


Office of Employee Benefits Administrative Manual 	DEPENDENT ELIGIBILITY AND ENROLLMENT	230
	INITIAL EFFECTIVE DATE: October 10, 2003	
	LATEST REVISION DATE: September 2021	
	PURPOSE: To provide guidance in determining the eligibility requirements and enrollment options of Dependents for the UT Uniform Group Insurance Program	
	SCOPE: Spouse and Dependent Children of active Employees and Retired Employees of The University of Texas System institutions	
STATUTORY AND ADMINISTRATIVE REFERENCES: Texas Insurance Code, Chapter 1601 Texas Family Code, Title 1, Chapter 2 Texas Government Code, Chapter 667		

1.0 BACKGROUND

Eligible Dependents of Employees and Retired Employees of The University of Texas (UT) System may participate in the UT Uniform Group Insurance Program (Program). The Act is codified in the Texas Insurance Code, Chapter 1601.

This Policy describes eligibility requirements, Program coverage options and documentation requirements for Dependents. The Policy is intended to ensure compliance with *Texas Insurance Code Chapter 1601* and Internal Revenue Service requirements for Changes in Family Status, and to provide consistency amongst the benefits eligible Employees, Retired Employees and their Dependents. For more information about Program options for Dependents, see Policy 210 (Employees) and Policy 220 (Retired Employees).

2.0 ELIGIBILITY FOR UT GROUP INSURANCE

A Dependent of an Employee or Retired Employee of a System institution is eligible to be enrolled in Program coverage as follows:

2.1 Spouse

An individual to whom an Employee or Retiree is lawfully married under applicable law.

Important: Texas law does not recognize a domestic partner of the same or opposite sex as a Spouse. For purposes of UT Group Insurance eligibility, an informal marriage (often referred to as “common law” marriage) must be certified by a county clerk or by another appropriate governmental entity (if originating outside of Texas).

2.2 Children

The following individuals are eligible as Dependent children of a Subscriber:

- (1) a child under age 26 including the biological, adopted or stepchild of a Subscriber;
- (2) a foster child in a parent-child relationship with the Subscriber;
- (3) a grandchild under age 26, if the child qualifies and is claimed as the Subscriber's Dependent for federal tax purposes;
- (4) a child over age 26, who is determined by OEB to be medically incapacitated and is unable to provide their own support;
- (5) a child for whom the Subscriber is named a legal guardian by a United States court;
- (6) a child for whom a Subscriber is required to provide health insurance through a Medical Support Order or other valid court order; or
- (7) a child for whom a Subscriber has been named as the custodial parent in a valid gestational agreement.

3.0 DOCUMENTATION

3.1 Documentation Required to Verify Dependent Eligibility

3.1.1 The institution Benefits Office must review, approve and maintain copies of adequate documentation to verify the eligibility of all newly covered Dependents, whether added at the time of initial enrollment of a newly hired Employee or newly Retired Employee, following a qualified Change of Status event during the plan year, or during an Annual Enrollment period. *Exception:* If the document is available in OEB's **My UT Benefits** online system, the institution is not required to maintain a paper copy in their files.

3.1.2 Examples of adequate documentation include but are not limited to: government issued birth certificate, marriage certificate, court order, paternity test (with accompanying legal documentation such as revised birth certificate, court order or medical support order), or adoption papers. To correctly determine if a legal obligation is established under court orders, divorce or legal separation decrees, and other filed court documentation, institution Benefit Offices may require a complete copy of the order. The court order must establish who the actual parties are named in the order and the terms that are relevant to benefits eligibility or ineligibility. The institution Benefits Office may seek clarification from OEB to ensure that a request for enrollment of an individual as a Dependent is supported by adequate documentation. If an institution Benefits Office requires clarification from OEB of a court order, the entire order must be provided.

3.1.3 The Subscriber must notify their institution Benefits Office within 31 days of the event that qualifies the Subscriber to add their eligible Dependent(s) to their UT group insurance coverage. The required document(s) to prove eligibility for the Dependent(s) must be received by the institution Benefits Office prior to enrolling the Dependent. The effective date may be the date of the qualifying event or the first of the following month. If there are extenuating circumstances

for late receipt of documentation beyond the initial 31 days, the institution HR Manager should approve (or deny) the exception request for late receipt of documentation.

3.1.4 The institution Benefits Office must maintain a copy of all documents. If a Subscriber shows the document but refuses to leave a copy, the HR Manager must note in the Subscriber's file that the institution has reviewed and approved the documentation, and the Subscriber elected not to leave a copy.

3.2 Documentation Chart

The Subscriber must provide the appropriate documentation (as listed in the [accompanying chart](#)) to the institution Benefits Office. In the event of extenuating circumstances that prevent the listed documentation from being available, the institution Benefits Office may seek clarification from OEB to ensure the enrollment is supported by adequate documentation.

3.3 Dependency Certification of a Grandchild

To add a grandchild as a Dependent, the Subscriber must establish that the child is the Subscriber's Dependent for federal income tax purposes by providing a copy of the Subscriber's most recent income tax return or an official transcript from the Internal Revenue Service. The Subscriber does not need to submit copies of any accompanying schedules or forms.

If an income tax return listing the grandchild as a Dependent of the Subscriber has not been filed at the time of enrollment, another form of documentation (such as Power of Attorney, daycare receipts, financial aid, or medical bills) establishing financial dependency must be provided and the institution Benefits Office must have the Subscriber complete a Grandchild Certification Form and set an appropriate deadline for the Subscriber to submit the tax return. A Power of Attorney is not acceptable proof on a stand-alone basis; however, a Power of Attorney can be used as proof of support until the income tax return listing the grandchild is provided. If the deadline to submit the tax return is not met, the Dependent's coverage will be cancelled, effective the end of the current month. By signing the form, the Subscriber understands that they are subject to audit. Therefore, obtaining the tax return is still necessary, and the Subscriber has the responsibility to notify their institution Benefits Office if the grandchild no longer is their financial responsibility.

An institution may request grandchild dependency certification annually. An institution may also request grandchild dependency certification at any time throughout the year if the institution believes the support relationship between the grandparent and grandchild no longer exists. Only OEB can approve the use of alternate documentation to support enrollment of a grandchild. The institution may require additional documentation to support their specific institutional requirements.

3.4 Coverage for an Incapacitated Over Age Dependent

3.4.1 Definitions for Purposes of the Policy

- (a) “Incapacitated” means any such child, regardless of age, who lives with or whose care is provided by an Employee or Retired Employee on a regular basis if such child is mentally or physically incapacitated to such an extent as to be dependent upon the Employee or Retired Employee for care or financial support, as determined by the Program.
- (b) “Mentally or physically incapacitated” means any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment, provided that the condition commences prior to such child reaching age 26. An individual who is enrolled in a vocational training program or an institution of higher education in an undergraduate or graduate degree program is presumed to be capable of earning his/her own living. This presumption may be rebutted by objective medical and other documentation that establishes that the individual is not capable of employment.

3.4.2 Enrollment Eligibility

An incapacitated child may be eligible to be enrolled if the Dependent is:

- (a) Covered by the Program as a Dependent of the Subscriber on the Dependent’s 26th birthday; OR
- (b) If the Subscriber is newly benefits-eligible and the Dependent was covered by the Subscriber’s previous health plan or a public insurance or medical assistance program with no break in coverage on the date of the Subscriber’s UT benefits eligible employment.

The Subscriber must submit satisfactory proof of the incapacitating condition and financial dependency within 31 days of the Dependent’s initial eligibility for enrollment as an Incapacitated Over Age Dependent based on (a) or (b) above.

Once approved, periodic recertification of eligibility may be required. Continuing eligibility will be determined based on current medical documentation at the time of recertification. To retain eligibility as an Over Age Incapacitated Dependent, continuous enrollment in the program is required.

An Over Age Incapacitated Dependent who is dropped from all program coverage after their 26th birthday may qualify for continuation of coverage as a Subscriber through COBRA. Once all UT coverage is dropped, they will not be eligible to be re-enrolled in the program as a Dependent after a break in coverage.

3.4.3 Responsibility of Institution Benefits Office

The institution Benefits Office will review the documentation received from the Subscriber and approve or deny eligibility based on the documentation requirements indicated in policy.

The institution Benefits Office will review and sign the completed “Application for Coverage of Incapacitated Over Age Dependent” form (available to UT institution Benefits Staff Only at the online UT System SharePoint site) and verify that medical

records are attached before forwarding to OEB for consideration. A physician's letter of medical necessity does not constitute adequate medical records. The request for enrollment will not be reviewed if the application is incomplete.

3.5 Children Subject to a Medical Support Order (MSO)

A Subscriber who is the subject of a Medical Support Order (MSO) or other valid court order may add the child to Program coverage in compliance with applicable laws and regulations and UT eligibility and enrollment requirements, as applicable.

3.5.1 Definition of MSO

A medical support order (MSO) is defined by the Texas Department of Insurance at 28 TAC21.2001 as "a court or administrative judgment, decree or order whether temporary, final or subject to modification for the benefit of a child that provides for health coverage of the child."

3.5.2 Family Status Change

Receipt of a MSO is considered a qualified Change of Status event. Therefore, upon receipt of a MSO, regardless of the date on the MSO, a Subscriber may enroll the Dependent child named in the MSO to the Subscriber's Program health plan.

3.5.3 Evidence of Insurability (EOI) Not Required

EOI is not required for a Subscriber to enroll a Dependent in UT SELECT Medical coverage following receipt of the MSO, which is a qualified status change.

3.5.4 Required Documentation

If a Subscriber receives a valid court order to enroll a Dependent in their UT SELECT Medical coverage, a complete copy of the MSO is required to be provided to the institution Benefits Office. No other documentation, including the Birth Certificate of the Dependent, is required.

3.5.5 Effective Date of Coverage

For a child who is the subject of a Medical Support Order (MSO) issued by the Texas Office of Attorney General or a U.S. court, enrollment in Program health coverage shall be automatic beginning the date of the MSO or the date the court order is received by the employing UT System institution, whichever is later.

If the institution Benefits Office receives a court order that is not from the Attorney General or directly from a U.S. court, you should consult with OEB regarding eligibility and effective date of coverage prior to taking any action.

3.5.6 Subscriber Refuses to Complete Enrollment Form

If a Subscriber refuses to enroll the Dependent child named in the MSO, the employing institution shall notify the ordering authority by first class mail, with a copy to the Subscriber, that the child has been added to Program coverage and premiums will be deducted from an Employee's monthly pay. If the Subscriber is a Retired Employee, the premium would be added to their regular billing statement or via electronic funds transfer (EFT).

3.6 Children Subject to a Court Order

If the Dependent relationship is created by a Court Order, the Subscriber must submit all portions of the order that relate to the eligibility and documentation requirements for adding the Dependent as described in this policy. An unsigned order will not be accepted as documentation to support the enrollment of a court ordered Dependent.

3.7 Children Eligible for CHIP

If the institution Benefits Office receives verification from a state agency that the Dependent(s) of a Subscriber is/are eligible for the Childrens Health Insurance Program (CHIP), the Subscriber may enroll the Dependent(s) in the UGIP. For more information, see Policy 310.

3.8 Dependents of International Employees

Other countries may have different laws and regulations for certifying marriage and birth. This sometimes makes it difficult for an Employee of international origin to provide the required documentation, as stated in this policy. In these extenuating circumstances, the institution HR Benefits Manager should determine the adequacy of the submitted documentation. In lieu of the documents listed in Section 3.2, preferred alternate documentation may include a passport, visa or other government issued document that establishes the relationship of the Subscriber and the Dependent.

3.9 Employee Transfers Between UT Institutions

If an Employee transfers from one UT institution to another UT institution, it is the responsibility of the gaining institution Benefits Office to ensure that all covered Dependents are eligible for the Uniform Group Insurance Program. Therefore, appropriate documentation, as defined in Section 3.0, should be requested from the transferring Employee. Upon receipt of written consent from the Employee, the gaining institution Benefits Office may contact the former institution Benefits Office to request copies of the appropriate documentation. *Exception:* If the document is available in the OEB's **My UT Benefits** online system, the institution is not required to maintain a paper copy in their files.

3.10 Newborn Dependent Resulting From Gestational Agreement

A validated gestational agreement may be used to establish that a newborn is an eligible Dependent of a Subscriber only if the following required steps are taken:

1. A legitimate governmental Court must validate the gestational agreement; however, this act itself does not convey or constitute proof of parentage for the Subscriber.
2. Once the child is born, the Subscriber must file a notice of birth with the Court not less than the 30th day after the occurrence of the date on which the assisted reproduction occurred that produced the pregnancy.
3. The Court will then issue an order declaring the Subscriber as the parent of the newborn child, ordering the gestational mother to deliver the child to the Subscriber, and ordering that the birth certificate be issued naming the Subscriber as the child's parent.
4. Once this order is issued and received by the institution Benefits Office, it must be forwarded to OEB who will refer to the System Office of General Counsel (OGC)

for review and approval (or denial). After OGC approves, the institution will be notified that the Subscriber can enroll the child for coverage, and coverage may be effective the date that the order reflects that the Subscriber has a legal right to custody of the child.

Important: The UT medical plan is not responsible for any pre-natal or delivery expenses incurred prior to the final Court Order issued under a gestational agreement.

3.11 Contact OEB for Assistance With Dependent Documentation

A UT Institution Benefits Office needing assistance in interpreting the validity or adequacy of documentation submitted in support of a Dependent enrollment may contact the Office of Employee Benefits.

Approval of a Dependent application that is not supported by valid documentation of a legal relationship will be considered void. A Subscriber may be responsible for repayment of all claims paid pursuant to the Dependent's enrollment which will subsequently be voided.

Important: OEB has the authority to audit any Subscriber's group insurance program records and/or to request an institution Benefits Office to provide a copy of the documentation received, as needed.

4.0 DEPENDENT BENEFITS

Important: Dependents of Employees and Retired Employees are not eligible for a specific coverage unless the Employee or Retired Employee is also enrolled in that coverage except in cases where this Policy clearly provides otherwise such as an Employee/Retired Employee on Active Military Service status or the coverage for other Surviving Dependent of a deceased Employee or Retired Employee. See Policy 320 (Active Military Duty) and Policy 270 (Evidence of Insurability) of this Administrative Manual for more information.

A Subscriber may be eligible for a portion of the premium for Dependent health coverage elected by an Employee or Retired Employee. The Subscriber is responsible for payment of any portion of the Dependent health premium not paid through Premium Sharing. An Employee eligible for the Insurance Premium Redirection Plan can pay premium owed for the following Dependent coverage on a pre-tax basis (see Policy 140 (Funding) and Policy 210 (Employee Eligibility and Enrollment) for more information about Premium Sharing and the Premium Redirection Plan):

- (a) Medical
- (b) Dental
- (c) Vision
- (d) Voluntary Accidental Death and Dismemberment

Benefits-eligible Dependents of Subscribers may be enrolled in Program benefits as described in this section:

4.1 Basic Coverage Package

Dependent coverage is not included in the Basic Coverage Package for an Employee or Retired Employee.

4.2 Health Coverage

A Dependent may be enrolled in the same health coverage in which the Subscriber is enrolled, without Evidence of Insurability (EOI). Other enrollment restrictions may apply following the Dependent's initial period of eligibility for enrollment (see Section 6.0 of this policy for more information).

4.3 Voluntary Group Term Life Coverage

If the Employee has Voluntary GTL coverage equal to at least one times the Employee's annual salary, the Dependent may be covered under Voluntary GTL. The Spouse of an Employee may be enrolled for Voluntary GTL coverage of \$10,000 without EOI. EOI is always required for spousal coverage of \$25,000 or \$50,000. Eligible Dependent children of an Employee may be enrolled for Voluntary GTL, limited to \$10,000 for each dependent child, without EOI. The Employee is responsible for full payment of premiums for Voluntary GTL coverage.

Voluntary GTL coverage is not available for the Dependent children of a Retired Employee. A Retired Employee may enroll their spouse in Voluntary Group Term Life (GTL) insurance coverage of \$3,000. No EOI is required if the Retired Employee elects the Spouse Voluntary GTL within the first 31 days of retirement and all of the following apply:

- There was Employee Voluntary GTL coverage in effect on the last day of coverage as an Active Employee; and
- There was Spouse Voluntary GTL coverage in effect on the last day of coverage as an Active Employee; and
- There is no break in coverage between the last day of Active Employment coverage and the first day of Retirement coverage.

4.4 Voluntary Accidental Death and Dismemberment Coverage

The Spouse of an Employee may be enrolled for Voluntary AD&D coverage of 50% of the Employee's level of coverage. Eligible Dependent child(ren) of an Employee may be enrolled for AD&D, limited to \$10,000 for each Dependent child. The Employee is responsible for full payment of premiums for Voluntary AD&D coverage.

Voluntary AD&D coverage is not available for the Spouse and Dependent child(ren) of a Retired Employee. The Subscriber is responsible for full payment of premiums for such coverage.

4.5 Dental and Vision Coverage

A Dependent may be enrolled in the same dental plan in which the Subscriber is also enrolled. The Subscriber is responsible for full payment of premiums for such coverage.

4.6 UT FLEX Participation

Dependents are not eligible to enroll in the pre-tax Insurance Premium Redirection Program, Health Care Reimbursement Account (HCRA) and/or Dependent Day Care Reimbursement Account (DCRA) offered under the UT FLEX program.

However, an Employee enrolled in the HCRA may file a claim for reimbursement of qualified health care expenses incurred by any person that the Employee reports as a Dependent for federal income tax purposes.

An Employee enrolled in the DCRA may file a claim for reimbursement of qualified dependent day care expenses for children under age 13 who are claimed as a Dependent for income tax purposes by the Employee.

4.7 Other Coverage Not Available

A Dependent is not eligible for:

- Basic Group Term Life (GTL) insurance coverage;
- Basic Accidental Death and Dismemberment (AD&D) coverage; or
- Short Term Disability (STD) or Long Term Disability (LTD) insurance coverage.

5.0 INITIAL PERIOD OF ELIGIBILITY

5.1 Dependents of Newly Benefits-Eligible Employees

A newly benefits-eligible Employee, including newly hired Employees, may enroll a Dependent in the coverages described in Section 3.0 of this policy during the Employee's initial 31 days of employment.

Regardless of whether an employing institution has a required waiting period for newly benefits-eligible Employees, the newly eligible Employee must make all Program coverage elections and add eligible Dependents within their first 31 days of employment.

***Important:* Monthly premiums are not pro-rated. A full month's premium will be due for the first month of coverage if the effective date of coverage for the Dependent begins on any day of the month.**

The effective date for the beginning of Dependent coverage is as follows:

5.1.1 No Waiting Period for Employee

If there is no required waiting period for the newly benefits-eligible Employee's Basic Coverage Package (health, Basic GTL and Basic AD&D coverage) and the Employee completes the enrollment form by no later than the last day of the month of hire, the Employee may add eligible Dependents to the Employee's health plan coverage effective either:

- (a) the first day of the Employee's active employment as a benefits-eligible Employee; or
- (b) the first of the month following the first day of such employment.

There is no required waiting period for optional coverages; however, the Employee's coverage must be in effect in order for the Dependent's coverage to be effective. The Employee may enroll eligible Dependents in coverage effective the date the Employee enrolls in the same coverage.

5.1.2 Waiting Period for Employee

If the Employee's employing institution has a required waiting period for newly hired Employees, the newly eligible Employee still must make all Program coverage elections within their first 31 days of employment. The effective date for the Basic Coverage Package will be the first of the month following the end of the waiting period. The Dependent's health coverage will become effective the same day as the Employee's coverage.

There is no waiting period for optional coverages; however, the Employee's coverage must be in effect in order for the Dependent's coverage to be effective. The Employee may enroll Dependents in the Employee's optional coverages when the Employee becomes eligible to enroll.

See Policy 141 of this Administrative Manual for more information on employing institutions with eligibility waiting periods.

5.1.2.1 Even if the employing institution has an eligibility waiting period, coverage elections for Dependents must be made within the 31 day period after the Employee's first day of Active Employment as a benefits-eligible Employee. Otherwise, the Dependent cannot be enrolled until the occurrence of a qualifying status change or the next Annual Enrollment period.

5.1.2.2 If an Employee waives or declines Program coverage during their initial period of eligibility, and subsequently enrolls at a later date following a qualified status change or during Annual Enrollment, the waiting period does not apply beyond what would have been the original effective date for the Basic Coverage package had the Employee not waived or declined the coverage.

5.2 Dependents of Newly Retired Employees

An individual who qualifies for participation in the Program as a Retired Employee must enroll all eligible Dependents within 31 days of the date of retirement.

An Eligible Dependent who is not enrolled during the Retired Employee's first 31 days of eligibility may not be enrolled until the next Annual Enrollment period or within 31 days of a qualifying status change.

5.2.1 No Break Between Employee and Retired Employee Coverage

There is no waiting period for coverage participation for the eligible Dependents of an Employee who retires and enrolls in Program coverage as a Retired Employee within 31 days from the date of termination of employment from a System institution without a break between coverage as an Employee and coverage as a Retired Employee. The newly Retired Employee may continue the coverage for any Dependents previously covered on the last date of coverage as an active Employee without being required to provide documentation of the dependent's eligibility.

A change from active employment to retirement is a qualified Change of Status event (see Policy 310 of this Administrative Manual). A newly Retired Employee is eligible to add (or remove) a Dependent as the result of the status change.

The coverage for a Dependent of a newly Retired Employee may take effect on either:

- (a) the date of retirement; or
- (b) the first of the month following the date of retirement.

Coverage effective dates for a newly Retired Employee and their eligible Dependents must be consistent for each coverage type (i.e. the initial effective date for medical coverage must be the same for all covered family members).

5.2.2 Break Between Employee and Retired Employee Coverage

An individual who enrolls in Program coverage as a Retired Employee within 31 days of the date the individual first becomes eligible for retirement may also enroll eligible Dependents with appropriate documentation of their eligibility.

If the Employee's application for benefits as a Retired Employee is more than 31 days after the initial date of eligibility for retirement, the Employee must wait until a subsequent qualified Change of Status event or Annual Enrollment to enroll a Dependent.

A Retired Employee's coverage must be in effect in order for the Dependent's coverage to be effective. If the Retired Employee has a required waiting period, the Dependent's coverage cannot become effective until the Retired Employee's coverage becomes effective. See Section 5.3 of Policy 220, Retired Employee Eligibility and Enrollment, for more information about the effective date of coverage for Retired Employees.

5.3 Newly Eligible Dependents

When a qualified Change of Status event occurs which results in a newly benefits-eligible Dependent (e.g., marriage, birth, adoption, entry of a medical support order), the Subscriber may add the new Dependent to specific Program coverages within 31 days of the event. See Section 3.0 of this policy for the eligible coverages. See Policy 310 of this Administrative Manual for more information about Change of Status events.

There is no required waiting period for individuals who are enrolled in coverage as the Dependent of Subscriber due to a qualifying Change of Status event. The effective date of the new Dependent coverage will be the date of the qualifying event unless the Subscriber requests in writing for the effective date to be the first of the month following the date of the qualifying event date.

5.3.1 Newborn

A newborn biological child or an eligible newborn grandchild of a Subscriber is automatically covered for benefits under the Subscriber's health insurance coverage for the first 31 days following the newborn's birth.

In order to enroll such a newborn in permanent coverage beyond the first 31 days of birth, the Employee or Retired Employee must submit a completed enrollment form to their institution Benefits Office within 31 days following the date of birth. The effective date may be either:

- (a) the date of birth; or

- (b) the first of the month following the date of birth.

Important: If a Subscriber fails to enroll a newborn in permanent coverage within the 31-day period, coverage for the newborn will lapse. Action must be taken within the following 31 days to add the child to coverage. If not enrolled during that second 31-day period, the newborn cannot be enrolled until the next annual enrollment period or upon the occurrence of a qualified change in status, even if the Subscriber already has enrolled other Dependent children in the Program.

6.0 CHANGE IN COVERAGE AFTER INITIAL PERIOD OF ELIGIBILITY

An Employee or Retired Employee who fails to enroll an eligible Dependent during the Employee's or Retired Employee's initial period of eligibility cannot enroll the Dependent in Program coverages until:

- (a) the next annual enrollment period; or
- (b) a qualifying status change occurs.

6.1 Annual Enrollment

An Employee or Retired Employee may enroll a Spouse and Dependent child(ren) in Program coverages during the Annual Enrollment period. The effective date of the coverage elected during Annual Enrollment is the first day of the Plan Year, September 1.

EOI is not required to enroll the Dependent in the UT SELECT Medical plan. However, EOI is always required to enroll a Spouse in Voluntary GTL coverage for the first time (\$25,000 or \$50,000 for the Employee's spouse and \$3,000 for the Retired Employee's spouse)

See Policy 270 of this Administrative Manual for more information about Evidence of Insurability.

6.2 Qualifying Change of Status Event

If a qualified Change of Status event occurs and the Dependent is newly eligible, the Employee or Retired Employee may enroll a Dependent in UT SELECT Medical coverage without EOI. If the Dependent is being enrolled for the first time (regardless of prior eligibility), EOI may be required for enrollment in the following coverages:

- (a) Voluntary GTL for an Employee's Spouse coverage of \$25,000 or \$50,000 (EOI is always required for these coverage amounts); and
- (b) Voluntary GTL for a Retired Employee's Spouse coverage of \$3,000 (EOI may be required. See Section 3.3 of this Policy for more information).

Following a qualified Change of Status event, an Employee/Retired Employee may choose for the effective date of Dependent coverage to be either:

- the date of the event; or
- the first of the month following the date of the event.

7.0 DUAL STATE PREMIUM SHARING AND DUPLICATE PROGRAM COVERAGE PROHIBITED

See Policy 140 (Funding for Group Insurance Coverage) for information on prohibitions for dual state Premium Sharing. See Policy 210 (Employee Eligibility and Enrollment) and Policy 220 (Retired Employee Eligibility and Enrollment) for information on restrictions for duplicate Program coverage.

8.0 TERMINATION OF DEPENDENT COVERAGE

A Dependent's coverage in the Program shall end when the Subscriber or the Dependent loses eligibility to participate in the Program. The following are examples of such events:

- (a) An Employee upon whom a Dependent's eligibility is conditioned terminates employment.
- (b) The required portion of the Dependent's premium is not paid.
- (c) The Employee or Retired Employee upon whom the Dependent's eligibility is conditioned dies, unless the Dependent qualifies for Surviving Dependent benefits. See Policy 240 of this Administrative Manual for more information.
- (d) Dissolution of the marriage between an Employee or Retired Employee and a Dependent Spouse.
- (e) A Dependent child reaches the age of 26 and is not certified as an Incapacitated Over Age Dependent.
- (f) A legal relationship upon which the Dependent's eligibility is conditioned expires or is rescinded.
- (g) Death of a Dependent.

The effective date of the termination of coverage is the end of the month in which the event occurred. For nonpayment of premiums, the effective date of termination of coverage is the end of the last month for which premium was paid. See Policy 140 of this manual for more information about termination due to nonpayment.

A Dependent who loses eligibility for a reason other than nonpayment of premium may be able to continue certain coverages in the Program as a COBRA participant (see Policy 250 of this Administrative Manual) or pursuant to other applicable OEB policies.

A Dependent who voluntarily terminates Voluntary GTL coverage is eligible to exercise any available conversion provisions. To exercise this provision, the Dependent must obtain the required form(s) from the institution Benefits Office and forward to the appropriate insurance Carrier within 31 days of the end of the month in which termination of coverage occurred. The Dependent should contact the Carrier for specific information regarding their conversion options.

9.0 DEPENDENT AUDIT PROCESS

On a periodic basis, the UT System Office of Employee Benefits (OEB) and UT System Internal Audit Office have the right to select an institution Benefits Office to audit their processes to ensure the institution has adequate procedures in place to effectively validate Dependent eligibility prior to enrollment in the UT Uniform Group Insurance Program.

Adequate Dependent documentation may include, but is not limited to, marriage certificates, birth certificates, court-ordered support and guardianship documents, and income tax returns.

At the conclusion of the audit, the Benefits Office will provide OEB a report of their processes and findings. During the audit process if the Benefits Office requests documentation from a Subscriber, failure of the Subscriber to provide valid proof of relationship may result in the termination of all Program insurance coverage for the Subscriber's Dependent(s) effective the end of the month of the request for documentation.

If the audit results indicate possible intentional misrepresentation of Dependent eligibility by a Subscriber, the Benefits Office shall report to OEB the results of their investigation and any action taken to terminate the ineligible Dependent's coverage and if any sanctions are imposed, as described in Section 10 of this policy.

Important: All UT institution Benefits Offices must provide all documentation for the Dependent of an Employee or Retired Employee requested by OEB to ensure that all participants in UGIP coverage meet the eligibility requirements, as set forth in Chapter 1601 of the Texas Insurance Code.

10.0 MISREPRESENTATION

Misrepresentation regarding meeting benefit eligibility requirements constitutes a violation of OEB's official policy. A verified misrepresentation by an Employee or Retired Employee shall be reported by OEB to the appropriate institution for investigation and possible sanctions. Possible sanctions for such a violation range from a reprimand to dismissal. In addition, reimbursement may be required for any benefits paid on behalf of an ineligible individual. Deliberate misrepresentation of Dependent eligibility by an Employee or Retired Employee may constitute criminal fraud and may result in a referral to a law enforcement office. Any ineligible Dependent may be terminated from plan participation upon discovery of ineligibility.