BlueCross BlueShield of Texas

UT SELECT

YOUR UT SELECT HEALTH BENEFITS

2024 - 2025

Effective September 1, 2024, through August 31, 2025

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This booklet is a guide to your UT SELECT Medical Plan (UT SELECT) benefits administered by Blue Cross and Blue Shield of Texas 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 a Health Advocate at **1-866-882-2034**, refer to the website (**bcbstx.com/ut**) or contact your institution benefits office.

Your prescription drug benefits under UT SELECT are administered by Express Scripts.

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.

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.

Identification Cards

The ID card issued to you by BCBSTX 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.

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

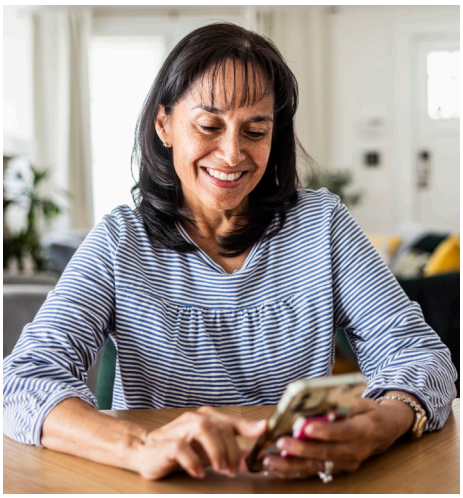
The unauthorized, fraudulent, improper or abusive use of ID cards by any **participant** can result in, but is not limited to, the following sanctions:

- 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

BCBSTX 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 a Health Advocate at **1-866-882-2034,** or log on to Blue Access for Members through **bcbstx.com/ut** to order medical ID cards online or print a temporary ID card
- **Non-Medicare Prescription Drug:** Call Express Scripts Customer Service at **1-800-818-0155** or print one through the Express Scripts website, **express-scripts.com**. A virtual card is also available through the Express Scripts app via your mobile phone.
- **Medicare Prescription Drug:** Call Express Scripts Medicare Part D Customer Service at **1-800-860-7849** or print one through the Express Scripts website, **express-scripts.com**. A virtual card is also available through the Express Scripts app (application) via your mobile phone.
- **UT CARE Medicare PPO:** Call Customer Service at **1-877-842-7562** (TTY 711) or log into Blue Access for Members through **bcbstx.com/retiree-medicare-ut**



Important Phone Numbers and Websites

Health Advocate
1-866-882-2034

UT SELECT and Online Provider Directory
bcbstx.com/ut

Express Scripts, Inc. Prescription Drug Program – Customer Service
1-800-818-0155
express-scripts.com

Express Scripts Medicare with UT CARE Medicare Part D for UT CARE members
1-800-860-7849

UT CARE Medicare PPO Customer Service
1-877-842-7562 (TTY 711) Help is available 24 hours per day, seven days per week.
bcbstx.com/retiree-medicare-ut

Websites

Office of Employee Benefits
utsystem.edu/offices/employee-benefits

Wellness Resources
utsystem.edu/offices/employee-benefits/living-well

Blue Access for Members Website Features

You can access helpful information and administrative forms through the UT SELECT website. Go to **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.

How to Find Blue Access for Members

Go to **bcbstx.com/ut**

Click on **Log In to Your Account**

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

Registered Blue Access for Members can:

- Check the status of a claim
- Confirm who is covered under your plan
- View and print detailed claim history and Explanation of Benefits (EOB). 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 a Health Advocate for assistance.
- Locate a physician or other provider in your network that meets your needs
- Shop and compare provider costs for common procedures and treatments
- Sign up to receive e-mail notifications of new claim activity
- Request a new or replacement ID card or print a temporary ID card

Express Scripts Website Features

- Check order status
- Refill and renew prescriptions
- Check prices and coverage
- Find convenient pharmacies, including an in-network 90-day maintenance location
- View your Rx claims and balances
- Pay your balance using a variety of payment options
- Transfer retail prescriptions to home delivery. Just click **Add to Cart** for eligible prescriptions and check out. Your provider will be contacted on your behalf and take care of the rest. Click on **Check Order Status** to track your order.
- Much more

Your UT SELECT Medical Benefits

In-Area Summary of Benefits

In-area network and non-network benefits apply to eligible members 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 BCBSTX. 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.

IN-AREA		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network[1]
Annual Deductible (applicable when coinsurance is required)	$600/person[2] $1,800/family	$1,800/person $5,400/family
Coinsurance Maximum	$3,500/person $10,500/family	Unlimited
Annual Out-of-Pocket Maximum[3]	$9,100/person $18,200/family (includes medical and prescription drug deductibles, copayments and coinsurance)	Unlimited
Pre-existing Condition Limitation	None	None
Lifetime Maximum Benefit	No limit	No limit
OFFICE SERVICES		
Virtual Visit with MDLIVE®	$0 copay	N/A
Preventive Care	100% plan (no copayment required)	
Diagnostic Office Visit – Office Setting Family Care Physician (FCP) Behavioral Health Practitioner Family Practice Internal Medicine OB/GYN Pediatrics	FCP $30 copay	60% plan/40% member
Specialist Office Visit	$50 copay	60% plan/40% member
Urgent Care	$50 copay	60% plan/40% member
Diagnostic Lab and X-Ray	Included in office visit copay	60% plan/40% member
Other Diagnostic Tests (Bone Scan, Cardiac Stress Test, CT Scan (with or without Contrast), MRI, Myelogram, PET Scan)	$150 copay	60% plan/40% member
Allergy Testing	FCP $30 copay; specialist $50 copay	60% plan/40% member
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	60% plan/40% member
EMERGENCY CARE		
Ambulance Service (if transported)	80% plan/20% member	80% plan/20% member
Hospital Emergency Room, Including Physician Services	$500 copay/visit If admitted, ER services are added to claims for inpatient services	$500 copay/visit If admitted, ER services are added to claims for inpatient services
OUTPATIENT CARE		
Observation	80% plan/20% member	60% plan/40% member
Surgery – Facility	$200 copay; then 80% plan/20% member	60% plan/40% member
Surgery – Physician	80% plan/20% member	60% plan/40% member
Diagnostic Lab and X-Ray	100% covered (except when billed with surgery; then 80% plan/20% member)	60% plan/40% member
Other Diagnostic Tests (Bone Scan, Cardiac Stress Test, CT Scan (with or without Contrast) MRI, Myelogram, PET Scan)	$150 copay	60% plan/40% member

IN-AREA (continued)		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network[1]
Outpatient Procedures	80% plan/20% member	60% plan/40% member
INPATIENT CARE		
Hospital – Semiprivate Room and Board[4]	$200 copay/day ($1,000 max/admission); then 80% plan/20% member	60% plan/40% member
Hospital Inpatient Surgery[4]	80% plan/20% member	60% plan/40% member
Physician	80% plan/20% member	60% plan/40% member
OBSTETRICAL CARE		
Prenatal and Postnatal Care Office Visits	FCP $30 copay; specialist $50 copay (initial visit only)	60% plan/40% member
Delivery – Facility/Inpatient Care[4]	$200 copay/day ($1,000 max/admission); then 80% plan/20% member	60% plan/40% member
Obstetrical Care and Delivery – Physician	80% plan/20% member	60% plan/40% member
THERAPY		
Physical Therapy/Chiropractic Care (max. 35 visits/year/condition)	$50 copay/visit	60% plan/40% member
Occupational Therapy (max. 35 visits/year/condition)	$50 copay/visit	60% plan/40% member
Speech and Hearing Therapy (max. 60 visits/year/condition)	$50 copay/visit	60% plan/40% member
EXTENDED CARE		
Skilled Nursing/Convalescent Facility[4] (max. 180 visits)	80% plan/20% member	60% plan/40% member
Home Health Care Services[4] (max.120 visits)	80% plan/20% member	60% plan/40% member
Hospice Care Services[4]	80% plan/20% member	60% plan/40% member
Home Infusion Therapy[4]	80% plan/20% member	60% plan/40% member
BEHAVIORAL HEALTH		
Applied Behavior Analysis[4]	FCP $30 copay, specialist $50 copay 80% plan/20% member outpatient or home health services	60% plan/40% member
Virtual Visit with MDLIVE[5]	$0 copay	N/A
Serious Mental Illness – Office Visit	FCP $30 copay; specialist $50 copay	60% plan/40% member
Serious Mental Illness – Outpatient[4]	80% plan/20% member	60% plan/40% member
Serious Mental Illness – Inpatient[4]	$200 copay/day ($1,000 max/admission) then 80% plan/20% member	60% plan/40% member
Mental Illness – Office	FCP $30 copay; specialist $50 copay	60% plan/40% member
Mental Illness – Outpatient[4]	80% plan/20% member	60% plan/40% member
Mental Illness – Inpatient[4]	$200 copay/day ($1,000 max/admission) then 80% plan/20% member	60% plan/40% member
Substance Use Disorder – Office	FCP $30 copay; specialist $50 copay	60% plan/40% member
Substance Use Disorder – Outpatient Treatment[4]	80% plan/20% member	60% plan/40% member
Substance Use Disorder - Inpatient Treatment[4]	$200 copay/day ($1,000 max/admission) then 80% Plan/20% Member	60% plan/40% member

IN-AREA (continued)		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network[1]
OTHER SERVICES		
Durable Medical Equipment[4]	80% plan/20% member	60% plan/40% member
Prosthetic Devices	80% plan/20% member	60% plan/40% member
Hearing Aids (adult) ($1,000 per ear; once every 3 years)	80% plan/20% member deductible does not apply	80% plan/20% member deductible does not apply
Hearing Aids (pediatric) (one per ear every 3 years)	80% plan/20% member deductible does not apply	80% plan/20% member deductible does not apply
Bariatric Surgery (pre-determination recommended)	After $3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum), plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount. Individual must have been continuously enrolled in the UT SELECT or UT CONNECT plan for 36 continuous months prior to date of the surgery to receive benefits.	
Fertility and Family Building Benefit	2 Smart Cycles covered per lifetime. The person(s) receiving fertility treatment must be a covered primary subscriber or spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Get started and activate your benefit by contacting Progyny at **1-844-535-0711**.	

1. For services provided out-of-network, any charges over the allowable amount are the patient's responsibility.
2. J Visa holders have a $500 individual deductible and a $1,500 family deductible.
3. Certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act and member cost share will not be applied toward satisfying the out-of-pocket maximum or prescription drug deductible.
4. These services require preauthorization to establish medical necessity.
5. MDLIVE charges a fee for missed, cancelled or rescheduled behavioral health appointments. A fee is only charged for cancelled and rescheduled behavioral health appointments with less than 24 hours' notice, or for missed behavioral health appointments. The fee is an out-of-pocket expense and is not covered by your plan.

The UT Health Network

The benefit tier known as the UT Health Network offers an enhanced plan design for UT SELECT Medical participants receiving services from certain UT physicians and certain UT medical facilities. You will pay lower copays and coinsurance when seeing a participating UT physician at a participating UT-owned facility and you can also save on physician charges when treatment is received from a participating UT physician at a non-UT-owned facility.

	UT HEALTH NETWORK BENEFIT	CURRENT UT SELECT NETWORK BENEFIT*
Primary Care	$20 copay	$30 copay
Specialist	$40 copay	$50 copay
Employee Clinic	$10 copay	$30 copay
Deductible	$600	$600
Coinsurance	10%	20%
Inpatient	Deductible plus 10% coinsurance	$200/day ($1,000 max) plus 20% coinsurance
Outpatient	Deductible plus 10% coinsurance	$200/day plus 20% coinsurance

*See the summary of benefits charts for out-of-network details.

Current points of service for the UT Health Network include:

- UT Medical Branch Galveston facilities and providers
- UT Rio Grande Valley facilities and providers
- UT Health Northeast (Tyler) facilities & providers
- UT Austin, UT Health Houston, and UT Health San Antonio Employee & Nursing Clinics and University Health System in San Antonio; and
- UT Dallas Callier Center for audiology and hearing aids

For additional information, including details about available employee and nursing clinics, please see the individual city links under "UT Health Network" in the navigation menu of the OEB website.

You can also log into Blue Access for Members to access the Provider Finder specific to UT SELECT Medical, where participating providers and facilities are clearly marked as part of the UT Health Network. You must be logged in to see the UT Health Network designation.

Out-of-Area Summary of Benefits

Out-of-area benefits apply to any members 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 of Texas. 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 BCBSTX 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[1]
Annual Deductible (applicable when coinsurance is required)	$600/person; $1,800/family
Coinsurance Maximum	$3,500/person; $10,500 family
Annual Out-of-Pocket Maximum[2]	$9,100/person; $18,200/family (includes medical and prescription drug deductibles, copayments and coinsurance)
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No limit
OFFICE SERVICES	
Virtual Visit with MDLIVE	$0 copay
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 (if no office visit billed)	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 (Bone Scan, Cardiac Stress Test, CT Scan (with or without Contrast) MRI, Myelogram, PET Scan)	75% plan/25% member
Outpatient Procedures	75% plan/25% member
INPATIENT CARE	
Hospital – Semiprivate Room and Board[3]	75% plan/25% member

COVERAGE	OUT-OF-AREA[1] (continued)
Hospital Inpatient Surgery[3]	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[3]	75% plan/25% member
Obstetrical Care and Delivery – Physician	75% plan/25% member
THERAPY	
Physical Therapy/Chiropractic Care (max. 35 visits/year/condition)	75% plan/25% member
Occupational Therapy (max. 35 visits/year/condition)	75% plan/25% member
Speech and Hearing Therapy (max. 60 visits/year/condition)	75% plan/25% member
EXTENDED CARE	
Skilled Nursing/Convalescent Facility[3] (max. 180 visits)	75% plan/25% member
Home Health Care Services[3] (max. 120 visits)	75% plan/25% member
Hospice Care Services[3]	75% plan/25% member
Home Infusion Therapy[3]	75% plan/25% member
BEHAVIORAL HEALTH	
Applied Behavioral Analysis[3]	75% plan/25% member
Virtual Visit with MDLIVE	$0 copay
Serious Mental Illness – Office Visit	75% plan/25% member
Serious Mental Illness – Outpatient[3]	75% plan/25% member
Serious Mental Illness – Inpatient[3]	75% plan/25% member
Mental Illness – Office	75% plan/25% member
Mental Illness – Outpatient[3]	75% plan/25% member
Mental Illness – Inpatient[3]	75% plan/25% member
Substance Use Disorder – Office	75% plan/25% member
Substance Use Disorder – Outpatient Treatment[3]	75% plan/25% member
Substance Use Disorder – Inpatient Treatment[3]	75% plan/25% member
OTHER SERVICES	
Durable Medical Equipment[3]	75% plan/25% member
Prosthetic Devices	75% plan/25% member
Hearing Aids (adult) ($1,000 per ear; once every 3 years)	75% plan/25% member
Hearing Aids (pediatric) One per ear, every 3 years	75% plan/25% member
Bariatric Surgery[1] (pre-determination recommended)	After $3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum), plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount. Individual must have been continuously enrolled in the UT SELECT or UT CONNECT plan for 36 continuous months prior to date of the surgery to receive benefits.
Fertility and Family Building Benefit	2 Smart Cycles covered per lifetime. The person(s) receiving fertility treatment must be a covered primary subscriber or spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Contact Progyny at **1-844-535-0711** to activate fertility benefits.

1. For services provided out-of-network and out-of-area, any charges over the allowable amount are the patient's responsibility.
2. Certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act and member cost share will not be applied toward satisfying the out-of-pocket maximum or prescription drug deductible.
3. 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	
	ParPlan Provider	Non-Network Provider (not a contracting provider)
• 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 allowable amount for covered services • Your provider will preauthorize necessary services	• 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 allowable amount for covered services • In most cases, ParPlan providers will preauthorize necessary services	• 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 allowable amount for covered services • You must preauthorize necessary services

Network vs. Non-Network Providers

If You Need To:	Network	Non-Network (Including ParPlan)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the allowable amount as determined by BCBSTX. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount.
Visit a Doctor or Specialist	• Visit any network doctor or specialist • Pay the applicable copayment • Pay any deductible and coinsurance • Your doctor or other provider cannot charge more than the allowable amounts for covered services	• Visit any licensed doctor or specialist • Pay for the office visit • File a claim and get reimbursed for the visit minus any deductible and coinsurance • Your costs will be based on allowable amounts; the non-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
Receive Preventive Care	• Visit any network doctor or specialist • Plan pays 100% for certain age-specific and gender-specific preventive care services; see the preventive care section of this guide • Your doctor or other provider cannot charge more than the allowable amounts for covered services	• Visit any licensed doctor or specialist • Pay for the preventive care visit • File a claim and get reimbursed for the visit minus any deductible and coinsurance • Your costs will be based on allowable amounts; the non-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
Receive Emergency Care	• Call **911** or go to any hospital or doctor immediately; you will receive network benefits for emergency care • Pay the copayment (If admitted, ER services are added to claims for inpatient services - see Emergency Care)	
Be Admitted to the Hospital	• Your network doctor will preauthorize your admission • Go to the network hospital • Pay any applicable copayment, deductible and coinsurance	• You, a family member, your doctor or the hospital must preauthorize your admission • Go to any licensed hospital • Pay any deductible and coinsurance each time you are admitted • Your costs will be based on allowable amounts; the non-network doctor/ facility from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX

If You Need To:	Network	Non-Network (Including ParPlan)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the allowable amount as determined by BCBSTX. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount.
Receive Behavioral Health or Substance Use Disorder Services	• Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider or go to any network hospital or facility • Pay any applicable copayment, deductible and coinsurance	• Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider or go to any licensed hospital or facility • Pay any deductible and coinsurance • Your costs will be based on allowable amounts; the non-network doctor or other provider from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
File a Claim	Claims will be filed for you	You may need to file the claim yourself

What is a ParPlan provider?

ParPlan providers have agreed to accept the BCBSTX 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 BCBSTX 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 BCBSTX, but BCBSTX preauthorizes your visit to a non-network provider prior to the visit, network benefits will be paid based on the allowable amount. 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 **bcbstx.com/ut** and click on **Doctors & Hospitals**. You can always call a Health Advocate 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 BCBSTX – a non-contracting provider – you receive non-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting allowable amount, which in most cases is less than the allowable amount applicable for BCBSTX contracted providers. The non-contracted provider is not required to accept the BCBSTX non-contracting allowable amount as payment in full and may balance bill you for the difference between the BCBSTX 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 BCBSTX will pay for eligible expenses you incur under UT SELECT. BCBSTX has established an allowable amount for medically necessary services, supplies and procedures provided by providers that have contracted with BCBSTX or any other Blue Cross and Blue Shield Plan and providers that have not contracted with BCBSTX or any other Blue Cross and Blue Shield Plan. When you receive services, supplies or care from a provider that does not contract with Blue Cross and BCBSTX, you will be responsible for any difference between the BCBSTX 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 BCBSTX 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 BCBSTX 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 BCBSTX 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 BCBSTX. 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 BCBSTX. 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 BCBSTX. 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 BCBSTX within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid & 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. This difference may be considerable. To find out the BCBSTX non-contracting allowable amount for a particular service, participants may call the toll-free 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.

NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when 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. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and

- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
  1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
  2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
  3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments. For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing. For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Predetermination of Benefits

As participants in UT SELECT, you and your covered dependents are entitled to a review by the BCBSTX medical division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if BCBSTX 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 BCBSTX. After a decision is reached, you and your physician will be notified in writing. **Predetermination is not a guarantee of payment**.

Facility Fees

Some medical centers charge a separate facility fee for doctor visits or other procedures and services performed in an outpatient or inpatient facility. If your services take place at a medical center that charges a facility fee, you may be charged for outpatient or inpatient services. These fees can be up to a few hundred dollars for each visit – even if the provider is in the network. When making an appointment, always ask your provider's office if a separate facility fee will be charged for your visit.

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, (4) is past the 24th week of pregnancy and receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that provider's services at the in-network benefit level.

Special circumstances means a condition 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 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 90 days after enrollment.

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 **Transition of Care form** available at **bcbstx.com/ut** under **Tools and Resources**. Instructions for submitting the request to BCBSTX 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 BCBSTX 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 including the network status of providers, 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 admissions
- Applied behavior analysis
- 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
- Advanced imaging
- Cardiology
- Joint and spine surgery
- Pain management
- Sleep study
- All inpatient treatment of behavioral health care, substance use disorder and serious mental illness
- Electroconvulsive therapy
- Repetitive transcranial magnetic stimulation
- Intensive outpatient program

Other services may require preauthorization. Visit with your provider and/or a Health Advocate if you have additional questions. 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)
- 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 BCBSTX, non-network providers paid at the network level may bill for charges exceeding the BCBSTX allowable amount for covered services. You are responsible for these charges, which can be significant.

What happens if services are not preauthorized?

BCBSTX will review the medical necessity of your treatment prior to the final benefit determination. If BCBSTX 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 a Health Advocate at the toll-free number **(1-866-882-2034)** on the back of your Medical ID Card. The call for preauthorization should be made between 6 a.m. and 6 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned no later than 24 hours after the call is received. 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 C-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 BCBSTX 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 BCBSTX.

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 BCBSTX 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
- When the treatment plan is altered

BCBSTX 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 a Health Advocate at the number on your ID card **(1-866-882-2034**). If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Behavioral Health Care

All inpatient and certain outpatient treatment of behavioral health care should be preauthorized by calling a Health Advocate at the toll-free number on your ID card **(1-866-882-2034)**.

Cost Comparison

You have a choice when selecting where to go for health care. Many times, you can choose between different providers or facilities and receive the same procedure at a lower cost. This is where your Health Advocate will assist. You can call a Health Advocate and get cost comparison information from providers in your area for:

- MRIs, CAT/CT scans
- Knee, hip and spine surgery
- Maternity services
- Colonoscopies

A Health Advocate can also help you:

- Find in-network providers
- Schedule visits for you
- Request preauthorization
- Access online educational tools

Accessing 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 a Health Advocate at **1-866-882-2034** 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 services have been rendered, 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. Blue Cross and Blue Shield 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 regarding other Blue Cross and Blue Shield's separate financial arrangements with providers.

One call can result in big savings ... for you and for UT SELECT!

Call **1-866-882-2034** to talk to a Health Advocate.

Note: Cost comparison is only available to members covered by the PPO plan.

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

Yes. Through the Blue Cross Blue Shield Global Core® program, you have access to hospitals on almost every continent and to a broad range of assistance services when you travel or live outside the United States. Blue Cross Blue Shield Global Core 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 the service center at **1-800-810-BLUE (2583)** or call collect at **1-804-673-1177**, 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 Blue Cross Blue Shield Global Core hospitals.

In an emergency, go directly to the nearest hospital.

Call BCBSTX 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 Blue Cross Blue Shield Global Core number.)

In most cases, you will not need to pay for inpatient care at Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center to receive any applicable reimbursement for covered expenses. The claim form is available online at **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. You must submit claim information within 12 months of the date of service.

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 Blue Cross Blue Shield Global Core 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 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
- 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.

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. The plan will not pay for injections and testing occurring on the same date.

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
  - 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 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 BCBSTX
- Not primarily for the convenience of the participant, 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 BCBSTX, 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.

Autism Spectrum Disorder

Generally recognized services prescribed in relation to autism spectrum disorder by the participant's physician or behavioral health practitioner in a treatment plan are available for a covered UT SELECT participant. Generally recognized services may include services such as:

- Evaluation and assessment services
- Screening at 18 and 24 months
- Applied behavior analysis (preauthorization required)
- Behavior training and behavior management
- Speech therapy (subject to plan limits and clinical review)
- Occupational therapy (subject to plan limits and clinical review)
- Physical therapy (subject to plan limits and clinical review)

Behavioral Health Care (preauthorization required for all inpatient care and certain outpatient care, see preauthorization section)

UT SELECT covers charges for inpatient and outpatient behavioral 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 BCBSTX, 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 certain outpatient treatment for behavioral health should be preauthorized by calling the toll-free number on your ID card **(1-866-882-2034)**.

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, alcoholism, substance use disorder or the treatment of co-occurring mental illness and substance use disorder with drug addiction, substance abuse or alcoholism. Dual diagnosis 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. Dual diagnosis programs are delivered by behavioral health practitioners who are cross-trained.

Intensive outpatient program services may be available with less intensity if you are recovering from severe and/or chronic mental illness and/or substance use disorder conditions. If you are recovering from severe and/or chronic mental illness and/or substance use disorder conditions, services may include psychotherapy, pharmacotherapy and other interventions aimed at supporting recovery, such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills and the provision of peer support services.

Intensive outpatient programs may be used as an initial point of entry into care, as a step up from routine outpatient services or as a step down from acute inpatient, residential care or a partial hospitalization treatment program.

Breastfeeding Support, Services and Supplies

To be considered preventive care, covered health services, services must be received from a network provider. 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 of manual or electric breast pumps, accessories and supplies and the rental of hospital-grade breast pumps. Manual and electric pumps with a valid prescription to rent or purchase through network providers are covered at 100% of the allowable amount. Contracted providers will file the claim for you. Breast pumps purchased from retail stores; you must submit a claim form to BCBSTX for reimbursement. Any shipping costs related to purchase of a breast pump are non-covered health services under this benefit.

Limited benefits are also included for the rental of hospital grade breast pumps.

If you use a non-network provider, the benefits may be subject to the out of network benefit. Additionally, you may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the breast pump, accessories and supplies.

Coverage is provided for one pump per pregnancy. For assistance, please contact a BCBSTX Health Advocate at the number on your medical ID card.

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
- 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.

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; 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 for the treatment or correction of a congenital defect
- 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 BCBSTX and prescribed by your doctor, covered oral surgery is limited to:

- Covered oral surgery, including removal of complete 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
- 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)
- 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
- 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. The specific diabetic management service (supplies or equipment) is payable by either BCBSTX or your prescription drug program administrator. Please call your Health Advocate for assistance.

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
- Family involvement in the care and treatment of the diabetic patient, including 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 their family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

Durable Medical Equipment

UT SELECT covers the rental or purchase at the discretion of BCBSTX 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 health care emergencies wherever they occur. Examples of health care 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 they 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 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:

- Serious jeopardy to the person's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious jeopardy to the health of a pregnant woman and/or fetus

24/7 Nurseline

1-888-315-9473

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 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.

Fertility

Testing for problems with infertility is covered under this medical plan.

Note: Fertility and family building benefits are available with Progyny. To access the Progyny benefit, the person(s) receiving fertility treatment must be a primary subscriber or covered spouse continuously enrolled for 12 months in an employee health plan offered through the University of Texas System. Prior periods of coverage under a UT System medical plan (with a break following coverage) cannot be counted toward the continuous coverage requirement. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Dependent children are not eligible for the Progyny benefit. Your coverage will be subject to out-of-pocket payments. To learn more and activate your benefit, you can reach out to your dedicated Patient Care Advocate at **1-844-535-0711**.

Hearing Aids

For covered adults, age 19 and older, UT SELECT allows a **$1,000 maximum benefit per ear every three years** for non-disposable hearing aids, fittings and molds. BCBSTX will pay up to a $1,000 maximum benefit and you will be responsible for the difference between that benefit and the BCBSTX allowable amount when using network or ParPlan providers. If you use a non-contracting provider, BCBSTX will pay up to a **$1,000 maximum benefit**, based on the non-contracting allowable amount 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.

For covered members through age 18, UT SELECT allows coverage for medically necessary hearing aids and related services and supplies including fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; any treatment related to hearing aids, including coverage for habilitation and rehabilitation as necessary for educational gain. Coverage is limited to one hearing aid in each ear every three years as medically or audiologically necessary.

For medical emergencies, call **911**.
24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

Savings on Hearing Aids

BCBSTX has given its members access to savings on hearing aids through TruHearing.* TruHearing saves members 30% to 60% off the average retail price on over 100 hearing aid models from name brand manufacturers. Included with your TruHearing purchase are three follow-up visits with a provider for fitting and programming after the initial exam, a 45-day money-back guarantee, three-year warranty for repairs and one-time loss and damage replacement and 48 free batteries per hearing aid. As a UT SELECT member, your children, parents and grandparents can also access this discount hearing program.

To access the program, call TruHearing, toll-free, at **1-866-581-9466**, 8 a.m. to 8 p.m. CT, Monday through Friday, to locate a provider near you and schedule a hearing exam. It's that easy! For additional information, visit **TruHearing.com**.

*The relationship between BCBSTX 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:

- Private duty nursing (PDN) or coordinated home care (CHC) provided 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
- 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 and services provided primarily for custodial care.

Limits:

- CHC – Limit of 30 visits per condition per year
- PDN – Limit of 90 days per year
- When physical therapy, speech therapy or occupational therapy are being ordered under CHC, standard plan limits apply

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
- 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
- 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
  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.

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 BCBSTX and BCBSTX preauthorizes your visit to a non-network provider prior to the visit, network benefits will be paid. 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. If a non-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

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 that include, but are not limited to, the following:

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

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

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

Lab and X-ray services, including interpretations performed in the office, in an outpatient setting are paid at 100% of the allowed amount. Lab and X-ray services performed at an in-patient 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?

Members will no longer receive "balance bills" for certain non-par services. Specifically, non-par providers cannot balance bill for:

- Emergency services.
- Non-participating services in a network facility.
- Non-participating air ambulance.

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 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.

When using a network facility: If the mother is a covered participant, she will be responsible for inpatient copayments of $200 per day, not to exceed $1,000 per stay, in addition to any applicable deductible and coinsurance. Deductible and inpatient copays for newborn will be waived. Baby has coinsurance only regardless whether or not mother is covered.

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
- 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 midwife as a practitioner?

UT SELECT will only allow benefits for midwife services provided by an advanced practice nurse (APN). UT SELECT does not recognize these or other designations/certifications for midwife services: (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.

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

UT SELECT will only allow benefits for birth at home using midwife services provided by an advanced practice nurse (APN). Please see above.

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 including behavioral health physicians and 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 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, a substance use disorder 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
- 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.

Obesity

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

- It is determined to be medically necessary
- It satisfies the criteria established in BCBSTX medical policy guidelines

Contact a Health Advocate for current medical necessity determination criteria. A member must be continuously enrolled in a UT Medical Plan for 36 months prior to coverage for bariatric surgery.

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 the criteria established by BCBSTX in its written medical policy guidelines
- Recipient meets all 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

Orthotics are covered when determined by BCBS medical policy as medically necessary and prescribed by a physician, chiropractor or other qualified provider. Covered orthotics include, but are not limited to:

- Braces for leg, arm, neck, back and shoulder
- Corsets for the back or for use after special surgical procedures
- Splints for extremities
- Trusses (including Sykes hernia control device)
- Orthopedic shoes when either one or both shoes are an integral part of a leg brace
- Functional foot orthotics
- Compression garments

Non-covered items include, but are not limited to:

- Over-the-counter items such as arch supports, other foot support devices and foot orthotics, including transferrable shoe inserts, compression stockings
- Oral orthotics for temporomandibular joint (TMJ)
- Accommodative foot orthotics (that do not address structural or functional abnormalities)
- Experimental/investigational orthoses and stabilizers
- Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the participant's responsibility.

Outpatient Facility Services

UT SELECT covers services provided through a hospital outpatient department or a free-standing facility when medically necessary. Services include but are not limited to:

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

Preauthorization for outpatient procedures is not required, but calling a Health Advocate to confirm benefits before services are performed is recommended.

Prenatal Genetic and Chromosomal Metabolic Testing

Benefits for medically necessary expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chorionic villus sampling (CVS).

Preventive Care Covered Under Medical

Preventive care services will be provided for the following covered services:

- 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
- With respect to women, such additional preventive care and screenings, not described in the items listed above, as provided for in comprehensive guidelines supported by the HRSA

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

For purposes of this benefit provision, 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).

Covered preventive care services may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at **bcbstx.com/ut** or contact a Health Advocate at the number on your identification card.

Drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the USPSTF and that are listed in the ACA Preventive Services drug list (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to

any copayment amount, coinsurance amount, deductible or dollar maximum when obtained from a participating pharmacy. Drugs on the Preventive Services drug list that are obtained from a non-participating pharmacy may be subject to copayment amount, coinsurance amount, deductibles or dollar maximum, if applicable.

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for colorectal cancer, smoking cessation counseling service, healthy diet counseling and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the pharmacy benefits portion of your plan, when prescribed by a health care practitioner.

Examples of covered immunizations included are diphtheria, Haemophilus influenzae type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services included in items above provided by an in-network provider will not be subject to coinsurance, deductible, copayment or dollar maximums. Deductibles and coinsurance are not applicable to immunizations covered under required benefits for childhood immunizations provision.

Preventive care services included in items above provided by an out-of-network provider will be subject to coinsurance and deductibles.

If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment or setting in which it must be provided, BCBSTX may use reasonable medical management techniques to apply coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, you may be responsible for coinsurance, deductible and/or copayments for the office visit only. If an office visit and the preventive care service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for coinsurance, deductible and/or copayments.

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

Benefits are available for certain tests for the detection of human papillomavirus and cervical cancer, for each woman enrolled in the plan 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 (FDA) alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a participant is a qualified individual, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a participant's risk of osteoporosis and fractures associated with osteoporosis.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer.

All colorectal cancer examinations, preventive services and laboratory test assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future.

Benefits provided above by an in-network provider will not be subject to a deductible, copayment amounts or coinsurance amounts.

Benefits provided above by an out-of-network provider will be subject to any applicable deductible, copayment amounts or coinsurance amounts.

Benefits for Outpatient Contraceptive Drugs, Devices and Procedures

Benefits for outpatient contraceptive drugs, devices and procedures not subject to coinsurance, deductible, copayment or benefit maximum benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination

contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives; vaginal contraceptive devices; spermicide and female condoms. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified.

NOTE: Prescription contraceptive medications are covered under the pharmacy benefits portion of your plan.

Contact Express Scripts at the toll-free number on your identification card to determine what contraceptive drugs and devices are covered under this benefit provision.

Benefits will be provided for female sterilization procedures for women with reproductive capacity and outpatient contraceptive services benefits.

You can find more information about covered preventive care services by visiting **healthcare.gov** or by contacting a Health Advocate 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.

Professional Services

Covered services must be medically necessary as determined by BCBSTX 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 offered by a professional:

- Advanced practice nurse (APN)
- Board certified behavior analyst
- Doctor of chiropractic
- Doctor of dentistry
- Doctor of medicine
- Doctor of optometry
- Doctor of osteopathy
- Doctor of podiatry
- Doctor of psychiatry
- Doctor of 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

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)
- 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, 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.

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

Substance Use Disorder Treatment (preauthorization required for all inpatient care and certain outpatient care)

Substance use disorder treatments are an organized, intensive, structured, rehabilitative treatment program by either a hospital or substance use disorder treatment facility which may include, but is not limited to, acute treatment services and clinical stabilization services. It does not include programs consisting primarily of counseling by individuals other than a behavioral health practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats. Substance use disorder is the abuse of, psychological or physical dependence upon or addiction to alcohol or a controlled substance.

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.

Substance use disorder means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. All inpatient and certain outpatient treatment for substance use disorders should be preauthorized by calling the toll-free number on your ID card **(1-866-882-2034)**.

Substance use disorder treatment facility means a facility (other than a hospital) with a primary function to treat substance use disorder. It is licensed by the appropriate state and local authority to provide such service when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that primarily provide a supportive environment, even if counseling is provided in such facilities.

A series of treatments is a planned, structured and organized program to promote substance-free status. A program may include different facilities or modalities, such as inpatient detoxification, inpatient rehabilitation/treatment partial hospitalization, intensive outpatient treatment or a series of these 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.

Inpatient treatment of substance use disorder must be provided in a substance use disorder 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.

UT SELECT Value-Added Services

Health Advocates

Get coordinated help and personal health care support from a team of experts.[1] Features include:

- Help with understanding your care options and benefits
- Help finding network providers and scheduling appointments
- Ability to speak to the same Health Advocate for follow-up questions and discussions
- Coordinated help from your Health Advocate and other experts to access resources you need, when you need them

[1] Health Advocates do not give medical advice or replace the care of a doctor. You should talk to your doctor about any medical questions or concerns.

Cancer Services and Support

Tools, resources and experts are available to help you before, during and after cancer treatment - at no additional costs to you. Skilled cancer care nurses can help you prepare for doctor office visits, share treatment information or give emotional support - wherever you are in your cancer journey.

You can ask that a medical expert reviews your case. This specialist will keep in touch with your doctor to discuss your treatment plan and possible clinical trials. If you've received a rare or complex cancer diagnosis, your case will be automatically reviewed and recommendations are given to your oncologist, so you can stay with your local support system.

Cancer care nurses are here with you throughout your journey including diagnosis, treatment decision, active treatment and post treatment. It's important to reach out to us as soon as you are diagnosed so we can make sure you have what you need to get started on the right path. Call a Health Advocate to learn more.

Virtual Doctor Visits – $0 Copayment: Powered by MDLIVE®

Care when and where you need it, at no cost to you, through MDLIVE – available 24 hours a day, seven days a week, 365 days a year. Features include:

- Physicians with expertise in primary care, pediatrics and more
- Treatment for many non-emergency medical conditions, including: colds and flu, fever (age 3+), sinus infections, ear problems (age 12+), allergies, etc
- Behavioral health services

MDLIVE requires credit card information to verify eligibility and for missed, cancelled or rescheduled behavioral health appointments. A fee is only charged for cancelled and rescheduled behavioral health appointments with less than 24 hours' notice, or for missed behavioral health appointments.

The fee is an out-of-pocket expense and is not covered by your plan.

To avoid this charge, cancel or reschedule behavioral health appointments more than 24 hours in advance. Visit **mdlive.com/bcbstx** for more information and to activate your account

Headway Behavioral Health

If you're ready to see a mental health specialist but are overwhelmed by the process, you're not alone. It can take a great deal of effort to find a provider who has open sessions that fit your schedule and aren't months away. Introducing Headway Behavioral Health as part of your UT SELECT Medical plan to help you with these types of situations.

With Headway, you can find the right fit with a specialized provider from over 4,000+ mental health clinicians committed to providing high quality care across Texas.

Through an easy-to-use platform, you can find providers who accept your UT SELECT medical insurance and book and manage appointments and even pay directly through the Headway website.

Headway's personalized matching support can help match you with a provider who fits your needs using a questionnaire, or through a one-to-one conversation with their support team if that's your preference.

Headway lets you see what's available and book mental health visits online, quickly and easily. Most people are able to start getting care within a week. Try it out at **headway.co/m/bcbstx**.

1. Find the right fit.

Share your preferences, and the site will search through thousands of therapists and psychiatrists to find your matches.

2. Get the in-network price.

Add your health plan details, and see the cost for your session. Headway providers are in-network for most BCBSTX plans.

3. Book your session.

See open dates and times for virtual or in-person appointments, and book the one that works for you.

Headway is a contracted provider Blue Choice PPO and Medicare Advantage PPO.

Hinge Health

A new approach to help you conquer chronic pain without surgery or drugs. Features include:

- At-home exercise therapy and behavioral coaching program for chronic back and knee pain based on proven, non-surgical care guidelines
- Delivered remotely using mobile and wearable technology provided at no cost to you
- Programs for chronic hip, shoulder and neck pain
- No out-of-pocket cost

Visit **hingehealth.com/UTS** for more information.

Learn to Live

Learn to Live is a behavioral health digital platform which offers condition-specific programs, each delivered in a user-paced multimedia experience. Services are also available on demand with the options for one-to-one clinician coaching services. Go to **learntolive.com/welcome/BCBSTX** and enter access code **BETTERME** to get started.

If you are in crisis, call the national hotline at **1-800-273-TALK (8255)** or call **911** if you feel you are in immediate danger.

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Hinge Health is an independent company that has contracted with BCBSTX to provide an online musculoskeletal program for members with coverage through BCBSTX.

Learn to Live provides educational behavioral health programs; members considering further medical treatment should consult with a physician. Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Ovia Health: A Digital Support Program

Ovia Health provides maternity and family apps to support you through the entire parenthood journey. These apps are included in your UT SELECT health plan, offered through BCBSTX.

With Ovia, you'll have access to enhanced, personalized health and wellness features:

- Health assessment and symptom tracking; receive alerts and predictive, personal coaching when Ovia detects a potential medical issue
- More than fifty physician-developed clinical programs to help you be as healthy as possible; engage with personalized health and wellness programs to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding and more
- Unlimited one-on-one coaching; message a health coaches to ask all your questions
- Career and return-to-work programs; find coaching and career advice about preparing for maternity leave, returning to work and being a working parent

Download the app that's right for you:

- **Ovia** – Reproductive Health, Fertility and Menopause
- **Ovia Pregnancy** – Pregnancy & Postpartum
- **Ovia Parenting** – Family & Working Parents

To create an account, choose "I have Ovia Health as a benefit" before tapping "Sign up." Select BCBSTX as your health plan and enter your employer name. You can also contact a Health Advocate at **1-866-882-2034** for more information or should you have any questions.

Progyny Fertility and Family Building Benefits

The Progyny benefit offers inclusive and comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists and personalized emotional support and guidance from dedicated patient care advocates (PCAs).

Your Progyny coverage includes:

Two Smart Cycles, Progyny Rx (integrated fertility medication coverage), fertility preservation (egg and sperm freezing) and donor tissue (egg and sperm coverage). Contact your Progyny patient care advocate at **1-844-535-0711** to learn more.

Note: The person(s) receiving fertility treatment must be a primary subscriber or covered spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to utilizing the benefit. Prior periods of coverage under a UT System medical plan (with a break following coverage) cannot be counted toward the continuous coverage requirement. Enrollment in the student health plan does not count towards the 12 months of continuous coverage. Your coverage may be subject to copayments.

Seasons of Life℠

Seasons of Life is a proactive outreach program offered through your UT SELECT benefits and BCBSTX that provides personalized claims resolution assistance to you and your dependents dealing with the death of a loved one.

When BCBSTX learns of a death, a specially trained customer advocate will send a handwritten sympathy card. This advocate will become your single point of contact for the duration of the program. You and/or your family can then contact the customer advocate at a time that is convenient for you to discuss any insurance-related matters.

BCBSTX will conduct a full review of the deceased's reimbursement history, claims status and Customer Service history before contacting you and/or your family, so the customer advocate can anticipate needs and ensure that compassionate help is available when it's needed most.

While the Seasons of Life program is launched proactively based on information provided to BCBSTX, please know that you and/or your dependents can contact a Health Advocate for assistance if needed. Simply call **1-866-882-2034**.

Wondr Health™

Wondr Health is a weekly, self-paced, online program that teaches you how to lose weight and improve your health without giving up your favorite foods. To find out more and join the waitlist, go to **wondrhealth.com/livingwell**.

Wondr Health is an independent company that that has contracted with Blue Cross and Blue Shield of Texas to provide Metabolic Syndrome Management for members with coverage through BCBSTX.

Ovia Health is an independent company that provides maternity and family benefits solutions for Blue Cross and Blue Shield ofTexas.

Progyny is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide fertility and family building benefits for members through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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, 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 services or supplies relating to the treatment of personnel for work-related health requirements, including but not limited to medical services that are required such as testing, vaccination or treatments. This includes and is not limited to a time period where a public health emergency has been declared. Work-related services are the responsibility of the employer, not the UT SELECT health plan.
4. Any portion of a charge for a service or supply that is in excess of the allowable amount as determined by BCBSTX
5. 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
6. Any services or supplies for which benefits are, or could be upon proper claim, 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
7. 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 intellectual disability provided by a tax supported institution of the State of Texas
8. Any services or supplies provided by a person who is related to the participant by blood or marriage
9. Any services or supplies provided for injuries sustained:
   - As a result of war, declared or undeclared, or any act of war
   - While on active or reserve duty in the armed forces of any country or international authority
10. 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
11. 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
12. 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
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 related to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions is subject to medical necessity
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. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as LASIK, other refractive eye surgery and radial keratotomy, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in benefits for eyeglasses and vision services, and eye exercises or vision therapy, except those ordered by a physician and determined by BCBSTX to be medically necessary
18. 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
19. 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
20. 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
21. 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
22. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning
23. Sterilization reversal (male or female)
24. 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
25. Any services or supplies in connection with:
    - Routine foot care, including the removal of warts, corns, calluses, cutting and trimming toenails in the absence of severe systemic disease
    - Foot care for flat feet, fallen arches and chronic foot strain
26. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, topical oral solutions or preparations
27. Any services or supplies provided for the following treatment modalities:
    - Acupuncture
    - Intersegmental traction
    - Surface EMGs
    - Spinal manipulation under anesthesia
    - Muscle testing through computerized kinesiology machines such as isostation, digital myograph and dynatron
28. 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 BCBSTX will be paid at the non-network benefit level
29. 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
30. Any services or supplies provided for reduction mammoplasty, except when medically necessary
31. Any items that include, but are not limited to, an orthodontic or other dental appliance; including oral orthotics for temporomandibular joint (TMJ) disorders, accommodative foot orthotics (that do not address structural or functional abnormalities), stock orthotics (over-the-counter items such as compression garments, arch supports and other foot support devices and foot orthotics, including transferrable shoe inserts), garter belts, experimental/investigational orthoses and stabilizers and any orthotics not considered medically necessary according to BCBSTX medical policy
32. Any benefits in excess of specified benefits maximums
33. 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

34. Replacement prosthetic appliances except those necessitated by growth due to maturity of the participant
35. Inpatient private duty nursing services
36. Outpatient drugs except as provided under the plan by the prescription drug program
37. Outpatient contraceptive services, drugs and devices, except for contraceptive prescription drugs provided under the prescription drug program portion of this plan or as Preventive Services under the Affordable Care Act.
38. 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
39. Any services or supplies provided for reduction of obesity or weight, except surgery 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
40. The use of the procedures, supplies or medications for treatment of psychological/psychogenic male sexual or erectile dysfunction/impotence
41. 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
42. Services or supplies used primarily for patient convenience
43. Most supplies available for purchase over the counter without a doctor's prescription
44. 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
45. Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient, except for telehealth
46. 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. 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.
47. Long-term care service, respite care service (except as specifically mentioned under hospice care) and maintenance care
48. 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 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 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, then 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	You can download a claim form from the website by logging onto **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. • Patient's name • Subscriber number, including the alpha prefix (UTS or UZS) • Correct address • Diagnosis (preferably indicated by your provider on an itemized bill) • 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: • 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 Keep a copy of the claim form and itemized bills for your records	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 the UT System. This will only delay processing. **Note:** Foreign claims must be translated. If no translation is attached, processing may be delayed. You must file and BCBSTX must receive claims for expenses within 12 months after the date of service.
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 **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 BCBSTX receives the claim at the proper address and with all of the required information. If the claim is not complete, BCBSTX will return it. On claims that need further information for proper processing, BCBSTX may contact either you or the provider for the additional information. The claim will be processed when BCBSTX 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 the 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 BCBSTX 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 three days of oral notification.
- Contact information for applicable office of health insurance consumer assistance or ombudsman

BCBSTX 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 for benefits for health 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 health 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 health 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
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**
BCBSTX must notify you of the claim determination (whether adverse or not):
• 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 your UT SELECT ID card as soon as possible to appeal an urgent care clinical claim.

Pre-Service Claims
Type of notice or extension
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**
BCBSTX must notify you of the claim determination (whether adverse or not):
• 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
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**
BCBSTX must notify you of the claim determination (whether adverse or not):
• 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

4. Adverse benefit determination means a denial, reduction, termination or failure to provide or make payment (in whole or 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, not medically necessary or appropriate. If an ongoing course of treatment was 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.

5. 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.
6. Clinical appeal means a request to change an adverse determination for care or services that were denied on the basis of lack of medical necessity or when services are determined to be experimental, investigational or cosmetic. May be pre- or post-service. Review is conducted by a physician. Members or their authorized representative may file a clinical appeal. Providers may also file a clinical appeal on their own behalf.
7. Non-clinical appeal means a request to reconsider a previous inquiry, complaint or action by BCBSTX that has not been resolved to the member's satisfaction. This relates to administrative health care services such as membership, access, claim payment, etc. and may be pre-service or post-service. Review is conducted by a non-medical appeal committee. Only members or their authorized representative may file a non-clinical appeal.

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 (clinical or non-clinical) may be filed by you or a person authorized to act on your 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 at the number on your UT SELECT ID card, or download the standard authorization form to use or disclose protected health information from **bcbstx.com/ut** within the section for forms and resources.

For clinical adverse determinations made of the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic, a health care provider may appeal on your behalf.

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
  BCBSTX
  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 provided 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 chance 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 claims procedures or the review procedure, write to BCBSTX or call a Health Advocate at **1-866-882-2034**

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 in the case of a clinical appeal, any health care provider who recommended the services involved in the appeal and 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) 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
- 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

210 West 7th Street
Austin, Texas 78701
Phone: 1-512-499-4616
Toll Free: 1-800-888-6824
Fax: 1-512-499-4620
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 with a written notice of the determination 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. 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
- 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 claims procedures or the review procedure, write or call BCBSTX at **1-866-882-2034**. BCBSTX Customer Service is accessible from 8 a.m. to 6 p.m. Monday through Friday.

Claim Review Section
BCBSTX
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 at the number on your UT SELECT ID card, or download the HIPAA Authorization Form to Disclose PHI from the **bcbstx.com/ut** website within the section for Forms and Resources.

1. Request for external review

Within four 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 five 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
- You or your authorized representative has provided all the information and forms required to process an external review. You will be notified within one 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 four-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 three 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:

- Utilize legal experts where appropriate to make coverage determinations under the plan
- Provide 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 five 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 one 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 one 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 one 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
  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:
  1) 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)
  2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision
  3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
  4) 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
  5) 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, you or your authorized representative
  6) A statement that judicial review may be available to you or your authorized representative
  7) 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 six 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, 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

- 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

Subrogation

If the plan pays or provides benefits for you or your dependents, the plan is subrogated to all rights of recovery which you or your dependent have in contract, tort, or otherwise against any person, organization or insurer for the amount of benefits the plan has paid or provided. That means the plan may use your rights to recover money

through judgment, settlement or otherwise from any person, organization or insurer. For the purposes of this provision, subrogation means the substitution of one person or entity (the plan) in the place of another (you or your dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized or are precluded by factual circumstances, the plan will have a right of reimbursement. If you or your dependent recovers money from any person, organization or insurer for an injury or condition for which the plan paid benefits, you or your dependent agree to reimburse the plan from the recovered money for the amount of benefits paid or provided by the plan. That means you or your dependent will pay to the plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the plan.

Right to Recovery by Subrogation or Reimbursement

You or your dependent agree to promptly furnish to the plan all information which you have concerning your rights of recovery from any person, organization or insurer and to fully assist and cooperate with the plan in protecting and obtaining its reimbursement and subrogation rights. You, your dependent or your attorney will notify the plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your dependent further agree not to allow the reimbursement and subrogation rights of the plan to be limited or harmed by any acts or failure to act on your part.

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
- 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 in which benefits are determined before those of the other plan and without considering the other plan's benefit. A secondary plan is a plan in which 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

1. 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.

2. 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 (1) secondary to the plan covering the participant as a dependent and (2) 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.
- Dependent Child/Parents Not Separated or Divorced – Except as stated in paragraph below, when this plan and another plan cover the same child as a dependent of different parents:
  - 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
  - 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, 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
- 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:
  - First, the plan of the parent with custody of the child
  - Then, the plan of the spouse of the parent with custody, if applicable
  - 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 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 Dependent Child/Parents Not Separated or Divorced paragraph
- 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, Dependent Child/Parents Separated or Divorced paragraph 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:
  - The COBRA continuation coverage plan that covers member as a subscriber/policyholder is the primary plan
  - Secondary liability is the plan that covers the UT SELECT subscriber as a dependent
- 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

1. When This Section Applies

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.

2. 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
- 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

BCBSTX assumes no obligation to discover the existence of another plan or the benefits available under the other plan, if discovered. BCBSTX has the right to decide what information is needed to apply these COB rules. BCBSTX 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 BCBSTX 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, BCBSTX 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. BCBSTX 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, BCBSTX 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 UT CARE™ Medicare PPO

The majority of members eligible for Medicare are covered under the UT CARE Medicare Advantage PPO plan. For coverage information about that plan, please refer to the UT CARE materials at **utbenefits.link/UTCARE**.

In certain circumstances, a person may be enrolled in Medicare and UT SELECT. The information below further explains the interaction of UT SELECT and Medicare in these situations.

Active Employees

In most cases, we recommend that any active employee or spouse/dependent of an active employee enrolled in UT SELECT, enroll in Medicare Part A once they reach age 65 and decline enrollment in Part B. Failure to enroll in Medicare Part A once you qualify due to age may affect your ability to enroll in Part A later. 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 continue to be be primary coverage and your covered dependents, regardless of age, and Medicare will be secondary.

Retired Employees

If you have UT SELECT Medical coverage as a retiree, when you or your covered dependent(s) become eligible for Medicare, you must be enrolled in Part A and Part B coverage. Failure to do so will result in a reduction or cancellation of benefits available from the UT medical plan. Also, declining Part B when you are first eligible to enroll may result in your having to pay a higher Medicare premium once you do apply for Medicare coverage.

You can enroll online at: **https://www.ssa.gov/benefits/medicare/**

All Medicare-eligible retirees and Medicare-eligible dependents of retirees will be enrolled into the UT CARE Medicare Advantage PPO plan unless you take action to opt out. If you opt out of UT CARE, you will not have UT medical or prescription drug coverage, and opted out retirees will not have the UT Basic life insurance. Your enrollment into the UT CARE plan may take a month or two after your initial Medicare eligibility. Until you are enrolled in the UT CARE plan, you will keep your coverage under UT SELECT which will pay as secondary to Medicare starting the month of your 65th birthday.

You should start the Medicare enrollment process 90 days before your 65th birthday.

For prescription benefits, UT System automatically enrolls Medicare-eligible retirees and Medicare-eligible dependents of retirees into the UT CARE Part D plan. The UT CARE Part D plan maintains the familiar copays and other benefits of the employee prescription plan.

Return-to-work Retirees:

If you are retired and enroll in UT CARE medical coverage and then return to work at UT System in a benefits-eligible position (generally 20 hours or more per week), you and any Medicare-eligible dependents are not required to be enrolled in Medicare Part B. However, if at any point you drop below working 20 hours a week or stop working at UT System, you and your Medicare-eligible dependents need to be enrolled in Medicare Part B to avoid disruption in coverage.

In most cases, if you are eligible for Medicare, work for UT System at least 20 hours/week, and participate in a UT System medical plan, UT SELECT will be primary for you and your covered Medicare-eligible dependent(s), and Medicare (if you are enrolled) will be secondary. Medicare may be primary for some Medicare-eligible active employees who have certain medical conditions such as end-stage renal disease (ESRD). Consult with your local Social Security Administration office prior to turning age 65 to learn which illnesses qualify for primary Medicare coverage.

UT CARE Medicare PPO is an open access Medicare Advantage PPO plan. On occasion, you may receive automated communications that reference plan name 'Blue Cross Group Medicare Advantage Open Access (PPO)℠.' This plan name also refers to UT CARE Medicare PPO.

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 $200 annual deductible per plan participant, per plan year.

UT SELECT Prescription Drug Benefits			
Annual Deductible (does not apply to medical plan annual deductible)	$200/person/year*		
ACCESS OPTIONS	GENERIC DRUG COPAYMENT	PREFERRED DRUG COPAYMENT	NON-PREFERRED DRUG COPAYMENT
Retail Network Pharmacy: • Up to a 30-day supply • Refills allowed as prescribed • Good option for new prescriptions	$10	$35	$60
90-Day at Walgreens, UT Pharmacy or Express Scripts Home Delivery: • Up to a 90-day supply • Refills allowed as prescribed • Best option for maintenance medication	$20	$87.50	$150

* Certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act and the plan and will not be applied toward satisfying the out-of-pocket maximum or prescription drug deductible.

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 (**express-scripts.com**) 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 $200 annual deductible per person per plan year. Sometimes the cost difference is quite large. Here is an example of how this type of claim would process if you had already met your $200 annual deductible:

Cost of brand name drug	$150
Minus 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 30-day retail pharmacy network. If you fill a prescription at a non-network 30-day retail 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 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 a retail pharmacy that has a generic promotion program, please present your prescription drug ID card to a 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. The online **price a medication** tool (available at **express-scripts.com**) 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.

Smart90 Retail Prescriptions

Save time and money! You can get both savings and convenience with a 90-day supply of maintenance medications at Walgreens or a UT pharmacy for the same copayment as the ESI Home Delivery Pharmacy. Be sure to have your physician write your prescription for a 90-day supply.

Patient Assurance Program

This program assures UT members filling prescriptions for preferred program diabetic medications, including insulin, will pay no more than $25 copay per 30-day supply, $50 for 60 days or $75 for 90 days.

Diabetic Supplies

Diabetic supplies covered by the plan are available for $0 copayment.

Automatic Fills

The automatic refills program helps address one of patients' main sources of anxiety when using home delivery: fear of running out of medication because they forgot to refill or the medication was not delivered as expected. With automatic refills, patients no longer need to worry because the pharmacy automatically delivers refills to the patient. When the medication is out of refills, your doctor will be contacted for a new prescription. To enroll a medication into automatic refills, visit **express-scripts.com** or call Member Services at **1-800-818-0155**.

Note: For safety and other reasons, prescriptions for some medications are not eligible to be automatically filled. These prescriptions include specialty medications and controlled substances. When a prescription expires or the last refill is processed, you will need to coordinate with your provider to send a new prescription to Express Scripts.

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. There is an 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 **express-scripts.com**.

After your one-time registration, any alerts will automatically be waiting for you whenever you log in to **express-scripts.com**. 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.

Manufacturers' Coupons

Brand-name drugs often cost more than generic medications. 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,

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, 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 preferred brand-name drug that's less expensive. The online **price a medication** tool will provide potential lower-cost alternatives under your plan to help guide future conversations with your doctor. 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. All alternative options are available through **price a medication**.

Prescription Limitations

Some drugs or therapeutic classes of drugs may have limits based on 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 them. Your doctor can also contact Express Scripts directly through the physician prior authorization process.
- **Step Therapy** - Coverage under this 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 or per prescription.

Consult the Express Scripts website **(express-scripts.com)** 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 Express Scripts 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. You and your doctor will be notified 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.

What's not covered?

Some drugs are not covered, or are excluded, from the prescription drug plan, which means there are no alternatives to try or exceptions to coverage. To check whether a particular medication is covered, go to the Express Scripts website at **express-scripts.com** or call Express Scripts Member Services (**1-800-818-0155**). The following list of exclusions outlines general categories of some items not covered under the plan.

- Compound medications
- Medical foods
- Dietary supplements
- Over-the-counter medications (OTCs) not included under the Affordable Care Act (See Preventive Medications below)
- GLP1s for weight loss

Preventive Medications

In accordance with the Affordable Care Act (ACA), the UT SELECT prescription drug plan covers certain preventive items and services at a $0 cost share. The list of preventive medications under your benefit is based on the recommendations of the U.S. Preventive Services Task Force. 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.

Drug categories include:

- **Aspirin** – Generic over-the-counter (OTC) product after 12 weeks of gestation in pregnant persons who are at high risk for preeclampsia

- **Statins** – Low-to-moderate dose generic statins for prevention of cardiovascular disease in adults greater than or equal to 40 and less than or equal to 75 years of age
- **Folic Acid** – Generic prescription and OTC products, 0.4 - 0.8 mg strength single entity and combination products (applies to persons who are planning and capable of pregnancy)
- **Fluoride** – A prescription product for children age six months to 16 years to prevent dental cavities
- **Immunizations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be administered at a network retail pharmacy if available. The cost of the vaccine is covered under the UT SELECT pharmacy plan. See the summary of the medical plan for more details on vaccines administered in the doctor's office
- **Bowel prep** generic prescription and OTC products, for colonoscopies for persons greater than or equal to 45 and less than or equal to 75 years of age
- **Tobacco cessation** products for adults 18 and over
  - nicotine replacement therapy (gum, lozenger, patch, inhaler, nasal spray)
  - sustained release bupropion (generic Zyban)
  - varenicline (generic Chantix)
- **Breast cancer prevention therapy** with tamoxifen, raloxifene, Soltamox, generic anastrozole and generic exemestane for adults 35 and over at high risk with copay review approval
- **HIV pre-exposure prophylaxis** will be covered for emtricitabine/tenofovir disoproxil fumarate 200mg/300mg for persons at high risk of HIV acquisition.
- **Contraceptives** for individuals capable of child bearing
  - 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

$0 copay applies for the generic or single source contraceptive options. A cost may be applied for multisource brands unless the covered generic or single source contraceptive option would be medically inappropriate for that individual and the prescribed multisource contraceptive is medically appropriate as determined through a clinical review. Express Scripts handles all clinical reviews at **1-800-818-0155**.

The list of covered medications is subject to change. For more specific information regarding coverage options and limitations, please contact Express Scripts Customer Service.

Specialty Pharmacy

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
- Difficult to administer and may cause adverse reactions
- May have restrictions as determined by the U.S. Food and Drug Administration
- 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.

IMPORTANT: To receive benefits, you must obtain medications designated by Express Scripts as specialty drugs using either the Accredo pharmacy or a UT pharmacy.

You will be responsible for paying the corresponding mail order or retail pharmacy copayment. The exception to this would be for certain products that are available through only one or two U.S. pharmacies. For those products, Express Scripts will direct you to a pharmacy that can fill your prescription. If using a UT pharmacy, please call ahead and ensure they dispense the required specialty medication and have it in stock.

Accredo Pharmacy

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 a physician – in implementing the prescribed course of treatment
- Compliance programs to promote patient persistency and help the patient improve their 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, seven days a week
- Expedited, scheduled delivery of 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

SaveOn SP

The UT SELECT prescription drug plan has partnered with SaveOn SP to provide a specialty pharmacy co-pay assistance program.

- Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum or deductible. A list of the program drugs can be found at **saveonsp.com/uts**
- Although the cost of the program drugs will not be applied towards satisfying a participant's out-of-pocket maximum or deductible, for UT SELECT members who qualify and enroll in the SaveOnSP program, the cost of the specialty medication will be reimbursed by the manufacturer and result in no financial responsibility for the participant

PRESCRIPTION DRUG CLAIMS AND APPEALS

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, 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 Express Scripts® Pharmacy, your doctor will be contacted directly. You will need to provide 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, they 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 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 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., P.O. Box 66588, St. Louis, MO 63166-6588 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)
- Any additional information that may be relevant to your appeal

This information should be mailed to **Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588 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

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 **1-800-753-2851** or send a written request to: **Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588, 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 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, the request must be mailed or faxed to MCMC, LLC within four months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: **MCMC LLC Attn: Express Scripts Appeal Program, 300 Crown Colony Drive, Suite 203, Quincy, MA, 02169-0929. Phone: 617-375-7700 Fax: 617-375-7683**.

Non-Urgent External Review

Once you have submitted your external review request, the plan will review, within five business days, your claim to determine if you are eligible for external review and within one 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 five 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 a summary of eligibility information. Consult your institution's 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 they become 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's benefits office for your eligibility date.

You are eligible to receive the benefits described in this benefit booklet if you are eligible to participate in the UT System uniform group insurance program under chapter 1601 of the Texas Insurance Code as:

- An employee
- A non-Medicare-eligible retired employee
- A retired employee working 20 or more hours at a UT institution in a benefits-eligible position, regardless of Medicare eligibility
- The dependent of an employee
- The dependent of a retired employee working 20 or more hours at a UT institution in a benefits-eligible position, regardless of Medicare eligibility
- A non-Medicare-eligible dependent of a retired employee, or
- A non-Medicare-eligible surviving dependent

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).

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 period 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 UT SELECT is allowed and state premium sharing is available. Consult with your institution benefits office for additional information regarding the waiting period.

Life Event Changes

You have 31 days from the date of a qualifying life 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 life 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
- 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 if:

- 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 meet the plan's definition of a dependent
- You become eligible for, and are enrolled into the UT CARE plan

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.

GLOSSARY OF TERMS

The definitions used in this benefit booklet apply to all coverage unless otherwise indicated.

Accidental injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a physician or professional other provider.

Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Allowable amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure.

- For hospitals and facility other providers, physicians and professional other providers contracting with BCBSTX in Texas or any other BCBS 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 facility other providers, physicians, professional other providers and any other provider not contracting with BCBSTX in Texas or any other BCBS plan outside Texas (non-contracting allowable amount), the allowable amount will be the lesser of: (i) the provider's billed charges, or; (ii) the BCBSTX non-contracting allowable amount. Except as otherwise provided in this section, the non-contracting allowable amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting allowable amount for home health care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by BCBSTX. 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 BCBSTX. 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 network 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 BCBSTX within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid & 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-contracted provider will be responsible for the difference between the non-contracting allowable amount and the non-contracted provider's billed charge and this difference may be considerable. To find out the BCBSTX non-contracting allowable amount for a particular service, participants may call the number on your BCBSTX identification card.

Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the allowable amount shall be the lessor of billed charge or the amount prescribed by law.

- 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 recipient, the allowable amount will not exceed Medicare's limiting charge.
- For covered drugs as applied to participating and non-participating pharmacies, the allowable amount for participating pharmacies and the mail-order program will be based on the provisions of the contract between BCBSTX and the participating pharmacy or pharmacy for the mail-order program in effect on the date of service. The allowable amount for non-participating pharmacies will be based on the participating pharmacy contract rate.
- For covered drugs as applied to participating and non-participating pharmacies, the allowable amount for participating pharmacies and the mail-order program will be based on the provisions of the contract between BCBSTX and the participating pharmacy or pharmacy for the mail-order program in effect on the date of service. The allowable amount for non-participating pharmacies will be based on the participating pharmacy contract rate.
- For non-emergency care provided by an out-of-network provider when a contracting provider is not reasonably available as defined by applicable law or when services are preapproved or have received prior authorization based upon the unavailability of a preferred provider and balance billing is not prohibited by Texas or federal law, the allowable amount will be the plan's usual and customary rate as defined by Texas law or as prescribed under applicable law and regulations or at a rate agreed to between BCBSTX and the out-of-network provider, not to exceed billed charges.
- For out-of-network emergency care, care provided by an out-of-network facility-based provider in a network hospital, ambulatory surgery center or birthing center, or services provided by an out-of-network laboratory or diagnostic imaging service in connection with care delivered by a network provider, the allowable amount will be the plan's usual and customary rate or at a rate agreed to between BCBSTX and the out-of-network provider as prescribed by the Texas Insurance Code, not to exceed billed charges. The plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less than the non-contracting allowable amount as defined in this plan.

Approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration
2. Exempt from obtaining an investigational new drug application
3. Approved or funded by:
   a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services or a cooperative group or center of any of the foregoing entities
   b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs
   c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups
   d. The United States Departments of Veterans Affairs, Defense or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to: (1) be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (2) provide unbiased scientific review by individuals who have no interest in the outcome of the review
4. Conducted and approved by 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

Autism spectrum disorder (ASD) means a neurobiological disorder that includes autism, Asperger's syndrome or pervasive developmental disorder not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic or other biological factors.

Average wholesale price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a pharmacy.

Behavioral health care means any one or more

of the following:

1. The 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 as used by the carrier, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin
2. The diagnosis or treatment of any symptom, condition, disease or disorder by a physician or professional other provider (or by any person working under the direction or supervision of a physician, behavioral health practitioner or professional other provider) when the eligible expense is:
    a. Individual, group, family or conjoint psychotherapy
    b. Counseling
    c. Psychoanalysis
    d. Psychological testing and assessment
    e. The administration or monitoring of psychotropic drugs
    f. Hospital visits or consultations in a facility listed in subsection 5 below
3. Electroconvulsive treatment
4. Psychotropic drugs
5. Any of the services listed in subsections 1 through 4, above, performed in or by a hospital, facility, other provider or other licensed facility or unit providing such care

Behavioral health practitioner means a physician or professional other provider who renders services for mental health care, serious mental illness or substance use disorder (SUD), only as listed in this benefit booklet.

Calendar year means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.

Certain diagnostic procedures means:

- Bone scan
- Cardiac stress test
- CT scan (with or without contrast)
- MRI (magnetic resonance imaging)
- Myelogram
- PET scan (positron emission tomography)

Clinical ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant to determine whether or not it reduces or kills white blood cells)
2. Urine auto injection (injecting one's own urine into the tissue of the body)
3. Skin irritation by Rinkel method
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen)
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth)

Cognitive communication therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.

Cognitive rehabilitation therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Coinsurance amount means the dollar amount expressed as a percentage of eligible expenses incurred by a participant during a calendar year that exceeds benefits provided under the plan.

Community reintegration services means services that facilitate the continuum of care as an affected individual transitions into the community.

Complications of pregnancy means:

1. 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 acute 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
2. Non-elective cesarean section, termination of ectopic pregnancy and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible

Contract anniversary means the corresponding date in each year after the contract date for as long as the

contract is in force.

Contract date means the date on which coverage for the Employer's Contract with BCBSTX commences.

Contract month means each succeeding monthly period, beginning on the Contract Date.

Contracting facility means a Hospital, a facility other provider, or any other facility or institution with which the carrier has executed a written contract for the provision of care, services or supplies furnished within the scope of its license for benefits available under the plan. A contracting facility shall also include a hospital or facility other provider located outside the state of Texas with which any other Blue Cross plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the plan shall be deemed a non-contracting facility regardless of the existence of a written contract with another Blue Cross plan.

Cosmetic, reconstructive or plastic surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a participant
2. Is performed for psychological purpose
3. Restores form but does not correct or materially restore a bodily function

Covered oral surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths
2. Incision and drainage of facial abscess
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology
5. Removal of complete bony impacted teeth

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

Custodial care means any service primarily for personal comfort for convenience that provides general maintenance, preventive and/or protective care without any clinical likelihood of improvement of your condition. Custodial care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible means the dollar amount of eligible expenses that must be incurred by a participant before benefits under the plan will be available.

Dependent means your spouse or any child covered under the plan.

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States, is also considered a dependent child under the plan.

For purposes of this plan, the term dependent will also include those individuals who no longer meet the definition of a dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code.

Dietary and nutritional services means the education, counseling or training of a Participant (including printed material) regarding:

1. Diet
2. Regulation or management of diet

3. The assessment or management of nutrition

Durable medical equipment provider means a provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Eligible employee means an employee who works on a full-time basis, who usually works at least 30 hours a week and meets the participation criteria established by a large employer. The term includes a sole proprietor, a partner and an independent contractor if the individual is included as an employee under a health benefit plan of a large employer regardless of the number of hours the sole proprietor, partner or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. Participation criteria means any criteria or rules established by a large employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan. The participation criteria may not be based on health status related factors.

Eligible expenses mean either inpatient hospital expenses, medical-surgical expenses extended care expenses, special provisions expenses or pharmacy expenses as described in this benefit booklet.

Emergency care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility or comparable facility to evaluate and stabilize conditions of a recent onset and severity, including but not limited to 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:

1. Placing the patient's health in serious jeopardy
2. Serious impairment of bodily functions
3. Serious dysfunction of any bodily organ or part
4. Serious disfigurement
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus

Employee means an individual employed by a large employer.

For purposes of this plan, the term employee may also include those individuals who are no longer an employee of the large employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code.

Environmental sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment
2. Sanitizing the surroundings, removal of toxic materials
3. Use of special non-organic, non-repetitive diet techniques

Experimental/investigational means the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated and 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. Approval by a federal agency will be taken into consideration by BCBSTX in assessing experimental/investigational status but will not be determinative.

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 other provider in which they were performed
- The physician or professional other provider has had the appropriate training and experience to provide the treatment or procedure

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device or supply is experimental/investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid or other government-financed programs and approval by a federal agency in making its determination.

Although a physician or professional other provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX 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 expenses means the allowable amount of charges incurred for those medically necessary services and supplies provided by a skilled nursing facility, a home health agency or a hospice as described in the extended care expenses portion of this benefit booklet.

Health benefit plan means a group, blanket or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. Accident-only or disability income insurance or a combination of accident-only and disability income insurance
2. Credit-only insurance
3. Disability insurance coverage
4. Coverage for a specified disease or illness
5. Medicare services under a federal contract
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits or any combination of those coverages or benefits
8. Coverage that provides limited-scope dental or vision benefits
9. Coverage provided by a single service health maintenance organization
10. Coverage issued as a supplement to liability insurance
11. Workers' compensation or similar insurance
12. Automobile medical payment insurance coverage
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that:
    - Contain a plan of benefits for employees
    - Is negotiated in a collective bargaining agreement governing wages, hours and working conditions of the employees
    - Is authorized under 29 U.S.C. Section 157
14. Hospital indemnity or other fixed indemnity insurance
15. Reinsurance contracts issued on a stop-loss, quota-share or similar basis
16. Short-term major medical contracts
17. Liability insurance, including general liability insurance and automobile liability insurance
18. Other coverage that is:
    - Similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits
    - Specified in federal regulations
19. Coverage for onsite medical clinics
20. Coverage that provides other limited benefits specified by federal regulations

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.

Health status related factor means:

1. Health status
2. Medical condition, including both physical and mental illness
3. Claims experience
4. Receipt of health care
5. Medical history
6. Genetic information
7. Evidence of insurability, including conditions arising out of acts of family violence
8. Disability

Home health agency means a business that provides home health care and is licensed, approved or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of home health care.

Home health care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a home health agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home infusion therapy means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home infusion therapy shall include:

1. Drugs and IV solutions
2. Pharmacy compounding and dispensing services
3. All equipment and ancillary supplies necessitated by the defined therapy
4. Delivery services

5. Patient and family education
6. Nursing services

Over-the-counter products which do not require a physician's or professional other provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home infusion therapy provider means an entity that is duly licensed by the appropriate state agency to provide home infusion therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing)
2. Certified by Medicare as a supplier of hospice care

Hospice care means services for which benefits are provided under the Plan when 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.

Hospital means a short-term acute care facility that:

1. 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 Healthcare Organizations or certified as a hospital provider under Medicare
2. 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 or behavioral health practitioners for compensation from its patients
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the hospital on a contractual prearranged basis and maintains clinical records on all patients
4. Provides 24-hour nursing services by or under the supervision of a registered nurse
5. Has in effect a hospital utilization review plan

Hospital admission means the period between the time of a participant's entry into a hospital or a substance use disorder treatment center as a bed patient and the time of discontinuance of bed-patient care or discharge by the admitting physician, behavioral health practitioner or professional other provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a hospital admission.

Bed patient means confinement in a bed accommodation of a chemical dependency treatment center on a 24-hour basis or 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 (other than a chemical dependency treatment center) designed, staffed and operated to provide long-term institutional care on a residential basis.

Identification card means the card issued to the employee by the carrier indicating pertinent information applicable to coverage.

Imaging center means a provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed by an agency of the state of Texas having legal authority to so license, certify or approve.

Independent laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-network benefits means the benefits available under the plan for services and supplies that are provided by a network provider or an out-of-network provider when acknowledged by BCBSTX.

Inpatient hospital expense means the allowable amount incurred for the medically necessary items of service or supply listed below for the care of a participant, provided that such items are:

1. Furnished at the direction or prescription of a physician, behavioral health practitioner or professional other provider
2. Provided by a hospital or a substance use disorder treatment center
3. Furnished to and used by the participant during an inpatient hospital admission

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made. Inpatient hospital expense shall include:

1. Room accommodation charges. If the participant is in a private room, the amount of the room charge in excess of the hospital's average semiprivate room charge is not an eligible expense.
2. All other usual hospital services, including drugs and

medications, which are medically necessary and consistent with the condition of the participant. Personal items are not an eligible expense.

Medically necessary mental health care or treatment of serious mental illness in a psychiatric day treatment facility, a crisis stabilization unit or facility, a residential treatment center, or a residential treatment center for children and adolescents in lieu of hospitalization shall be inpatient hospital expense.

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 or substance use disorder, or specializes in the treatment of co-occurring mental illness with substance use disorder. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the participants will benefit from programs that focus solely on mental illness conditions.

Late enrollee means any employee or dependent eligible for enrollment who requests enrollment in an employer's health benefit plan: (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer; (2) after the expiration of an open enrollment period or; (3) after the expiration of a special enrollment period.

An employee or a dependent is not a late enrollee if:

1. The individual:
   a. Was covered under another health benefit plan or self-funded health benefit plan at the time the individual was eligible to enroll
   b. Declines in writing, at the time of initial eligibility, stating that coverage under another health benefit plan or self-funded health benefit plan was the reason for declining enrollment
   c. Has lost coverage under another health benefit plan or self-funded health benefit plan as a result of:
      1. Termination of employment
      2. Reduction in the number of hours of employment
      3. Termination of the other plan's coverage
      4. Termination of contributions toward the premium made by the Employer
      5. The death of a spouse
      6. Divorce
      7. COBRA coverage or state continuation benefits have been exhausted
      8. End of dependent status
      9. The plan no longer offers any benefits to the class of similarly situated individuals that include the individual
      10. In the case of coverage offered through a health maintenance organization (HMO), the individual no longer resides, lives or works in the service area of the HMO and no other benefit option is available
   d. Requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded health benefit plan terminates
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period.
4. A court has ordered coverage to be provided for a spouse under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the employer receives the court order or notice of the court order.
6. A dependent child is not a late enrollee if the child:
   a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll
   b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage
   c. The child has lost coverage under Medicaid or CHIP
   d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates

7. The individual has a change in family composition due to marriage or birth of a newborn child, placement as a foster child, adoption of a child or because a participant becomes a party in a suit for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or birth, adoption or date an insured becomes a party in a suit for the adoption
8. The individual becomes a dependent due to marriage or birth of a newborn child, placement as a foster child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child provided the request for enrollment is made no later than the 31st day after the date of the marriage or birth, adoption or date an insured becomes a party in a suit for the adoption

Life-threatening disease or condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Marriage and family therapy means the provision of 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.

Maternity care means care and services provided for treatment of the condition of pregnancy, other than complications of pregnancy.

Medical social services means those social services relating to the treatment of a participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the participant's sickness, need for care, response to treatment and adjustment to care
2. Relationship of the participant's medical and nursing requirements to the home situation, financial resources and available community resources

Medical-surgical expenses means the allowable amount for those charges incurred for the medically necessary items of service or supply listed below for the care of a participant, provided such items are:

1. Furnished by or at the direction or prescription of a physician, behavioral health practitioner or professional other provider
2. Not included as an item of inpatient hospital expense or extended care expense in the plan

A service or supply is furnished at the direction of a physician, behavioral health practitioner or professional other provider if the listed service or supply is:

1. Provided by a person employed by the directing physician, behavioral health practitioner or professional other provider
2. Provided at the usual place of business of the directing physician, behavioral health practitioner or professional other provider
3. Billed to the patient by the directing physician, behavioral health practitioner or professional other provider

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

Medically necessary or medical necessity means those services or supplies covered under the plan which are:

1. Essential to, consistent with and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury or bodily malfunction
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
3. Not primarily for the convenience of the participant, physician, behavioral health practitioner, hospital or other provider
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the participant; 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; BCBSTX does not determine course of treatment or whether particular health care services are received; The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the participant, physician, behavioral health practitioner, the hospital or the other provider.

The medical staff of BCBSTX shall determine whether a service or supply is medically necessary under the plan and will consider 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, behavioral health practitioner or professional other provider may have prescribed treatment, such treatment may not be medically necessary within this definition.

Network means identified physicians, professional or other providers, hospitals and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and Blue Shield Plans) for participation in a managed care arrangement.

Network provider means a hospital, physician or other provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and Blue Shield plans) to participate as a managed care provider.

Neurobehavioral testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews with the individual, family and others.

Neurobehavioral treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

Neurofeedback therapy means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters that are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatment means interventions that focus on the functions of the nervous system.

Neuropsychological testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-contracting facility means a hospital, a facility other provider or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services or supplies for which benefits are provided by the plan. Any hospital, facility other provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a non-contracting facility.

Open enrollment period means the 31-day period preceding the next contract anniversary date during which employees and dependents may enroll for coverage.

Other provider means a person or entity other than a hospital or physician that is licensed where required to furnish to a participant an item of service or supply described herein as eligible expenses. Other provider shall include:

1. Facility other provider - an institution or entity, only as listed:
   a. Substance use disorder treatment center
   b. Crisis stabilization unit or facility
   c. Durable medical equipment provider
   d. Home health agency
   e. Home infusion therapy provider
   f. Hospice
   g. Imaging center
   h. Independent laboratory
   i. Prosthetics/orthotics provider
   j. Psychiatric day treatment facility
   k. Residential treatment center for children and adolescents
   l. Skilled nursing facility
   m. Therapeutic center
2. Professional other provider - a person or practitioner, when acting within the scope of their license and who is appropriately certified, only as listed:
   a. Advanced practice nurse

b. Doctor of chiropractic
c. Doctor of dentistry
d. Doctor of optometry
e. Doctor of podiatry
f. Doctor of psychology
g. Doctor of psychiatry
h. Licensed acupuncturist
i. Licensed audiologist
j. Licensed substance use disorder counselor
k. Licensed dietitian
l. Licensed hearing instrument fitter and dispenser
m. Licensed marriage and family therapist
n. Licensed clinical social worker
o. Licensed occupational therapist
p. Licensed physical therapist
q. Licensed professional counselor
r. Licensed speech-language pathologist
s. Licensed surgical assistant
t. Nurse first assistant
u. Physician assistant
v. Psychological associates who work under the supervision of a doctor of psychology

The listings shown above in 1 and 2, unless otherwise defined in the plan, shall have the meaning assigned to them by the Texas Insurance Code. In states where there is a licensure requirement, other providers must be licensed by the appropriate state administrative agency.

Out-of-network benefits means the benefits available under the plan for services and supplies that are provided by an out-of-network provider.

Out-of-network provider means a hospital, physician, behavioral health practitioner or other provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and Blue Shield Plan) as a managed care provider.

Out-of-pocket maximum means, if "employee only" coverage is elected, the cumulative dollar amount of eligible expenses, including the calendar year deductible, incurred by the employee during a calendar year. If "family" coverage is elected, out-of-pocket maximum means the cumulative dollar amount of eligible expenses, including the calendar year deductible, incurred by the family during a calendar year.

Outpatient contraceptive services means a consultation, examination, procedure or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Outpatient day treatment services means structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration or non-residential treatment settings.

Participant means an employee or dependent whose coverage has become effective under this contract.

Physical medicine services means those modalities, procedures, tests and measurements listed in the physicians' current Procedural Terminology Manual (procedure codes 97010-97799), whether the service or supply is provided by a physician or professional other provider and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing and orthotics or prosthetic training.

Physician means a person, when acting within the scope of their license, who is a doctor of medicine or doctor of osteopathy. The terms doctor of medicine or doctor of osteopathy shall have the meaning assigned to them by the Texas Insurance Code.

Plan service area means the geographical area or areas specified in the contract in which a network of providers is offered and available and is used to determine eligibility for managed health care plan benefits.

Post-acute care treatment services means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-service medical necessity review means the process of determining coverage after treatment has

already occurred and is based on medical necessity guidelines. Can also be referred to as a retrospective review or post-service claims request.

Prior authorization means the process that determines in advance the medical necessity or experimental/investigational nature of certain care and services under this plan.

Proof of loss means written evidence of a claim including:

1. The form on which the claim is made
2. Bills and statements reflecting services and items furnished to a participant and amounts charged for those services and items that are covered by the claim
3. Correct diagnosis code(s) and procedure code(s) for the services and items

Prosthetic appliances means 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 replace all or part of 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.

Prosthetics/orthotics provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a hospital, physician, other provider or any other person, company or institution furnishing to a participant an item of service or supply listed as eligible expenses.

Psychiatric day treatment facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a psychiatric day treatment facility must be certified in writing by the attending physician or behavioral health practitioner to be in lieu of hospitalization.

Psychophysiological testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified ABA provider means a provider operating within the scope of their license or certification that has met the following requirements: For the treatment supervisor/case manager/facilitator:

1. Master's level, independently licensed clinician, who is licensed, certified, or registered by an appropriate agency in the state where the services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without ABA service techniques; OR
2. Master's level clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e., Board-Certified Behavior Analyst [BCBA] or Board-Certified Behavior Analyst Doctor [BCBA-D]), to supervise and provide treatment planning, with ABA service techniques. The provider must have an appropriate state license in addition to their BCBA certification in those states that have ABA licensing requirements; OR
3. Master's level clinician with a plan state-specific professional credential or certification.

For the para-professional/line therapist:

1. Two years of college educated staff person with a Board-Certified Assistant Behavior Anaylst (BCaBA) for the para-professional/therapist, OR
2. An individual acting under the supervision of a qualified ABA Provider described in the definition above.

Remediation means the process(es) of restoring or improving a specific function.

Renal dialysis center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Research institution means an institution or provider (person or entity) conducting a phase I, phase II, phase III or phase IV clinical trial.

Residential treatment center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served

or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission on Accreditation of Hospitals (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

Retail health clinic means a provider that provides treatment of uncomplicated minor illnesses. Retail health clinics are typically located in retail stores and are typically staffed by advanced practice nurses or physician assistants.

Routine patient care costs means the costs of any medically necessary health care service for which benefits are provided under the plan, without regard to whether the participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The investigational item, device or service itself
2. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Serious mental illness means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. Bipolar disorders (hypomanic, manic, depressive and mixed)
2. Depression in childhood and adolescence
3. Major depressive disorders (single episode or recurrent)
4. Obsessive-compulsive disorders
5. Paranoid and other psychotic disorders
6. Schizo-affective disorders (bipolar or depressive)
7. Schizophrenia

Skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility)
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care

Specialty care provider means a physician or professional other provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and Blue Shield Plans) to participate as a managed care provider of specialty services.

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 status as a dependent. A subscriber is also the primary policyholder.

Substance use disorder means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance. Also referred to in this benefit booklet as substance use disorder (SUD).

Substance use disorder treatment center means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a behavioral health practitioner and a facility that is also one or more of the following:

1. Affiliated with a hospital under a contractual agreement with an established system for patient referral
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations
3. Licensed as a chemical dependency treatment program by an agency of the state of Texas having legal authority to so license, certify or approve
4. Licensed, certified or approved as a chemical dependency treatment program or center by any

other state agency having legal authority to so license, certify or approve

Teledentistry dental service means a health service delivered by a dentist or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth service means a health service, other than a telemedicine medical service or a teledentistry dental service, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service means a health care service delivered by a physician or behavioral health practitioner licensed in Texas or a health professional acting under the delegation and supervision of a physician or behavioral health practitioner licensed in Texas, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Therapeutic center means an institution which is appropriately licensed, certified or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility
2. A freestanding radiation therapy center
3. A freestanding birthing center

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

Virtual provider means a licensed provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

Virtual visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in benefits for virtual visits provision.

NOTICES

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. Standards related to benefits for mothers and newborns
2. Required coverage for reconstructive surgery following mastectomies
3. Coverage of dependent students on medically necessary leave of absence

The exemption from these federal requirements will be in effect for the 2024-2025 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 and Privacy page on the Office of Employee Benefits' website, **utsystem.edu/offices/employee-benefits/hipaa-and-privacy**. A paper copy of the privacy notice is available to anyone upon request from OEB free of charge by calling **1-800-888-6824**.

For more information, contact your institution's 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 Blue Cross and Blue Shield providers 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
- 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, withholdings, other contingent payment arrangements and non-claims transactions with your health care provider or 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 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 Blue Cross Blue Shield Global Core method noted above or require a surcharge, Blue Cross and Blue Shield will 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
2. Employee retirement or termination (voluntary or involuntary), except for discharge for gross 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)
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:
   - The maximum time period expires
   - 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 pre-existing condition of the participant
   - A continued participant becomes covered by any Medicare benefits after the date of election
   - The employer no longer provides group health coverage for employees
   - 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.

If you have questions, contact your institution's benefits office or call VOYA COBRA Customer Service at **1-833-232-4673** during business hours.

.**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.

Notice About Nondiscrimination and Accessibility Requirements

The University of Texas Office of Employee Benefits complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The University of Texas Office of Employee Benefits does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The University of Texas Office of Employee Benefits provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the UT Office of Talent and Innovation.

If you believe that The University of Texas Office of Employee Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with The UT System Office of Talent & Innovation, 210 W. 7th Street, Austin, Texas 78701, **P: 1-512-499-4587, F: 1-512-499-4395, grp-hrsp@utsystem.edu**. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the UT Office of Talent & Innovation is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr**.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

Tener cobertura médica es importante para todos.

Ofrecemos comunicación y servicios gratuitos para cualquier persona con impedimentos o que requiera asistencia lingüística. No discriminamos por motivos de raza, color, país de origen, sexo, identidad de género, edad, orientación sexual, estado de salud o discapacidad.

Para recibir asistencia lingüística o comunicativa de manera gratuita, llámenos al 855-710-6984.

Si cree que no hemos proporcionado un servicio, o si cree que ha sido discriminado de cualquier otra manera, comuníquese con nosotros para presentar una inconformidad.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Teléfono: 855-664-7270 (correo de voz)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

Tiene el derecho de presentar una queja por derechos civiles en la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services, Office for Civil Rights) por estos medios:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Teléfono: 800-368-1019
TTY/TDD: 800-537-7697
Portal de quejas: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Formulario de quejas: http://www.hhs.gov/ocr/office/file/index.html

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

The University of Texas System

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