

# UT Benefits

Insurance, Retirement & Wellness Programs for The University of Texas System

As an important part of our UT community, your quality of life is of utmost importance to all of us here at UT System's Office of Employee Benefits. That's why we're providing you with *UT Benefits*, a dynamic and flexible package of valuable programs. Designed exclusively for UT faculty, staff, retirees and eligible dependents, *UT Benefits* provides you and your family with a wide range of comprehensive health insurance programs, financial protection with life insurance and numerous resources for your overall well-being. *UT Benefits* supplements your institution's offerings and, together, provide you with the best total benefits package possible to help meet your family's needs.

## How *UT Benefits* can help you:

- *Manage your health and be prepared for the unexpected*

Group Insurance - Medical, Dental, Vision, Life and Long Term Care

- *Take control and live a healthier lifestyle*

Wellness - Living Well Health Manager & Wellness Programs

**UT Benefits + Your Institution's Offerings = Your TOTAL Benefits Package**

Whether you are a new UT retiree or are just checking up on the latest offerings, we encourage you to use the resources in these pages to build a unique benefits package that cares for you today, tomorrow and beyond.

If you can't find the information you're looking for, please contact your institution Benefits Office listed in the back of this handbook.



THE UNIVERSITY of TEXAS SYSTEM

*Nine Universities. Six Health Institutions. Unlimited Possibilities.*

OFFICE of EMPLOYEE BENEFITS

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# UT BENEFITS HANDBOOK

## *For Retired Employees*

SEPTEMBER 1, 2010 - AUGUST 31, 2011

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### *Welcome*

Your *UT Benefits Handbook for Retired Employees* has been designed to help you make the best benefits decisions possible for you and your family. Detailed information about each plan offered, including all plan guides and provider lists, is available on the UT System Office of Employee Benefits (OEB) website at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits).

Website addresses and Customer Service telephone numbers for each plan are listed in the back of this handbook. Please read all materials carefully, attend local institution benefits meetings, and discuss your options and any questions with your institution Benefits Office staff. Contact information for your institution Benefits Office is also located in the back of this handbook.

#### **Helpful Tools**

Many of the group administrators offer time-saving, online tools that allow you to:

- Print ID cards;
- Search for the most up-to-date provider networks in the medical, dental, and vision plans;
- Review your benefits;
- See UT SELECT Explanation of Benefits (EOB) summaries once your claim is paid in the Blue Cross Blue Shield of Texas website;
- Receive status updates on the processing of your prescription requests through the Medco Home Delivery pharmacy; and
- Search for medications and low cost alternatives through My Rx Choices on the Medco website.

Website addresses for each plan are located at the end of that plan section so you can find out more about the online services available to you.

**Important!** This Handbook describes benefits available to eligible UT retired employees and their dependents. The benefits available to employees are different. If you are an active employee seeking information about benefits for yourself or your eligible dependents, please consult the *UT Benefits Handbook for Employees*.

[www.utsystem.edu/benefits](http://www.utsystem.edu/benefits)

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# Group Insurance Benefits

## What's New Beginning September 1, 2010

### Plan and Premium Rate Changes for the 2010-2011 Plan Year

The following chart highlights changes for the 2010-2011 plan year. More information is available in each plan section and the Benefits Cost Worksheet in this handbook.

Plan	Vendor	Benefit Changes	Premium Changes
UT SELECT Medical	Blue Cross and Blue Shield of Texas	Increase in deductible, out-of-pocket maximum, and emergency copayment. \$5,000 separate deductible for bariatric surgery.	Increase in out-of-pocket premiums for dependent coverage from \$20.31 - \$39.99 per month
UT SELECT Prescription Drug	Medco Health	Several medications added to therapy programs. No other changes.	Included in UT SELECT medical premiums
UT SELECT Dental	Delta Dental	No change	Modest increase in out-of-pocket premiums ranging from \$0.90 to \$2.67 per month
Dental HMO	Assurant DMO	No change	No change
Vision	Superior Vision	No change	No change
Group Term Life	Dearborn National®	Increase in Basic Life. Several enhancements in benefits. Addition of Voluntary Spouse Life Benefit. See Group Term Life section for details.	Decrease in out-of-pocket cost for retired employee voluntary life.
Long Term Care	CNA	No change	No change
Wellness	WebMD	No change	Free for UT SELECT participants

## New Announcements and Reminders

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### **Dearborn National Selected as Carrier for Group Term Life and AD&D**

Dearborn National (as the new brand name for Fort Dearborn Life) has been selected through a competitive bid process to continue to administer the Group Term Life insurance plan effective September 1, 2010. The Basic Group Term Life benefit is increasing from \$3,000 to \$6,000 at no additional cost to the Retired Employee.

Retired Employee Voluntary Group Term Life rates are decreasing with no change in the benefits.

**NEW!** Available for the first time will be Voluntary Group Term Life coverage for your spouse in the amount of \$3,000. The premium of \$1.83 per month will be fully paid by the retired employee. The retired employee must have Voluntary Group Term Life in order to enroll the spouse in this new coverage. Evidence of Insurability may be required.

Several enhancements are being added including online beneficiary management and online will preparation. See the Group Term Life section for more details.

### **Online Beneficiary Management**

Beginning July 1, 2010, Dearborn National offers a new Online Beneficiary Management feature. The Online Beneficiary Management tool is a valuable service available for individuals covered under our group life product.

This easy-to-use, secure service allows you to make your beneficiary designations online while protecting your privacy. There are no paper forms to complete. Beneficiaries can be changed as often as your life circumstances change and the changes are effective immediately.

If you have previously submitted beneficiary information, be sure to access the Online Beneficiary Management tool to verify and/or update your designations. Visit the Dearborn National website for more details: [www.dearbornnational.com/ut](http://www.dearbornnational.com/ut).

### **Be Sure to Submit EOI Forms on Time**

During this 2010 Annual Enrollment, Evidence of Insurability (EOI) forms can be signed and submitted electronically using the online *My UT Benefits*. **All EOI forms submitted during this Annual Enrollment for medical or voluntary group term life coverage must be electronically signed by August 15, 2010 to be considered.** Forms cannot be electronically submitted after this date. If you do not have online access, you may request a paper form from your institution's Benefits Office.

For more information about EOI requirements, consult the EOI section of this handbook.

### **Re-Take Your Living Well HealthQuotient<sup>SM</sup> (HQ)**

Do you know your health score? Whether you've already completed the HealthQuotient<sup>SM</sup> (HQ) or are taking it for the first time, it's important to know your current health score. Your health changes over time and can even change significantly within a year, which is why we encourage you to complete your (HQ) each year. To find your current health score, visit Living Well Health Manager, powered by WebMD, at [www.Webmdhealth.com/ut](http://www.Webmdhealth.com/ut) and select "HealthQuotient".

# What You Need to Know

## Eligibility

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### Retired Employees

1. Individuals who met the requirements in Texas Insurance Code Section 1601.102(b)(1)-(3), and who retired, as an annuitant (for ORP you do not have to be an annuitant), on or before 8/31/03 may participate as a retired employee in group insurance benefits if:
  - the individual had at least 3 years of service with UT for which the individual was eligible to participate in the group insurance plan; and
  - the individual's last state employment before retirement was with UT; and
  - the individual retired under the jurisdiction of:
    - the Teachers Retirement System of Texas; or
    - the Employees Retirement System of Texas; or
    - the Optional Retirement Program established by Chapter 830, Government Code or any other federal or state statutory retirement program to which UT has made employer contributions.
2. Individuals who were employed with UT, or were eligible to retire on 8/31/03 but chose not to, and currently meet the requirements in Section 1601.102(b) as enumerated above, and who retire as an annuitant after 8/31/03 must meet the criteria as defined above in number one.
3. Individuals who began work on or after 9/1/03 and who subsequently retire as an annuitant, must meet the following criteria in order to be eligible for UT group retirement benefits:
  - the individual has at least 10 years of UT service; and
  - the individual's last state employment before retirement was with UT; and
  - the individual retires under the jurisdiction of:
    - the Teachers Retirement System of Texas; or
    - the Employees Retirement System of Texas; or
    - the Optional Retirement Program established by Chapter 830, Government Code or any other federal or state statutory retirement program to which UT has made employer contributions; or
  - the individual meets the rule of 80 with at least 10 years total creditable service, or the individual has 10 years total creditable service and is age 65.
4. Individuals, regardless of age and years of service credit, who worked in a benefits-eligible position with UT and are members of the Teacher Retirement System of Texas (TRS) may participate in the UT Benefits program if the TRS Medical Board determines the individual is eligible for disability retirement and certifies that:
  - the individual is mentally or physically disabled from the further performance of his or her UT System job duties; and
  - the disability is probably permanent.
  - Individuals who are participants in the Optional Retirement Program (ORP) may also qualify for disability retirement if the two conditions in the prior paragraph are met. In lieu of the TRS Medical Board, determination of disability by the Social Security Administration or the Disability carrier will suffice.

For more information about disability retirement, contact TRS or refer to the Office of Employee Benefits Administrative Manual, Policy 220 on the OEB website at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits).

## Dependents

You may also enroll your eligible dependents under plans offered by UT. Your eligible dependents are:

- Your spouse as defined by Texas state law;
- Your unmarried child(ren) under age 25, including:
  - Stepchildren,
  - Adopted children, and
  - Children for whom you are the legal guardian;
- Your unmarried grandchild under age 25, if the child qualifies and is claimed as your dependent for federal tax purposes; and
- Certain children over age 25, who are determined by OEB to be medically incapacitated and are unable to provide their own support.

UT requires additional supporting documentation when you request to add a dependent to your plan. You may be asked to provide copies of your marriage certificate, your children's birth certificate(s), and/or appropriate adoption paperwork. This paperwork is required not only to support the coverage of eligible dependents but also, in the case of marriage or the birth of a new child, to support a mid-year change of status.

Examples of dependents who are not eligible for coverage include:

- Your common-law spouse, unless you can establish proof of a valid common law marriage as defined by Texas state law
- Your same-sex partner
- Your former spouse
- Your married child
- Your child over age 25, if not medically incapacitated and unable to provide their own support
- Foster children covered by another government program, unless coverage is required by law or court order
- Any dependent insured by another UT employee or retired employee

- Any dependent insured by another plan that receives State of Texas premium contributions, and
- Any dependent who is on Active Duty in the Armed Forces of any country

Misrepresentation of benefit eligibility requirements constitutes a violation of OEB's official policy. A verified misrepresentation by an employee or retired employee shall be reported by OEB to the appropriate institution for investigation and possible sanctions. Possible sanctions for such a violation range from a reprimand to dismissal.

In addition, reimbursement may be required for any benefits paid to an ineligible individual. Deliberate misrepresentation of dependent eligibility by an employee or retired employee may constitute criminal fraud and may result in a referral to a law enforcement office.

## Premium Sharing

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As a retired employee, UT and the State of Texas will provide 100% of your premiums for the Basic Coverage Package, and up to 50% of the premiums for your dependents' medical coverage. You are responsible for all Optional Coverage premiums.

## Change of Status

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Changes to your UT Benefits may be made during Annual Enrollment each year or following a qualified Change of Status. You have 31 days from the date of the Change of Status event to notify your institution Benefits Office and change your benefit selections. If you do not make your changes during the 31-day Status Change Period, your changes cannot be made until the next Annual Enrollment in July, to be effective the following September 1.

The list below includes common examples of qualified Change of Status events:

- 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 non-benefits eligible part-time to full-time)
- Change in dependent's eligibility (e.g., marriage or reaching age 25,)
- Change in coverage or cost of other benefit plans available to you and your family

#### A Retired Employee

- whose dependent loses insurance coverage under the Medicaid or CHIP program as a result of loss of eligibility of either the employee or the dependent; or
- whose dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

may enroll this dependent in the basic coverage under UT Benefits without Evidence of Insurability, 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 retired employee, the retired employee will also be eligible to enroll.

Your benefit changes must be consistent with your Change of Status event. For questions regarding a qualified Change of Status, please refer to OEB Policy 310, available online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits), or contact your institution Benefits Office.

**Note:** Evidence of Insurability may be required for some benefit changes if you wait until Annual

Enrollment instead of enrolling during the 31-day Status Change Period.

## Basic Coverage Package

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UT Benefits provides eligible retired employees with the following Basic Coverage Package:

- UT SELECT Medical Plan, with Prescription Drug Coverage
- \$6,000 Basic Group Term Life Insurance

## Optional Coverage

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You may select the following Optional Coverage(s) for you and your eligible dependents, unless stated otherwise:

- UT SELECT Medical Plan, with Prescription Drug Coverage, for your eligible dependents
- Dental Insurance
- Vision Insurance
- Voluntary Group Term Life Insurance (in addition to Basic Group Term Life Insurance)
- Long-Term Care Insurance

## Evidence of Insurability (EOI)

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Evidence of Insurability (EOI) is the record of a person's past and current health events. EOI is used by insurance companies to verify whether a person meets the definition of good health.

An EOI form is required to:

- Add certain dependents to UT SELECT medical coverage who were previously eligible but not enrolled during the employee's initial 31-day benefit election period. (If these certain dependents can show proof of other group medical coverage that was in effect

within 63 days prior to the beginning date of the UT SELECT coverage, EOI will be waived for the UT SELECT medical plan);

- Reinstate retired employees' medical coverage that was previously terminated or waived, unless proof of other active group medical coverage can be provided;
- Increase or reinstate retired employees' Voluntary Group Term Life insurance coverage;
- Add Spouse Voluntary Group Term Life insurance; or
- Add Long-Term Care insurance coverage after your initial 31-day benefit election period. EOI is required at all times for spousal enrollment.

Completed EOI forms must be submitted electronically or printed and mailed by the deadline to the appropriate insurance company for review. **The postmark deadline for Annual Enrollment is August 15.** For a newly retired employee, your EOI form must be postmarked no later than 15 days following your initial eligibility period. Forms are available through your local institution Benefits Office and, during Annual Enrollment, through online My UT Benefits at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits).

## Continuation of Group Coverage (COBRA)

If you or your dependents lose eligibility for coverage, UT will offer you the option to continue coverage for any UT medical, dental, and/or vision plan. You are responsible for the full premium for elected COBRA coverage plus a 2% administration fee. For information regarding the conditions for continuation of coverage, please contact your institution Benefits Office.

If you lose eligibility for coverage and are already enrolled in the Basic or Voluntary Group Term Life, and/or Long-Term Care plans, you may also be able to access a conversion benefit provided directly to you under an individual plan from

the plan carrier. To do so, you must obtain the required form(s) from your institution Benefits Office and forward them to the appropriate plan carrier within 31 days of the end of the month in which your eligibility status changes or terminates.

## Surviving Dependent Benefits

The surviving spouse or other benefits-eligible dependent of a Retired Employee is eligible for benefits as a surviving dependent if the dependent was participating in *UT Benefits* at the time of the Retired Employee's death.

For Non-Disability Retired Employees, a benefits-eligible surviving spouse may continue *UT Benefits* coverage for the remainder of the surviving spouse's life unless they otherwise lose status as an eligible dependent. A dependent child may continue, until age 25 or until they otherwise lose his or her status as an eligible dependent. For Disability Retired Employees, a surviving spouse or other benefits-eligible dependent may continue *UT Benefits* coverage for the number of months equal to the number of months of UT service of the deceased Disability Retired Employee prior to retirement unless they otherwise lose status as an eligible dependent. If the amount of creditable UT service is less than thirty-six (36) months, the surviving spouse or other dependent may be eligible to elect COBRA coverage for a number of months not to exceed 36 months minus the number of months of coverage received as a surviving dependent.

Loss of status as a surviving spouse or dependent occurs when:

- Surviving Dependent dies
- Surviving Child marries
- Surviving Child reaches the age of 25 and is not certified as an Incapacitated Adult Dependent
- Legal relationship that forms the basis for a Surviving Child's eligibility as a dependent, such as a medical support order, is terminated

- Managing conservatorship is terminated
- Required premium is not paid

## HIPAA

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Title 1 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans, including

- Limitations on pre-existing condition exclusion periods;
- Special enrollment periods for individuals (and dependents) losing other coverage;
- Prohibitions against discriminating against individual participants and beneficiaries based on health status;
- Standards relating to benefits for mothers and newborns; and
- Parity in the application of certain limits to mental health benefits.

HIPAA also permits certain self-funded, governmental group health plans the right of exemption from certain provisions of this federal law. The Office of Employee Benefits has elected to exempt the UT self-funded health plan (UT SELECT) from most of the HIPAA provisions listed above. Pre-existing condition limitations are no longer included in the UT SELECT plan; however, some plan limitations and exclusions apply.

Although UT is exempt from the HIPAA provisions relating to hospital stays for mothers and newborns, it is our intent to satisfy all the requirements for maternity and newborn benefits as set out in HIPAA regulations.

Title 2 of HIPAA requires self-funded health plans to comply with certain regulations concerning the privacy and security of personally identifiable health information the plan collects or maintains about its enrollees. A copy of the HIPAA privacy notice for the UT SELECT Medical and UT SELECT Dental Plans can be found on the following page of this booklet.

The HIPAA privacy policies can be found on the HIPAA Privacy Policies and Forms page of the OEB website. A paper copy of the privacy notice is provided to all new enrollees and is available from OEB to anyone upon request. You can obtain HIPAA privacy information about the fully-insured health plans described in this booklet, including the plan, directly from the insurance carrier providing the plan.

For more information, contact your institution's Benefits Office.

## Notice of Privacy Practices

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REVISION EFFECTIVE AS OF March 23, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

**I. PURPOSE OF THIS NOTICE.** This Notice of Privacy Practices (this “Notice”) describes the privacy practices of the UT SELECT, UT DENTAL SELECT and UT FLEX Self-funded Group Health Plans (“the Plans”) which are funded by The University of Texas System and administered by the Office of Employee Benefits (“OEB”) of the University of Texas System Administration. Federal law requires OEB to ensure that any medical information that it collects, creates or holds on behalf of the Plans which identifies you remains private. Federal law also requires OEB to provide this Notice of OEB’s legal duties and privacy practices with respect to your medical information. Specifically, this Notice describes how OEB may use or disclose your medical information (see Section II), your rights concerning your medical information (see Section III), how you may contact OEB regarding OEB’s privacy policies (see Section IV), and OEB’s right to revise this Notice (see Section V).

OEB will abide by the terms of this Notice as long as it is in effect. This Notice applies to any use or disclosure of your medical information occurring on or after the effective date written at the top of this page, even if OEB created or received the information before the effective date. This Notice will no longer apply once a revised version of this Notice becomes effective.

**II. HOW OEB MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION.** OEB may use or disclose your medical information only as described in this Section II.

**A. Treatment.** OEB may disclose your medical information to a health care provider for your medical treatment.

**B. Payment.** OEB may use or disclose your medical information in order to determine premiums, determine whether OEB is responsible for payment of your health care, and make payments for your health care. For example, before paying a doctor’s bill, OEB may use your medical information to determine whether the terms of your Plan cover the medical care you received. OEB may also disclose your medical information to a health care provider or other person as needed for that person’s payment activities.

**C. Health Care Operations.** OEB may use or disclose your medical information in order to conduct “health care operations.” Health care operations are activities that federal law considers important to OEB’s successful operation. As examples, OEB may use your medical information to evaluate the performance of participating providers in a Plans’ networks, and OEB may disclose your medical information to an auditor who will make sure that a third party administrator of a Plan is complying with contracts and applicable laws. In addition, third party administrators of the

plan may contact you to give you information about treatment alternatives or other health-related services that may interest you. OEB may also disclose your medical information to a health care provider or other health plan that is involved with your health care, as needed for that person's quality-related health care operations.

**D. Required by Law.** OEB will use or disclose your medical information if a federal, state, or local law requires it to do so.

**E. Required by Military Authority.** If you are a member of the Armed Forces or a foreign military, OEB may use or disclose your medical information if the appropriate military authorities require it to do so.

**F. Serious Threat to Health or Safety.** OEB may use or disclose your medical information if necessary because of a serious threat to someone's health or safety.

**G. Limited Data Set.** OEB may use or disclose your medical information for purposes of health care operations, research, or public health activities if the information is stripped of direct identifiers and the recipient agrees to keep the information confidential.

**H. Disclosure to You.** OEB may disclose your medical information to you.

**I. Disclosures to Individuals Involved with Your Health Care.** OEB may use or disclose your medical information in order to tell someone responsible for your care about your location or condition. OEB may disclose your medical information to your relative, friend, or other person you identify, if the information relates to that person's involvement with your health care or payment for your health care.

**J. Disclosures to Business Associates.** OEB may contract with an entity to perform services on behalf of OEB. OEB may then disclose your medical information to such "business associate," and the business associate will use or disclose your medical information only to the extent OEB would be able to do so under the terms of this Section II.

**K. Other Disclosures.** OEB may disclose your medical information to:

- Authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law;
- Law enforcement officials if they need the information to investigate a crime or to identify or locate a suspect, fugitive, material witness, or missing person;
- Health oversight agencies, if authorized by law, in order to monitor the health care system, government benefit programs, or compliance with civil rights laws;
- Persons authorized by law to receive public health information, including reports of disease, injury, birth, death, child abuse or neglect, food problems, or product defects;
- Persons authorized by law to receive the information under a court order, subpoena, discovery request, warrant, summons, or similar process;
- Persons who need the information to comply with workers' compensation laws or similar programs providing benefits for work-related injuries or illnesses;
- Governmental agencies authorized to receive reports of abuse if you are a victim of abuse, neglect, or domestic violence;
- Coroners or medical examiners, after your death, to identify you, to determine your cause of death, or as otherwise authorized by law;
- Funeral directors, after your death, who need the information;
- The Secretary of Health and Human Services, a federal agency that investigates compliance with federal privacy law.

**L. Incidental Uses and Disclosures.** Uses and disclosures that occur incidentally with a use or disclosure described in this Section II are acceptable if they occur notwithstanding OEB's reasonable safeguards to limit such incidental uses and disclosures.

**M. Written Authorization.** OEB may use or disclose your medical information under circumstances that are not described above only if you provide permission by “written authorization.” After you provide written authorization, you may revoke that authorization, in writing, at any time by sending notice of the revocation to the Contact Person identified in Section IV of this Notice. If you revoke an authorization, OEB will no longer use or disclose your medical information under the circumstances permitted by that authorization. However, OEB cannot take back any disclosures already made under that authorization.

**III. YOUR RIGHTS CONCERNING YOUR MEDICAL INFORMATION.** You have the following rights associated with your medical information:

- A. Right To Request Restrictions.** Although OEB is generally permitted to use or disclose your medical information for treatment, payment, health care operations, and notification to individuals involved with your health care, you have the right to request that OEB limit those uses and disclosures of medical information. You must make your request in writing to OEB’s Contact Person identified in Section IV of this Notice. Your request must state (1) the information you want to limit, (2) to whom you want the limit to apply, (3) the special circumstances that support your request for a restriction on Plan disclosures, and (4) if your request would impact payment, how payment will be handled. OEB will consider your request but does not have to agree to it. If OEB does agree, OEB will comply with your request (unless the disclosure is for your emergency treatment or is required by law) until you or OEB cancels the restriction. There is a form you can use to make this request which is available on the OEB website or by contacting OEB or the Office of Human Resources at the component institution of The University of Texas System where you are employed.
- B. Right To Confidential Communications.** You have the right to request that OEB communicate your medical information to you by a certain method (for example, by e-mail) or at a certain location (for example, at a post office box). You must make your request in writing to OEB’s contact person. Your request must include the method or location desired. If your request would impact payment, you must describe how payment will be handled. Your request must indicate why disclosure of your medical information by another method or to another location could endanger you.
- C. Right To Inspect and Copy.** You have the right, in most cases, to inspect and copy your medical information maintained by or for OEB. You must make your request in writing to OEB’s Contact Person identified in Section IV of this Notice. If OEB denies your request, you may have the right to have the denial reviewed by a licensed health care professional selected by OEB. If OEB (or a licensed health care professional performing the review on behalf of OEB) grants your request to inspect your information, OEB will provide you with the requested access. If OEB (or the licensed health care professional on review) grants your request to copy your information, OEB will provide you with the requested documents, but OEB may charge you a fee.
- D. Right To Amend.** If you feel that medical information OEB has about you is incorrect or incomplete, you may ask OEB to amend the information. You have the right to request an amendment for as long as the information is kept by or for OEB. You must make your request in writing to the Contact Person identified in Section IV of this Notice, and you must give a reason that supports your request. If OEB denies your request for an amendment, OEB will explain to you its reasons for denial and your appeal rights following denial.

**E. Right To an Accounting of Disclosures.** You have the right to request a list of disclosures of your medical information that have been made by OEB and its business associates. OEB does not have to list the following disclosures:

- Disclosures for treatment;
  - Disclosures for payment;
  - Disclosures for health care operations;
  - Disclosures of a limited data set for health care operations, research, or public health activities;
  - Disclosures to you;
  - Disclosures to individuals involved with your health care;
  - Disclosures to authorized federal officials for national security activities;
  - Disclosures that occur incidentally with other permissible uses and disclosures;
  - Disclosures made under your written authorization; and
  - In certain circumstances, disclosures to law enforcement officials or health oversight agencies.
- You must make your request in writing to the Contact Person identified in Section IV of this Notice. Your request must state the time period during which the disclosures were made, which may not include dates more than six years prior to the request or before April 14, 2003. OEB may charge you a fee for the list of disclosures if you request more than one list within 12 months.

**F. Right To Make a Complaint.** If you believe your privacy rights have been violated, you may file a written complaint with OEB's contact person or with the federal government's Department of Health and Human Services. OEB will not penalize you or retaliate against you in any way if you file a complaint.

**G. Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this Notice, even if you have received this Notice electronically. You may make your request to the Contact Person identified in Section IV of this Notice at any time.

#### IV. WHOM TO CONTACT REGARDING OEB'S PRIVACY POLICIES.

**A. OEB's Contact Person.** To obtain a copy of the most current Notice, to exercise any of your rights described in this Notice, or to receive further information about the privacy of your medical information, you may contact OEB's Contact Person at:

Assistant Director, Employee Benefits  
Office of Employee Benefits  
702 Colorado Street, Suite 2.100  
Austin, Texas 78701  
(512) 499-4616

**B. Department of Health and Human Services.** To obtain further information about the federal privacy rules or to submit a complaint to the Department of Health and Human Services, consult the Department's website at [www.dhhs.gov/ocd/privacy/hipaa/complaints/index.html](http://www.dhhs.gov/ocd/privacy/hipaa/complaints/index.html). You can also contact the Department's Regional Office via regular mail, phone or fax:

Ralph Rouse, Regional Manager, Region IV  
Office of Civil Rights  
U.S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, TX 75202  
Voice Phone (214) 767-4056, FAX (214) 767-0432, TDD (214) 767-8940

**C. Electronic Copy of This Notice.** You may obtain an electronic copy of the most current version of this Notice at the following website: [www.utsystem.edu/benefits/hipaa](http://www.utsystem.edu/benefits/hipaa).

**V. OEB'S RIGHT TO REVISE THIS NOTICE.** OEB reserves the right to change the terms of this Notice at any time. OEB also reserves the right to make the revised notice effective for medical information OEB already has about you as well as any information OEB receives while such notice is in effect. Within 60 days of a material revision to this Notice, OEB will provide the revised notice to all individuals then covered by a Plan. If you want to make sure that you have the latest version of this Notice, you may contact OEB's Contact Person.

# Medicaid and the Children's Health Insurance Program (CHIP)

## Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed in this section, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums.

The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility.

### ALABAMA – Medicaid

Website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

Phone: 1-800-362-1504

### ALASKA – Medicaid

Website:

<http://health.bss.state.ak.us/dpa/programs/medicaid>

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

### ARIZONA – CHIP

Website: [www.azahcccs.gov/applicants/default.aspx](http://www.azahcccs.gov/applicants/default.aspx)

Phone: 1-877-764-5437

### ARKANSAS – CHIP

Website: [www.arkidsfirst.com](http://www.arkidsfirst.com)

Phone: 1-888-474-8275

### CALIFORNIA – Medicaid

Website: [www.dhcs.ca.gov/services/Pages/TPLRD\\_CAU\\_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx)

Phone: 1-866-298-8443

### COLORADO – Medicaid and CHIP

Medicaid Website: [www.colorado.gov](http://www.colorado.gov)

Medicaid Phone: 1-800-866-3513

CHIP Website: [www.CHIPplus.org](http://www.CHIPplus.org)

CHIP Phone: 303-866-3243

### FLORIDA – Medicaid

Website: [www.flhca.state.fl.us/Medicaid/index.shtml](http://www.flhca.state.fl.us/Medicaid/index.shtml)

Phone: 1-866-762-2237

## **GEORGIA – Medicaid**

Website: <http://dch.georgia.gov/>  
Click on Programs, then Medicaid  
Phone: 1-800-869-1150

## **IDAHO – Medicaid and CHIP**

Medicaid Website:  
[www.accesstohealthinsurance.idaho.gov](http://www.accesstohealthinsurance.idaho.gov)  
Medicaid Phone: 1-800-926-2588  
CHIP Website: [www.medicaid.idaho.gov](http://www.medicaid.idaho.gov)  
CHIP Phone: 1-800-926-2588

## **INDIANA – Medicaid**

Website: [www.in.gov/fssa/2408.htm](http://www.in.gov/fssa/2408.htm)  
Phone: 1-877-438-4479

## **IOWA – Medicaid**

Website: [www.dhs.state.ia.us/hipp](http://www.dhs.state.ia.us/hipp)  
Phone: 1-888-346-9562

## **KANSAS – Medicaid**

Website: [www.khpa.ks.gov](http://www.khpa.ks.gov)  
Phone: 800-766-9012

## **KENTUCKY – Medicaid**

Website: <http://chfs.ky.gov/dms/default.htm>  
Phone: 1-800-635-2570

## **LOUISIANA – Medicaid**

Website: [www.la.hipp.dhb.louisiana.gov](http://www.la.hipp.dhb.louisiana.gov)  
Phone: 1-888-342-6207

## **MAINE – Medicaid**

Website: [www.maine.gov/dbhs/oms](http://www.maine.gov/dbhs/oms)  
Phone: 1-800-321-5557

## **MASSACHUSETTS – Medicaid and CHIP**

Medicaid & CHIP Website:  
[www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Medicaid & CHIP Phone: 1-800-462-1120

## **MINNESOTA – Medicaid**

Website: [www.dhs.state.mn.us](http://www.dhs.state.mn.us)  
Click on Health Care, then Medical Assistance  
Phone: 800-657-3739

## **MISSOURI – Medicaid**

Website: [www.dss.mo.gov/mhd/index.htm](http://www.dss.mo.gov/mhd/index.htm)  
Phone: 573-751-6944

## **MONTANA – Medicaid**

Website:  
<http://medicaidprovider.bhs.mt.gov/clientpages/clientindex.shtml>  
Telephone: 1-800-694-3084

## **NEBRASKA – Medicaid**

Website: [www.dbhs.ne.gov/med/medindex.htm](http://www.dbhs.ne.gov/med/medindex.htm)  
Phone: 1-877-255-3092

## **NEVADA – Medicaid and CHIP**

Medicaid Website: <http://dwss.nv.gov>  
Medicaid Phone: 1-800-992-0900  
CHIP Website: [www.nevadacheckup.nv.org](http://www.nevadacheckup.nv.org)  
CHIP Phone: 1-877-543-7669

## **NEW HAMPSHIRE – Medicaid**

Website: [www.dbhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm](http://www.dbhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm)  
Phone: 1-800-852-3345 x 5254

## **NEW JERSEY – Medicaid and CHIP**

Medicaid Website:  
[www.state.nj.us/humanservices/dmahs/clients/medicaid](http://www.state.nj.us/humanservices/dmahs/clients/medicaid)  
Medicaid Phone: 1-800-356-1561  
CHIP Website:  
[www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710

## **NEW MEXICO – Medicaid and CHIP**

Medicaid Website:  
[www.hsd.state.nm.us/mad/index.html](http://www.hsd.state.nm.us/mad/index.html)  
Medicaid Phone: 1-888-997-2583  
CHIP Website:  
[www.hsd.state.nm.us/mad/index.html](http://www.hsd.state.nm.us/mad/index.html)  
Click on Insure New Mexico  
CHIP Phone: 1-888-997-2583

### **NEW YORK – Medicaid**

Website:

[www.nyhealth.gov/health\\_care/medicaid](http://www.nyhealth.gov/health_care/medicaid)

Phone: 1-800-541-2831

### **NORTH CAROLINA – Medicaid**

Website: [www.nc.gov](http://www.nc.gov)

Phone: 919-855-4100

### **OKLAHOMA – Medicaid**

Website: [www.insureoklahoma.org](http://www.insureoklahoma.org)

Phone: 1-888-365-3742

### **OREGON – Medicaid and CHIP**

Medicaid & CHIP Website:

[www.oregonhealthykids.gov](http://www.oregonhealthykids.gov)

Medicaid & CHIP Phone: 1-877-314-5678

### **PENNSYLVANIA – Medicaid**

Website: [www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm](http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm)

Phone: 1-800-644-7730

### **RHODE ISLAND – Medicaid**

Website: [www.dhs.ri.gov](http://www.dhs.ri.gov)

Phone: 401-462-5300

### **SOUTH CAROLINA – Medicaid**

Website: [www.scdhhs.gov](http://www.scdhhs.gov)

Phone: 1-888-549-0820

### **TEXAS – Medicaid**

Website: [www.gethipptexas.com](http://www.gethipptexas.com)

Phone: 1-800-440-0493

### **UTAH – Medicaid**

Website: <http://health.utah.gov/medicaid>

Phone: 1-866-435-7414

### **VERMONT– Medicaid**

Website: <http://ovha.vermont.gov>

Telephone: 1-800-250-8427

### **VIRGINIA – Medicaid and CHIP**

Medicaid Website:

[www.dmas.virginia.gov/rcp-HIPP.htm](http://www.dmas.virginia.gov/rcp-HIPP.htm)

Medicaid Phone: 1-800-432-5924

CHIP Website: [www.famis.org](http://www.famis.org)

CHIP Phone: 1-866-873-2647

### **WASHINGTON – Medicaid**

Website:

<http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>

Phone: 1-877-543-7669

### **WEST VIRGINIA – Medicaid**

Website: [www.wvrecovery.com/hipp.htm](http://www.wvrecovery.com/hipp.htm)

Phone: 304-342-1604

### **WISCONSIN – Medicaid**

Website: <http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm>

Phone: 1-800-362-3002

### **WYOMING – Medicaid**

Website:

[www.health.wyo.gov/healthcarefin/index.html](http://www.health.wyo.gov/healthcarefin/index.html)

Telephone: 307-777-7531

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Ext. 61565

# Enrolling in, Viewing and Changing Your Coverage

Representatives from your institution Benefits Office are available to help with Annual Enrollment selections, as well as any other benefit changes allowed during the year. You will find contact information for your Benefits Office located at the end of this handbook.

## Annual Enrollment

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Annual Enrollment begins on July 1 and ends on July 31 of each year. During this time you may change your group insurance benefit elections and add, update or remove dependents from coverage using the online *My UT Benefits* website. On or around July 1, you will receive “Your U.T. Benefit Enrollment Options” letter or e-mail that lists your current coverage and future coverage options and informs you if any action is required on your part. The elections you make will become effective on September 1, 2010, or on the date of EOI approval if EOI is required and approved after September 1, 2010.

## My UT Benefits

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*My UT Benefits* is a convenient, secure enrollment system that allows you to view and change your coverages on the Internet. With *My UT Benefits*, you can review your coverage at any time during the year and make benefit selections during Annual Enrollment. If you have any issues with browser compatibility, please visit the Help Center located under the log-in section of the *My UT Benefits* homepage.

## Using My UT Benefits

*My UT Benefits* can be accessed at [www.utsystem.edu/myUTBenefits](http://www.utsystem.edu/myUTBenefits). Users have several options for logging in including: 1) UT EID and password; 2) Benefits ID (BID) and PIN; 3) Social Security Number (SSN) and PIN; and 4) Campus ID and PIN.

The PIN for both the BID and SSN log-in options will be included in “Your U.T. Benefit Enrollment Options” letter/e-mail. A convenient Help Center link is located directly below the log-in section of *My UT Benefits* should you have any questions about the log-in process.

Also on the *My UT Benefits* homepage is an Online Cost Worksheet to assist you in determining what your out-of-pocket costs will be before you make your selections.

Once logged in, you may verify and update your Annual Enrollment preferences on the Personal Information page. If you have not already done so, you can designate an e-mail address for benefits-related communications by choosing the “Update Your Preferences” button. You may also verify your dependent(s) information and follow the instructions for making any required changes. If you add a dependent using *My UT Benefits*, you must provide supporting documentation (marriage certificate, birth certificate, etc.) to your institution Benefits Office.

The Benefits Enrollment page is divided into sections for each coverage type. Your current coverage and an area for making plan and level selections for the new plan year are located under each heading. There are also links to Plan Details and a Cost Estimate for that coverage. When you have made all your changes, click on “Record My Elections” to complete the enrollment process. If Evidence of Insurability (EOI) is required, you will be prompted to complete an online form.

Remember if you do not submit required EOI forms or if your EOI request is not approved, your selection will not take effect.

The final step in the online enrollment process is reviewing the Benefits Summary page to confirm all the selections you made are correct before logging off the system. You will also be sent a “Confirmation of Your UT Benefits Enrollment” letter/e-mail outlining your selections, and you should review your selections again for accuracy. You may change your benefit selections as often as you wish before midnight CST, July 31, 2010.

If after you review the “Your U.T. Benefit Enrollment Options” letter/e-mail, you plan to carry all the same coverage into the new plan year, you do not have to re-enroll on *My UT Benefits*.

# Plan Information

## UT SELECT Living Well Health & Wellness Program

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**Make it a Priority.**

The University of Texas System

We know good health is important to you and your family. That's why the University of Texas System offers UT SELECT members a great resource - Living Well Health & Wellness Program. From providing critical information about preventing or managing serious disease to developing a personalized health improvement plan, you will find a variety of powerful and easy-to-use tools for you and your family to take charge of your health and develop your own personal wellness program.

### **Take the WebMD HealthQuotient<sup>SM</sup> Health Risk Assessment**

#### **GET TO KNOW YOURSELF**

Do you know your health score? Whether you've already completed the HealthQuotient or are taking it for the first time, it's important to know your current health score. Your health changes over time and can even change significantly within a year, which is why we encourage you to complete your HealthQuotient each year.

The WebMD HealthQuotient (HQ) is one of the most powerful tools available to you through the 'Living Well Health Manager, powered by WebMD' online program. Just answer a few simple questions, and you will receive detailed information about your personal health risk factors – along with a customized plan to help reduce or eliminate them. With HQ, your health isn't left up to fate. It's up to you.

HealthQuotient is available to anyone enrolled in the UT SELECT plan, including dependents age eighteen and older, at no additional cost and is accessible within your 'Living Well Health Manager, powered by WebMD' website. HQ gives you the information you need to identify and stay one step ahead of potentially serious or chronic health problems.

Here is what you can expect when you complete your WebMD HQ:

- Receive a personalized health risk assessment, including a confidential report with “at-a-glance” summary and prioritized results.
- Delivers personalized recommendations to help reduce or eliminate your risk factors.
- Explore compelling “what if” scenarios to see the impact of changing certain lifestyle behaviors.
- Results can help you determine if you need intervention before a more serious condition may develop. Complete your HQ today!

Be assured that the information you provide in the WebMD HQ is completely confidential and will not be released to your employer.

**HOW TO FIND THE WebMD HealthQuotient<sup>SM</sup> (HQ):** To find your current health score, visit Living Well Health Manager, powered by WebMD, at [www.webmdhealth.com/ut](http://www.webmdhealth.com/ut) and select HealthQuotient.

WebMD  
[www.webmdhealth.com/ut](http://www.webmdhealth.com/ut)  
(866) 584-5745  
livingwell@utsystem.edu

Don't let your pursuit of wellness end with the HQ. The UT SELECT Living Well Health and Wellness Program, through a collaborative effort with WebMD, Blue Cross and Blue Shield, and Medco, offers a variety of resources to help you improve or maintain your health. If you are enrolled in the UT SELECT Medical Plan, you and your covered dependents have access to the following programs to help you make Living Well a priority no matter where you are in your wellness journey.

### **NEW! Gym Membership Discount**

Now, there's a program designed to make it easier for you to get fit, feel good and have fun while doing it! The Fitness Program makes it easier for you to:

- Fit a quick workout into your busy day when it's convenient for you, wherever you are
- Find the fitness center that fits you without the hassle of an annual commitment
- Enjoy unlimited access to multiple fitness center locations for one low monthly fee
- Meet new friends and have fun!

To access follow the below steps:

- 1.** Log into [www.bcbstx.com/ut](http://www.bcbstx.com/ut). (You will need to register, if you've never done so before.)
- 2.** On the right side navigation bar, under "Quick Links", click on "Fitness Program".
- 3.** Once re-directed to the site, search for participating locations near you by entering your zip code and desired search distance below. Take the next step to becoming the fitter, healthier person you want to be by enrolling in the Fitness Program today.

### **High Risk Coaching Intervention Program with WebMD to support modifiable/preventable risks/conditions**

Some individuals may be eligible to receive support from a personal Health Coach. Through a series of convenient phone conversations, your Health Coach can help you establish your health goals — and create a personalized program to meet your needs. Your coach will help you focus on the lifestyle behaviors that can help maximize your health.

Some of the topics you discuss may include:

- Exercise
- Nutrition
- Strength training
- Weight management
- Stress management
- Smoking cessation
- Depression
- Alcohol Abuse

To see if you're eligible for a personal Health Coach, you must first complete your HQ located in your Living Well Health Manager. While it's up to you to take the first step toward better health by completing the HQ, support is just around the corner to help you achieve your big dreams of better health. Register online at [www.webmdhealth.com/ut](http://www.webmdhealth.com/ut) and complete your HQ now.

### **Condition Management**

If you experience a complex medical situation, registered nurse case managers can help you or a family member cope with the situation, identify and help you achieve your goals and access many of the services you need. Voluntary health improvement programs are available to help members with cancer, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, asthma, diabetes, metabolic syndrome (high cholesterol, high blood pressure and obesity) and low back pain. To request condition management, contact Blue Access® for UT SELECT members at 1-800-462-3275.

### **Lifestyle Management**

For participants who want to lose weight or stop smoking, UT SELECT coverage also features lifestyle management programs, comprised of Licensed Masters Level Social Workers and Licensed Professional Counselors, who promote wellness through a holistic approach of behavioral coaching, clinical coaching, education and condition management. To enroll in a lifestyle management program, please call toll-free at 1-800-462-3275.

### **Employee Assistance Program (EAP)**

The Employee Assistance Program (EAP) is a benefit of your UT employment that provides confidential, professional assistance to help resolve problems that affect your personal life or job performance. The program is designed to allow you to seek help when you need it, at no charge.

To find out more about the EAP or to make an appointment, select your UT institution from the directory available on the EAP homepage at [www.livingwell.utsystem.edu/eap.htm](http://www.livingwell.utsystem.edu/eap.htm).

### **24/7 Nurseline**

Health concerns don't always follow a 9-to-5 schedule. Fortunately, you can call the toll-free Nurseline 24 hours a day, seven days a week to get the information you need. The 24/7 Nurseline is staffed by registered nurses who can answer many of your general health questions and advise you to call your doctor or encourage you to seek emergency services if necessary.

Plus, when you call, you also have the option to access an audio library of more than 1,000 health topics – from allergies to women's health – with more than 600 topics available in Spanish. Call the 24/7 Nurseline toll free at 888-315-9473.

### **Special Beginnings®**

If you are expecting a new baby, this prenatal program can help guide you through your pregnancy and postpartum care. The program provides support and education, pregnancy risk factor identification and ongoing communication/monitoring from pregnancy until six weeks after delivery. Enrolled mothers-to-be receive personal contact from program staff who can help them better understand and manage their pregnancies and coordinate care with their doctor. See your benefit administrator for information on enrolling or call Special Beginnings at 888-421-7781. UT SELECT offers a \$50 Target reward card to women who enroll in their first trimester and complete the Special Beginnings program after delivery.

### **Complementary Alternative Medicine**

Complementary Alternative Medicine (CAM) includes a variety of therapies that may help to improve your health, prevent illness, and address existing symptoms and conditions. As a BCBSTX member, you are automatically eligible to receive up to 30% off standard fees through a national network of more than 35,000 practitioners, spas, wellness and fitness centers. You are also eligible to receive discounts on vitamins, herbal supplements, and health and wellness magazines. To learn more about CAM discounts, go to [www.bcbstx.com/ut](http://www.bcbstx.com/ut) for more details or call (866) 656-6069.

## Medical

### UT SELECT Medical Plan

UT offers UT SELECT, a self-funded medical PPO plan, administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

For the 2010-2011 plan year, the State and UT will continue to pay 100% of the premium cost for retired employees. For retired employees with spouse or children coverage, your out-of-pocket cost will increase approximately \$20 per month. For retired employees with family coverage, your out-of-pocket cost will increase approximately \$40 per month. The annual deductible, the out-of-pocket maximum, and the emergency room co-pay are increasing. There is also an additional, separate deductible for bariatric surgery. In addition, several medications have been added to the Preferred Step Therapy Program and the Medco drug programs that require authorization. Please read this Medical section for more information.

### Choice of Doctors — Each Time You Need Health Care

When you enroll in UT SELECT, you can receive care from any licensed doctor you choose; no referrals are required. If you use a Network doctor, you will receive the highest level of benefits, pay less out of pocket, and will usually not have to file any claims. If you use an Out-of-Network doctor, you will still be covered, but your out-of-pocket costs for health care services will be higher. If you are enrolled in Medicare Part B, you will receive the highest level of benefits if your provider accepts Medicare assignment. See the UT SELECT and Medicare section for more details.

### Access to One of the Largest Networks in Texas with Worldwide Coverage

UT SELECT participants have access to one of the largest networks of contracting doctors and hospitals in Texas, with more than 60,000 physicians and specialists and over 400 hospitals. If you are traveling outside Texas, there are even more Blue Cross and Blue Shield Network providers from which to choose. More than 85 percent of all doctors and hospitals throughout the United States contract with Blue Cross and Blue Shield plans. Outside of the U.S., you will have access to doctors and hospitals in over 200 countries. With UT SELECT, you have worldwide coverage for both emergency and non-emergency care.

To find a physician or specialist near you, search online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut) or contact UT SELECT Customer Service toll free at 1-866-882-2034.

*Even if you visit an Out-of-Network doctor, you may still save money.*

Blue Cross and Blue Shield of Texas contracts with many out-of-network doctors and hospitals. ParPlan providers accept the Blue Cross and Blue Shield of Texas allowable amounts for covered services and cannot bill you more. In most cases ParPlan providers will file claims, too. Look for participating doctors and hospitals for UT SELECT at [www.bcbstx.com/ut](http://www.bcbstx.com/ut) under ParPlan.

### Your Health Care 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 you and your covered dependents have access to Blue Cross and Blue Shield network providers throughout the United States and around the world.

Follow these steps to receive the network (highest) level of benefits while traveling or away from home.

***If you need to locate the nearest network doctors and hospitals:***

Refer to your UT SELECT Medical ID card and call BlueCard Access at 1-800-810-BLUE (2583).

***If you need to be admitted to a hospital and/or preauthorize care:***

Refer to your UT SELECT Medical ID card and call 1-800-441-9188 to preauthorize care for medical or 1-800-528-7264 to preauthorize care for behavioral health (mental health and chemical dependency).

***If you need to receive medical attention:***

Pay any applicable deductible, copayment or coinsurance amount and pay for any non-covered services.

***If you need to file a claim:***

BlueCard (network) providers will file your claims for you. BlueCard providers have also agreed to accept Blue Cross and Blue Shield's allowable amount for covered services and will not balance bill you for any costs exceeding the allowable amount. If you do not use a BlueCard provider for care, you will need to pay the doctor or hospital at the time of service. Then, you will need to complete and submit a claim form. The claim form is available online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut).

**Transitional Benefits**

If you or a covered dependent are being treated for a chronic or ongoing medical condition at the time you enroll in UT SELECT, and your doctor is not in the UT SELECT PPO network, ongoing care with your current doctor for up to three months may be requested.

Some medical conditions that are eligible for transitional benefits include:

- Pregnancy (if you are in your third trimester on September 1 or at the time of your enrollment)
- Cancer
- Allergy Treatments
- Organ Transplant
- Heart Failure
- Physical Therapy
- Behavioral Health Care
- Diabetes

Transitional benefits are subject to approval. To request transitional benefits, complete a "Transitional Benefits Form" available from your institution Benefits Office or online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut). Instructions for submitting the request to Blue Cross and Blue Shield of Texas are on the form. If the transitional care request is approved, you or your covered dependent may continue to see the Out-of-Network doctor and receive the Network level of benefits from the UT SELECT plan for up to three months. If the transitional care request is denied, you may still continue to see your current doctor, but benefits will be paid at the Out-of-Network level.

*If your doctor under your previous plan is in the UT SELECT PPO Network, you do not have to complete a "Transitional Benefits Form."*

**Preauthorization Requirements**

Preauthorization establishes in advance the medical necessity of certain care and services covered under UT SELECT. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits.

Benefits are always subject to other applicable requirements, such as limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient hospital admissions
- Skilled nursing care in a skilled nursing facility
- Private-duty nursing
- Home health care
- Hospice care
- Home infusion therapy
- Motorized and customized wheelchairs and certain other durable medical equipment totaling over \$5,000
- Transplants
- All inpatient treatment of chemical dependency
- All inpatient and outpatient treatment of serious mental illness and mental health care

To satisfy preauthorization requirements, you, your physician, provider of services, or a family member must call the toll-free number (800-441-9188) on the back of your UT SELECT Medical ID Card.

### **Your UT SELECT Medical ID card will be mailed to your home**

BCBSTX will issue your UT SELECT Medical ID card prior to your effective date of coverage. You will receive a separate Prescription ID card from Medco for your pharmacy benefits under UT SELECT. Your ID card contains important information about you, your family, 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. To request additional Medical ID cards or to replace lost or damaged cards, call Customer Service at 866-882-2034, or log onto Blue Access for Members to order UT SELECT Medical ID Cards online. There is no charge for ID cards.

### **Blue Access® for Members**

#### *Information is a Powerful Tool*

Go to [www.bcbstx.com/ut](http://www.bcbstx.com/ut), log onto Blue Access for Members, and:

- Check the status of a claim and your claims history
- Confirm who in your family is covered under your plan
- View and print an Explanation of Benefits (EOB)\* for a claim
- Locate a doctor or hospital in the Network
- Sign up to receive claim status e-mail alerts
- Request e-mail notification of finalized claims
- Request a new or replacement ID card or print a temporary ID card
- Access the Personal Health Manager and earn Blue Points

To register for Blue Access® for Members, you will need your group and identification numbers from your UT SELECT Medical ID card. You will be asked to create a user ID and password for immediate and secure access to your personal information.

\*BCBSTX no longer mails an Explanation of Benefits (EOB) statement to UT SELECT participants unless they specifically request that their EOBs continue to be mailed. EOBs can be accessed electronically via Blue Access for Members. Always review your EOBs following medical treatment to ensure the accuracy of provider billing and payment.

Register for Blue Access® for Members at [www.bcbstx.com/ut](http://www.bcbstx.com/ut) and view 18 months of up-to-the-minute claim status and Explanation of Benefits statements.

### **Other Resources for Health Care Information from Blue Cross and Blue Shield of Texas**

#### **Hospital Comparison Tool**

When your physician has recommended a surgical treatment, you can easily find and review the outcome history of procedures previously performed at hospitals.

You can review a hospital's performance based on factors such as:

- Mortality
- Length of stay
- Complications
- Number of procedures performed
- Cost

To review hospital outcome data, log onto Blue Access® for Members, click on the My Health section and select Compare Hospitals.

### Treatment Cost Advisor

Through the Treatment Cost Advisor\* tool, you can find the typical cost of a health care procedure from a list of common medical conditions. You simply need to enter information, such as age, gender, and state or ZIP code to help determine a cost estimate for a specified medical procedure. To get started, log onto Blue Access® for Members, click on the My Health section and select Treatment Cost Advisor.

\* All information is intended for your general use only and is not a substitute for medical advice or treatment for specific medical conditions. You should seek prompt medical care for specific health issues and consult your physician before taking any action on your health conditions. Use of this online service is subject to Terms and Conditions.

### TruHearing

[www.truhearing.com](http://www.truhearing.com)

(877) 882-2020

Save on digital hearing aids through TruHearing. Get a free hearing test by a licensed hearing specialist when performed for the purpose of a fitting for a hearing aid. Enjoy a 45-day money back guarantee, a two-year warranty and a selection of hearing aid styles at various price levels. To learn more about the TruHearing discount, log into Blue Access for Members.

### Davis Vision

[www.davisvision.com](http://www.davisvision.com)

(800) 501-1459

Save on eyeglasses (frames and lenses), as well as contact lenses, laser vision correction services, examinations and accessories through one of the nation's leading providers of routine vision care programs.

The Davis Vision network consists of major national and regional retail locations, such as Eyemasters and Visionworks, as well as independent ophthalmologists and optometrists. To learn more about the Davis Vision discount, log into Blue Access for Members.

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors. BlueExtras is a discount program available to BCBSTX members. This is NOT insurance. Some of the services offered through BlueExtras may be covered under your health plan. Please refer to your benefits booklet or call the customer service number on the back of your ID card for specific benefit information under your health plan. Use of BlueExtras does not affect your premium, nor do costs of BlueExtras' services or products count toward your plan deductible, calendar year or lifetime maximums. Discounts are only available through participating vendors. BCBSTX does not guarantee or make any claims or recommendations regarding the services or products offered under BlueExtras. You may want to consult with your physician prior to use of these services and products. Services and products are subject to availability by location. BCBSTX reserves the right to discontinue or change this discount program at any time without notice.

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

### International SOS

When traveling abroad, coverage is provided for your medical needs through your UT SELECT program; however, additional services are available through the UT System-wide International SOS program. This is a comprehensive, 24-hour medical response organization that provides international assistance services worldwide through the use of multilingual Alarm Centers on duty 24 hours a day, 365 days a year. International SOS responds to calls for help and advice from students, travelers and expatriates, managing issues from the simplest task of a doctor referral to the most complex emergency evacuation.

Membership is included for no charge for staff, faculty and students when traveling abroad on official UT business, and is available at a discount when traveling for a personal trip. You may obtain a membership card from your institution travel office. All UT-related travel abroad not booked using one of the University's contracted travel agencies should be reported to International SOS in advance.

This can be done via the UT System SOS portal at [www.internationalosos.com](http://www.internationalosos.com) (use U.T. System Membership # 11BSGC000037 to log on). International SOS is not a Uniform Group Insurance Program benefit.

You may read additional information about medical plan features and exclusions in Your UT SELECT Health Benefits booklet available online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits) or from your institution Benefits Office.

**UT SELECT PPO (medical coverage)**

Blue Cross and Blue Shield of Texas

[www.bcbstx.com/ut](http://www.bcbstx.com/ut)

(866) 882-2034

8:00 AM - 6:00PM CT

## UT SELECT BENEFIT SUMMARY CHART

September 1, 2010 - August 31, 2011

Coverage	UT SELECT – Medical Plan		
	Network	Out-of-Network *	Out-of-Area *
Annual Deductible	\$350/person \$1,050/family (applicable when coinsurance is required)	\$750/person \$2,250/family (applicable when coinsurance is required)	\$350/person \$1,050/family (applicable when coinsurance is required)
Annual Out-of-Pocket Maximum	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family	\$2,500/person \$7,500/family
Pre-existing Condition Limitation	No	No	No
Hospital - Semi private Room and Board**	\$100 Copay/Day (\$500 max/admission); then 80% Plan/20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Outpatient or Same Day Surgery	\$100 Copay; then 80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Office Visit	FCP \$30 Copay Specialist \$35 Copay 100% covered after copay	60% Plan / 40% Member	75% Plan / 25% Member
<b>Preventive Care</b> Routine Physical Exam* Well-Woman Exam* Well-Child Exam (under age 2) Prostate Screening	FCP \$30 Copay Specialist \$35 Copay 100% covered after copay	60% Plan / 40% Member	75% Plan / 25% Member
<b>Preventive Care</b> Immunizations - <u>Up to age 6</u> *Limited to one per person per plan year		Plan pays 100% (no copayment required)	
<b>Preventive Care</b> Immunizations - <u>Age 6 and older</u> , applies for injection only	FCP \$30 Copay Specialist \$35 Copay 100% covered after copay	60% Plan / 40% Member	75% Plan / 25% Member
<b>Preventive Care</b> Routine Mammograms* Colonoscopy Osteoporosis Screening *Limited to one per person per plan year	No Copay; Plan pays 100%	60% Plan / 40% Member	75% Plan / 25% Member
Prenatal and Postnatal Care	\$30 Copay (initial visit only)	60% Plan / 40% Member	75% Plan / 25% Member
Hospital Obstetrical Care**	\$100 Copay (\$500 max/admission); then 80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Hospital Inpatient Surgery**	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Surgical Assistant	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Bariatric Surgery**	\$5000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$5,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers (For non-network providers and out-of-area services, after \$5,000 deductible, plan pays 100% up to the allowable amount ; member pays charges exceeding the allowable amount)		
Office Surgery	FCP \$30 Copay Specialist \$35 Copay	60% Plan / 40% Member	75% Plan / 25% Member
Skilled Nursing/Convalescent Facility**	80% Plan / 20% Member (max. 180 days)	60% Plan / 40% Member (max. 180 days)	75% Plan / 25% Member (max. 180 days)
Radiologist, Pathologist, and Anesthesiologist	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Allergy Testing	FCP \$30 Copay Specialist \$35 Copay	60% Plan / 40% Member	75% Plan / 25% Member
Hospice Care Services**	80% Plan / 20% Member (max. 90 visits per year)	60% Plan / 40% Member (max. 90 visits per year)	75% Plan / 25% Member (max. 90 visits per year)

Coverage	UT SELECT – Medical Plan		
	Network	Out-of-Network *	Out-of-Area *
Home Health Care Services**	80% Plan / 20% Member (max. 120 visits)	60% Plan / 40% Member (max. 120 visits)	75% Plan / 25% Member (max. 120 visits)
Physical Rehabilitation Therapy	80% Plan / 20% Member (max. 20 visits/yr)	60% Plan / 40% Member (max. 20 visits/yr)	75% Plan / 25% Member (max. 20 visits/yr)
Laboratory Services	Included in Office Visit Copay	60% Plan / 40% Member	75% Plan / 25% Member
Diagnostic X-Rays, therapeutic radiology, mammography	Included in Office Visit Copay	60% Plan / 40% Member	75% Plan / 25% Member
Hospital Emergency Room	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	75% Plan / 25% Member
Ambulance Service (if transported)	80% Plan / 20% Member	80% Plan / 20% Member	75% Plan / 25% Member
Chemical Dependency - <u>Inpatient</u> Treatment** (max 30 days/yr)	\$100 Copay/Day (\$500 max/admission); then 80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Chemical Dependency - <u>Outpatient</u> Treatment** (max 20 visits/yr for outpa- tient facility and office visits combined)	<b>Outpatient Facility:</b> 80% Plan/20%Member <b>Office Setting:</b> FCP \$30 Copay Specialist \$35 Copay	60% Plan / 40% Member	75% Plan / 25% Member
Smoking Cessation	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Serious Mental Illness - <u>Inpatient</u> **	\$100 Copay/Day (\$500 max/admission); then 80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Serious Mental Illness - <u>Outpatient</u> **	FCP \$30 Copay Specialist \$35 Copay	60% Plan / 40% Member	75% Plan / 25% Member
Mental Illness - <u>Inpatient</u> ** (Other than Serious Mental Illness)	\$100 Copay/Day (\$500 max/admission); then 80% Plan / 20% Member (max. 30 days/yr)	60% Plan / 40% Member (max. 30 days/yr)	75% Plan / 25% Member (max. 30 days/yr)
Mental Illness - <u>Outpatient</u> **	FCP \$30 Copay Specialist \$35 Copay (max. 20 visits/yr.)	60% Plan / 40% Member (max. 20 visits/yr.)	75% Plan / 25% Member (max. 20 visits/yr.)
Birth Control Management	FCP \$30 Copay Specialist \$35 Copay	60% Plan / 40% Member	75% Plan / 25% Member
Durable Medical Equipment	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Prosthetic Devices	80% Plan / 20% Member	60% Plan / 40% Member	75% Plan / 25% Member
Speech and Hearing Therapy	80% Plan / 20% Member (max. 60 visits per year)	60% Plan / 40% Member (max. 60 visits per year)	75% Plan / 25% Member (max. 60 visits per year)

\* Out-of- Network and Out-of-Area, any charges over the allowable amount are the patient's responsibility.

\*\*These services require preauthorization to establish medical necessity.

**NETWORK** – Network benefits are available to UT SELECT participants living in Texas and certain areas of New Mexico and Washington, D.C. who receive services from providers who have a Network contract agreement with BCBSTX. Network benefits may also be available when services are rendered by providers outside of Texas if that provider has a Network contract agreement with the Blue Cross and Blue Shield plan in the state services were rendered. Network providers have agreed to charge only up to the BCBSTX allowed amount. You are responsible for applicable deductibles, copays and/or coinsurance.

**OUT-OF-NETWORK** – Out-of-Network benefits are available to UT SELECT participants living in Texas and certain areas of New Mexico and Washington, D.C. who receive services from providers who do not have a network contract agreement with BCBSTX. When receiving services from Out-of-Network providers, you may be responsible for applicable deductibles, copays and/or coinsurance, as well as any amounts exceeding the BCBSTX allowed amount.

**OUT-OF-AREA** – Out-of-Area benefits are available only to those UT SELECT participants who reside outside of Texas and who do not reside in certain areas of New Mexico and Washington, D.C.

## Frequently Asked UT SELECT Questions and Answers

*UT SELECT Medical Plan (Blue Cross and Blue Shield of Texas)*

### 1. Is there a deductible for the UT SELECT Medical plan?

You are responsible for the first \$350 of eligible benefits each plan year for certain medical charges, including inpatient hospital stays, outpatient surgical procedures, physical therapy, some lab work and some other outpatient services. This amount is deducted from the payable benefit and will be included in your patient share.

**New!** Effective September 1, 2010, there is a separate \$5,000 deductible for Bariatric Surgery which is not applicable to the regular plan year deductible. UT SELECT provides coverage for bariatric surgery procedures subject to BCBSTX medical policy guidelines and a separate \$5,000 deductible for bariatric surgery. The bariatric surgery deductible is separate from the plan year deductible and does not apply to the patient's out-of-pocket maximum. When using network providers, the patient will be responsible for paying the \$5,000 deductible, then the plan will pay 100 percent of the covered expenses for the surgeon, assistant surgeon, anesthesia and facility charges. When using non-network providers, after the \$5,000 deductible, the plan will pay up to 100 percent of the allowable amount for covered expenses. The patient will also be responsible for paying any amounts billed by the non-network provider which exceed the allowable amount.

### 2. Will I be required to pay the \$350 deductible for office visits?

A deductible is not required for an office visit when using a network provider; only the applicable Family Care Physician copayment of \$30 or the Specialist copayment of \$35 is due. If eligible for out-of-area benefits, an office visit will be subject to deductible and coinsurance.

### 3. How much am I required to pay out-of-pocket for an in-network hospital stay?

You are responsible for a \$100 per day copayment (up to 5-day maximum of \$500), \$350 deductible (if not already met for the plan year), and 20% coinsurance. The maximum annual out-of-pocket maximum for the plan is \$2,500, and does not include copayments.

### 4. What is the maximum annual out-of-pocket cost for the coinsurance?

The maximum out-of-pocket amount is \$2,500 per person and \$7,500 per family per plan year if you utilize network providers. The maximum out-of-pocket for out-of-network providers is \$5,000 per person and \$15,000 per family per plan year.

### 5. Will any of my copayments, such as Family Care Physician visit copayments, Specialist visit copayments or the \$100 per day inpatient copayment, be applied towards the UT SELECT out-of-pocket annual maximum?

The \$350 deductible and the 20% coinsurance will be applied toward the out-of-pocket annual maximum; copayments are not applicable.

### 6. Will I need a referral from my Preferred or Family Care Physician (PCP) to obtain covered services?

Under UT SELECT, you may personally designate a Preferred Care Provider (PCP); however, you are not required to obtain a referral from a PCP before obtaining service as is typical with many managed care plans. You will have the flexibility to utilize the services of any Network Provider without a referral; however, your coverage for those services will be reduced if you choose to go outside of the Network, and some services are subject to a pre-authorization requirement.

## UT SELECT and Medicare

When you or your covered dependent(s) become eligible for Medicare, you and your Medicare-eligible dependents should enroll in Part A (typically inpatient coverage) and Part B coverage (typically office visits and doctor fees). **The University of Texas System urges all retired employees and dependents to enroll in Medicare Parts A and B when they become eligible at age 65, or earlier if they are eligible due to a disability.** Retired employees, or soon-to-be retired employees, or their dependents who are eligible for Medicare must have Medicare Parts A and B to receive the maximum benefits available from the UT SELECT plan. It is your responsibility to inform your institution Benefits Office if your covered dependents are Medicare-eligible.

In most instances, if you are eligible for Medicare and are working in a position for at least 20 hours per week, your UT medical plan will be primary, and Medicare will be secondary. Medicare may be primary for some Medicare-eligible active employees with certain medical conditions. Consult with your local Social Security Administration office to learn what illnesses qualify for Medicare coverage prior to turning age 65.

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

If you decline Part B, you will have to pay a higher premium if you ever re-apply for Medicare coverage.

**As a retired employee, if you or your Medicare-eligible dependent have declined Medicare Part B and fail to re-apply, you will be required to pay the portion that Medicare Part B would have paid as primary insurer for Part B-covered items for yourself and any Medicare-eligible dependents.**

To ensure claims are correctly processed, you should contact Blue Cross and Blue Shield of Texas and report your or your dependent's Medicare Health Insurance Claim (HIC) number and the effective dates of Medicare Parts A and B immediately upon enrollment.

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

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

If your doctor does not accept Medicare assignment:

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

This chart shows you how UT SELECT coordinates benefits with Medicare. All benefits are subject to plan limitations.

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

<sup>1</sup> Provider who does not participate with Medicare may not bill more than the Medicare Limiting Charge (115% of Medicare Allowed).

<sup>2</sup> Allowed charges are the lesser of the Medicare Limiting Charge or the Blue Cross Blue Shield allowed amount. If the Blue Cross Blue Shield allowed amount is less, the member may be billed the difference.

## COORDINATION OF BENEFITS WITH UT SELECT, MEDICARE AND A THIRD COVERAGE

Special rules are mandated by federal law when coordinating benefits between UT SELECT, Medicare and another coverage. Generally, the law states that Medicare is primary to retiree plans.

Medicare is secondary when

- The Beneficiary has Medicare Part A or Parts A and B;
- The Beneficiary is eligible for Medicare due to age (65) or disability; and
- The Beneficiary has group plan coverage through active employment

The following examples show the proper coordination of benefits for some common insurance situations:

### EXAMPLE A

John is 68, continues to have a full-time position at UT, and is covered as a dependent under his wife's retiree plan with ABC Company. John's claims will be paid in this order:

1. UT SELECT
2. Medicare
3. ABC Company

John and his wife may wish to consider whether the reimbursements received as a dependent on the Target plan justify their additional premium costs. In many instances, Medicare's secondary payment will cover the out-of-pocket costs remaining after the primary insurer pays.

### **EXAMPLE B**

Linda is 67, has retired from UT and returned to work in a position working less than 20 hours per week. Linda's husband also covers her under his retiree plan with XYZ Company. Linda's claims will be paid in this order:

1. Medicare
2. UT SELECT
3. XYZ Company

Although Linda has returned to work after retiring, her position is not benefits-eligible; therefore, her insurance benefits are obtained as a result of retirement, not employment.

### **EXAMPLE C**

Meredith is 72 and has retired from UT. During her phased retirement, she returns to teach for the Fall semester, from September 1 through January 15. She is covered by her husband's employer.

During the semester that Meredith has returned to a benefits-eligible position at UT, her claims are paid in this order:

1. UT SELECT
2. Spouse's Employer
3. Medicare

For the remainder of the year, when Meredith is not teaching, her claims are paid as follows:

1. Spouse's Employer
2. Medicare
3. UT SELECT

It is important to inform your providers and health plan carriers of all the insurances in which you are enrolled. Understanding correct coordination of benefits will help to ensure timely and accurate claims payments.

If you have questions regarding your specific insurance situation, please contact your institution Benefits Office, the UT System Office of Employee Benefits, or your health care administrator.

## Pharmacy Benefits

Your Pharmacy benefits under UT SELECT are administered by Medco Health Solutions (Medco) and require a \$100 annual deductible per plan participant, per plan year.

### Your UT SELECT Prescription ID card will be mailed to your home

Medco will issue your UT SELECT Prescription ID card and mail it to your home address on file. (You will receive a separate UT SELECT Medical ID card from Blue Cross and Blue Shield for your medical 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. To request additional Prescription ID cards or to replace lost or damaged cards, call Medco Customer Service at 1-800-818-0155. There is no charge for ID cards.

## UT SELECT Pharmacy Benefits

Annual Deductible (does not apply to medical plan annual deductible)		\$100/person/year		
Access Options	Generic Drug Copayment	Preferred Drug Copayment	Non-Preferred Drug Copayment	
Retail Network Pharmacy: Up to a 30-day supply. Refills allowed as prescribed. (good option for new prescriptions)	\$10	\$35	\$50	
Home Delivery Pharmacy: Up to a 90-day supply. Refills allowed as prescribed. (best option for maintenance medication)	\$20	\$87.50	\$125	

The UT SELECT Prescription Drug Plan administered by Medco uses a preferred drug list or formulary of covered drugs. This list of covered drugs is reviewed periodically resulting in changes to the prescription drug list throughout the year. If you are taking a medication that is affected by one of these changes, Medco will mail a letter to your address on file to alert you of the change in benefits.

Your prescription drug program offers three different benefit levels based on the drug category. Medications on the Medco prescription drug management programs are subject to change. Please refer to the Medco website ([www.medco.com/ut](http://www.medco.com/ut)) or call Medco Customer Service (1-800-818-0155) for current information on specific medications.

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

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

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

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

Cost of Brand Name Drug	\$150
Less cost of Generic Equivalent	- \$55
Plus Cost of Generic Copayment	<u>+\$20</u>
Your Payment	\$115

The UT SELECT Plan administered by Medco also offers a smaller benefit for Out-of-Network pharmacies. If you fill a prescription at an Out-of-Network pharmacy, you will pay the full cost of your prescription and send a claim form and your receipt to Medco. Your reimbursement will be based on your total cost, minus the UT discount, the applicable annual deductible and copayment. You will be responsible for payment of any amount above the UT contracted rate.

### The Generic Drug Advantage

**Important:** For both mail order and the retail pharmacy, if you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug. Generic drugs may have unfamiliar names, but they are safe and effective. Be assured, generic drugs and their brand-name counterparts:

- Have the same active ingredients
- Are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that they have the same strength, purity, and quality as the brand-name alternatives. Prescriptions filled with generic drugs often have lower copayments.

Therefore, you may be able to get the same health benefits at a lower cost. You should ask your doctor or pharmacist whether a generic version of your medication is available and whether it would be right for you. By using a generic drug, you will receive a high-quality medication that may reduce your expenses.

### Prescription Limitations

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

These programs 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. (Example: Potential for use in unproven, experimental indications.) To initiate a prior authorization, please contact Medco Health Solutions. Your doctor can also contact Medco directly through the Physician Prior Authorization process.
- **Preferred Drug Step Therapy program:** Coverage under the Step Therapy Program may require that you try a generic drug or lower-cost brand-name alternative drug before using higher cost non-preferred drugs.
- **Quantity Per Dispensing Event:** A medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that is subject to any of the above limitations, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Medco Pharmacy, your doctor will be contacted directly. When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. Medco will notify you and your doctor in writing of the decision.

If coverage is approved, the amount of time for which coverage is valid will be communicated to you. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Consult the the Medco website ([www.medco.com/ut](http://www.medco.com/ut)) or call Medco Customer Service (1-800-818-0155) for the most up-to-date information on these managed drug classes.

### **Renewal of Prior Authorization**

For certain drugs, the evidence of ongoing effectiveness may be needed to authorize additional coverage beyond the initial duration of approval. Prior to the expiration of the authorized period of these drugs, Medco will contact you via letter accompanied by an outbound phone call, to remind you that your prior authorization will expire and include instructions for renewal. Letters are sent between 30 and 60 days before the prior authorization expiration date. If the prior authorization is allowed to expire, coverage cannot be provided until the prior authorization is renewed.

### **Personalized Medicine Program**

Your prescription drug coverage includes the Personalized Medicine Program, a program that incorporates genetic testing to optimize prescription drug therapies for certain conditions. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available and are included in the program.

As of July 1, 2010, the Personalized Medicine Program is available to participants meeting a specified clinical profile who are prescribed Tamoxifen for breast cancer or Warfarin for blood clotting. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at [www.medco.com/ut](http://www.medco.com/ut) or by calling a Medco customer service representative at 1-800-818-0155.

If you are a qualified participant, additional services are available to you through the Personalized Medicine Program at no additional cost. The Personalized Medicine Program includes: (i) access to certain specified genetic tests administered and analyzed by one of several designated clinical laboratories; and (ii) a clinical program that includes the interpretation of test results and consultation with your prescriber by a representative of Medco trained specifically in genetic testing. Medco will also offer on-going outreach and education to physicians and patients when appropriate.

When you qualify, Medco will contact you and/or your physician to enroll you in the program. With approval from your physician, the clinical laboratory will facilitate the processing of a genetic test and share the results of the test with your physician and Medco. The results of the genetic test are for informational purposes only; any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and if you decide to participate, Medco will facilitate your coverage under the Program.

### **Specialty Pharmacy (Accredo)**

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

- Reimbursement services to review the patient's coverage and coordinate payment from the health plan and/or patient, as appropriate
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment
- Compliance programs to promote patient persistency and help the patient improve his/her quality of life

- Toll-free access to National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of your medications at no additional charge
- Registered nurses available for in-home medication administration, when clinically appropriate and as your plan allows
- Necessary supplies, such as needles and syringes, provided with your medications
- Refill reminder calls

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

### What is a specialty drug?

Specialty drugs are medications that typically cost \$500 or more per dose or \$6,000 or more per year\* and have one or more of the following characteristics:

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

\*Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a specialty drug. In addition, a follow-on-biologic or generic product will be considered a specialty drug if the innovator drug is a specialty 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 healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

### Are there any limitations on where I can get my specialty medication?

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

You may read additional information about pharmacy plan features and exclusions in the Your UT SELECT Health Benefits booklet available online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits) or from your institution Benefits Office.

### My Rx Choices

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

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

Accessed via the web ([www.medco.com/ut](http://www.medco.com/ut)) or through the Medco toll-free service line (1-800-818-0155), *My Rx Choices* features include:

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

### UT SELECT PPO Pharmacy Benefits (prescription drug coverage)

Medco Health Solutions, Inc.

[www.medco.com/ut](http://www.medco.com/ut)

(800) 818-0155

24 hours a day/7 days a week

## Frequently Asked UT SELECT Questions and Answers

*UT SELECT Prescription Drug Program  
(Medco Health Solutions)*

### 1. How can I find out if my prescription medication is covered?

You can access [www.medco.com/ut](http://www.medco.com/ut) to learn more about medications that are covered. Additionally, once enrolled as a UT SELECT participant, you can log into the Medco website and compare price differences of medications with the help of *My Rx Choices*.

### 2. How should my doctor write my mail order prescription?

To maximize your savings, ask your doctor to write your prescription for a 90-day supply (or your plan's mail order limit) with refills when appropriate instead of 30-day supply with refills. This will allow you to receive up to 90 days of medication for one mail-order copayment.

Please note that you may be charged a mail-order copayment regardless of the number of days' supply written on the prescription. Therefore, make sure your doctor has written the prescription for 90 days.

Please note that the actual quantity and/or days' supply may vary for each drug. Your doctor's instructions on how to take the medication, state and federal dispensing guidelines, or how the medication is packaged may impact the quantity and/or days' supply you can receive.

### 3. Can Medco transfer my prescriptions from a retail pharmacy to Medco By Mail?

Yes. For your existing prescriptions, you can go online and request to have them transferred from a retail pharmacy and delivered to you through Medco By Mail. However, most retail prescriptions are not written for the maximum supply that is available through the mail order pharmacy.

It is suggested that you ask your doctor to provide you with a new prescription if you wish to change your retail prescription to a mail order prescription. This enables your doctor to prescribe the maximum days' supply for your mail order, which is typically 90 days for long term drugs. That is more than your maximum supply at a retail pharmacy. It also gives your doctor an opportunity to review your prescription and make any necessary adjustments.

### 4. Can I still use my retail drugstore?

Yes. You are still covered at your retail pharmacy and can use your UT SELECT Prescription ID card for other prescribed medications as well.

### 5. How do I find out where to send my mail order prescriptions?

If you do not have a prescription from your doctor, you can have your physician fill out the physician fax form, (available at [www.medco.com/ut](http://www.medco.com/ut)) and follow the instructions to send it in directly to Medco By Mail.

**IMPORTANT:** Only your physician may fax the completed form to Medco.

Your doctor may also obtain fax forms and instructions directly by calling 1-888-EASYRX1 (1-888-327-9791). This number is for physicians only.

#### **6. Can I speak to a Medco pharmacist?**

Registered pharmacists are available 24 hours a day, seven days a week to answer any questions about your medications. Call the toll-free number located on your UT SELECT Prescription ID card. You can also contact one of Medco's registered pharmacists online at [www.medco.com/ut](http://www.medco.com/ut).

#### **7. How long does it take to get my medications when I use mail order?**

First-time orders arrive within 8 to 11 days. Refills arrive in less time – typically 7 to 9 days. At [www.medco.com/ut](http://www.medco.com/ut) you can review more detailed information about when your order will be processed, shipped or expected to arrive at your address. The best time to reorder is when you have about a 14-day supply of your medication remaining. This will help ensure you receive the medication you need, when you need it. Refill orders received by noon through the Internet or Medco's automated telephone system will be processed and shipped on the same day.

#### **8. How do I find out if my medication requires a prior authorization?**

Consult the the Medco website ([www.medco.com/ut](http://www.medco.com/ut)) or call Medco Customer Service (1-800-818-0155) for the most up-to-date information on these managed drug classes. If a medication you take regularly changes to require Prior Authorization, a letter will be sent to you alerting you of the change.

#### **9. How do I find out if there are quantity limits on my medication?**

Quantity-Duration rules prevent coverage of excessive quantities of a drug within a defined time interval.

These rules evaluate the quantity of a drug requested in conjunction with prior claims submitted within a specific period of time. Quantity-duration rules alert the pharmacist when the total quantity over time exceeds that for which UT SELECT normally provides coverage. Consult the the Medco website ([www.medco.com/ut](http://www.medco.com/ut)) or call Medco Customer Service (1-800-818-0155) for the most up-to-date information on these managed drug classes. To initiate a prior authorization for quantity limits, please contact Medco Health Solutions toll free at (800) 818-0155.

#### **Your UT SELECT Prescription Drug Plan and Medicare Part D**

The Federal Medicare program provides a Medicare-approved prescription drug benefit – Medicare Part D. The University of Texas System continues to offer your current UT SELECT prescription drug benefit, and enrollment in Medicare Part D will have a negative financial impact for most UT participants. UT strongly urges you NOT to enroll in the Medicare Part D program. UT is committed to providing your prescription drug coverage now and in the future and to helping you make informed choices about your prescription drug benefit. For a relatively small number of very low-income UT retirees, enrolling in Medicare Part D may save money if the retiree also qualifies for a “low income subsidy” provided as part of the Medicaid Part D Program. For more information about the low income subsidy, call 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov).

If you choose to enroll in a Medicare prescription drug plan, you will not be eligible for another policy that offers prescription drug coverage. You can keep your UT SELECT prescription drug policy only if you do not enroll in the Medicare Part D plan. You may find additional information about the Medicare Part D program at [www.medicare.gov/pdphome.asp](http://www.medicare.gov/pdphome.asp).



## NOTICE OF CREDITABLE COVERAGE

### IMPORTANT NOTICE FROM THE UNIVERSITY OF TEXAS SYSTEM OFFICE OF EMPLOYEE BENEFITS (OEB) REGARDING YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D COVERAGE

Please read this notice carefully and keep it where you can find it. No action is required of you at this time.

A copy of this notice is provided for all Medicare-eligible retired employees, employees or Medicare eligible covered dependents.

This notice provides:

- Important information about your current prescription drug coverage
- Answers that will assist you in deciding whether you should purchase prescription drug coverage under the Medicare Part D program
- Contact numbers for more information
- A document that you can use later to avoid a penalty for late enrollment in the Medicare Part D prescription drug program

## Frequently Asked Medicare Questions and Answers

### 1. What is Creditable Coverage?

Beginning January 1, 2006, Medicare beneficiaries had the opportunity to receive subsidized prescription drug coverage through the new Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enter the program at a later date. Beneficiaries who have other sources of drug coverage - through a current or former employer or union, for example - may stay in that plan and choose not to enroll in the Medicare drug plan. If their other coverage is at least as good as the new Medicare drug benefit (and therefore considered “creditable coverage”), then the beneficiary can continue to get the high quality care they have now as well as avoid higher payments if they sign up later for the Medicare drug benefit. Under §423.56(a) of the final regulation, coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the entity’s prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

## **2. What is Medicare Part D?**

Medicare Part D is a new prescription drug coverage that became available to people who qualify for Medicare Part A or Medicare Part B beginning January 1, 2006.

## **3. How does UT SELECT prescription drug coverage compare to Medicare Part D prescription drug coverage?**

The benefits provided by the UT SELECT drug plan have been examined by consulting actuaries and have been determined to be comparable to the benefits provided by Medicare Part D. This allows OEB to send you this “Notice of Creditable Coverage.”

## **4. Should I enroll in Medicare Part D?**

Most Medicare-eligible participants in the UT SELECT drug plan should NOT enroll in a Medicare prescription drug plan since, for most people, the UT prescription drug coverage will provide better benefits at lower cost.

If you qualify for financial assistance, you could benefit from Medicare Part D and you would get savings on premiums, copayments and coinsurance. If you think you might qualify for this assistance, you may want to enroll in Medicare Part D.

## **5. Is Medicare Part D free?**

No. If you enroll in a Medicare prescription drug plan, you will pay a monthly premium which will likely increase each year. You will also have to pay the Medicare Part D deductibles and copayments which also may increase each year.

## **6. How will Medicare Part D work?**

Medicare Part D coverage is offered through private prescription drug plans that have been approved by Medicare. All Medicare prescription drug plans offer a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. If you enroll in a Medicare prescription drug plan, you will receive a drug card that you will present to your pharmacy to cover a portion of your prescription drug costs.

## **7. Will Medicare Part D have any effect on coverage provided under UT?**

No. There will be no change in the medical or prescription drug coverage provided under the UT SELECT plan as a result of Medicare Part D. You will still be eligible to receive all of your current medical and prescription drug benefits under UT SELECT whether or not you enroll in a Medicare prescription drug plan.

## **8. If I decide to enroll in Medicare Part D, do I have to drop my UT coverage?**

No. You are not required to drop your UT coverage. If you use your UT SELECT drug card, you will pay the regular UT SELECT deductibles and copayments; however, you cannot use both your UT SELECT drug card and a Medicare prescription drug card for the same prescription.

## **9. Will I have better prescription drug coverage if I have both Medicare Part D and my current UT SELECT drug coverage?**

No. As noted above, you cannot use both plans for the same prescription. You would have to choose whether to get a prescription filled under your UT SELECT coverage or Medicare Part D coverage. Medicare Part D benefits do not coordinate benefits with your current UT SELECT prescription drug plan.

## **10. Why is creditable coverage important to Medicare-eligible participants in the UT SELECT prescription drug plan?**

Since you have Creditable Coverage under the UT SELECT prescription drug plan, the Social Security Administration has said that you will not have to pay a penalty if you join a Medicare Part D prescription drug plan later. People with Medicare can enroll in a Medicare prescription drug plan from mid-November through mid-May. Although you will have more chances to enroll in each subsequent year, normally, you would have to pay a penalty if you enrolled after your initial eligibility date. However, since you have Creditable Coverage under UT, you can choose to join a Medicare prescription drug plan later without a penalty.

### **11. How do I know if I qualify for financial assistance with Medicare Part D?**

Financial assistance will be available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level (FPL) and limited resources. The FPL is set each year. The Office of Employee Benefits does not make this determination or set the guidelines.

To determine if you qualify for financial assistance with Medicare Part D, you should contact the Social Security Administration (SSA) at 1-800-772-1213 (TTY 1-800-325-0778) or visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov).

### **12. Most UT participants are encouraged not to enroll in Medicare Part D last year. What about this year?**

Pay close attention to the Medicare Part D information OEB sends to you. If you need to enroll in Medicare Part D, OEB will notify you in advance.

You should also know that if you drop or lose your coverage under UT and don't enroll in Medicare Part D within 63 days after your current UT coverage ends, you may be required to pay more to enroll in Medicare prescription drug coverage later.

### **13. Where can I get more information?**

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You should get a copy of the handbook in the mail from Medicare each year. You may also be contacted directly by approved Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from the following places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**NOTE:** You may receive this Notice of Creditable Coverage at other times in the future such as before the next period you can enroll in Medicare Part D prescription drug coverage, and if this coverage changes. You also may request a copy of this notice from your institution Benefits Office.

# Dental

Depending on where you live, you may have a choice between UT SELECT Dental, the self-funded dental plan administered by Delta Dental, or Assurant DMO, a fully insured dental HMO plan administered by Assurant Employee Benefits. “Your UT Benefits Enrollment Options” letter/e-mail will tell you which plans are available to you. For the 2010-2011 plan year, there is no increase in the monthly premium for the Assurant DMO plan.

For employees enrolled in the UT SELECT Dental plan, your out-of-pocket monthly premium increase will range from \$0.90 for Employee Only coverage to \$2.67 for family coverage. There are no benefit changes in either dental plan.

The following chart shows which portion of the dental charges you are expected to pay and the service areas for each dental plan option.

Dental Service	UT SELECT Dental <sup>1</sup>	ASSURANT Heritage Plus Plan
Service Area	Available Nationwide	Austin, Dallas/Ft. Worth, El Paso Galveston, Houston, San Antonio
Maximum Annual Benefit	\$1,250	None
Annual Deductible	\$25 per Person <sup>2</sup>	None
Oral Exam, X-rays, Cleaning	\$0	\$0-5
Fluoride Treatment	\$0, up to age 19	\$0 up to age 14
Sealants	\$0, up to age 14	\$10, per tooth
Space Maintainers	\$0, up to age 14	\$60-105
Fillings	20%	\$10-110
Extractions	20%	\$15-135
Root Canals	20%	\$95-175
Periodontics <sup>3</sup>	20%	\$27-140
Crowns, Jackets and Cast Restorations	50%	\$275 (lab fees may also apply)
Bridges and Dentures	50%	\$295-400 (lab fees may also apply)
Orthodontics	50%, \$1,250 Lifetime benefit per person	25% discount off Network Dentist Retail Fee, no lifetime maximum
Out-of-Network Benefits	Yes	Limited to Emergencies

<sup>1</sup> Reimbursement is based on a percentage of the allowable amount

<sup>2</sup> Excludes oral exams, x-rays, cleanings, fluoride treatments, sealants, space maintainers and specialist consultations

<sup>3</sup> Scaling, root planing and treatment of gum disease

## UT SELECT Dental Plan Highlights:

*(administered by Delta Dental)*

The UT SELECT Dental Plan offers you the following choices:

- You may see Network or Out-of-Network dentists

- Two Networks: Delta Premier and DPO
- Pre-approval is not required to change dentists
- Referrals are not required to see a specialist
- Dental locations nationwide
- Delta Dental pays Network dentists directly

## Understanding Delta Dental's Two Unique Dentist Networks

### DeltaPremier

UT SELECT Dental subscribers who choose a Delta Premier dentist receive these benefits:

- No advance billing
- No claim forms
- Dentist fees limited to DeltaPremier “allowance”
- No balance billing
- Out-of-pocket costs limited by Delta Dental’s calculation of DeltaPremier “allowance”
- Credentialed dentist network
- Protection under Delta Dental’s unique participating dentist agreements offering:
  - quality assurance/consultant review
  - cost management systems
  - the benefit of all Delta Dental policies and procedures

- Access to one of the largest dental networks in the United States.
- 210,000 DeltaPremier Dental offices nationwide

### DPO (Dental Provider Organization)

UT SELECT Dental subscribers who choose a dentist from the smaller DPO network gain all the advantages of the larger DeltaPremier Network plus:

- Out-of-pocket costs lower due to lower DPO contracted “allowance”
- Discounted fee agreements average 30-35% off of submitted charges
- 130,900 DPO Dental offices

### Delta Dental Savings Procedure: Two surface amalgam filling

Sample Claim	DPO Dentist	Delta Premier Dentist	Non-Participating Dentist
Billed Charges	\$125	\$125	\$125
Allowable	\$76	\$101	\$101
Savings	\$49	\$24	\$0
80% Benefit Payment	\$61	\$81	\$81
Patient Out of Pocket	\$15	\$20	\$44

### Procedure: Porcelain Crown

Sample Claim	DPO Dentist	Delta Premier Dentist	Non-Participating Dentist
Billed Charges	\$901	\$901	\$901
Allowable	\$602	\$800	\$800
Savings	\$298	\$101	\$0
50% Benefit Payment	\$301	\$400	\$400
Patient Out of Pocket	\$301	\$400	\$501

\*Billed charges are for illustration purposes only

You may read additional information about plan features and exclusions in the UT SELECT Dental Plan guide available online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits) or from your institution Benefits Office.

### UT SELECT Dental

*Delta Dental*

[www.deltadentalins.com/universityof-texas](http://www.deltadentalins.com/universityof-texas)

(800) 893-3582

6:15 AM - 6:30 PM CT

## **Frequently Asked UT SELECT Dental Questions and Answers**

*UT SELECT Dental Plan (Delta Dental)*

### **1. What is the maximum amount Delta Dental will pay toward my dental care?**

Delta Dental will process payments up to the \$1,250 annual maximum for each individual person enrolled in the UT SELECT Dental plan. The Orthodontic Benefits have a separate lifetime maximum of \$1,250 for each person.

### **2. Will I receive free preventive care with UT SELECT Dental?**

You will receive two preventive care visits for the plan year. These are covered at 100% based upon reasonable and customary charges. Should you receive services out of network, you may be required to pay any additional amounts charged by the dental provider. Two additional cleanings, for a total of four, are paid per year for individuals with periodontal disease. These services do not require a deductible.

### **3. What is the difference between a DPO Provider and a DeltaPremier Provider with UT SELECT Dental?**

A DPO dentist requires a lower out-of-pocket cost for a dental procedure because their contracted reimbursement rate is lower in comparison to a Premier dentist, who may require a slightly higher out-of-pocket cost because their contracted rate allows a higher reimbursement.

These cost differences are a result of Delta's negotiated contracts with providers. The UT SELECT Dental program includes both DPO and Premier networks. Half of the Premier network makes up the DPO network. If you receive dental services from a provider who participates in both the DPO and Premier network, Delta will process your benefits at the lower DPO charge to allow you greater savings.

### **4. Will I be allowed to see a Dentist that is not a UT SELECT Dental Provider?**

Yes. You may visit any dentist of your choice; however, non-Delta dentists may charge a higher dollar amount resulting in the patient paying a higher out-of-pocket cost than a contracted dentist. The non-Delta dentist may require your payment at the time of service and may require you to file your claim with Delta Dental.

Any charges above the reasonable and customary Contracted Provider amount are the responsibility of the patient.

### **5. Is there a deductible for UT SELECT Dental?**

The deductible for UT SELECT Dental is \$25 per enrolled person per plan year. The deductible does not apply to the Diagnostic/Preventive or Orthodontic Services.

## Assurant Dental Maintenance Organization (DMO) Dental Plan

The DMO plan offered to you by Assurant Employee Benefits is called the Heritage Plus plan. The chart below provides examples of several copayment amounts for the Heritage Plus plan.

### Copayment Examples

ADA Code	Procedure	Heritage Plus Plan Copayment
None	Office Visit	\$0
0210	X-Ray	\$0
0330	Panoramic X-Ray	\$5
1110	Adult Cleaning	\$0
1120	Child Cleaning	\$0
2150	Amalgam Filling (2 Surface)	\$15
2331	Resin Filling (2 Surface)	\$40
2740*	Crown	\$275
2962*	Labial Veneer	\$290
3310	Root Canal (Anterior)	\$95
7140	Extraction, erupted tooth or exposed root	\$15
9972	External Bleaching (per arch)	\$155

\*Members are responsible for additional lab fees for these services

### Selecting and Changing a Dentist

At the time of enrollment you will need to select a Plan Dentist for yourself and each enrolled member of your family. Each enrolled family member may choose a different Plan Dentist.

If you do not select a Plan Dentist, one will be selected for you. Services must be provided by this selected dentist unless you contact Assurant to change your Plan Dentist selection.

You have two options for locating Plan Dentists:

- Search online at [www.assurantemployeebenefits.com/UT](http://www.assurantemployeebenefits.com/UT). Under “Find a Dentist”, select “Heritage Series”.
- Contact customer service at 800-443-2995 for assistance with locating or changing your Plan Dentist.

The dental plan is simple to use when you follow these steps:

- Verify with your Plan Dentist that you are on their roster before making a dental appointment.
- Call 6-8 weeks early for routine dental care for the best availability of appointment times.

- Be familiar with your copayment schedule to determine your costs for dental services.
- Discuss concerns regarding proposed treatments with your Plan Dentist.

### When You Need to See a Specialty Dentist

All Assurant participants are eligible for the Specialty Benefit (SB). The SB offers three benefit options when seeking treatment from a specialty dentist. With your Assurant Heritage Plus Plan, a referral is not necessary.

#### Option One

When seeking treatment by an SB Plan Specialty Dentist including in-Network Endodontists, Periodontists and Oral Surgeons who accept the SB Copayment Schedule, here is how the benefit works:

- You pay a fixed copayment amount for services listed on the SB Copayment Schedule, which is much lower than the normal retail charge.
- You receive a 25% discount for procedures not listed on the SB Copayment Schedule (15% discount for Endodontist) off the normal retail charge. This includes a 25% discount on orthodontic and pedodontic services.

- To find an SB Specialty Dentist, please refer to the Provider Directory (indicated with an S) online at [www.assurantemployeebenefits.com](http://www.assurantemployeebenefits.com) under “Find a Dentist”, select “Heritage Series”. When making an appointment, please confirm your chosen Specialty Dentist participates in the SB.

If you do not see a Plan Specialty Dentist who participates in the SB, the following options are available to you. We recommend you call Customer Service for assistance in determining your best option.

### Option Two

When seeking treatment from a Network Specialty Dentist who does not participate in the SB, you will receive a flat discount on all procedures.

- You will receive a 25% discount off the Specialty Dentist’s (excluding Endodontist’s) normal retail charge. You will receive a 15% discount off an Endodontist’s normal retail charge.
- To find a Plan Specialty Dentist, please refer to the Provider Directory online at [www.assurantemployeebenefits.com/ut](http://www.assurantemployeebenefits.com/ut) under “Find a Dentist”, select “Heritage Series”.

### Option Three

When seeking treatment from an Out-of-Network Specialty Dentist, you can still receive a benefit under the plan. Plan benefits are provided for procedures listed in the Maximum Non-Plan Specialty Reimbursement list, which can be obtained at [www.assurantemployeebenefits.com/ut](http://www.assurantemployeebenefits.com/ut). A claim must be submitted to Assurant Employee Benefits.

Here’s how it works:

- At the time of service, you pay the Specialty Dentist’s normal retail charge for the services performed.
- If the procedure is listed on the SB Schedule, you will be reimbursed the amount shown in the Maximum Non-Plan Specialty Reimbursement list or the amount charged by the Specialty Dentist for the procedure, whichever is less. An annual \$2,000 maximum applies.
- No benefits are available for services not listed on the SB Schedule.

You may read additional information about plan features and exclusions in the Assurant Dental HMO Plan guide available online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits) or from your institution Benefits Office.

### Assurant Dental DMO

[www.assurantemployeebenefits.com/ut](http://www.assurantemployeebenefits.com/ut)

(800) 443-2995

7:00 AM – 6:00 PM CST

## Frequently Asked Dental HMO Questions and Answers

*Assurant Employee Benefits*

### 1. Will I be required to choose a Primary Dentist to have access to the Assurant Dental Plan?

Yes. This plan is a single-service HMO; therefore, you must choose a Primary Dentist for both you and your enrolled family members. Additionally, you can only receive services from your Primary Family Dentist under the Assurant plan.

### 2. Will I be required to see my Primary Dentist if I have to see a Specialty Dentist and there are no contracted Dentists for Assurant in my area?

You can self refer to a Specialty Dentist; however, you will be required to pay the bill and be reimbursed from Assurant Dental via claim form for the services.

### 3. Does the Assurant DMO plan have a deductible to meet?

There is no annual deductible associated with the Assurant DMO plan. Services are provided on a contractual fee basis.

### 4. Will I receive free preventive care with the Assurant DMO plan?

The copayment for cleanings, fluorides, exams and most x-rays is \$0, so there is no cost to you. There is a \$5 copayment for panoramic x-rays.

### 5. Is there a maximum amount Assurant will pay toward my dental care?

There is no annual or lifetime maximum amount with Assurant Dental for either Dental or Orthodontia care.

# Vision

Fully insured Vision Care benefits will continue to be offered by Superior Vision Services. There is no change in benefits or increase in the monthly premium for the Vision plan for the 2010-2011 plan year.

Superior Vision continues to build and enhance their network and administration. Valuable information can be found on the Superior Vision website at [www.superiorvision.com/ut](http://www.superiorvision.com/ut).

Covered Services <sup>1</sup>	Network Benefits	Out-of-Network Benefits
Comprehensive eye exam by an ophthalmologist or optometrist	Covered in full after \$35 Copay (does not include Contact Lens Fitting fees). See below for information about benefit for Contact Lens Fitting Fees.	Up to \$42 (ophthalmologist) Up to \$37 (optometrist)
Standard lenses (per pair) - plastic (CR39), clear, uncoated	Covered in full	Up to \$32 (single vision) Up to \$46 (bifocal) Up to \$61 (trifocal) Up to \$84 (lenticular)
Frames	Covered in full up to \$140 retail allowance	Up to \$53
Contact lenses <sup>2</sup>	Up to \$125 retail allowance (elective/cosmetic) Covered in full (non-elective/medically necessary). See additional explanation below.	Up to \$100 (elective/cosmetic) Up to \$210 (non-elective/medically necessary)
Standard Contact Lens Fitting <sup>3</sup>	Covered in full after a \$35 Copay (separate from comprehensive eye exam copay)	No out-of-network benefit
Specialty Contact Lens Fitting <sup>3</sup>	Covered in full after a \$35 Copay up to an allowance of \$50 (separate from comprehensive eye exam copay)	No out-of-network benefit

<sup>1</sup> Only one comprehensive exam is covered per plan year. Only one pair of eyeglass lenses and one set of frames or one contact lens allowance is covered per plan year.

<sup>2</sup> Contact lenses in lieu of eyeglass lenses and one set of frames

<sup>3</sup> Standard contact lens fitting fee applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50 after the copayment is paid.

All costs and allowances are retail; member is responsible for any charges in excess of the retail allowances. All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your specific benefits.

## Contact Lenses (Non-elective/medically necessary)

Contact lenses (non-elective/medically necessary) are covered in full for members who have them prescribed solely for the purpose of correcting one of the following conditions\*:

- Aphakia
- Anisometropia of 4.0 diopters or more; provided visual acuity improves to 20/60 or better in the weak eye

- Keratoconus
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses

\*Prior authorization is required.

Contact lenses (elective) are also covered for those who prefer to wear contacts instead of glasses. Mail order contact lenses are available online at [www.svcontacts.com](http://www.svcontacts.com).

## LASIK PROCEDURE

Superior Vision offers discounted rates off the usual and customary prices for LASIK surgery. These discounts vary depending on the provider but are the best possible discounts available to Superior Vision.

## Additional Discount Features

<b>Frames</b> (Discounts do not apply when prohibited by manufacturer.)	20% off the difference between the covered frame allowance and the retail prices of the selected frame
<b>Lens Options/Upgrade</b>	20% off retail; your out-of-pocket will not exceed:
Standard Single Vision Lenses	• \$13
• Scratch Coat (factory)*	• \$15
• UV Coat	• \$50
• Standard AR Coat*	• \$55
• High Index 1.6*	• \$80
• Photochromics*	• \$40
• Polycarbonate*	
<b>Standard Lined Bi &amp; Tri-focal Lenses</b>	20% off retail; your out-of-pocket will not exceed:
• Scratch Coat (factory)*	• \$13
• UV Coat	• \$15
• Standard AR Coat*	• \$50
• High Index 1.6**	• 20% off retail
• Polycarbonate**	• 20% off retail
• Photochromics**	• 20% off retail
<b>Additional Services available on any lens</b>	20% off retail; your out-of-pocket will not exceed:
• Plastic Tints Solid or Gradient	• \$25
• Glass Coloring	• \$35
• Power over 4.00 D Sphere, 2.00 D Cylinder & 5.00 D Prism**	• 20% off retail
• Cosmetic Finishing, Beveling, Edging & Mounting**	• 20% off retail
• Miscellaneous Options**	• 20% off retail

\* Higher-end or brand-name lens upgrades are at an additional expense to member.

\*\* An out-of-pocket limit does not apply to these lens upgrades or add ons.

**NOTE:** These discounts are available from specific providers contracted to participate in the discount plan. Two providers that do not participate in the discount plan are Wal-Mart Vision Centers and Sam's Clubs. Please check the Superior Vision website for additional confirmation of discount plan providers. Look for providers in the Superior Vision Provider Directory at [www.superiorvision.com/ut](http://www.superiorvision.com/ut); please verify their discounts prior to service. Discounts are subject to change without notice.

## Superior Vision's SmartAlert Program!

Superior Vision's SmartAlert provides an easy way to foster communication between you, your Superior Vision eye care provider and your primary care physician or specialist. Vision exams can play an important role in the accurate diagnosis and monitoring of conditions or diseases, which may impact your total wellness or larger health issues. The SmartAlert program provides you and your Superior Vision eye doctor an important conduit for sharing the findings of your eye exam, at your discretion, with your primary care physician or wellness plan administrator.

SmartAlert includes a valuable member tool to assist you in preparing and sharing information about your lifestyle and environment with your Superior Vision provider. This tool is the My Vision Lifestyle Update\* form and is located on the Superior Vision website at [www.superiorvision.com/ut](http://www.superiorvision.com/ut) in the Member portal. You should print a copy of the form, review and answer the questions carefully, then share this form with your Superior Vision provider during your next eye exam appointment.

\*Superior Vision Services makes no representation about the suitability of this information for medical purposes or any other purpose. In no event shall Superior Vision be liable for any special, indirect, or consequential damages whatsoever, arising out of or in connection with the use of this form.

### **Superior Vision Services**

[www.superiorvision.com/ut](http://www.superiorvision.com/ut)

(800) 507-3800

M-F 7:00 AM - 8:00 PM CT

Sat 10:00 AM - 3:30 PM CT

## **Frequently Asked Vision Plan Questions and Answers**

*Superior Vision*

### **1. What is a Contact Lens Fitting (CLF) exam?**

The Contact Lens Fitting (CLF) is an additional, stand-alone benefit. It is separate from the contact lens benefit. A CLF measures and examines your eyes for the purpose of evaluating them for contacts. Providers often charge a separate fee for this service. With this new benefit, CLF charges do not get deducted from your contact lens allowance. You may also get two prescriptions for both glasses and contact lenses if you wear both. It also provides you the opportunity to determine if you can wear contact lenses without using your glasses benefit as your annual material selection.

### **2. How are progressive lenses (no-line lenses) covered?**

Lined bifocals and trifocals are standard lenses and covered in full. If you select no-line progressive lenses, you will pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount from selected providers.

# Group Term Life Insurance

Group Term Life options for you and your dependents will continue to be offered by Dearborn National, the new brand name for Fort Dearborn Life Insurance Company (FDL). The Retired Employee Basic Group Term Life benefit is increasing from \$3,000 to \$6,000 at no cost to the Retired Employee, and Spouse Voluntary Group Term Life insurance is now available. The out-of-pocket cost for the Retired Employee Voluntary Group Term Life plan is decreasing. In addition, the following enhancements will become available beginning July 1, 2010:

- Online beneficiary management
- Online will preparation
- Freedom account
- Grievance counseling, financial counseling, and legal assistance following death of the retired employee or covered dependents.

More detailed information is provided later in this section.

Dearborn National offers the following plan options for Retired Employees and spouses:

- Retired Employee Basic Group Term Life
- Retired Employee Voluntary Group Term Life
- New! Spouse Voluntary Group Term Life

*Group Term Life Insurance benefits information for Employees is available in the UT Benefits Handbook for Employees, or at your institution Benefits Office.*

## Group Term Life Options

Member	Basic GTL	Voluntary GTL
Retired Employee	\$6,000 (provided as part of the Basic Package at no cost to you)	\$7,000 <sup>1,2</sup> \$10,000 <sup>1,2</sup> \$25,000 <sup>1,2</sup> \$50,000 <sup>1,2</sup>
Spouse	N/A	\$3,000 <sup>3</sup>

<sup>1</sup> The Retired Employee's Voluntary Group Term Life (GTL) amount will be in addition to the Basic Group Term Life coverage. NOTE: You must be enrolled in a UT medical plan to be enrolled in the Basic GTL coverage.

<sup>2</sup> Evidence of Insurability (EOI) is required for retired employees who were previously eligible but did not elect the Voluntary GTL or to increase the Voluntary GTL.

<sup>3</sup> The Retired Employee must have Voluntary GTL coverage and EOI is required to add Spouse Voluntary GTL coverage. An active Employee with Spouse Voluntary GTL Coverage who retires effective September 1, 2010 or later may enroll the spouse in Voluntary GTL coverage without EOI if there is no break in coverage prior to retirement.

## Plan Features of Voluntary Group Term Life Insurance

- **Accelerated Payment Benefit:** Retired Employees may receive 50% of your coverage amount if they become terminally ill.
- The Voluntary Group Term Life plan does not pay benefits for death by suicide during the first two years of coverage.
- **New!** A new online Beneficiary Management program will be available for you to be able to review your current beneficiary designations and make changes online.
- **New!** A new online Will Preparation program will be available to assist you in writing a basic will at no cost. Additional services will also be available for an additional fee. This service is provided by Dearborn National, in partnership with EstateGuidance®, as part of the Life insurance plan.
- **New!** When a covered Retired Employee or dependent dies, support services will be available at no cost to the survivor(s) which includes grievance counseling, financial counseling, legal advice, and The Freedom Account, an interest bearing checking account for the life insurance proceeds.

*Who Will Receive Your Life Insurance Benefit? Keep your beneficiary designations up to date!*

The purpose of your life insurance coverage is to provide financial security for your family and loved ones after your death. However, if you have experienced a major life change, such as a marriage, divorce, or death of a loved one, your life insurance benefit may go to someone other than the person you thought would receive it.

A beneficiary is the person who will receive the money from your life insurance in the event of your death. It is important to review and update your beneficiary designations regularly and especially following life changes to ensure your benefits are distributed according to your wishes.

If you need to see if you have a beneficiary designation on file with Dearborn National or update your beneficiary designations, go to the Dearborn National website at [www.dearbornnational.com/ut](http://www.dearbornnational.com/ut) and follow the instructions.

You may read additional information about plan features and exclusions in the Group Term Life Plan certificate available at your institution Benefits Office or online at [www.utsystem.edu/benefits](http://www.utsystem.edu/benefits).

**Dearborn National**  
[www.dearbornnational.com/ut](http://www.dearbornnational.com/ut)  
(866) 628-2606  
TDD (888) 421-5844  
M-F 7:00 AM - 7:00 PM CT

## Frequently Asked Group Term Life Plan Questions and Answers

*Dearborn National*

### 1. If I would like to increase my life insurance to a higher amount, will I be required to submit an Evidence of Insurability (EOI) application?

You will be required to complete an EOI form and receive approval from Dearborn National if you want to increase or add life insurance.

### 2. Can I add my spouse to the life insurance plan?

Available for the first time during Annual Enrollment 2010 will be your opportunity to elect Spouse Voluntary Group Term Life coverage in the amount of \$3,000. The premium will be fully paid by the Retired Employee. The Retired Employee must have Voluntary Group Term Life in order to enroll the spouse in this new coverage. However, for UT to be able to offer this new benefit at an affordable rate, Evidence of Insurability (EOI) will be required to enroll your spouse. If satisfactory EOI is provided, coverage will begin either September 1 or the date of EOI approval, whichever comes first.

### **3. Will I be required to complete a new Beneficiary Form this year for Dearborn National?**

You can elect from one times to six times your annual compensation for life insurance; however, you will be required to provide EOI to enroll in greater than three times your annual compensation.

## Group Long-Term Care (LTC)

The fully insured Group Long-Term Care (LTC) insurance is offered to you through CNA. For the 2010-2011 plan year, there are no premium or benefit changes.

The LTC plan is available to you, your spouse, adult children (25 years and older), parents, grandparents, parents-in-law and grandparents-in-law. Your eligible family members may apply without you having applied for coverage. Only the premiums for you and your spouse may be deducted from your UT paycheck. Other enrolled family members will be set up for direct billing from CNA.

Evidence of Insurability (EOI) is required for enrollment in the LTC coverage.

LTC insurance provides funds for necessary services when an individual becomes incapable of caring for himself or herself. Covered services can vary depending on the individual's condition and can range from assistance in the home with day-to-day activities to care provided in a nursing home. It is important to note the need for long-term care does not just affect the elderly. The need for long-term care can occur at any age. Also, keep in mind this type of care is not covered by disability insurance. In addition, health insurance and Medicare will only pay for limited amounts of care. Medicaid does pay for LTC but only after you spend most of your financial assets.

LTC coverage is portable, so if you leave your employment with UT System, you can keep your LTC coverage, and your premium will remain the same.

### Long-Term Care Benefit Summary

<b>Daily Maximum Nursing Home Benefit</b>	\$100	\$125	\$150	\$200
<b>Daily Max for Community Based Care</b>	\$50	\$72.50	\$75	\$100
<b>Lifetime Maximum Benefit</b>	\$182,500	\$228,125	\$273,750	\$365,000

The four choices for the maximum daily nursing home benefit are \$100, \$125, \$150 and \$200. This is the most that would be payable for each day of care in a nursing home. The Lifetime Maximum is equal to 1,825 times the Daily Maximum Nursing Home Benefit selected. (This is also the number of days in a 5 year period.)

Inflation causes everything to cost more in the future than it may today. To help counter the effects of inflation, you may elect either the Guaranteed Benefit Increase Option (GBO), which will offer periodic opportunities to increase (buy-up) your existing coverage, or the optional Lifetime Automatic Benefit Increase (ABI).

If ABI is chosen, on each anniversary of your coverage effective date CNA will increase each benefit amount in effect by 5%.

A person becomes eligible for LTC benefits when they are certified as chronically ill by a licensed health care practitioner. Chronically ill means the person is unable to perform two or more activities of daily living (bathing, continence, dressing, eating, toileting, transferring) for at least 90 days without substantial assistance or supervision. Chronically ill can also mean that an individual has a severe cognitive impairment that can cause threats to the individual's health and safety without a great deal of supervision.

The waiting period for benefits is 90 days, starting on the first day of chronic illness and ending 90 calendar days later. Premiums are waived once a person begins to receive benefits.

For additional information, or to order a complete package of information including enrollment materials, please call CNA Customer Service at (888) 825-0353. Additional information is also available at [www.ltcbenefits.com/uts](http://www.ltcbenefits.com/uts) or your institution Benefits Office.

**CNA Group Long-Term Care**  
[www.ltcbenefits.com/uts](http://www.ltcbenefits.com/uts)  
(888) 825-0353  
7:00 AM – 5:00 PM CT

## Frequently Asked Long-Term Care Questions and Answers

*CNA*

### 1. What are the eligibility criteria to receive Long-Term Care (LTC) benefits?

A person becomes eligible for LTC benefits when they are certified chronically ill by a licensed health care practitioner. Chronically ill means the person is unable to perform two or more activities of daily living (bathing, continence, dressing, eating, toileting, transferring) for at least 90 days without substantial assistance or supervision.

### 2. How much coverage can I apply for on LTC?

There are four different daily maximum benefits from which you can choose. The choices of \$100, \$125, \$150 and \$200 are available to you as the maximum amount that can be paid for each day of long term care services. Each one has a corresponding Lifetime Maximum that is equal to 1825 times the daily maximum benefit you have chosen (1825 is also the number of days in a 5 year period). In addition you have two choices for inflation protection because, like everything else, inflation will make the costs for care rise in the future.

You may periodically elect either the Guaranteed Benefit Increase Option (GBO) which will provide you with an opportunity to increase your coverage every three years, or the optional benefit, the Lifetime Automatic Benefit Increase (ABI). If the optional ABI is chosen, on each anniversary of your coverage effective date CNA will increase the benefit amount in effect by 5%.

### 3. Is Evidence of Insurability (EOI) required if I want to enroll in LTC this year?

Yes. Employees and their spouses must complete a short form application, and other qualified classes (retirees, parents, grandparents, etc) must complete a long form application. Applications are available on the CNA website [www.ltcbenefits.com/Home.asp](http://www.ltcbenefits.com/Home.asp).

### 4. Can I cover my family members on the LTC plan?

Yes. Your spouse, adult children (25 years or older), parents, grandparents, parents-in-law and grandparents-in-law can all apply for coverage. You may only have a payroll deduction for the employee and spouse. For all other family members, the LTC premium will be billed to an address designated by the person applying for coverage.

### 5. What happens to my LTC insurance when I terminate employment or retire from UT?

The LTC plan is portable; this means you are able to retain the LTC coverage at the same rate after you terminate employment or retire from UT.

### 6. How much does LTC insurance cost?

The cost is based on your age when you enroll, so the younger you are, the lower your premium will be. This means that as you grow older, if you make no changes to your plan in the future, your premium will remain based on your original age at entry into the plan.

# Retirement Program Information for Retired Employees

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## TRS Retired Employees

If you plan to return to work in Texas public education after retirement, you should carefully review all requirements that apply to such work. If you do not effectively terminate employment, or if your work is not in compliance with the requirements, you could lose monthly annuity payments for work that exceeds the allowable amount and possibly even revoke your retirement entirely.

To work after retirement without revocation of retirement or loss of benefits, you must:

- have an effective date of retirement by terminating employment,
- wait to negotiate a return to employment as permitted under law,
- not be employed or otherwise work for a TRS-covered employer during the required break in service after the retirement effective date, and
- work only the amount of time permitted under one of the “employment after retirement” exceptions. The exceptions permit certain kinds of employment without losing the annuity for the month in which the employment is performed.

These requirements apply to all retirees, both service and disability and both normal age and early age. However, there are some differences in how the requirements are applied, depending on retirement circumstances. Please contact TRS if you are considering returning to employment in Texas public education after retirement and are unsure whether your employment will affect your retirement or your monthly annuity payment.

Once retired and receiving an annuity from TRS, you are no longer eligible to participate as an active member with TRS.

## ORP Retired Employees

Unlike the Teacher Retirement System, retirees from the Optional Retirement Program (ORP) do not have the same limitations on employment after retirement. However, ORP retirees who later return to employment in Texas public institutions of higher education are not eligible to participate in ORP, with the following exceptions:

- ORP retirees who enrolled in retiree group insurance on or before June 1, 1997;
- Employees who elected ORP in lieu of ERS at the Texas Higher Education Coordinating Board (THECB) and who, after terminating employment with the THECB and enrolling in retiree group insurance as an ORP retiree from the THECB, subsequently become employed in an ORP-eligible position at a Texas public institution of higher education;
- Employees who elected ORP in lieu of TRS and who, after terminating employment with all Texas public institutions of higher education and enrolling in retiree group insurance as an ORP retiree from a Texas public institution of higher education, subsequently become employed in an ORP-eligible position at the THECB; and
- ORP retirees who enroll in retiree group insurance as a part of a phased retirement program, as defined in 19 Texas Administrative Code Chapter 25.

## Your UTSaver Voluntary Retirement Programs at a Glance

UTSaver Voluntary Programs	UTSaver TSA		UTSaver DCP
	Traditional	Roth	
Eligibility	All employees	All employees	All employees
Employee contribution	Pre-tax dollars	After-tax dollars	Pre-tax Dollars
Employer Contribution	None	None	None
Employee withdrawals	Taxable when withdrawn	Tax free when withdrawn as a "qualified" distribution <sup>1</sup>	Taxable when withdrawn
General contribution limits	\$16,500 IRS maximum (2010) for both traditional and Roth sources. (Each dollar of a Roth contribution reduces the amount that can be contributed pretax, and vice versa.) <sup>2</sup>		\$16,500 IRS maximum (2010)
Over age 50 catch-up contribution	\$5,500 combined with Roth	\$5,500 combined with Traditional	\$5,500
15-year catch-up contribution	\$3,000 combined with Roth	\$3,000 combined with Traditional	N/A
Three years prior to retirement catch-up (special catch-up) <sup>3</sup>	N/A	N/A	Up to \$16,500 (may not be used simultaneously with age 50 catch-up)
Distributions made prior to age 59 ½ will be subject to ordinary income tax and a possible 10% penalty	Distributions made prior to age 59 ½ will be subject to ordinary income tax and a possible 10% penalty	"Nonqualified" distributions made prior to age 59 ½ will be subject to ordinary income tax and possibly a 10% penalty	Distributions made prior to age 59 ½ will be subject to ordinary income tax only.

<sup>1</sup> A "qualified" distribution occurs when the Roth account has been in place for five taxable years (from the year of first contribution) and one of the following events has occurred: (1) attainment of age 59 ½; (2) disability; or (3) death.

<sup>2</sup> Contribution limits for the UTSaver TSA may vary based on income, years of service, previous deferrals, and other factors. Contact your Benefits Office for a calculation of your personal contribution limit.

<sup>3</sup> For one or more of the employee's last three calendar years ending before the year in which the employee attains Normal Retirement Age. The special catch-up amount is \$16,500.00 for 2010. May not be used simultaneously with the Age 50 and Over catch-up.

## Your UTRetirement Programs Authorized Providers

Authorized Provider	Products	Services available at no cost to the employee						Services available for a fee to the employee		Enrollment
		In person appointment	Discuss UT Retirement Plan Options	Assess employee risk tolerance and retirement goals	Consider outside assets with no advice on those assets	Provide asset allocation models and the list of available company funds in those models	Suggestion of which company fund(s) to select	Suggestion of which company fund(s) to select	Actively manage company accounts	
Fidelity	Mutual Funds Lifecycle Funds Self-Directed Brokerage Accounts	Yes	Yes	Yes	Yes	Yes	Yes	Available at no cost online	No	Online or by downloadable forms at <a href="http://www.fidelity.com/ut">www.fidelity.com/ut</a>
ING	Annuities Mutual Funds Lifecycle Funds	Yes	Yes	Yes	Yes	Yes	Yes-online only	Yes-In person or at no cost online	Yes-mutual funds only	Online or by downloadable form at <a href="http://www.ingretirementplans.com/utexas">www.ingretirementplans.com/utexas</a>
Lincoln	Annuities Mutual Funds Lifespan Models	Yes	Yes	Yes	Yes	Yes	Yes	Yes-In addition to comprehensive financial planning	No	Forms may be downloaded at <a href="http://www.lfg.com/ut">www.lfg.com/ut</a>
MetLife	Annuities Mutual Funds Lifecycle Funds	Yes	Yes	Yes	Yes	Yes	Yes	Available at no cost	No	Call 1-800-236-8489 or see <a href="http://www.metlife.com/uts">www.metlife.com/uts</a>
TIAA-CREF	Annuities Mutual Funds Lifecycle Funds	Yes	Yes	Yes	Yes	Yes	Yes	Available at no cost	Yes	Online from the TIAA-CREF UT site at <a href="http://www.tiaa-cref.org/utexas">www.tiaa-cref.org/utexas</a>
VALIC	Annuities Mutual Funds Lifecycle Funds Self-Directed Brokerage Accounts	Yes	Yes	Yes	Yes	Yes	Yes	Available at no cost	Yes	You may enroll online at <a href="http://www.valic.com/utexasorp">www.valic.com/utexasorp</a>

\* Employees with overall assets of at least \$500,000 receive comprehensive financial planning at no cost to the employee.

# Contact Information

## Institution Benefits Offices

<b>UT Arlington</b>	Office of Human Resources J. D. Wetsel Bldg. 1225 W. Mitchell, Ste 212 Arlington, TX 76019	Phone: (817) 272-5558 Benefits Line or (817) 272- 5554 Fax: (817) 272-5798 E-mail: <a href="mailto:benefits@uta.edu">benefits@uta.edu</a>
<b>UT Austin</b>	<b>Physical Address:</b> Human Resource Service Center North Office Building A, Suite 2.200 101 E. 27th St. Austin, TX 78712 <b>Mailing Address:</b> Human Resource Service Center P.O. Box V Austin, Texas 78713	Phone: (512) 471-4772 or Toll Free: (800) 687-4178 Fax: (512) 232-3524 E-mail: <a href="mailto:hpsc@austin.utexas.edu">hpsc@austin.utexas.edu</a>
<b>UT Brownsville</b>	Human Resources UTB/TSC, Cortez 129 80 Fort Brown Brownsville, TX 78520	Phone: (956) 882-8205 Fax: (956) 882-6599
<b>UT Dallas</b>	Mail Station AD 10 800 W. Campbell Rd. Richardson, TX 75080	Phone: (972) 883-2221 Fax: (972) 883-2156 E-mail: <a href="mailto:benefits@utdallas.edu">benefits@utdallas.edu</a>
<b>UT El Paso</b>	Administration Building, Room 216 500 West University Ave. El Paso, TX 79968	Phone: (915) 747-5202 Fax: (915) 747-5815 E-mail: <a href="mailto:benefits@utep.edu">benefits@utep.edu</a>
<b>UT Health Science Center Tyler</b>	11937 US Highway 271 Tyler, TX 75708-3154	Phone: (903) 877-7784 Fax: (903) 877-5394 E-mail: <a href="mailto:benefits@uthct.edu">benefits@uthct.edu</a>
<b>UT Health Science Center Houston</b>	7000 Fannin The University Center Tower (UCT) 10th Floor Houston, TX 77030	Phone: (713) 500-3960 Fax: (713) 500-0342 E-mail: <a href="mailto:benefits@uth.tmc.edu">benefits@uth.tmc.edu</a>
<b>UT Health Science Center San Antonio</b>	7703 Floyd Curl Drive, MSC 7972 San Antonio, TX 78229-3900	Phone: (210) 567-2600 Fax: (210) 567-6791 E-mail: <a href="mailto:benefits@uthscsa.edu">benefits@uthscsa.edu</a>
<b>UT Medical Branch at Galveston</b>	301 University Blvd. Galveston, TX 77555-0140	Phone: (409) 772-2630, Option "0" Toll Free: (866) 996-8862 Fax: (281) 554-5381 E-mail: <a href="mailto:benefits.services@utmb.edu">benefits.services@utmb.edu</a>
<b>UT MD Anderson Cancer Center</b>	<b>Physical Address:</b> 2450 Holcombe Blvd. Human Resources Benefits Houston, TX 77021-2024 <b>Mailing Address:</b> HR Benefits Unit 634 PO Box 301402 Houston, TX 77230-1402	Phone: (713) 745-6947 Fax: (713) 745-7160 E-mail: <a href="mailto:hrcbenefits@mdanderson.org">hrcbenefits@mdanderson.org</a>

*(Contact Information for Institution Benefits Offices continued)*

<b>UT MD Anderson Cancer Center Physicians Referral Service (PRS)</b>	<b>Physical Address:</b> 6900 Fannin St., Suite 3.1001 Houston, TX 77030  <b>Mailing Address:</b> Physicians Referral Service (PRS) 1515 Holcombe Blvd., Unit 702 Houston, TX 77030	Phone: (713) 792-7600 Fax: (713) 794-4812 E-mail: <a href="mailto:PRSAAdministrativeServices@mdanderson.org">PRSAAdministrativeServices@mdanderson.org</a>
<b>UT Pan American</b>	1201 W. University Dr. PSBL Edinburg, TX 78541	Phone: (956) 381-2451 Fax: (956) 381-2340 E-mail: <a href="mailto:hrbenefits@utpa.edu">hrbenefits@utpa.edu</a>
<b>UT Permian Basin</b>	4901 East University Blvd. Odessa, TX 79762	Phone: (432) 552-2751 Fax: (432) 552-3747
<b>UT San Antonio</b>	1 UTSA Circle San Antonio, TX 78249	Phone: (210) 458-4250 Fax: (210) 458-7890 E-mail: <a href="mailto:benefits@utsa.edu">benefits@utsa.edu</a>
<b>UT Southwestern Medical Center</b>	5323 Harry Hines Blvd Dallas, TX 75390-9023	Phone: (214) 648-9830 Fax: (214) 648-9881 E-mail: <a href="mailto:benefits@utsouthwestern.edu">benefits@utsouthwestern.edu</a>
<b>UT System</b>	Office of Employee Services 702 Colorado St., Ste 1.104 Austin, TX 78701	Phone: (512) 499-4660 Fax: (512) 499-4380 Email: <a href="mailto:esc@utsystem.edu">esc@utsystem.edu</a>
<b>UT Tyler</b>	Office of Human Resources 3900 University Blvd. Tyler, TX 75799	Phone: (903) 566-7358 Fax: (903) 565-5690

## Retirement Providers

Fidelity Investments	P.O. Box 770002 Cincinnati, OH 45277-0090	(800) 343-0860 M-F 7:00 AM-11:00 PM CT	<a href="http://www.fidelity.com/ut">www.fidelity.com/ut</a>
ING	One Orange Way Windsor, CT 06095-4774	(800) 584-6001 M-F 7:00 AM-9:00 PM CTS 7:00 AM-3:00 PM CT	<a href="http://www.ingretirementplans.com/utexas">www.ingretirementplans.com/utexas</a>
Lincoln Financial Group	Lincoln Financial Group Attn: UT Retirement Servicing 1300 South Clinton Street For Wayne, IN 46802	(800) 454-6265 * 8 M-F 7:00 AM-7:00 PM CT	<a href="http://www.lfg.com/ut">www.lfg.com/ut</a>
MetLife Resources	2805 North Dallas Parkway Suite 215 Plano, TX 75093	(800) 236-8489 M-F 8:00 AM-5:00 PM CT	<a href="http://www.metlife.com/uts">www.metlife.com/uts</a>
TIAA-CREF	TIAA-CREF (Products, Services) P.O. Box 1259	(800) 842-2776 TDD (800) 842-2755 M-F 7:00 AM-9:00 PM	<a href="http://www.tiaa-cref.org/utexas">www.tiaa-cref.org/utexas</a>
VALIC	VALIC Document Control P.O. Box 15648 Amarillo, TX 79105-5648	(888) 568-2542 M-F 8:00 AM-7:00 PM CT	<a href="http://www.valic.com/utexasorp">www.valic.com/utexasorp</a>

# Insurance Plan Administrators

UT SELECT Medical (Blue Cross and Blue Shield of Texas) Group: 71778	P.O. Box 660044 Dallas, TX 75266-0044	(866) 882-2034 M-F 8:00 AM-6:00 PM CT	<a href="http://www.bcbstx.com/ut">www.bcbstx.com/ut</a>
UT SELECT Prescription (Medco Health Solutions) Group: UTSYSRX	PAID Prescriptions Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512	(800) 818-0155 24hrs a day 7 days a week	<a href="http://www.medco.com">www.medco.com</a>
Living Well Health Manager (powered by WebMD)	N/A	(866) 584-5745 M-F 7:00 AM-7:30 PM CT	<a href="http://www.webmdhealth.com/ut">www.webmdhealth.com/ut</a>
UT SELECT Dental (Delta Dental) Group: 5968	P.O. Box 1809 Alpharetta, GA 30023	(800) 893-3582 M-F 6:15 AM-6:30 PM CT	<a href="http://www.deltadentalins.com/universityoftexas">www.deltadentalins.com/universityoftexas</a>
Assurant Dental DMO Group: CX 86	P.O. Box 830607 Birmingham, AL 35283-0949	(800) 443-2995 7:00 AM-6:00 PM CT	<a href="http://www.assurantemployeebenefits.com/ut">www.assurantemployeebenefits.com/ut</a>
Superior Vision Group: 26856	P.O. Box 967 Rancho Cordova, CA 95741-0967	(800) 507-3800 M-F 7:00 AM-8:00 PM CT Sat 10:00 AM-3:30 PM CT	<a href="http://www.superiorvision.com/ut">www.superiorvision.com/ut</a>
Group Term Life (Dearborn National) Group: GFZ71778	P.O. Box 655403 Dallas, TX 75265-5403	(866) 628-2606 M-F 7:00 AM-7:00 PM CT	<a href="http://www.dearbornnational.com/ut">www.dearbornnational.com/ut</a>
Long-Term Care (CNA) Group: 0010025TQ	Continental Casualty Attn: LTC Claims P.O. Box 946760 Maitland, FL 32794-6760	(888) 825-0353 7:00 AM-5:00 PM CT	<a href="http://www.ltcbenefits.com/uts">www.ltcbenefits.com/uts</a>

# UT Benefits Cost Worksheet

For Retired Employees • Plan Year 2010-2011



This is NOT an enrollment form. You must enroll online using *My UT Benefits* during Annual Enrollment or, for new Retired Employees, through your institution's Benefits Office.

Please remember that this form only provides you (the subscriber) with an estimate of your total out-of-pocket cost per month based on state-appropriated funds and contracted premium rates. Be sure to review available benefits information for more information on the plans listed.

For each section, figure the correct cost and enter it in the TOTAL boxes to the right of each section.

MEDICAL OUT-OF-POCKET COST PER MONTH:				
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
UT SELECT	\$0	\$189.54	\$198.24	\$373.27
<i>(Administered by Blue Cross &amp; Blue Shield of Texas)</i>				
<b>Medical Plan Rates include: \$6,000 Life</b>				

**MEDICAL  
TOTAL**

*If you are electing health coverage for previously eligible dependents or if you currently waived your coverage, Evidence of Insurability (EOI) will be required unless proof of other group coverage can be provided at the time of enrollment.*

DENTAL OUT-OF-POCKET COST PER MONTH:				
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
<b>Worldwide:</b>				
UT SELECT Dental <i>(Administered by Delta Dental)</i>	\$30.86	\$58.58	\$64.57	\$91.81
<b>Austin, Dallas, El Paso, Galveston, Houston &amp; San Antonio:</b>				
Assurant Dental HMO	\$10.05	\$19.10	\$21.11	\$30.15

**DENTAL  
TOTAL**

VISION OUT-OF-POCKET COST PER MONTH:				
Plan Available – Nationwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
Superior Vision	\$6.80	\$10.76	\$10.96	\$17.40

**VISION  
TOTAL**

<b>LIFE OUT-OF-POCKET COST PER MONTH:</b>		<b>Dearborn National</b>
Enter Elected Coverage Amount: • Select from the following options and enter here (see <sup>1</sup> below). ➤ \$7,000 ➤ \$10,000 ➤ \$25,000 ➤ \$50,000  <i>Note: For those Retired Employees of the U.T. System who retired through the 1993 one-time retirement option, enter the amount of coverage currently in place.</i>		<b>A</b>
Divide total in <b>A</b> by 1,000 to determine units of \$1,000 for premium calculation. Enter here.		<b>B</b>
Refer to <b>Retiree Rate Chart</b> below. Enter the rate that corresponds with your age on September 1, 2010.		<b>C</b>
To determine the premium cost per month, multiply <b>B x C</b> .		<b>D</b>
<i>The remainder of the Life Out-of-Pocket calculation section relates to the eligible spouse of a Retired Employee. Dependent children of Retirees are not eligible for life coverage.</i>		
If you are electing the \$3,000 Spouse Coverage option (see <sup>2</sup> below) enter \$1.83. Otherwise, enter zero.		<b>E</b>
To determine total Life premium cost per month, add <b>D + E</b> . Otherwise, enter zero.		<b>F</b>
		<b>LIFE TOTAL</b>
		<input style="width: 100px; height: 20px;" type="text"/>

<b>RETIREE RATE CHART</b>	
<b>Age of Subscriber on 9/01/10</b>	<b>Rate per \$1,000 Coverage</b>
< 35	\$0.038
35 - 39	\$0.048
40 - 44	\$0.065
45 - 49	\$0.100
50 - 54	\$0.155
55 - 59	\$0.240
60 - 64	\$0.375
65 - 69	\$0.670
70 and over	\$0.752

<sup>1</sup> If you are increasing your life coverage amount, Evidence of Insurability (EOI) is required.

<sup>2</sup> In order to elect Spouse life coverage, the Retiree must have Voluntary Life coverage or apply for Voluntary Life coverage and pass EOI. EOI is always required for Spouse life coverage.

LONG TERM CARE (LTC) OUT-OF-POCKET COST PER MONTH								CNA
Age	PLAN A				PLAN B			
	Basic Benefit with Guaranteed Benefit Increase Option				Basic Benefit with Lifetime Automatic Benefit Increase Option (Inflation Protection)			
	\$100 BENEFIT	\$125 BENEFIT	\$150 BENEFIT	\$200 BENEFIT	\$100 BENEFIT	\$125 BENEFIT	\$150 BENEFIT	\$200 BENEFIT
<25	5.64	7.05	8.46	11.28	16.96	21.20	25.44	33.92
25-29	6.68	8.35	10.02	13.36	19.88	24.85	29.82	39.76
30-34	8.00	10.00	12.00	16.00	23.09	28.86	34.64	46.18
35-39	9.76	12.20	14.63	19.51	29.99	37.49	44.99	59.98
40	11.84	14.81	17.77	23.69	34.52	43.15	51.78	69.04
41	12.60	15.75	18.90	25.20	35.76	44.70	53.64	71.52
42	13.39	16.74	20.09	26.78	37.43	46.79	56.14	74.86
43	13.99	17.49	20.98	27.98	39.10	48.88	58.65	78.21
44	14.64	18.31	21.97	29.29	40.85	51.06	61.27	81.70
45	15.42	19.27	23.12	30.83	43.09	53.87	64.64	86.18
46	16.17	20.21	24.25	32.34	45.18	56.48	67.77	90.36
47	17.04	21.29	25.55	34.07	47.54	59.42	71.31	95.08
48	18.12	22.65	27.18	36.24	50.05	62.56	75.07	100.09
49	19.28	24.10	28.92	38.56	52.63	65.79	78.95	105.26
50	20.78	25.97	31.16	41.55	56.01	70.02	84.02	112.02
51	22.27	27.84	33.40	44.54	59.36	74.20	89.04	118.71
52	24.14	30.18	36.21	48.28	63.39	79.23	95.08	126.77
53	26.28	32.85	39.43	52.57	67.94	84.93	101.91	135.89
54	28.73	35.91	43.10	57.46	72.88	91.10	109.32	145.76
55	32.43	40.54	48.65	64.86	78.93	98.66	118.39	157.85
56	36.28	45.35	54.42	72.55	84.78	105.98	127.17	169.56
57	40.21	50.27	60.32	80.42	91.24	114.05	136.86	182.48
58	44.14	55.17	66.20	88.27	98.69	123.36	148.03	197.37
59	48.49	60.62	72.74	96.98	106.93	133.66	160.40	213.86
60	54.16	67.70	81.24	108.32	116.55	145.68	174.82	233.09
61	59.65	74.57	89.48	119.30	125.17	156.47	187.76	250.34
62	65.29	81.61	97.93	130.57	133.34	166.68	200.02	266.69
63	70.61	88.27	105.92	141.23	139.99	174.99	209.99	279.99
64	76.53	95.67	114.80	153.06	146.88	183.60	220.32	293.76
65	83.69	104.62	125.54	167.39	155.31	194.14	232.97	310.63
66	91.32	114.15	136.98	182.64	164.13	205.16	246.20	328.26
67	98.84	123.55	148.26	197.68	176.10	220.13	264.15	352.20
68	107.48	134.35	161.22	214.96	190.68	238.35	286.02	381.36
69	116.92	146.15	175.38	233.84	204.96	256.20	307.44	409.92
70	127.68	159.60	191.52	255.36	221.56	276.95	332.34	443.12
71	140.44	175.55	210.66	280.88	241.32	301.65	361.98	482.64
72	155.80	194.75	233.70	311.60	264.84	331.05	397.26	529.68
73	173.92	217.40	260.88	347.84	292.16	365.20	438.24	584.32
74	194.36	242.95	291.54	388.72	322.68	403.35	484.02	645.36
75	216.96	271.20	325.44	433.92	355.80	444.75	533.70	711.60
76	241.32	301.65	361.98	482.64	390.96	488.70	586.44	781.92
77	267.24	334.05	400.86	534.48	427.56	534.45	641.34	855.12
78	294.48	368.10	441.72	588.96	465.28	581.60	697.92	930.56
79	320.56	400.70	480.84	641.12	500.04	625.05	750.06	1,000.08
80	350.88	438.60	526.32	701.76	540.36	675.45	810.54	1,080.72
81	380.00	475.00	570.00	760.00	577.60	722.00	866.40	1,155.20
82	414.40	518.00	621.60	828.80	621.56	776.95	932.34	1,243.12
83	452.04	565.05	678.06	904.08	669.00	836.25	1,003.50	1,338.00
84	492.80	616.00	739.20	985.60	719.48	899.35	1,079.22	1,438.96
85	530.56	663.20	795.84	1,061.12	764.00	955.00	1,146.00	1,528.00
86	572.68	715.85	859.02	1,145.36	813.24	1,016.55	1,219.86	1,626.48
87	613.48	766.85	920.22	1,226.96	858.88	1,073.60	1,288.32	1,717.76
88	647.08	808.85	970.62	1,294.16	893.00	1,116.25	1,339.50	1,786.00
89	679.52	849.40	1,019.28	1,359.04	924.12	1,155.15	1,386.18	1,848.24
90	717.32	896.65	1,075.98	1,434.64	961.20	1,201.50	1,441.80	1,922.40

**LTC  
TOTAL**

\* EOI is required for new Retirees who enroll in LTC during their initial period of eligibility and for all other new enrollees.

**Estimated Total Monthly Out-of-Pocket Cost**  
(Add ALL boxes and enter total)