized bills to: BCBSTX, P.O. Box 660044, Dallas, TX 75266-0044. (The address also appears on the form.) Do not send the claim form to UT System. This will only delay processing. Note: Foreign claims must be translated. If no translation is attached, processing may be delayed. <i>You must file and Blue Cross and Blue Shield of Texas must receive claims for expenses within 12 months after the date of service.</i>
5 Review your Explanation of Benefits (EOB) statement after the claim is processed	The EOB will confirm if the expense is covered by UT SELECT and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reasons why. Note: EOBs are available online through Blue Access for Members at www.bcbstx.com/ut , you must log in and elect to receive paper copies by mail.

To assist providers in filing your claims, you should always carry your UT SELECT ID card with you.

Receipt of Claims

A claim will not be considered received for processing until Blue Cross and Blue Shield of Texas actually receives the claim at the proper address and with all of the required information. If the claim is not complete, Blue Cross and Blue Shield of Texas will return it. On claims that need further information for proper processing, Blue Cross and Blue Shield of Texas may contact either you or the provider for the additional information. The claim will be processed when Blue Cross and Blue Shield of Texas receives all the requested information. After processing the claim, BCBSTX will notify the participant by way of an Explanation of Benefits summary.

Review of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion to interpret and determine benefits in accordance with UT SELECT plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and UT System.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your UT SELECT medical plan.

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by BCBSTX; then review this Benefits Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision as described in **Medical Claim Appeal Procedures**.

If the claim is denied in whole or in part, you will receive a notice from BCBSTX with the following information, if applicable:

- **The** reasons for the determination;
- **A** reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- **A** description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- **Subject** to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- **An** explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- **In** certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s);
- **In** certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
- **The** right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- **Any** internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- **An** explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- **In** the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care/expedited claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Medical Claim Appeal Procedures

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

1. **Urgent Care Clinical Claim** is any pre-service claim that requires preauthorization (see page 13) for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
2. **Pre-Service Claim** is a non-urgent request for approval that BCBSTX requires you to obtain before you get medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.
3. **Post-Service Claim** is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	24 hours
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	48 hours after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call BCBSTX at the toll-free number listed on the back of your UT SELECT ID card as soon as possible to appeal an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your claim is filed improperly, BCBSTX must notify you within:	5 days
If your claim is incomplete, BCBSTX must notify you within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is incomplete, within:	15 days*
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
If you require post-stabilization care after an emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

* This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is complete, within:	30 days*
After receiving the completed claim (if the initial claim is incomplete), within:	45 days

* This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, notice of the final determination will be provided no later than 24 hours after receipt of your claim for benefits.

Claim Appeal Procedures – Definitions

- Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces or terminates such treatment (other than by amendment or termination of the UT SELECT medical plan) before the end of the approved treatment period, that is also an adverse benefit determination. A rescission of coverage is also an adverse benefit determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.
- Final Internal Adverse Benefit Determination** means an adverse benefit determination that has been upheld by UT System at the completion of BCBSTX's and UT System's internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. You or your authorized representative may request an expedited clinical appeal either orally or in writing. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. BCBSTX shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization or any other determination made by BCBSTX regarding your UT SELECT benefits.

An appeal of an adverse benefit determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you, except to your authorized representative. To obtain an authorization form, you or your representative may call BCBSTX customer service at the number on the back of your UT SELECT ID card, or download the *HIPAA Authorization Form to Disclose PHI* from the www.bcbstx.com/ut website within the section for Forms and Resources.

If you believe all or part of your benefits were incorrectly denied, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedures:

Within 180 days after you receive notice of a denial or partial denial, you may call or write to BCBSTX to appeal.

- If you appeal in writing, send your written request to appeal along with any additional written comments, documents, records, and any other information you wish BCBSTX to consider as part of your appeal to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-0044

If you appeal by phone, you should specifically state that you wish to appeal a claim denial. BCBSTX will assign and provide you with an appeal reference number during the call. You should make a note of the reference number and use it each time you are calling or writing BCBSTX about your appeal. BCBSTX will also mail you an acknowledgement of your appeal within 10 days. An appeal by phone may also be supplemented by written comments, documents, records, and any other information you may wish to submit to support your appeal. If you appeal by phone, you will be responsible for mailing in any additional written comments, documents, records, and any other information you wish BCBSTX to consider as part of your appeal to the address provide above for written appeals.

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. The designation and the appeal along with any other documents should be mailed to the address above.
- In support of your appeal review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your appeal file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an adverse benefit determination. Once you have filed a timely appeal, you may also submit additional information at any time during the claim review process.
- BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a change to respond. The appeal determination will be made by a physician associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by BCBSTX or UT System.
- If you have any questions about the claims procedures or the review procedure, write to BCBSTX or call Customer Service **866-882-2034**.

Timing of Appeal Determinations

- BCBSTX shall render a determination of a non-urgent pre-service appeal as soon as practical, but in no event more than 15 days after the appeal has been received by BCBSTX.
- BCBSTX shall render a determination of a non-urgent post-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by BCBSTX.

Notice of First-Level Internal Appeal Determination

BCBSTX will notify the party filing the appeal, you, and if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination, followed by a written notice of the determination. The written notice will include:

- The reason for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of UT System's second level appeal process;
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Appeal of Second-Level Internal Appeal Determination

If BCBSTX's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you have the right to appeal to The University of Texas System. Your written request must be submitted within 60 days after the receipt of the notice of a denial from BCBSTX. Your appeal should include any written comments, documents, records, and any other information you may wish to submit to support your position. Submit your written appeal by U.S. Mail, fax or e-mail to:

Office of Employee Benefits
The University of Texas System
Attn: Appeals
702 Colorado Street, Suite 2.100
Austin, Texas 78701
Phone: (512) 499-4616
Fax: (512) 499-4620
[***benefits@utsystem.edu***](mailto:benefits@utsystem.edu)

- UT System shall render a determination of a non-urgent pre-service appeal as soon as practical, but in no event more than 15 days after the appeal has been received by UT System.
- UT System shall render a determination of a non-urgent post-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by UT System.

UT System will provide you; if another party filed the appeal, that party; and in case of a clinical appeal, any health care provider who recommended the services involved in the appeal, with a written notice of the determination. The written notice will include:

- The reason for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of BCBSTX external review process (and how to initiate an external review);
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If UT System's decision is to continue to deny or partially deny your claim, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call BCBSTX at **866-882-2034**. BCBSTX customer service is accessible from 8:00A.M. to 6:00 P.M., Monday through Friday.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

Standard External Review

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination of a clinical appeal by an independent review organization (IRO). To obtain an authorization form, you or your representative may call BCBSTX customer service at the number on the back of your UT SELECT ID card, or download the *HIPAA Authorization Form to Disclose PHI* from the www.bcbstx.com/ut website within the section for Forms and Resources.

1 Request for external review.

Within 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination from UT System, you or your authorized representative must file your request for standard external review.

2 Preliminary review.

Within 5 business days following the date of receipt of the external review request, BCBSTX must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse internal benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- You have exhausted BCBSTX's and UT System's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within 1 business day after BCBSTX completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSTX will outline the reasons it is ineligible in the notice.

3 Referral to Independent Review Organization.

When an eligible request for external review is completed within the time period allowed, BCBSTX will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, BCBSTX will take action against bias and ensure independence. Accordingly, BCBSTX must contract with at least 3 IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within 5 business days after the date of assignment of the IRO, BCBSTX must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by BCBSTX to timely provide the documents and information must not delay the conduct of the external review. If BCBSTX fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within 1 business day after making the decision, the IRO must notify BCBSTX and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to BCBSTX. Upon receipt of any such information, BCBSTX may reconsider the adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by BCBSTX must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSTX decides, upon completion of its reconsideration, to reverse the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within 1 business day after making such a decision, BCBSTX must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSTX.

- In reaching a decision, the assigned IRO will review the claim de novo (independently) and not be bound by any decisions or conclusions reached during BCBSTX's and UT System's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by BCBSTX, UT System, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence--based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by BCBSTX, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSTX and you or your authorized representative.
- The notice of final external review decision will contain:
- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either BCBSTX or you or your authorized representative;
- A statement that judicial review may be available to you or your authorized representative; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by BCBSTX, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4 Reversal of plan's decision.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, BCBSTX must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1 Request for expedited external review.

BCBSTX must allow you or your authorized representative to make a request for an expedited external review with BCBSTX at the time you receive:

- An adverse benefit determination or final internal adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2 Preliminary review.

Immediately upon receipt of the request for expedited external review, BCBSTX must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. BCBSTX must immediately send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.

3 Referral to independent review organization.

Upon a determination that a request is eligible for external review following the preliminary review, BCBSTX will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. BCBSTX must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSTX's internal claims and appeals process.

4 Notice of final external review decision.

BCBSTX's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSTX and you or your authorized representative.

Exhaustion

For standard internal review of a clinical appeal, you have the right to request external review once the internal review process has been completed and you have received the final internal adverse benefit determination from UT System. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSTX or UT System waives the internal review process or BCBSTX or UT System has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by BCBSTX or UT System to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under law.

Refund of Benefit Payments

If the *plan* pays benefits for eligible expenses incurred by you or your covered dependents and it is found that the payment was more than it should have been, or was made in error, the plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the plan may deduct any refund due it from any future benefit payment. The Office of Employee Benefits will pursue necessary steps to receive reimbursement for ineligible medical or prescription benefits paid on your behalf, including possible referral for collections.

Subrogation, Reimbursement and Third Party Recovery Provision

All Participants Deemed to Assign Subrogation Rights to UT SELECT Without Reservation

When this Provision Applies: If you, your spouse, a dependent child, or anyone who receives benefits under this health *plan* is entitled to receive money from any source, including but not limited to any party's liability or auto insurance and uninsured/ underinsured motorist proceeds, then the benefits provided or to be provided by UT SELECT (the *plan*) are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of UT SELECT.

As a condition of receiving benefits under UT SELECT, all *participants* agree that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. If the *participant* retains an attorney, then the *participant* agrees to only retain one who will not assert the Common Fund or Made Whole Doctrines. Reimbursement shall be immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The *participant* agrees to sign any documents requested by UT SELECT, including but not limited to reimbursement and/or subrogation agreements the *plan*'s Third Party Administrator or its agent(s) may request. Also, the *participant* agrees to furnish any information as requested by the plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the plan from exercising its rights to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the plan. Any excess after 100% reimbursement of the *plan* may be divided up between the employee or covered person and their attorney if applicable. The *participant* agrees to take no action that in any way prejudices the rights of the plan.

If it becomes necessary for the plan to enforce this provision by initiating any action against the *participant*, then the participant agrees to pay the plan's attorney's fees and costs associated with the action regardless of the action outcome.

The terms of this provision shall be interpreted to apply to the fullest extent permitted by applicable law. The *plan* has the sole authority to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary to comply with applicable law.

If the *participant* takes no action to recover any money from any source, the participant agrees to allow the *plan* to initiate its own direct action for reimbursement.

Note: A new Texas state law affecting *participant* subrogation rights will take effect in 2014. New information on how subrogation works under UT SELECT will replace this section before the new law takes effect.

Coordination of Benefits

UT SELECT includes a Coordination of Benefits (COB) provision that determines how benefits will be paid when you or your dependent is covered by more than one group health plan. When you have other group medical coverage (through your spouse's employer, for example), your UT SELECT benefits may be combined with others to pay covered charges. The COB provision eliminates duplicate payments for the same medical expenses.

If this COB provision applies, the order of benefit determination rules will determine whether the benefits of UT SELECT are applied before or after those of another *plan*. The benefits of UT SELECT shall not be reduced when UT SELECT determines its benefits before another plan; but may be reduced when another plan determines its benefits first.

Coordination of Benefit Definitions

Plan means any group insurance or group-type coverage, whether insured or uninsured. This includes:

- group or blanket insurance;
- franchise insurance that terminates upon cessation of employment;
- group hospital or medical service plans and other group prepayment coverage;
- any coverage under labor-management trusted arrangements, union welfare arrangements, or employer organization arrangements;
- governmental plans, or
- coverage required or provided by law.

Plan does not include any coverage held by the *participant* for hospitalization and/or medical-surgical expense which is written as a part of or in conjunction with any automobile casualty insurance policy; a policy of health insurance that is individually underwritten and individually issued; or school accident type coverage. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan means the order of benefit determination rules that state whether UT SELECT is a Primary Plan or Secondary Plan covering the *participant*. A Primary Plan is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A Secondary Plan is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the *participant*, UT SELECT may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans. **Note:** When there is a basis for a dental claim under UT SELECT and a dental plan offered by the UT System, UT SELECT is the Primary Plan.

Allowable Expense means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the *participant* for whom claim is made.

Claim Determination Period means a *plan year*. However, it does not include any part of a year during which a *participant* has no coverage under UT SELECT, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

General Information

When there is a basis for a claim under this *plan* and another plan, this plan is a Secondary Plan which has its benefits determined after those of the other plan, unless (a) the other plan has rules coordinating its benefits with those of this plan, and (b) both those rules and this plan's rules require that this plan's benefits be determined before those of the other plan.

Rules

This plan determines its order of benefits using the following rules, as applicable in the order as they appear below:

- Non-Dependent/Dependent** – The benefits of the plan, which covers the *participant* as an employee, member or *subscriber*, are determined before those of the plan which covers the *participant* as a dependent. However, if the *participant* is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (a) secondary to the plan covering the *participant* as a dependent and (b) primary to the plan covering the *participant* as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the *participant* as a dependent are determined before those of the plan covering that *participant* other than as a dependent.

b. *Dependent Child/Parents Not Separated or Divorced* – Except as stated in paragraph c below, when this *plan* and another plan cover the same child as a dependent of different parents:

1. The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
2. If both parents have the same birthday, the benefits of the plan, which covered one parent longer, are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. *Dependent Child/Parents Separated or Divorced* – If two or more plans cover a *participant* as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the plan of the parent with custody of the child
2. Then, the plan of the spouse of the parent with custody, if applicable
3. Finally, the plan of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph c does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has actual knowledge of the decree.

- ***Joint Custody*** – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is primarily responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.

- ***Active/Inactive Employee*** – The benefits of a Plan, which covers a *participant* as an employee who is neither laid off nor retired, are determined before those of a plan which covers that *participant* as a laid off or retired employee. The same would hold true if a *participant* is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph c does not apply.

- ***Continuation Coverage*** – If a *participant* whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:

1. The COBRA continuation coverage plan that covers member as a *subscriber*/policyholder is the Primary Plan.
2. Secondary liability is the plan that covers the UT SELECT *subscriber* as a dependent.

d. *Longer/Shorter Length of Coverage* – If none of the above rules determine the order of benefits, the benefits of the plan, which covered an employee, member or *subscriber* longer, are determined before those of the plan, which covered that *participant* for the shorter period of time.

Effect on the Benefits of this Plan

When This Section Applies

This section applies when this *plan* is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of this plan may be reduced under this section.

Reduction in This Plan's Benefits

The benefits of this *plan* will be reduced when the sum of:

- The benefits that would be payable for the allowable expense under this *plan* in the absence of this COB provision; and
- The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Blue Cross and Blue Shield of Texas assumes no obligation to discover the existence of another plan, or the benefits available under the other plan, if discovered. Blue Cross and Blue Shield of Texas has the right to decide what information is needed to apply these COB rules. Blue Cross and Blue Shield of Texas may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under this *plan* must give Blue Cross and Blue Shield of Texas any information concerning the existence of other plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this *plan*. If it does, Blue Cross and Blue Shield of Texas may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this plan. Blue Cross and Blue Shield of Texas will not have to pay that amount again.

Right to Recovery

If the payments the *plan* makes are more than should have been paid under this COB provision, Blue Cross and Blue Shield of Texas may recover the excess from one or more of:

- the persons paid or for whom payment has been made
- insurance companies
- *hospitals*, physicians, or other providers
- any other person or organization

UT SELECT and Medicare

Active Employees

In most cases, an active employee or spouse of an active employee enrolled in UT SELECT should enroll in Medicare Part A and decline Parts B and D at age 65. Once you retire, you should then enroll in Part B without penalty and continue to waive Part D. In most instances, if you are eligible for Medicare and are working in a benefits-eligible position for at least 20 hours per week, UT SELECT will be primary for you and your covered dependent, regardless of age, and Medicare will be secondary. Medicare may be primary for some Medicare-eligible active employees with certain medical conditions, such as End Stage Renal Disease. Consult with your local Social Security Administration office to learn what illnesses qualify for Medicare coverage prior to turning age 65.

Retired Employees

All retired *participants* in UT SELECT are required to enroll in Medicare Parts A and B when they become eligible, usually at age 65, or earlier if they are eligible due to a disability. Retired employees, or soon-to-be retired employees, or their dependents who are eligible for Medicare must have Medicare Parts A and B to receive the maximum benefits available from the UT SELECT plan. It is your responsibility to inform your institution Benefits Office when you and/or your covered dependents become Medicare-eligible.

If you are retired and also eligible for Medicare, Medicare becomes your primary payer and pays your medical claims first; UT SELECT pays second. If you choose a doctor who accepts Medicare assignment, you will not be responsible for any difference between the billed charge and the Medicare allowed amount.

If you decline Part B, you will have to pay a higher premium if you ever re-apply for Medicare coverage. As a retiree, if you or your Medicare-eligible dependent have declined Medicare Part B and fail to re-apply, you will be required to pay the portion that Medicare Part B would have paid as primary insurer for Part B-covered items for yourself and any Medicare-eligible dependents.

To ensure claims are correctly processed, you should contact Blue Cross and Blue Shield of Texas and report you or your dependent's Medicare Health Insurance Claim (HIC) number and the effective dates of Medicare Parts A and B immediately upon enrollment. It is important to inform your providers of all the insurance plans in which you are enrolled. Understanding correct coordination of benefits will help to ensure timely and accurate claims payments.

If you or your dependents are enrolled in Medicare and your provider accepts Medicare assignment:

- The provider may be in or out of the UT SELECT network;
- UT SELECT will pay 100% of benefits approved but not paid by Medicare (subject to UT SELECT plan limitations);
- There are no deductibles, copayments or coinsurance; and
- When you or your dependents are an inpatient at a facility that accepts Medicare assignment, UT SELECT will pay the Medicare inpatient deductible, and the \$100 per day Co-pay (\$500 maximum) will not apply.

If your provider does not accept Medicare assignment:

- Network and Out-of-Network benefits apply;
- UT SELECT will coordinate with Medicare; and
- Deductibles, copayments and coinsurance may apply.

The UT System assumes all retired individuals will enroll in Medicare Part B when eligible. If you and/or your dependents decline Part B, you will be required to pay the portion that Medicare would have paid for covered services under Part B. If you and/or your dependents are under age 65 and are eligible for Medicare benefits because of a disability, the same conditions apply as if you were age 65.

If you and/or your dependents do not enroll in Medicare Part B when eligible, Blue Cross and Blue Shield of Texas will assume that Medicare paid 80% of the Medicare allowed amount when processing your claim. Blue Cross and Blue Shield of Texas will calculate the benefits payable for the allowable expense under UT SELECT as if Blue Cross and Blue Shield of Texas were the primary payer. UT SELECT will pay up to this amount, but not more than the difference between the Medicare allowable and the Medicare paid amount. You may be responsible for *deductibles*, *copayments* or *coinsurance* amounts in some cases.

If you and/or your dependents are enrolled in Medicare Part B and go to a provider that accepts Medicare assignment and services are covered by Medicare, you will not be responsible for *deductibles*, *copayments* or *coinsurance* amounts. UT SELECT will reimburse up to 100% of the Medicare allowed amount for approved services.

Please review the Medicare Coordination of Benefits table on the next page.

UT SELECT
Medicare Coordination of Benefits
UT SELECT MEMBER 65+ w/Part A and Part B

Important: If you are retired and you or your dependents do not enroll in Medicare Part B when eligible, Blue Cross and Blue Shield of Texas will assume that Medicare paid 80% of the Medicare allowed amount when processing your claim. Blue Cross and Blue Shield of Texas will calculate the benefits payable for the allowable expense under UT SELECT as if Blue Cross and Blue Shield of Texas were the primary payer. UT SELECT will pay up to this amount, but not more than the difference between the Medicare allowable and the Medicare paid amount. You may be responsible for deductibles, copayments or coinsurance amounts in some cases.

Provider Accepts Medicare Assignment Y/N	BCBSTX In-Network Provider Y/N	Service Covered by Medicare Y/N	Medicare Pays	UT SELECT Pays ¹	Member Pays
Y	Y	Y	80% MC Allowed	20% MC Allowed	No Charge
Y	N	Y	80% MC Allowed	20% MC Allowed	No Charge
Y	Y	N	0	80% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	20% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or <i>Copay</i> , whichever is applicable
Y	N	N	0	60% of BCBS <i>Allowed</i> after \$750 UT SELECT <i>Deductible</i>	\$750 UT SELECT <i>Deductible</i> + 40% of BCBS <i>Allowed</i> + Difference between Billed Charge and BCBS <i>Allowed</i>
N	Y	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$350 <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	\$350 UT SELECT <i>Deductible</i> and 20% <i>coinsurance</i> or <i>Copay</i> , whichever is applicable
N	N	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$750 UT SELECT <i>Deductible</i>	\$750 UT SELECT <i>Deductible</i> and 40% <i>coinsurance</i>
N	Y	N	0	80% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	20% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or <i>Copay</i> , whichever is applicable
N	N	N	0	60% of BCBS <i>Allowed</i> after \$750 UT SELECT <i>Deductible</i>	\$750 <i>Deductible</i> + 40% of BCBS <i>Allowed</i> + Difference between Billed Charge and BCBS <i>Allowed</i>

¹ If a service is not covered by the UT SELECT plan, no payment will be made.

² Provider who does not participate with Medicare may not bill more than the Medicare Limiting Charge (115% of MC Allowed).

³ Allowed charges are the lesser of the Medicare Limiting Charge (115% of MC Allowed) or the Blue Cross and Blue Shield allowed amount. If the Blue Cross and Blue Shield allowed amount is less, the member may be billed the difference.

The UTSW Network Pilot Program and Medicare

Since UTSW accepts Medicare assignment and claims will continue to be processed with Medicare as primary and UT SELECT as secondary, the pilot program has minimal impact on our Medicare-eligible retired employees.

How Your UT SELECT Prescription Drug Program Works

Prescription Drug Benefits

Your prescription drug benefits under UT SELECT are administered by Express Scripts and require a \$100 annual deductible per plan participant, per plan year.

UT SELECT PRESCRIPTION DRUG BENEFITS			
Annual Deductible (does not apply to medical plan annual deductible)	\$100/person/year		
Access Options	Generic Drug Copayment	Preferred Drug Copayment	Non-Preferred Drug Copayment
Retail Network Pharmacy: <ul style="list-style-type: none"> Up to a 30-day supply Refills allowed as prescribed Good option for new prescriptions 	\$10	\$35	\$50
Home Delivery Pharmacy: <ul style="list-style-type: none"> Up to a 90-day supply Refills allowed as prescribed Best option for maintenance medication 	\$20	\$87.50	\$125

The prescription drug program offers three different benefit levels based on the drug category. Medications on the Express Scripts prescription drug management programs are subject to change. Please refer to the Express Scripts website (www.express-scripts.com/ut) or call Express Scripts Customer Service (1-800-818-0155) for current information on specific medications.

Generic Drugs are medications sold under a standard name that by law must have the same active ingredients and are subject to the same U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterpart. Generic drugs usually cost less than brand name drugs.

Preferred Drugs are a list of brand name medications preferred for their clinical effectiveness and opportunities to help contain participant and plan costs.

Non-Preferred Drugs are brand name medications that are not on the Preferred Drug list because there are effective and less expensive alternatives available. These medications require the highest copayments.

If you purchase a Brand Name Drug when there is a less expensive Generic alternative, you must pay the difference between the cost of the Brand Name drug and the Generic drug **plus the applicable Generic Copayment**. This difference does NOT count toward your \$100 annual deductible per person per plan year. Sometimes the cost difference is quite large. Below is an example of how this type of claim would process if you had already met your \$100 annual deductible:

Cost of Brand Name Drug	\$150
Less cost of Generic Equivalent	- \$55
Plus Cost of Generic Copayment	+ \$10
Your Payment	\$105

The UT SELECT Prescription Drug Plan allows you to utilize both the retail pharmacies and the mail order pharmacy. Most retail pharmacies participate in the nation-wide retail pharmacy network. If you fill a prescription at a non-network pharmacy, you will pay the full cost of your prescription and send a claim form and your receipt to Express Scripts. Your reimbursement will be based on your total cost, minus the UT System discount, the applicable annual deductible and copayment. You will be responsible for payment of any amount above the UT System contracted rate.

If your retail pharmacy offers a price that is less than your plan’s retail copayment, you will always pay the lesser amount. Certain retail pharmacies that participate in Express Scripts’ network offer a low, “usual and customary” price for some medications. You will pay either this price or your plan’s retail copayment, whichever is less.

You should still use your Express Scripts prescription drug ID card if you fill a prescription in a pharmacy that has a generic promotion program. If you’re purchasing a generic drug at retail pharmacy that has a generic promotion program, please present your prescription drug ID card to the pharmacist. Otherwise, we will not be able to check your prescription for potential interactions with your other medications. It also ensures that your payment will be applied to your plan’s deductible or out-of-pocket maximum (if applicable).

The best thing you can do is research your options. Prices vary by retail store. *My Rx Choices* can help you find out whether any of the medications that you’re taking are on a generic program list. If they *are* on the list, review your plan’s copayments and see whether you could save even more money.

My Rx Choices

An industry-leading prescription savings program, *My Rx Choices* is offered as an enhancement to your benefit plan allowing you to

- View a single presentation of medications with potential savings;
- Comparison-shop for available lower-cost alternatives;
- Use the “Continue” option to have Express Scripts contact physicians on members’ behalf to request approval for equivalent conversions received through mail; and
- Review options with your doctor and request prescriptions for lower-cost alternatives.

Accessed via the web (www.express-scripts.com/ut), via the new Express Scripts app or through the toll-free service line (1-800-818-0155), *My Rx Choices* features include

- Personal assessment of cost-saving opportunities;
- Best-value alternatives based upon greatest cost savings to you presented in order from highest value to you;
- The most accurate, actionable drug pricing information available in the industry today; and
- Brand-to-generic and retail-to-mail comparison options.

Manufacturers’ Coupons

Brand-name drugs often cost more than generic medications. And so the brand manufacturers often use coupons to sway you into getting the more expensive product. If you decide to get a brand because you have a coupon from the manufacturer, then yes, you’ll pay less for it, but the UT SELECT plan will continue to pay the same high share of the drug’s cost. That can quickly add up to thousands of dollars—possibly resulting in higher health care premiums or copayments in the future.

Certain retail pharmacies do accept manufacturers’ coupons. UT System does not encourage coupon use, however, because it could lead to higher costs for you later. Coupons are not accepted through the mail order benefit, although you may be able to send your coupon to the manufacturer for a rebate or partial rebate after the fact, if the manufacturer allows it. If you have such a coupon, please review the information on it or on the manufacturer’s website for instructions on requesting a rebate. These coupon offers are not available for patients enrolled in Medicare, Medicaid, or other federal programs, or where prohibited by law.

Ultimately, you and the UT SELECT medical plan save the most when you fill prescriptions with generic drugs whenever possible. If a generic isn’t available, consider using a brand-name drug that’s less expensive. Visit **My Rx Choices**[®] to find potential lower-cost alternatives under your plan, and ask your doctor which alternative would be right for you. For medications you need to treat an ongoing condition, such as high blood pressure or high cholesterol, you’ll typically pay even less by using your mail-order service, the **Medco Pharmacy**[®]. Please note – Medco is now a part of the Express Scripts family of pharmacies. All alternative options are available through **My Rx Choices**[®].

Prescription Limitations

Some drugs or therapeutic classes of drugs may have limits based upon accepted clinical guidelines, dosage limitations, recommended standards of care and/or shelf life stability limits.

Programs with limitations include:

- **Prior Authorization:** Prior Authorization is a process requiring physician review to obtain additional clinical information for select drugs to determine qualification of coverage under the UT SELECT Plan. To initiate a prior authorization, please contact Express Scripts. Your doctor can also contact Express Scripts directly through the Physician Prior Authorization process.
- **Preferred Drug Step Therapy program:** Coverage under the Step Therapy Program may require that you try a generic drug or lower-cost brand-name alternative drug before using higher cost non-preferred drugs.
- **Quantity Per Dispensing Event:** A medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

Consult the Express Scripts website (www.express-scripts.com/ut) or call Express Scripts Customer Service (1-800-818-0155) for the most up-to-date information on these managed drug classes.

If you submit a prescription for a drug that is subject to any of the above limitations, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Medco Pharmacy, your doctor will be contacted directly. When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. Express Scripts will notify you and your doctor in writing of the decision. If coverage is approved, the amount of time for which coverage is valid will be communicated to you. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal. For additional information on the appeals process, please see the claims and appeals information below.

Preventive Medications

The UT SELECT Prescription Drug plan covers the following medications at a \$0 copayment when they are used for prevention as noted. To receive these medications at a \$0 copayment, you must have an authorized prescription for the product and it must be dispensed by a participating mail or retail pharmacy.

- Aspirin – an Over-the-Counter (OTC) product for men ages 45 – 79 and women age 55 – 79 for cardiovascular protection
- Folic Acid – Over-the-Counter doses of 400 to 800 mcg/day for women who are pregnant or who are planning to become pregnant
- Vitamin D for men and women 65 years of age and older
- Fluoride – a prescription product for children to prevent dental cavities
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Any charge related to the administration of a vaccine in a doctor's office is covered under the UT SELECT medical plan. See the summary of the medical plan for more details.
- Prescription and OTC Bowel Prep medications for colonoscopy for men and women age 49-76
- Iron Supplements – an OTC product to treat/prevent anemia
- Tobacco Cessation Products
 - Nicotrol NS
 - Nicotrol Inhaler
 - Zyban
 - Chantix
 - Nicorette Gum/Lozenge
 - Nicotine Transdermal System
- Female contraceptives for women up to age 50
 - Prescription FDA-approved contraceptive agents (includes prescription IUDs—Mirena, Depo-Provera, patches, and oral agents)
 - Emergency contraceptives (Plan B and Ella)
 - OTC contraceptive devices and medications

For more specific information regarding coverage options and limitations, please contact Express Scripts customer service.

Personalized Medicine Program

Your prescription drug coverage includes the Personalized Medicine Program, which is a program that incorporates genetic testing to optimize prescription drug therapies for certain conditions. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available and are included in the program. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at www.express-scripts.com/ut or by calling a Express Scripts customer service representative at **1-800-818-0155**.

If you are a qualified participant, additional services are available to you through the Personalized Medicine Program at no additional cost.

Process description: Upon receipt of a prescription that has an associated genetic test, Express Scripts will contact your physician to request a prescription for that test. If your physician prescribes the test, the clinical laboratory will facilitate sending you the test. You mail back the test to the laboratory for processing. The laboratory shares the results of the test with your physician and Express Scripts. The results of the genetic test are for informational purposes only; any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and if you decide to participate, Express Scripts will facilitate your coverage under the Program.

Specialty Pharmacy (Accredo)

Express Scripts provides specialty pharmacy services for patients with certain complex and chronic conditions through its wholly owned subsidiary, Accredo Health Group, Inc. (Accredo), with locations throughout the United States. Accredo offers comprehensive therapy management solutions, including:

- Reimbursement services to review the patient's coverage and coordinate payment from the health plan and/or patient, as appropriate
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment
- Compliance programs to promote patient persistency and help the patient improve his/her quality of life
- Toll-free access to National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of your medications at no additional charge
- Registered nurses available for in-home medication administration, when clinically appropriate and as your plan allows
- Necessary supplies, such as needles and syringes, provided with your medications
- Refill reminder calls

Accredo focuses on infused, injectable, and oral drugs that are very expensive and often have restrictions as determined by the FDA. These specialty drugs may be difficult to self-administer, have a potential for adverse reactions, and require temperature control or other specialized handling.

Specialty Drugs

Specialty drugs are medications that are typically high in cost and have one or more of the following characteristics:

- Complex therapy for complex disease
- Specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage
- Potential for significant waste due to the high cost of the drug

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

You can obtain drugs designated by Express Scripts as specialty drugs using either your retail or mail order benefit. You will be responsible for paying the corresponding mail order or retail pharmacy copayment. If you choose to receive specialty drugs from a mail order pharmacy, you must use Accredo as your pharmacy. The exception to this would be for certain products that are available through only one or two U.S. pharmacies. For those products, you will be directed to a pharmacy that can fill your prescription.

Worry-free Fills

Express Scripts has created the Worry-free Fills™ (WFF) program, so your prescriptions can be refilled automatically. If you elect to utilize WFF for your eligible prescriptions, there's no need to call or order your refills. As you near the end of your current supply, Express Scripts will automatically send your next refill using your existing address and payment information. To enroll in WFF, visit [Express Scripts.com/ut](https://www.express-scripts.com/ut), or call Member Services at (800) 818-0155.

Note: For safety and other reasons, prescriptions for some medications are not eligible to be automatically filled. These prescriptions include specialty medications, controlled substances, and over-the-counter medications. When a prescription expires, you will need to get a new one and re-enroll that prescription in Worry-free Fills; the new prescription or a renewal of the earlier prescription will not be enrolled automatically.

Gaps in Care Alerts

Gaps in care, such as poor patient adherence with essential medication instruction have been associated with poorer clinical outcomes and higher total costs. Express Scripts now offers a new online safety feature that could help protect you and your family from gaps in care. It's already available at no cost to you as part of your UT SELECT plan.

It's easy to use and works whether you get your medications at a retail pharmacy or by mail from the Express Scripts Pharmacy®. If you wish to access the Gaps in Care feature, register at www.express-scripts.com/ut.

After your one-time registration, any alerts will automatically be waiting for you whenever you log in to [Express Scripts.com/ut](https://www.express-scripts.com/ut). These personalized alerts identify potential risks and enable you to respond quickly, which could help **participants** avoid unnecessary hospitalization, and prevent health setbacks to your health, staying on track with taking your medications as prescribed.

Alerts are based on established medical and scientific guidelines designed to help promote better health.

This protection works for people who take medications regularly (typically 3 months or more) for an ongoing condition, such as high blood pressure, high cholesterol, or diabetes. People with one or more chronic conditions are more likely to require medical care and hospitalization if they do not take their medications as prescribed, so having this added protection could make a difference.

You can take advantage of this new online safety feature today by registering at [Express Scripts.com/ut](https://www.express-scripts.com/ut). You will need your prescription drug ID card and a recent prescription number. If you are already registered on [Express Scripts.com/ut](https://www.express-scripts.com/ut), your new online safety feature is already activated and your protection is working.

Prescription Drug Claims and Appeals

(For Medical Claims and Appeals Procedures, see page 36.)

Initial Review

Non-Urgent Claims (Pre-Service and Post-Service)

If you submit a prescription for a drug that is subject to any limitations such as prior authorization, preferred drug step therapy, or quantity limitations, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Medco Pharmacy, your doctor will be contacted directly. Express Scripts will need the following information:

- patient name
- benefit ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal

You will be notified of the decision no later than 15 days after receipt of a pre-service claim that is not an urgent care claim if Express Scripts has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If Express Scripts does not have the necessary information needed to complete the review, Express Scripts will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

Urgent Claims (Expedited Reviews)

In the case of an urgent care claim, the plan will notify you of its decision as soon as possible, but no later than 72 hours after receipt of the claim, unless there is insufficient information to decide the claim. If further information is needed, the plan will notify you within 24 hours of receipt of your claim that further information is needed and that you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of request. The plan will then notify you of its decision within 48 hours of receipt of the information. If the missing information is not received within the 48 hours for you to submit the missing information, the claim is deemed denied and you have the right to appeal the claim.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Appeal of Adverse Benefit Determination

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- benefit ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal

This information should be mailed to: **Express Scripts, Inc., PO Box 631850, Irving, TX 75063-0030 Attn: Appeals.** A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. Additional assistance and notices are available in Spanish, Tagalog, Chinese, and Navajo by calling 1-800-818-0155.

If you are not satisfied with the coverage decision made on appeal, you may request a second level appeal. All second level appeals must be made in writing and be received by Express Scripts within 90 days of the receipt of notice of the decision. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- your name
- benefit ID
- phone number
- the prescription drug for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal

This information should be mailed to **Express Scripts, Inc., PO Box 631850, Irving, TX 75063-0030 Attn: Appeals.** A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e. your “final adverse benefit determination”) you also have the right to submit your claim for review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call **800-753-2851** or send a written request to: **Express Scripts, Inc., PO Box 631850, Irving, TX 75063-0030, Attn: Appeals**. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Independent External Review

External Appeals Review

Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, Express Scripts must receive your external review request within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: **Express Scripts Attn: External Review Requests P.O. Box 631850 Irving TX 75063-0030. Phone: 800-753-2851 Fax: 888-235-8551**

Non-Urgent External Review

Once you have submitted your external review request, the Plan will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, your determination letter will contain contact information for applicable office of health insurance consumer assistance or ombudsman.

Urgent External Review

Once you have submitted your urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, your determination letter will contain contact information for applicable office of health insurance consumer assistance or ombudsman.

UT SELECT Plan Provisions

Eligibility for *UT SELECT* Coverage

Important: This is just a summary of eligibility information. Consult your institution Benefits Office and/or the Office of Employee Benefits Administrative Manual for complete eligibility policies.

The *eligibility date* is the date a person becomes eligible to be covered under UT SELECT. A person becomes eligible to be covered when he becomes an employee, retiree or a dependent and is in a class eligible to be covered under the *plan*.

Your *eligibility date* will be determined by the UT System in accordance with their established eligibility procedures. Please contact your institution Benefits Office for your *eligibility date*.

Employee Eligibility

If you are eligible to participate in the UT System uniform group insurance program under Chapter 1601 of the Texas Insurance Code, you are eligible for the benefits described in this Benefit Booklet.

For purposes of this plan, the term Eligible Employee will also include those individuals who are no longer an employee of The University of Texas System, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may apply for coverage for yourself (or for yourself and your dependents) on or before your *eligibility date*, within 31 days of your *eligibility date* or during the annual enrollment period.

Retired Employee Eligibility

You are eligible to receive the benefits described in this Benefit Booklet if you are a former UT employee who meets all eligibility as determined by UT and has retired under the:

- Teacher Retirement System of Texas;
- Employees Retirement System of Texas; or
- Optional Retirement Program.

Dependent Eligibility

If you are eligible for coverage, you may include your dependents. If both you and your spouse are UT employees, then your children may be covered as dependents of either parent, but not both. In addition, a spouse that is a UT Employee may be covered as a dependent only if the spouse's medical coverage as an employee is waived.

The *plan* defines a dependent as:

- Your spouse, as defined by Texas Family Code;
- Your children, including stepchildren and adopted children, who are under age 26 regardless of marital status for the UT SELECT Medical plan,
- Your unmarried grandchild(ren) under age 25, provided the child meets the requirements which includes proof that you claim the child as your dependent for federal tax purposes;
- Certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and
- Children for whom you are named a legal guardian by a court or who are the subject of a medical support order requiring such coverage.

Surviving Dependent Benefits

Certain individuals who qualify as surviving spouse or other benefits-eligible dependent of an employee or retired employee who meet certain service requirements are eligible for benefits as a surviving dependent if the dependent had been participating in UT SELECT at the time of the employee or retired employee's death. See policy on surviving spouses for more information.

Initial Period of Eligibility for Employees

You have 31 days from your initial period of eligibility to complete benefits enrollment. Employees moving from a non-benefits eligible status to a benefits-eligible status also have 31 days from their change of status (initial period of eligibility) to complete benefits enrollment. If elections are not made within the 31-day initial period of eligibility, you will be required to wait until the next Annual Enrollment or a qualified change of status event to make changes, including adding or dropping coverage.

Waiting Period

Newly hired employees and their dependents may be required to satisfy a state-mandated waiting period before enrollment in the UT SELECT Medical plan is allowed and state premium sharing is available. Consult with your institution Benefits Office for additional information regarding the waiting period.

Changes in Your Status

You have *31 days* from the date of a qualifying change of status event to notify your institution Benefits Office and change your benefit selections. If you do not make your changes during the *31-day* status change period, your changes cannot be made until the next Annual Enrollment in July, to be effective the following September 1.

Examples of qualified change of status events include:

- Marriage, divorce, annulment, legal separation or spouse's death
- Birth, adoption, medical child support order, or dependent's death
- Significant change in residence if the change affects you or your dependents' current plan eligibility
- Starting or ending employment, starting or returning from unpaid leave of absence, or a change of job status (e.g. from part-time to full-time)
- Change in dependent eligibility
- Significant change in coverage or cost of other benefit plans available to you and your family.

Your benefit selection changes must be consistent with your change in status.

An employee or retired employee...

- Whose dependent loses insurance coverage under the Medicaid or CHIP program as a result of loss of eligibility of either the employee or the dependent; or
- Whose dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll this dependent in UT SELECT, as long as the dependent meets all other UT eligibility requirements and is enrolled within 60 days from the date of the applicable event. If enrollment of the dependent is conditioned on enrollment of the employee, the employee will also be eligible to enroll.

For questions regarding status changes, please contact your institution Benefits Office.

Address Changes

It is your responsibility to keep UT SELECT aware of any address changes for yourself and your covered dependents. Please notify your institution Benefits Office promptly of all address changes for yourself and your dependents. An address change may result in benefit changes for you and your dependents if you move out of your ***plan service area***.

Address changes must be submitted through your institution Benefits Office.

Termination of Coverage

Coverage under UT SELECT for you and/or your dependents will automatically terminate when:

- Your portion of the group contribution is not received timely by the plan
- The last day of the month in which you lose eligibility to participate in the plan occurs
- The plan is amended to terminate the coverage of the class of employees to which you belong
- A dependent ceases to be a dependent as defined in the plan

We may refuse to renew the coverage of an eligible employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as disabled and dependent on the parent will not terminate upon reaching the limiting age shown in the *Benefits Summary* if the child continues to be both disabled and dependent upon the employee as determined by UT System as an incapacitated coverage dependent.

As a condition to the continued coverage of a child as a disabled dependent beyond the limiting age, the UT System may require periodic certification of the child's physical or mental condition but not more frequently than annually.

Termination of the Plan

The coverage of all *participants* will terminate if the *plan* is terminated in accordance with its terms.

Certificates of Creditable Coverage

Upon termination of your coverage under UT SELECT, your institution Benefits Office will provide Certificates of Creditable Coverage. (Blue Cross and Blue Shield of Texas will provide Certificates of Creditable Coverage for COBRA *participants* when their coverage terminates.)

This form provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a non-UT System group health plan that excludes coverage for certain medical conditions that you have before you enroll (preexisting conditions). You may use this form to provide documentation of your previous UT System coverage and thereby obtain credit toward any preexisting waiting period of the new plan. These certificates will be sent to your last known address. Each certificate will contain up to 24 months of history for you and all of your dependents, if any.

You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under UT SELECT.

Glossary of Terms

These definitions apply to all UT SELECT benefits unless specifically limited.

Allowable Amount: The allowable amount is the maximum amount that will be paid by UT SELECT for a medical service or supply. The allowable amount is determined by Blue Cross and Blue Shield of Texas and is based on either charges made for the same service by providers in the same geographic area with similar training, experience and facilities, or negotiated rates with providers who have contracted with Blue Cross and Blue Shield of Texas. See page 11 for additional information.

Clinical Ecology: The inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or

Sublingual provocative testing (droplets of allergenic extracts are placed in mouth). **UT SELECT does not provide coverage for clinical ecology; the definition is included for clarification purposes only.**

Coinsurance: A participant's share of covered services and supplies, not counting the deductible or copays. It is usually a percentage of the allowable amount. For example, if the coinsurance amount is "80/20" that means that UT SELECT pays 80% and you pay 20% of the allowable amount for the eligible charges.

Copayment (Copay): The set amount you pay for certain medical services and prescription drugs at the time of service. Copays do not apply to deductibles or out-of-pocket maximums. The \$30 amount a participant must pay for an FCP office visit when using network physicians is an example of a copay amount.

Creditable Coverage: Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid.

Crisis Stabilization Unit: An institution which is appropriately licensed and accredited as a crisis stabilization unit or facility for the provision of mental health care services to persons who are demonstrating an acute, demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care: Services and supplies, including room and board and other institutional services, provided primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. Custodial care is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a person walk, bathe, dress, eat, prepare special diets, and take medication. **UT SELECT does not provide coverage for custodial care; the definition is included for clarification purposes only.**

Deductible: The amount of out-of-pocket expense that must be paid for health care services by the covered individual before becoming payable by UT SELECT. The family deductible means three individuals in the family must each meet a plan year deductible under one UT SELECT subscriber identification number.

Dental Care Services: The professionally recognized dental services, supplies, or appliances which are provided to a participant by a physician or provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental care services include, but are not limited to, cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium process of the maxilla and the mandible. **UT SELECT does not provide coverage for dental services; the definition is included for clarification purposes only.**

Effective Date: The date the participant's coverage begins under UT SELECT or any portion for which the participant has enrolled.

Eligibility Date: The date the participant satisfies the definition of a(n) employee, retiree, or dependent and is in a class eligible for coverage under UT SELECT.

Emergency: An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

UT SELECT covers medical emergencies wherever they occur. In case of emergency, call 911 or go to the nearest emergency room.

Environmental Sensitivity: The inpatient or outpatient treatment of allergic symptoms by controlled environment; or sanitizing the surroundings, removal of toxic materials; or use of special non-organic, non-repetitive diet techniques. **UT SELECT does not provide coverage for environmental sensitivity; the definition is included for clarification purposes only.**

Evidence of Insurability: Such evidence of the condition of one's health including medical records and a physical examination, as may be required by Blue Cross and Blue Shield of Texas for changes in existing coverage or issuance of new coverage pursuant to the rules of the UT System Office of Employee Benefits.

Experimental/Investigational: The use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or facility in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of Blue Cross and Blue Shield of Texas shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is experimental/investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a physician or other professional provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, Blue Cross and Blue Shield of Texas still may determine such services or supplies to be experimental/investigational within this definition. Treatment provided as part of a clinical trial or a research study is experimental/investigational.

Extended Care Expense: Means the services and supplies provided by a skilled nursing facility, a home health agency or a hospice.

Facility Other Provider: Is licensed to provide services and supplies that are covered by UT SELECT and is approved by Blue Cross and Blue Shield of Texas, including:

- Birthing Center
- Chemical Dependency Treatment Center
- Crisis Stabilization Unit or Facility
- Durable Medical Equipment Provider
- Home Health Agency
- Home Infusion Therapy Provider
- Hospice
- Imaging Center
- Independent Laboratory
- Prosthetics/Orthotics Provider
- Psychiatric Day Treatment Facility
- Radiation Therapy Center
- Renal Dialysis Center
- Residential Treatment Center for Children and Adolescents
- Rural Health Clinic
- Skilled Nursing Facility
- Therapeutic Center

Health Care Practitioner: Means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

Hospital: A short-term acute care facility which:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from its patients
- Has organized departments of medicine and major surgery and maintains clinical records on all patients
- Provides 24-hour nursing services by or under the supervision of a registered nurse
- Has a hospital utilization review plan, and
- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

Hospital Admission: The period between entry into a hospital as a bed patient and the time of discharge. If a patient is admitted to and discharged from a hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time confined in the hospital, the admission shall be considered a hospital admission. *Bed patient* means confinement in a bed accommodation located in a portion of a hospital which is designed, staffed and operated to provide acute, short-term hospital care on a 24-hour basis; the term does not include confinement in a portion of the hospital designed, staffed and operated to provide long-term institutional care on a residential basis.

Marriage and Family Therapy: Includes professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Medicare Limiting Charge: This is the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Out-of-Pocket Maximum: Your share of eligible expenses incurred during a plan year excluding the copays (medical and prescription drug). After you reach the out-of-pocket maximum, UT SELECT pays 100% of the allowable amount for covered charges for the rest of the plan year. Copays do not apply to the out-of-pocket maximum. **Preauthorization penalties and billed charges exceeding the Blue Cross and Blue Shield of Texas allowable amount also do not apply to the out-of-pocket maximum.**

Participant: An employee, or retiree or a dependent whose coverage has become effective according to the requirements of UT SELECT.

Plan: UT SELECT

Plan Service Area: Means the geographical area designated by UT System that is used to determine eligibility for UT SELECT benefits.

Plan Year: The plan year for UT SELECT begins September 1 and ends August 31.

Psychiatric Day Treatment Facility: An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to participants for time periods not to exceed eight hours in any 24-hour period. Treatment must be in lieu of hospitalization and certified in writing by the attending physician.

Residential Treatment Center for Children and Adolescents: An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children and/or is approved by Blue Cross and Blue Shield of Texas as a residential treatment center for certain mental health care and serious mental illness services for emotionally disturbed children and adolescents.

Subscriber: Means an employee, retiree or other individual who is eligible to participate in UT SELECT and who is not eligible to participate based on his or her status as a dependent. A subscriber is also the primary policyholder.

Telemedicine: The use of interactive audio, video or other electronic media (excluding telephone or fax machines) to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Therapeutic Center: Means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is an ambulatory (day) surgery facility; a freestanding radiation therapy center; or a freestanding birthing center.

The University of Texas System (UT System): Means your employer and is also the plan sponsor.

Notices

UT SELECT Medical Plan Opt Out of Certain Provisions of the Public Health Services (PHS) Act

Group health plans sponsored by State governmental employers, such as UT System must generally comply with certain requirements in title XXVII of the federal Public Health Services Act. However, the Act also permits State governmental employers that sponsor “self-funded” health plans (rather than provide coverage through a health insurance policy) to elect to exempt the self-funded plan from such requirements. UT System has elected to exempt the UT SELECT Medical plan, which is self-funded, from the following requirements:

1. Protection against limiting stays in connection with the birth to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section. (Newborn and Mother’s Health Protection Act)
2. Certain requirements to provide benefits for reconstructive surgery following a mastectomy. (Women’s Health & Cancer Rights Act (WHCRA) of 1988)
3. Protection against having benefits for mental health and substance abuse disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
4. Continued coverage for up to one year for a dependent child who is covered under a plan solely based on student status, who takes a medically necessary leave of absence from a post-secondary educational institution. (Michelle’s Law)

The exemption from these federal requirements will be in effect for the 2012-2013 plan year. The election may be renewed for subsequent plan years.

However, UT System currently voluntarily provides coverage that substantially complies with the requirements of the Newborn and Mother’s Protection Act and the WHCRA. Information about coverage available to newborns and mothers after delivery and coverage for reconstructive surgery can be found in the UT SELECT Medical plan guide.

HIPAA Privacy Notice

Title II of HIPAA requires self-funded health plans to comply with certain regulations concerning the privacy and security of personally identifiable health information that the plan collects or maintains about its enrollees. A copy of the privacy notice and policies that apply to UT SELECT can be found on the [*HIPAA Policies and Forms*](#) page on the Office of Employee Benefits’ website, www.utsystem.edu/benefits. A paper copy of the privacy notice is provided to all new enrollees and is available to anyone upon request from OEB.

For more information, contact your institution Benefits Office.

Other Blue Cross and Blue Shield Plans' Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blue”) may have contracts similar to the contracts described above with certain providers (“Host Blue Providers”) in their service area.

When you receive health care services through BlueCard outside of Texas and from a provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

Often, this “negotiated price” will consist of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Continuation of Group Coverage

(You and your dependents should take the time to read this notice carefully)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by the 99th Congress provides that when participants (employees and dependents) lose their eligibility for group health coverage due to any of the events listed below, they may elect to continue group health coverage. The continued coverage can remain in effect for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility terminated.

Events qualifying for 18-month continuation are loss of eligibility as a result of:

1. Reduction of employee work hours, or
2. Employee retirement or termination (voluntary or involuntary), except for discharge for group misconduct. Note: The 18 continuation period months can be extended up to 29 months when any participant is determined by the Social Security Administration to be disabled at any time during the first 60 days following election of COBRA and able to supply documentation of proof prior to the end of their original 18 month eligibility period.

NOTE: If documented proof of the Social Security Administration disability entitlement is not provided during the initial 18-month eligibility period, the extension will not be permitted.

Events qualifying for 36-month continuation for dependents are loss of eligibility as a result of:

1. Death of the employee;
2. Divorce or legal separation from the employee;
3. Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without group health coverage);
or
4. Children who lose coverage due to eligibility provisions (for example: reaching age 26).

Who is eligible for the continuation option?

Participants (employees and dependents) who are covered by the group health Plan at the time of the qualifying event are qualified beneficiaries and are eligible to continue coverage. Each may make an independent election. A child born or adopted by the employee during COBRA continuation is eligible to be a qualified beneficiary upon timely application.

How do the participants apply?

1. If a qualifying event is either: (a) the divorce of an employee; or (b) a child becoming ineligible for coverage, the eligible participants notify the employer in writing. Then, the employer will give written notice to the participants of the continuation option. If the qualifying event is the employee's death, Medicare eligibility, or termination of employment (or reduction of hours), the employer will give written notice to the participants of the continuation option.
2. The eligible participants have 60 days to give written notice to the employer of their desire to continue coverage. The election must specify names of covered individuals and the reason for and date of the qualifying event.
3. If you elect continuation coverage, you do not have to send any payment with the Application Form. However, you must make your first payment for continuation coverage to the plan administrator not later than 45 days after the date of your election. (This is the date the Application is post-marked, if mailed.) Benefits cannot be accessed until the initial payment is received and processed. If you fail to make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plans. You are responsible for making sure that the amount of your first payment is correct. You may contact the appropriate plan administrator using the contact information on the application form to confirm the correct amount of your first payment.
4. After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each level of coverage is shown separately in this notice. If you make a periodic payment by the due date, coverage under the Plans will continue for each coverage period without any break. If payment is not received by the due date, coverage will be temporarily suspended until premium is paid. If payment is received prior to the end of the grace period, coverage will be reinstated once payment has been processed. The Plans will notify you of payments due for each coverage period.
5. Although periodic payments are due on particular dates as billed, you are entitled to a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, until payment for the period is received and processed by the plan administrator, coverage may be temporarily suspended and benefits may not be accessible during a particular period.

6. If you fail to make the full periodic payment before the end of the grace period for a particular coverage period, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to the appropriate plan administrator as noted on the application form.
7. A participant's coverage shall terminate upon the occurrence of any of the following:
 - a. The maximum time period expires;
 - b. A continued participant obtains coverage after the date of election under any other group health Plan (as an employee or otherwise) which does not contain an applicable exclusion for any Preexisting Condition of the participant;
 - c. A continued participant becomes covered by any Medicare benefits after the date of election;
 - d. The employer no longer provides group health coverage for employees; or
 - e. The required payment to continue coverage is not made on a timely basis.

A continued participant's coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued participant could be terminated.

Benefits for a continued participant will be the same as those for active employees. Rates will be based upon the rates for active employees. If the employer changes benefits or rates, the continued participants will receive the new benefits and/or a new rate.

A service fee of 2% of the premium for active participants is added to the Basic premium and is payable by the continued participant. An extra premium of 50% may be added to the basic premium for participants who extend coverage from 18 to 29 months, due to a disability. You are responsible for the full premium payment.

Contact your institution Benefits Office if you have any questions about COBRA.

If continuation of coverage is not elected, your group coverage will end the last day of the month in which you were eligible and enrolled.

Notice Regarding Network Facilities and Non-Network Providers

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan.

Claims Address

Blue Cross and Blue Shield of Texas

P.O. Box 660044

Dallas, TX 75266-0044

Customer Service

866-882-2034

8 a.m. to 6 p.m. (CT)

Monday–Friday

Online Provider Directory and Website

bcbstx.com/ut