



Let UT SELECT *Work for You*

# UT SELECT

2005-2006 Benefit Booklet  
Effective September 1, 2005



Self-funded Health Insurance Plan ★ The University of Texas System

# UT SELECT

## Self-funded Health Insurance Plan

Effective September 1, 2005



**BlueCross BlueShield  
of Texas**



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

# IMPORTANT INFORMATION

## **Customer Service help line**

The Blue Cross and Blue Shield of Texas (BCBSTX) Customer Service Representatives can assist you in identifying your Plan Service Area, provide information about BlueChoice® and ParPlan Providers, distribute claim forms, answer your medical claim questions and provide benefit information. You can reach the customer service help line Monday through Friday from 8 a.m. through 5 p.m. Central Time (CT).

**Toll free: 1-866-882-2034**

## **Mental Health help line**

Assistance in selecting a BCBSTX BlueChoice® or ParPlan Mental Health or Chemical Dependency Provider is available by calling INROADS® Behavioral Health Services of Texas, L.P.

Your BlueChoice® Provider will do the Preauthorization for you. You are responsible for obtaining Preauthorization of all inpatient and outpatient Out-of-Network Mental Health and/or Chemical Dependency care.

**Toll free: 1-800-528-7264**

## **Medical Preauthorization help line**

To satisfy all medical Preauthorization requirements for Inpatient Hospital Admissions, Skilled Nursing Facility, Home Health Care, Hospice Care, or Home Infusion Therapy, call the Medical Preauthorization help line, Monday through Friday, 7:30 a.m. to 8 p.m. Central Time (CT).

Your BlueChoice® Provider will do the Preauthorization for you. You are responsible for obtaining Preauthorization when choosing an Out-of-Network Provider.

**Toll free: 1-800-441-9188**  
**Dallas area: (972) 783-4475**

## **24/7 Nurseline**

A staff of trained, experienced registered nurse counselors is available 24/7 to answer health care questions and provide information about a wide variety of health care issues and medical, non-emergencies.

**Toll-Free: 1-888-315-9473**

## **Special Beginnings® prenatal program**

Special Beginnings is a comprehensive prenatal program that helps mothers take better care of themselves and their babies. The program assesses pregnancy risk level and provides close monitoring through a series of calls from an experienced obstetrical nurse from pregnancy through six weeks after delivery. Call to enroll or ask questions about the program.

**Toll-free: 1-800-462-3275**

# IMPORTANT INFORMATION

## UT SELECT Web site

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

The information found in this Benefit Booklet and much more is available on the UT SELECT Web site.

You can search for:

- BlueChoice<sup>®</sup> providers
- Review your benefits
- E-mail UT SELECT Customer Service
- Review participant eligibility and claim status
- Download claim forms

## Online provider directory

You can conduct customized searches for family care physicians or specialists and/or download an entire directory. The online provider directory also allows you to e-mail your search results to a family member, your physician or anyone with a valid e-mail address.

Regional Provider Directories are found on the UT SELECT Web site [www.bcbstx.com/ut](http://www.bcbstx.com/ut). Posting this information online provides you with the most up-to-date information regarding UT SELECT BlueChoice<sup>®</sup> providers. The UT SELECT Web site is updated monthly and available 24 hours a day.

The Provider Finder<sup>®</sup> online directory provides detailed information about the physicians including:

- If they are accepting new patients
- Board certification
- Hospital affiliations

## Blue Access for Members (Registration required)

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

Blue Access for Members is an exciting feature on the UT SELECT Web site that allows you to:

- Check the status of a claim
- Confirm who is covered under your plan
- View and print detailed claim history and information (Explanation of Benefits)
- Opt-out of receiving paper copies of your Explanation of Benefits
- Locate a physician in your network that meets your needs
- Sign up to receive email notifications of new claim activity
- Request a new or replacement ID card or print a temporary ID card

Blue Access for Members is available from 6 a.m. to 3 a.m. (CT), seven days a week.

# Table of Contents

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	<b>Page Number</b>
<b>IN-AREA SUMMARY OF BENEFITS</b> .....	7
<b>OUT-OF-AREA SUMMARY OF BENEFITS</b> .....	13
<b>UNDERSTANDING YOUR PLAN</b>	
About this Benefits Booklet .....	16
Service Area .....	16
Identification Card .....	17
<b>WHO GETS BENEFITS</b>	
Eligibility for Coverage .....	18
Changes in your Status .....	19
Certificates of Credible Coverage .....	20
Address Changes .....	20
<b>HOW TO RECEIVE BENEFITS</b>	
Selecting a Provider .....	21
Network Benefits .....	21
Out-of-Network Benefits .....	21
Out-of-Area Benefits .....	21
ParPlan/Traditional Indemnity Providers .....	22
Preauthorization of Medical Services .....	23
Preauthorization of Mental Health Services .....	23
Disease Management .....	24
Case Management .....	25
Predetermination of Benefits .....	25
BlueCard Program .....	26
BlueCard Worldwide .....	26
<b>MEDICAL BENEFITS PROVIDED</b>	
Eligible Expenses .....	28
Deductible .....	28
Out-of-Pocket Maximum .....	29
Maximum Lifetime Benefits .....	29
Changes in Benefits .....	29
Inpatient Hospital Expense .....	29
Medical-Surgical Expense .....	30
Extended Care/Home Infusion Therapy .....	30
Skilled Nursing Facility .....	31
Home Health Care .....	31
Home Hospice Care .....	32
Facility Hospice Care .....	32
Other Benefit Provisions .....	32
Prenatal Genetic and Chromosomal Metabolic Testing .....	32
Obstetrical Care .....	32

Emergency Care and Treatment of Accidental Injury .....	33
Ambulance Services .....	34
Mental Health Care .....	35
Chemical Dependency .....	35
Serious Mental Illness .....	35
Mammography Screening .....	35
Preventive Care .....	36
Prevention and Detection of Osteoporosis .....	36
Detection of Prostate Cancer .....	36
Colorectal Cancer Screening .....	36
Childhood Immunizations .....	37
Hearing Impairment Screening .....	37
Hearing Aids .....	37
Cosmetic, Reconstructive or Plastic Surgery .....	37
Covered Dental Services .....	38
Organ and Tissue Transplant .....	38
Transportation/Travel Reimbursement Costs .....	39
Eyeglasses or Lenses .....	39
Male Sexual Dysfunction .....	39
Durable Medical Equipment .....	40
Obesity .....	40
<b>LIMITATIONS AND EXCLUSIONS .....</b>	<b>41</b>
<b>NOTICES</b>	
HIPAA .....	46
Women’s Health and Cancer Rights .....	47
Continuation of Group Coverage (COBRA) .....	48
Other Blue Cross and Blue Shield Plans’ Separate Financial Arrangements with Providers .....	50
<b>GENERAL INFORMATION</b>	
Participant/Provider Relationship .....	51
Assignment and Payment of Benefits .....	51
Subrogation, Reimbursement and Third Party .....	51
Recovery Provision	
Coordination of Benefits .....	52
UT SELECT and Medicare .....	55
Refund of Benefit Payments .....	57
Termination of Coverage .....	57
<b>ADMINISTRATION OF UT SELECT CLAIMS</b>	
Claims Liability .....	58
Claim Filing Procedures .....	58
Receipt of Claims by the Plan .....	60
Interpretation of Plan Provisions .....	60
Claim Determinations .....	60
Appeal Rights .....	61
<b>DEFINITIONS .....</b>	<b>62</b>

**PRESCRIPTION DRUG PROGRAM**

Covered Prescription Drug Charges..... 78  
How to Obtain Covered Prescription Drugs..... 79  
Limitations..... 80  
Exclusions..... 80  
Specific Definitions..... 81  
Medications Requiring Authorization..... 83

## In-Area Summary of Benefits

In-Area Network and Out-of-Network benefits apply to eligible Employees, Retirees and their covered dependents residing in Texas or New Mexico. Payment for Out-of-Network (including ParPlan) services is limited to the Allowed Amount as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the Allowed Amount. **Any charges over the Allowed Amount are the patient's responsibility and are in addition to deductible, coinsurance and out-of-pocket maximums.**

General Provisions	In-Area	
	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Deductible ( <i>per plan year</i> ) <i>When using Network providers, office visit and related services are not subject to deductible</i> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$250 \$750	\$500 \$1,500
Out-of-Pocket Maximum <i>(per plan year; includes deductible and coinsurance; does not include copayments, charges exceeding the Allowed Amount or non-covered services and supplies)</i> <i>Benefits will be paid at 100% for the remainder of the plan year once the out-of-pocket maximum is met</i> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$1,750 \$5,250	\$4,000 \$12,000
<b>Diagnostic Services (Office)</b>		
Family Care Physician (FCP) <ul style="list-style-type: none"> <li>• Family Practice</li> <li>• Internal Medicine</li> <li>• OB/GYN</li> <li>• Pediatrics</li> </ul>	\$25 copayment	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Specialists <i>(other than Behavioral Health)</i>	\$30 copayment	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Chiropractic Care <i>(subject to 20 visit plan year maximum per condition if traditional physical therapy modalities billed)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Allergy Services <i>(testing)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Allergy Serum/Injections <i>(if no office visit billed)</i>	Plan pays 100% (no copayment required)	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

	<b>In-Area</b>	
<b>General Provisions</b>	<b>Network</b>	<b>Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility</b>
Family Planning Services <i>(birth control management)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Diagnostic Laboratory and X-ray Services <i>Contrast material administered in conjunction with radiology services is subject to the applicable deductible and coinsurance</i>	Plan pays 100% (no copayment required)	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Diagnostic Tests	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Preventive Care</b>		
Infertility Diagnostic Testing	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Periodic Physical Exam <i>(one per plan year)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Well Woman Exam <i>(one per plan year)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Mammogram <i>(one per plan year)</i>	Plan pays 100% (no copayment required)	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Well Child Care <i>(under age 2)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Immunizations <i>(up to age 6, applies for injection only)</i>	Plan pays 100% (no copayment required)	Plan pays 100% of the Allowed Amount
Immunizations <i>(age 6 and older, applies for injection only)</i>	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Obstetrical Care</b>		
Initial Office Visit	\$25 copayment FCP \$30 copayment Specialist	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

General Provisions	In-Area	
	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Delivery–Facility <i>(preauthorization required)</i> <i>When using a Network facility: If the mother is a covered participant, she will be responsible for inpatient copayments of \$100 per day, not to exceed \$500 per stay, in addition to any applicable deductible and coinsurance. A separate inpatient copayment will not be charged for the newborn unless the newborn's hospitalization exceeds the mother's or unless the mother is not a covered participant on the UT SELECT plan. No more than \$500 in copayments will apply to any individual delivery admission. Applicable deductible and coinsurance will be charged for the newborn.</i>	After \$100 copayment per day (\$500 maximum copayment per admission), plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Delivery–Physician	After deductible and \$25 or \$30 copayment, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Lab and Radiology <i>Contrast material administered in conjunction with radiology services is subject to the applicable deductible and coinsurance</i>	Plan pays 100% (no copayment required)	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Voluntary Sterilization–Facility <i>(preauthorization required)</i>	After \$100 copayment, plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Voluntary Sterilization–Physician	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Inpatient Care (preauthorization required)</b>		
Facility <ul style="list-style-type: none"> <li>• Preadmission Testing</li> <li>• Semi-private Room and Board</li> <li>• Intensive Care Unit (ICU)</li> <li>• Inpatient Hospital Care</li> <li>• Surgery</li> </ul>	After \$100 copayment per day (\$500 maximum copayment per admission), plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Physician	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Outpatient Care</b>		
Observation <i>(a patient treated in a hospital or clinic instead of an in overnight room or ward)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Surgery–Facility	After \$100 copayment, plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

	<b>In-Area</b>	
<b>General Provisions</b>	<b>Network</b>	<b>Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility</b>
Surgery–Physician	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Lab and Radiology <i>Contrast material administered in conjunction with radiology services is subject to the applicable deductible and coinsurance</i>	Plan pays 100% (no copayment required)	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Diagnostic Tests <i>Medical diagnostic tests such as, but not limited to: immune globulins, therapeutic or diagnostic infusions (excludes chemotherapy), biofeedback, dialysis, gastroenterology, cardiovascular, non-invasive vascular diagnostic studies, pulmonary and neurology</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Emergency Care</b>		
Facility–Emergency Room	\$100 copayment (waived if admitted)	
Physician	Plan pays 100% (no copayment required)	
Ambulance	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Extended Care (preauthorization required)</b>		
Skilled Nursing <i>(subject to 180 day plan year maximum)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Home Health Care <i>(subject to 120 day plan year maximum)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Home Infusion Therapy	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Hospice Care <i>(subject to 90 visit plan year maximum)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Therapy</b>		
Physical Therapy <i>(subject to 20 visit plan year maximum per condition if traditional physical therapy modalities billed)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Occupational Therapy <i>(subject to 20 visit plan year maximum per condition)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Speech and Hearing Therapy <i>(subject to 60 visit plan year maximum per condition)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

	<b>In-Area</b>	
<b>General Provisions</b>	<b>Network</b>	<b>Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility</b>
Respiratory Therapy	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Other</b>		
Medical Supply/Durable Medical Equipment ( <i>preauthorization required</i> )/Prosthetic/Orthotics	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Hearing Aids (\$500 per ear; once every 4 years)	Plan pays 80%; you pay 20% (no deductible)	
Transportation/Travel ( <i>reimbursement subject to State of Texas per diem limitations; \$10,000 maximum reimbursement per lifetime</i> )	Plan pays 100% (no deductible or coinsurance) Itemized receipts and documentation required	
<b>Serious Mental Illness (<i>preauthorization required</i>)</b> <i>The Serious Mental Illness Benefit is not part of, but is in addition to, the Mental Illness Benefit</i>		
Inpatient–Facility	After \$100 copayment per day (\$500 maximum copayment per admission), plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Inpatient–Physician	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Outpatient	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Office Visit	\$25 copayment	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
<b>Chemical Dependency (<i>preauthorization required; 3 episodes for treatment per lifetime</i>)</b>		
Inpatient–Facility ( <i>subject to 30 day plan year maximum</i> )	After \$100 copayment per day (\$500 maximum copayment per admission), plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Inpatient–Physician ( <i>subject to 30 visit plan year maximum</i> )	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Outpatient ( <i>subject to 20 visit plan year maximum for outpatient and office combined</i> )	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Office Setting ( <i>subject to 20 visit plan year maximum for outpatient and office combined</i> )	\$25 copayment	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

General Provisions	In-Area	
	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
<b>Other Mental Illness (preauthorization required)</b>		
Inpatient–Facility <i>(subject to 30 day plan year maximum)</i>	After \$100 copayment per day (\$500 maximum copayment per admission), plan pays 80%; you pay 20% after deductible	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Inpatient–Physician <i>(subject to 30 visit plan year maximum)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Outpatient <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	After deductible, plan pays 80%; you pay 20%	After deductible, plan pays 60%; you pay 40% of the Allowed Amount
Office Setting <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	\$25 copayment	After deductible, plan pays 60%; you pay 40% of the Allowed Amount

## Out-of-Area Summary of Benefits

Out-of-Area Benefits apply to any eligible Employees, Retirees and their dependents whose residence is outside of the State of Texas or New Mexico. Payment for services is limited to the Allowed Amount as determined by Blue Cross and Blue Shield. ParPlan (Texas) and Traditional Indemnity Network (outside of Texas) providers accept the Allowed Amount. **Any charges over the Allowed Amount are the patient's responsibility and will be in addition to deductible, coinsurance and out-of-pocket maximums.**

<b>General Provisions</b>	<b>Out-of-Area</b> Any charges over the Allowed Amount are the patient's responsibility
Deductible ( <i>per plan year</i> ) <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$250 \$750
Out-of-Pocket Maximum <i>(per plan year; includes deductible and coinsurance; does not include charges exceeding the Allowed Amount or non-covered services and supplies) Benefits will be paid at 100% for the remainder of the plan year once the out-of-pocket maximum is met</i> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$1,750 \$5,250
<b>Diagnostic Services (Office)</b>	
Office Visit	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Chiropractic Care ( <i>subject to 20 visit plan year maximum per condition if traditional physical therapy modalities billed</i> )	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Preventive Care</b>	
Infertility Diagnostic Testing	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Periodic Physical Exam <i>(one per plan year)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Well Woman Exam <i>(one per plan year)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Mammogram <i>(one per plan year)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Well Child Care <i>(under age 2)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Immunizations	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Obstetrical Care</b>	
Delivery ( <i>preauthorization required</i> )	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Voluntary Sterilization	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Inpatient Care (<i>preauthorization required</i>)</b>	
<ul style="list-style-type: none"> <li>• Preadmission Testing</li> <li>• Semi-private Room and Board</li> <li>• Intensive Care Unit (ICU)</li> <li>• Inpatient Hospital Care</li> <li>• Surgery</li> </ul>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount

<b>General Provisions</b>	<b>Out-of-Area</b> Any charges over the Allowed Amount are the patient's responsibility
<b>Outpatient Care</b>	
Including Observation, Surgery, Labs, Radiology and Diagnostic Testing	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Emergency Care</b>	
Facility and Physician–Emergency Room	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Ambulance	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Extended Care (preauthorization required)</b>	
Skilled Nursing <i>(subject to 180 day plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Home Health Care <i>(subject to 120 day plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Home Infusion Therapy	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Hospice Care <i>(subject to 90 visit plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Therapy</b>	
Physical Therapy <i>(subject to 20 visit plan year maximum per condition if traditional physical therapy modalities billed)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Occupational Therapy <i>(subject to 20 visit plan year maximum per condition)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Speech and Hearing Therapy <i>(subject to 60 visit plan year maximum per condition)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Respiratory Therapy	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Other</b>	
Medical Supply/Durable Medical Equipment <i>(preauthorization required)/Prosthetic/Orthotics</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Hearing Aids <i>(\$500 per ear; once every 4 years)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Transportation/Travel <i>(reimbursement subject to State of Texas per diem limitations; \$10,000 maximum reimbursement per lifetime)</i>	Plan pays 100% (no deductible or coinsurance) Itemized receipts and documentation required
<b>Serious Mental Illness (preauthorization required)</b> <i>The Serious Mental Illness Benefit is not part of, but is in addition to, the Mental Illness Benefit</i>	
Inpatient–Facility	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Inpatient–Physician	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Outpatient	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Office Visit	After deductible, plan pays 75%; you pay 25% of the Allowed Amount

<b>General Provisions</b>	<b>Out-of-Area</b> Any charges over the Allowed Amount are the patient's responsibility
<b>Chemical Dependency (preauthorization required; 3 episodes for treatment per lifetime)</b>	
Inpatient–Facility <i>(subject to 30 day plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Inpatient–Physician <i>(subject to 30 visit plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Outpatient <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Office Setting <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
<b>Other Mental Illness (preauthorization required)</b>	
Inpatient–Facility <i>(subject to 30 day plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Inpatient–Physician <i>(subject to 30 visit plan year maximum)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Outpatient <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount
Office Setting <i>(subject to 20 visit plan year maximum for outpatient and office combined)</i>	After deductible, plan pays 75%; you pay 25% of the Allowed Amount

# Understanding Your Plan

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## About This Benefits Booklet

This booklet is a guide to your UT SELECT benefits administered by Blue Cross and Blue Shield of Texas under the direction of the University of Texas (UT) System, Office of Employee Benefits (OEB). It is intended to be an information source and is not a contract. It will provide you with valuable information on such topics as:

- *Who Gets Benefits*
- *How to Receive Benefits*
- *Medical Benefits Provided*
- *Limitations and Exclusions*
- *Definitions*

The terms “you” and “your” as used in this Benefits Booklet refer to the Employee or Retiree. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

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

The benefits provided in UT SELECT are intended to assist you with many of your health care expenses. There are provisions throughout this Benefits Booklet which affect your medical coverage.

Capitalized words are defined terms. Whenever these terms are used, the meaning is consistent with the definition given. Terms in *italics* may be section headings describing provisions or they may be defined terms.

## Service Area

In-Area or Out-of-Area coverage is determined by the residential ZIP code of the Subscriber. All residents of Texas and New Mexico are considered In-Area Participants.

In-Area Participants have the option of receiving services at a Network or Out-of-Network benefit level. In order to receive the Network level of benefits, you must seek care from a BlueChoice<sup>®</sup> Provider. You can locate BlueChoice<sup>®</sup> Providers in the UT SELECT Provider Directory, online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut), or by contacting UT SELECT Customer Service.

Out-of-Area Participants receive a set benefit level regardless of the provider’s status. However, as an Out-of-Area Participant, you can reduce your Out-of-Pocket Maximum expenses by seeking care from a ParPlan provider.

If you are unsure about your service area status, contact your Campus Benefits Office.

## **Your UT SELECT Identification Card**

The identification card issued to you identifies you as a Participant in the UT SELECT health and pharmacy benefits plan for which you have enrolled. Your identification card contains important information about you, your family, your employer group, and the benefits to which you are entitled.

Your UT SELECT identification number is a randomly selected nine-digit number. The identification card tells Providers that you are entitled to medical benefits under the UT SELECT Plan. The card offers a convenient way of providing important information specific to your coverage.

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

Any change in family status may require a new identification card be issued to you. You must notify your Campus Benefits Office within 31 days of the change, and upon receipt of the information, BCBSTX will issue a new identification card if needed.

### ***Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards***

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

- Use of the identification card prior to your Effective Date
- Use of the identification card after your date of termination of coverage under the Plan

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

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

# Who Gets Benefits

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## Eligibility for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee, Retiree or a dependent and is in a class eligible to be covered under the Plan.

Your Eligibility Date will be determined by the UT System in accordance with their established eligibility procedures. Please contact your Campus Benefits Office for your Eligibility Date.

Please note: Employees, Retirees and Dependents who are not enrolled in another health plan offered by the UT System or UT SELECT during their initial period of eligibility may be subject to Evidence of Insurability (EOI) requirements to enroll at a later date in UT SELECT.

## *Employee Eligibility*

You are eligible for benefits as a full-time employee if:

- You work at least 40 hours per week, and
- Your appointment is expected to continue for at least 4 ½ months, and
- You are not currently insured by another State-sponsored medical insurance plan.

You are eligible for benefits as a part-time employee if:

- You work at least 20 hours, but less than 40 hours per week, and
- Your appointment is expected to continue for at least 4 ½ months, and
- You are not currently insured by another State-sponsored medical insurance plan.

NOTE: Certain non-employee Post Doctoral Fellows are eligible for certain benefits under the UT Group Insurance Program. Please contact your local Campus Benefits Office for more information.

## *Dependent Eligibility*

You may also insure your eligible dependents under UT SELECT. Your eligible dependents include:

- Your legally married spouse
- Your unmarried child under age 25, including
  - Stepchildren
  - Adopted children
  - Children for whom you are the legal guardian
- Your unmarried grandchild under age 25, who is your dependent for income tax purposes and whose biological parent is also enrolled under UT SELECT
- Your child over age 25, if determined by OEB to be medically incapacitated

Examples of dependents that are not eligible for coverage include:

- Your common-law spouse
- Same sex partner
- Your former spouse
- Your married child
- Your child, over age 25, if not medically incapacitated
- Foster children covered by another government program, unless required by law
- Any child for whom you have Power of Attorney only
- Any child insured by another UT employee or retiree
- Any dependent who is active in the Armed Forces of any country

## ***Retiree Eligibility***

- 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 has 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 The University of Texas System has made employer contributions.
- 2) Individuals who were employed with The University of Texas System on or 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 that 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 insurance 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; or
    - The Optional Retirement Program established by Chapter 830, Government Code or any other federal or state statutory retirement program to which The University of Texas System has made employer contributions.
  - 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.

## **Changes in Your Status**

You have *31 days* from the date of a qualifying change of status event to notify your Campus 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 period in July, to be effective the following September 1. Your dependent(s) may be required to provide Evidence of Insurability for some benefit changes.

The list below includes common examples of Status Changes:

- 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 and your dependents' current plan eligibility
- Starting or ending employment, starting or returning from unpaid leave of absence, or a change of job status (e.g. from part-time to full-time)
- Change in dependent eligibility (e.g. marriage or reaching the age limit)
- Change in coverage or cost of other benefit plans available to you and your family

Your benefit selection changes must be consistent with your Change in Status. For questions regarding Status Changes, please contact your Campus Benefits Office.

### **Certificates of Creditable Coverage**

Your Campus Benefits Office will provide Certificates of Creditable Coverage for all Participants, should your employment with the UT System terminate. BCBSTX will provide Certificates of Creditable Coverage for COBRA Participants when their coverage terminates.

This form provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a non-UT system group health plan that excludes coverage for certain medical conditions that you have before you enroll (preexisting conditions). You may use this form to provide documentation of your previous UT System coverage and thereby obtain credit toward any preexisting waiting period of the new Plan.

These certificates will be sent to your last known address. Each certificate will contain up to 24 months of history for you and all of your dependents, if any.

### **Address Changes**

Notify your Campus Benefits Office of all address changes for yourself and your dependents. An address change may result in benefit changes for you and your dependents if you move out of your Plan Service Area.

**Address changes must be submitted through your Campus Benefits Office.**

# How to Receive Benefits

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## Selecting a Provider

### *Network Benefits*

BCBSTX and other Blue Cross and Blue Shield Plans participating with the Claims Administrator have established Preferred Provider Organization (PPO) Networks of Physicians, Specialty Care Providers, Hospitals, and other health care providers to serve Participants throughout the United States. These Providers are available online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut). You may also call Customer Service toll free at 1-866-882-2034.

To receive Network Benefits, you must choose Providers within the BlueChoice® Network for all care (other than for emergencies). When you enroll in UT SELECT, you do not have to choose or select a Primary Care Physician (PCP) to coordinate your medical care within the Network or refer you to Specialists or Hospitals. You have the freedom of choice.

If you choose a BlueChoice® Provider, the Provider will bill BCBSTX for services provided. The BlueChoice® Provider will only bill you for applicable Copayments, Coinsurance and/or Deductible. The Provider has agreed to accept as payment in full the least of:

- The billed charges,
- The Allowed Amount as determined by BCBSTX for the Plan, or
- Other contractually determined payment amounts.

You will be responsible for Deductibles, Copayments and Coinsurance. In addition, you may be required to pay for limited or non-covered services.

### *Out-of-Network Benefits*

Participants who are eligible to receive In-Area benefits, but choose to receive care from a ParPlan (see definition below) or a non-contracting Provider will receive Out-of-Network Benefits. If you choose to see a non-contracting Provider, you will be responsible for:

- Paying billed charges above BCBSTX's Allowed Amount
- Paying required Deductibles, Copayments and Coinsurance Amounts
- Following the required Preauthorization procedures
- Filing your own claims for services
- Paying for limited or non-covered services

If you receive services from ParPlan Providers, you are not responsible for the difference between the billed charge and the BCBSTX Allowed Amount. Most ParPlan Providers will file your claims.

### *Out-of-Area Benefits*

Out-of-Area Coverage is only available to Subscribers living outside of Texas or New Mexico. As an Out-of-Area Participant, you can save time and money by seeking care through contracted physicians, facilities, and other providers. In Texas, this program is known as ParPlan. Nationwide, the program is known as the Traditional Indemnity Network.

ParPlan providers are available online at [www.bcbstx.com](http://www.bcbstx.com) and Traditional Indemnity providers may be located online at [www.bluecares.com](http://www.bluecares.com). You may also contact UT SELECT Customer Service at 1-866-882-2034.

By seeking services from ParPlan/Traditional Indemnity Providers, you can limit your Out-of-Pocket Maximum expenses. You will be responsible for:

- Any applicable Deductibles and Coinsurance amounts
- Limited or non-covered services

If using non-contracting Providers, you will be responsible for:

- Filing your own claims
- Billed charges above Plan Allowed Amounts
- Coinsurance amounts
- Deductibles
- Preauthorization of certain benefits and services
- Limited or non-covered services

### ***ParPlan/Traditional Indemnity Providers***

(Applies to Out-of-Network and Out-of-Area Benefits)

ParPlan/Traditional Indemnity Providers have agreed to file your claims for you and to accept Blue Cross and Blue Shield's Allowed Amount determination as payment in full for Medically Necessary services. When you access care from a ParPlan/Traditional Indemnity Provider, you limit your Out-of-Pocket Maximum expenses.

You will be responsible for:

- Any applicable Deductibles and Coinsurance amounts
- Limited or non-covered services

Remember:

- You or your dependents are solely responsible for making the choice of health care Provider(s).
- If you are enrolled as an In-Area Participant and you choose a BlueChoice<sup>®</sup> Provider, it is your responsibility to ensure that your chosen Provider is still in the BlueChoice<sup>®</sup> Network each time you schedule an appointment.
- If you choose a ParPlan Provider, it is your responsibility to ensure that your chosen ParPlan Provider is still participating each time you schedule an appointment.
- If you choose a BlueChoice<sup>®</sup> or ParPlan Facility, it is your responsibility to ensure that your chosen facility is still contracting with BCBSTX each time you schedule an inpatient or outpatient admission.

**If you are having difficulty locating a BlueChoice<sup>®</sup>, ParPlan or Traditional/Indemnity Provider in your area, please contact Customer Service at 1-866-882-2034 for assistance.**

## **Preauthorization**

Preauthorization is a determination only of the Medical Necessity of the treatment or admission you are seeking. **It is not a guarantee of payment.** Payment will be determined after the claim is filed and is subject to eligibility requirements and other UT SELECT provisions, exclusions and limitations including, but not limited to:

- Cosmetic procedure limitation
- Requirement to call for Preauthorization as explained below on a timely basis – (prior to an elective admission and within 48 hours of an emergency admission)
- Payment of premium for the date on which services are rendered

### ***Medical Services***

UT SELECT requires Preauthorization of certain medical services. Preauthorization is a determination of the Medical Necessity of the care before you receive it. It is required for:

- 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

### ***Mental Health Services***

When using a BlueChoice<sup>®</sup> Provider, the Provider is responsible for Preauthorization. **Please ensure that Preauthorization for mental health services has been obtained through INROADS Behavioral Health Services.**

If you do not use a BlueChoice<sup>®</sup> Provider, you are responsible for Preauthorization of the following:

- Hospital Admissions
- Intermediate care facilities
- Residential treatment centers
- Crisis stabilization units
- Psychiatric day treatment facilities

If you do not obtain Preauthorization for these services, you will receive a lower level of benefit coverage and you may be responsible for the full cost of the services, until the Medical Necessity of your treatment can be determined. Benefits may be reduced or denied if the treatment is not Medically Necessary.

### ***How to Preauthorize***

When you use a BlueChoice<sup>®</sup> Provider, he will be responsible for the Preauthorization.

If you do not use a BlueChoice<sup>®</sup> Provider, you are responsible for the Preauthorization. You, your Physician, Provider of Services, or a family member must ensure that your treatment has been preauthorized by BCBSTX.

<p align="center"><b>Medical Preauthorization Numbers</b></p>
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<p align="center"><b>In Dallas: (972) 783-4475</b></p>
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<p align="center"><b>Outside of Dallas: 1-800-441-9188</b></p>
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<p align="center"><b>INROADS Behavioral Health Services Telephone Numbers</b></p>
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<p align="center"><b>In Dallas: (972) 766-5204</b></p>
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<p align="center"><b>Outside of Dallas: 1-800-528-7264</b></p>
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This call should be made between 7:30 a.m. CT and 8 p.m. CT on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. Benefits management nurses will follow up with your Provider's office for Network care or with you for Out-of-Network care. In most cases, Preauthorization is made within minutes while BCBSTX is on the telephone with your Provider's office for Network care or with you for Out-of-Network care.

### ***Failure to Preauthorize Medical Services and Mental Health Services***

If Preauthorization for the services listed above is not obtained, the following will apply:

- BCBSTX will review the Medical Necessity of your treatment prior to the final benefit determination.
- If BCBSTX determines the treatment is not Medically Necessary, benefits will be denied.
- In connection with any Inpatient Hospital Admission, you will be responsible for a penalty charge of 50% reduction of Benefits. The penalty charge will be deducted from any benefit payment that may be due for the admission.
- If a Hospital Admission or extension for any treatment or service is not preauthorized and it is determined that the admission or extension was Medically Necessary, benefits may be reduced.
- If it is determined that the admission or extension was not Medically Necessary, no benefits will be available.

## **Disease Management**

UT SELECT provides voluntary disease management programs designed specifically for those who have been diagnosed with the following conditions:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Metabolic Syndrome (High Blood Pressure, High Cholesterol)
- Lower Back Pain Or End Stage Renal Disease

When you enroll in one of the programs, you'll receive helpful information about your condition, at no out-of-pocket cost to you.

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

- Decrease the intensity and frequency of your symptoms
- Enhance your self-management skills
- Minimize missed days at work
- Enrich your quality of life

Claims and pharmacy data review, preauthorization prior to a hospitalization or a physician referral are some of the factors that help determine if a disease management program is right for you. Blue Cross and Blue Shield of Texas will notify your doctor by letter if it finds that you would benefit by enrolling in a program.

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

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

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

- Personalized self-management planning
- Regularly scheduled monitoring by a registered nurse
- 24-hour-a-day telephone access to a specialty nurse
- An audio library of topics related to your condition, available by telephone around-the-clock
- Assistance in getting durable medical equipment covered under your health plan

Call 1-800-462-3275 to enroll or to find out more about how disease management programs can help you.

## **Case Management**

Under certain circumstances, the Plan allows the flexibility to offer alternative benefits which are not otherwise Eligible Expenses. The Plan may offer such alternative benefits, in its sole discretion, provided the:

- Participant, his family, and his Physician agree,
- Participant's medical condition would require continued hospitalization without such alternative benefits, and
- Plan anticipates future expenditures for Eligible Expenses that may be reduced by the cost-effective alternative benefits.

Any decision by the Plan to provide alternative benefits shall be made on a case-by-case basis. The case coordinator will initiate case management in appropriate situations.

## **Predetermination of Benefits**

As Participants in UT SELECT, you and your covered dependents are entitled to a review by the BCBSTX Medical Division to determine the Medical Necessity of any proposed medical procedure. It will inform you in advance if BCBSTX considers the service to be Medically Necessary and, therefore, eligible for benefits.

To have a Predetermination conducted, have your Physician provide BCBSTX a letter of Medical Necessity and any pertinent medical records supporting this position. After a decision is reached, you and your Physician will be notified in writing. **Predetermination is not a guarantee of payment.**

## **BlueCard<sup>®</sup> Program**

BlueCard<sup>®</sup> is a national program that enables you to obtain health care services while traveling or living in another Blue Cross and Blue Shield (BCBS) Plan's service area. The program links participating health care Providers and the independent BCBS Plans across the country through a single electronic network for claims processing and reimbursement. The BlueCard<sup>®</sup> Program enables other BCBS Plans, including international BCBS Plans, to electronically submit claims directly to your local BCBS Plan when accessing care through participating health care Providers.

### ***In-Area Members***

If you are eligible to receive In-Area benefits (see Service Area), you and your covered dependents will continue to receive the Network and Out-of-Network benefit levels depending on the contracting status of your health care Provider when traveling outside the states of Texas and New Mexico. As a reminder, membership identification cards for UT SELECT Subscribers who are designated as In-Area contain the BlueCard<sup>®</sup> program's "PPO-in-a-suitcase" logo.

Please remember that in order to receive Network Benefits, you must utilize Network Providers. A listing of Providers who participate in the BlueCard<sup>®</sup> program can be located on the web at [www.bluecares.com](http://www.bluecares.com). You can also contact BlueCard<sup>®</sup> Customer Service toll free at 1-866-676-2583.

### ***Out-of-Area Members***

If you are eligible to receive Out-of-Area Benefits, you and your covered dependents will continue to receive the Out-of-Area benefit level for all covered services even when you are away from home. You will receive the Out-of-Area benefit level regardless of the Provider's contracting status. However, you can reduce your Out-of-Pocket Maximum expense by utilizing Traditional/Indemnity providers who have agreed to accept BCBS Plan Allowed Amounts.

## **BlueCard Worldwide<sup>®</sup>**

When you travel or live abroad, always carry your UT SELECT Identification Card. Through the BlueCard Worldwide<sup>®</sup> program, you have access to a large number of Hospitals on almost every continent and to a broad range of medical assistance services when you travel or live outside the U.S. BlueCard Worldwide<sup>®</sup> provides the following services to Participants:

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

If you need to locate a Physician or Hospital, or need medical assistance, call BlueCard<sup>®</sup> Access toll free at 1-800-810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a Physician or arrange hospitalization, if necessary.

If you are eligible to receive In-Area benefits, you will receive the Out-of-Network benefit level for services provided in a foreign country (except for Emergency Care). If you are eligible for Out-of-Area Benefits, you will still receive the Out-of-Area benefit level.

**In an emergency, always go directly to the nearest Hospital.**

Call your local BCBS Plan for Preauthorization or prior authorization, if necessary (refer to the Preauthorization toll free telephone number on the back of your identification card. It is different than the BlueCard<sup>®</sup> Access toll free telephone number above). In most cases, you will not pay at the time services are rendered for inpatient care at BlueCard Worldwide<sup>®</sup> Hospitals.

You are responsible for the usual Out-of-Pocket Maximum expenses (non-covered services, Deductible, Copayment, and Coinsurance Amounts). The Hospital should submit your claim.

You pay the Physician or Hospital for inpatient care at non-BlueCard Worldwide Hospitals, outpatient Hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard<sup>®</sup> Access Service Center. The claim form is available online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut).

Bills from foreign Providers are different than normal billing in the U.S. They may be missing the Provider name and address, in addition to other critical information. It is very important that you fill out the BlueCard Worldwide<sup>®</sup> claim form completely and accurately and attach it to your bills. Any missing information will delay claim processing.

# Medical Benefits Provided

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## Eligible Expenses

Your Plan provides benefits for three major categories:

- Inpatient Hospital Expense
- Medical-Surgical Expense
- Extended Care Expense

This plan also provides benefits for an Outpatient Prescription Drug Program. Please refer to the Outpatient Prescription Drug Plan section in the back of this booklet.

This part of your booklet explains how benefits are provided for each of the three expense categories listed above, subject to all of the Plan's terms and provisions. Please remember to refer to **DEFINITIONS** in this Benefits Booklet for a description of terms such as Inpatient Hospital Expense, Medical-Surgical Expense, and Extended Care Expense.

Your benefits, including Deductible and Out-of-Pocket Maximum, are calculated each Plan Year (9/1-8/31), unless otherwise stated. At the end of a Plan Year a new Plan Year starts for each Participant.

Wherever "*Summary of Benefits*" is mentioned, please refer to the appropriate UT SELECT *Summary of Benefits* for the appropriate benefit level.

## Deductible

The benefits of the Plan will be available after you have met the Deductibles shown on your *Summary of Benefits*.

For Network Benefits there is an exception. Physician Office Visits and related services require the applicable Copayment Amount and are not subject to the Deductible.

- The Plan Year Deductible shown on your *Summary of Benefits* must be met by each Participant during each Plan Year prior to benefits being paid by the Plan. This Deductible will apply to most expenses incurred and reimbursed at the Coinsurance level shown on the *Summary of Benefits*. Services covered under the Office Visit Copayment Amount are not subject to the Plan Year Deductible.
- If you have three or more covered dependents, all charges used to apply toward each Participant's individual Deductible will be applied toward the Family Deductible amount. When that amount is reached, no further individual Deductibles will have to be satisfied for that Plan Year.
- No Participant will contribute more than the individual Deductible to the Family Deductible.

## **Out-of-Pocket Maximum**

After your Eligible Expenses have been totaled, Deductible subtracted, and benefits calculated, most remaining unpaid Eligible Expenses will apply toward your Out-of-Pocket Maximum. These are your responsibility to pay to the Provider. When your Out-of-Pocket Maximum equals the maximum shown on your *Summary of Benefits*, the benefit percentages increase to 100% for most additional Eligible Expenses for the remainder of that Plan Year.

The Out-of-Pocket Maximum will not include:

- Penalties for failure to preauthorize
- Services or supplies excluded by the Plan
- Expenses not covered because a benefit maximum has been reached
- Any Eligible Expenses paid by the Primary Carrier when the Plan is the Secondary Plan for purposes of Coordination of Benefits
- Copayments
- Amounts in excess of the Allowed Amount

There are separate Out-of-Pocket Maximums for Network, Out-of-Network and Out-of-Area Benefits. Eligible Expenses for Out-of-Network Benefits will apply to the Out-of-Pocket Maximum for Network Benefits.

When the Out-of-Pocket Maximum for the Network and Out-of-Network or Out-of-Area benefit levels for all Participants under your coverage equal the Family Out-of-Pocket Maximum during a Plan Year, the benefit percentages automatically increase to 100% for additional Eligible Expenses for all family Participants for the remainder of that Plan Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

## **Maximum Lifetime Benefits**

UT SELECT lifetime maximums are limited to the following:

- Three episodes for Chemical Dependency treatment
- \$10,000 for Transportation/Travel reimbursement

All other eligible services are not limited to a lifetime maximum.

## **Changes in Benefits**

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Other Facility Provider that begins before the change will be those benefits in effect on the day of admission.

## **Benefits for Inpatient Hospital Expense**

Expenses normally included under Inpatient Hospital Expense are, but not limited to, intensive and coronary care units; operating room; lab and x-ray; and blood. A private-room rate is allowed as Inpatient Hospital Expense only when Medically Necessary.

Inpatient Hospital stays require Preauthorization prior to admission (or within 2 business days of emergency admission).

- Under the Network portion of the Plan, the BlueChoice<sup>®</sup> Provider is responsible for obtaining Preauthorization.

- Under the Out-of-Network or Out-of-Area portion of the Plan, you are responsible for obtaining Preauthorization.

**Remember:** Failure to preauthorize an Out-of-Network or Out-of-Area hospitalization in accordance with BCBSTX's procedures may result in a 50% reduction of benefits.

**To satisfy Out-of-Network or Out-of-Area inpatient Preauthorization requirements, call:  
Outside of Dallas: 1-800-441-9188  
Dallas area: (972) 783-4475**

### **Benefits for Medical-Surgical Expense**

Medical-Surgical Expenses include but are not limited to: services of Physicians and Other Professional Providers; Durable Medical Equipment; diagnostic x-ray and laboratory examinations; and Prosthetic Appliances. Certain services require Preauthorization, and any Copayment Amounts and Deductibles shown on your *Summary of Benefits* will also apply. Refer to the *DEFINITIONS* portion of this Benefits Booklet for a detailed explanation of Medical-Surgical Expense.

### **Benefits for Extended Care and Home Infusion Therapy**

Extended Care includes Skilled Nursing Facility services, Home Health Care, and Hospice Care. Home Infusion Therapy is intravenous administration or injection of fluids, nutrition, or medication done in the home setting.

All Custodial Care is considered a contract exclusion; therefore, not covered. Custodial Care is defined as care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury.

Preauthorization is required for Extended Care or Home Infusion Therapy. The agency or facility providing the services must obtain Preauthorization and submit a treatment Plan to BCBSTX on a Preauthorization Review Form.

The Preauthorization Review Form must be completed:

- Before the start of Extended Care or Home Infusion Therapy;
- For periodic recertification of Extended Care or Home Infusion Therapy as required by BCBSTX; and
- Any time the treatment plan is altered.

If Extended Care or Home Infusion Therapy is to take place in less than one week, the agency or facility should call BCBSTX's Preauthorization telephone number.

**To obtain Preauthorization requirements for Extended Care or Home Infusion Therapy:  
Outside of Dallas: 1-800-441-9188  
Dallas area: (972) 783-4475**

BCBSTX will review the information submitted prior to the start of Extended Care or Home Infusion Therapy. A letter will be sent to you and the agency or facility indicating if benefits for the treatment plan requested are available.

If Extended Care or Home Infusion Therapy is scheduled to occur within 72 hours, the agency or facility will be notified by telephone. If notification has been given that benefits for the treatment plan requested are not available, claims will be denied.

**Network Benefits** will be available if you use a BlueChoice® Provider or if your BlueChoice® Provider refers you to agencies or facilities outside the Network because care is not available from BlueChoice® Providers.

**Out-of-Network** or **Out-of-Area** Benefits will be available if you use agencies or facilities outside the Network. You must preauthorize your care.

Preauthorization of a Hospital Admission does not include Preauthorization of Extended Care or Home Infusion Therapy.

Any charges incurred as Home Health Care or Home Hospice Care for drugs, laboratory services, and Durable Medical Equipment will not be considered an Extended Care Expense but as a Medical-Surgical Expense. The Deductible will apply. Any unpaid Extended Care Expense in excess of the maximum number of visits/days shown on your *Summary of Benefits* will not be applied to any Out-of-Pocket Maximums.

When an Extended Care Expense has been preauthorized, the Plan will pay benefits for the following services and supplies at the benefit percentage and up to the maximums shown on your *Summary of Benefits*.

Services and supplies include:

**Skilled Nursing Facility:**

- All usual nursing care by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.)
- Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility
- Physical, occupational, speech, and respiratory therapy services by licensed therapists

**Home Health Care:**

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.)
- Part-time or intermittent home health aide services which consist primarily of caring for the patient
- Physical, occupational, speech, and respiratory therapy services by licensed therapists
- Supplies and equipment routinely provided by the Home Health Agency

Benefits will not be provided for Home Health Care for the following:

- Food or home delivered meals
- Social case work or homemaker services
- Services provided primarily for Custodial Care
- Transportation services

**Home Hospice Care:**

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.)
- Part-time or intermittent home health aide services which consist primarily of caring for the patient
- Physical, speech, and respiratory therapy services by licensed therapists

**Facility Hospice Care:**

- All usual nursing care by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.)
- Room and board and all routine services, supplies, and equipment provided by the Hospice facility
- Physical, speech, and respiratory therapy services provided by licensed therapists
- Counseling services routinely provided by the Hospice facility, including bereavement counseling

**Remember:**

- Under the Network portion of the Plan, the BlueChoice® Provider is responsible for Preauthorization.
- Under the Out-of-Network or Out-of-Area portion of the Plan, you are responsible for Preauthorization.

**Other Benefit Provisions**

Benefits available under this section will be determined as indicated on your *Summary of Benefits*. Remember that certain services require Preauthorization and that any Copayment Amounts and Deductible will apply.

**Benefits for Prenatal Genetic and Chromosomal Metabolic Testing**

Benefits for Eligible Expenses incurred for Prenatal Genetic and Chromosomal Metabolic Testing include amniocentesis and Chronic Villus Sampling (CVS). These tests are eligible for coverage for the specific conditions listed:

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

**Benefits for Obstetrical Care**

Benefits for Eligible Expenses incurred for Obstetrical Care will be the same as for treatment for any other sickness as shown on your *Summary of Benefits*. Dependent children will be eligible for Obstetrical Care Benefits.

Services and supplies incurred by a Participant for the delivery of a child shall be considered Obstetrical Care and are subject to all provisions of this Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by caesarean section

Inpatient Hospital Expense incurred by the mother for the delivery of a child will not include the charges for routine well-baby nursery care during the mother's Hospital Admission. These charges will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described on the *Summary of Benefits*.

### ***Benefits for Treatment of Complications of Pregnancy***

Benefits for Eligible Expenses incurred for Treatment of Complications of Pregnancy will be the same as for treatment of any other illness as shown on your *Summary of Benefits*.

You (the Employee) have 31 days from the date of a qualifying event to make the appropriate changes to your benefit designations. Application for changes must be made through your Campus Benefits Office. If you do not finalize the appropriate changes during the 31-day status change period, the changes cannot be honored until the next Annual Enrollment Period and you may be required to supply Evidence of Insurability for your dependent. Previously eligible dependents are required to provide Evidence of Insurability. Please contact your Campus Benefits Office with questions or changes in status.

### **Benefits for Emergency Care and Treatment of Accidental Injury**

Your Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies include, but are not limited to:

- Unusual or excessive bleeding
- Broken bones
- Acute abdominal or chest pain
- Unconsciousness
- Convulsions
- Difficult breathing
- Sudden persistent pain
- Severe or multiple injuries
- Burns
- Poisonings

*In an EMERGENCY, you should do the following:*

- If reasonably possible, contact your Provider before going to the Hospital emergency room. He can help you determine if you need Emergency Care and recommend that care.
- If not reasonably possible to contact your Provider, go to the nearest emergency facility.
- Whether you require hospitalization or not, you should contact your Provider within 48 hours, or as soon as reasonably possible, of any medical treatment so he can recommend the continuation of any necessary medical services.
- If you must be hospitalized for Emergency Care, the admission must be precertified within two working days.

The following applies to Network Benefits in an emergency situation:

- Inpatient hospitalization received during the first 48 hours following the onset of a medical emergency will be eligible for Network Benefits. After 48 hours, Network Benefits will be available only if you use a BlueChoice<sup>®</sup> Facility.
- If you are in an Out-of-Network Facility and after the first 48 hours of treatment following the onset of an accident or medical emergency and you can be safely transferred to the care of a BlueChoice<sup>®</sup> Facility but you choose to continue your care in the Out-of-Network Facility, only

Out-of-Network Benefits will be available without a referral by a BlueChoice<sup>®</sup> Provider. The referral must be authorized by BCBSTX.

### ***Ambulance services***

Ambulance services are medically necessary as outlined below:

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

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

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

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

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

Non-emergency transports are defined as ambulance transports for a patient who has a medical problem requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. Disabled means the patient's physical condition limits his mobility and is unable to stand and sit unassisted or requires continuous life support systems.

Situations where non-emergency transportation is medically necessary for the patient described above include either of the following:

- The patient is a registered inpatient in a facility and the specialized services are not available in that facility
- The provider of a specialized service is the nearest one with the required capabilities (i.e., renal dialysis center)

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

## **Benefits for Mental Health Care**

### ***Benefits for Mental Health Care (does not include Serious Mental Illness) and Treatment of Chemical Dependency***

Benefits for Inpatient Hospital Expense and Medical-Surgical Expense for Mental Health Care and treatment of Chemical Dependency are available as indicated in your *Summary of Benefits*.

All Mental Health Care and treatment of Chemical Dependency, inpatient or outpatient, must be precertified through the Mental Health help line indicated on your UT SELECT identification card. Medically Necessary Mental Health Care in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center in lieu of hospitalization will be considered Inpatient Hospital Expense.

Mental Health Care provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency until completion of any recommended series of Chemical Dependency treatments. (Mental Health Care received after the completion of a series of Chemical Dependency treatments will be considered Mental Health Care.)

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Facility. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for illness generally as described under Benefits for Inpatient Hospital Expense, except that Inpatient Chemical Dependency treatment is limited to three (3) occurrences per lifetime.

The same Deductible and Copayment Amounts apply for medical, mental health and Chemical Dependency benefits.

Inpatient Hospital Expense for Mental Health Care and Chemical Dependency will be limited to the number of inpatient days shown on your *Summary of Benefits*.

Benefits for Medical-Surgical Expense incurred for Mental Health Care and Chemical Dependency Treatment will be limited to the number of inpatient Physician/Other Professional Provider visits shown on your *Summary of Benefits*.

Benefits for Medical-Surgical Expense incurred for Mental Health Care and treatment of Chemical Dependency will be limited to the combined number of outpatient Physician and/or Other Provider visits shown on your *Summary of Benefits*. The UT SELECT Plan allows a lifetime maximum of three Chemical Dependency treatments.

### ***Benefits for Serious Mental Illness***

Benefits for the treatment of Serious Mental Illness will be provided on the same basis as any other illness. Please refer to your *Summary of Benefits* to determine your benefits.

## **Benefits for Mammography Screening**

Benefits are available up to the amount shown on the *Summary of Benefits* for a screening by low-dose mammography for the presence of occult breast cancer. Benefits will:

- Be determined on the same basis as for other Medical-Surgical Expense as shown on your *Summary of Benefits*.
- Not be available for more than one preventive mammography screening each Plan Year.

## **Benefits for Preventive Care**

Benefits are available up to the amount shown on the *Summary of Benefits* for:

- Well-baby care (children up to age 2)
- Routine physical examinations, one per year after age 2
- Hearing examinations (except for benefits as provided under **Benefits for Screening Test for Hearing Impairment**, below)

Benefits are also available for immunizations for Participants age six and over. Benefits for childhood immunizations for children from birth to age 6 years of age will be provided as described in **Benefits for Childhood Immunizations**.

Benefits for Preventive Care services will be determined as indicated on your *Summary of Benefits* for Physician Office Visits, diagnostic lab and x-rays.

Benefits are not available for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

## **Benefits for the Prevention and Detection of Osteoporosis**

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

**Qualified Individual** means a Participant who is:

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

## **Benefits for Certain Tests for Detection of Prostate Cancer**

If a male Participant incurs Medical-Surgical Expense for diagnostic medical procedures incurred in conducting a plan year medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided for:

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

## **Benefits for Colorectal Cancer Screening**

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

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

### **Benefits for Childhood Immunizations**

Benefits for Medical-Surgical Expense incurred by a dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowed Amount. Any Deductible, Coinsurance and Copayment Amounts will not be applicable.

Benefits are available for:

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

### **Benefits for Screening Test for Hearing Impairment**

Benefits are available for Eligible Expenses incurred by a dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old
- Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old

### **Benefits for Hearing Aids**

UT SELECT allows a \$500 maximum benefit per ear every 4 years for non-disposable hearing aids, fittings, and molds. If you use a BlueChoice<sup>®</sup> or a ParPlan provider, the provider's total payment is based on the BCBS Allowed Amount. BCBS will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the BCBS Allowed Amount. If you use a non-contracting provider, BCBS will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider's billed charges. Deductibles do not apply.

Hearing aid repair and batteries are not covered.

### **Benefits for Cosmetic, Reconstructive, or Plastic Surgery**

Benefits for Eligible Expenses for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other illness as shown on your *Summary of Benefits* for the following services only:

- Treatment provided for the correction of defects resulting from an Accidental Injury sustained by the Participant while covered under a health care plan offered by UT System
- Treatment provided for Reconstructive Surgery following cancer surgery while the Participant was covered under a health care plan offered by UT System
- Surgery performed on a newborn child for the treatment or correction of a congenital defect

- Surgery performed on a dependent child (other than a newborn child) under the age of 25 for the treatment or correction of a congenital defect if that child has been covered since birth under a health care plan offered by UT System
- Reconstruction of the breast on which a mastectomy has been performed while covered under a health care plan offered by UT System; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses (two (2) per Plan Year) and treatment of physical complications; including lymphedemas, at all stages of the mastectomy

No other Cosmetic or Plastic Surgery is covered unless particularly specified in this Benefit Booklet.

### **Benefits for Covered Dental Care Services**

If a Participant incurs Eligible Expenses for the Dental Care Services listed below, benefits will be the same as for treatment of any other illness as shown on your *Summary of Benefits*.

Benefits under the Plan are provided only for:

- Covered Oral Surgery (including surgical removal of complete/bony and partial/bony impacted teeth); soft tissue wisdom tooth removal is not a covered benefit.
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect.
- The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues occurring while the Participant was covered under a health care plan offered by UT System; and coverage is limited to such services and supplies provided:
  - For 24 months from the date of the accident; or
  - To the termination date of the Plan, whichever occurs first.

Injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

### **Benefits for Organ and Tissue Transplants**

Covered Services and Supplies related to an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, and complications arising from such transplant.

Benefits for Covered Services and Supplies provided to a transplant Participant (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant are available, only if:

- The transplant procedure is not Experimental/Investigational in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- The recipient is a Participant under the Plan (benefits are also available to the donor who is a Participant under the Plan or a donor who is not a Participant under the Plan)
- The transplant procedure is preauthorized as required under the Plan
- The Participant meets all of the criteria established by BCBSTX
- The Participant meets all of the protocols established by the Hospital in which the transplant is performed

Benefits are available and will be determined on the same basis as any other illness when the transplant procedure is for the:

- Liver
- Heart
- Heart - Lung (heart and one lung or heart and both lungs)
- Kidney

- Cornea
- Lung
- Bone Marrow

Covered Services and Supplies include those provided for the:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Removal of organs or tissues from living or deceased donors
- Transportation and short-term storage of donated organs or tissues

No benefits are available for a Participant for the following services or supplies:

- Donor search and acceptability testing of potential living donors
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species

### **Benefits for Transportation/Travel Reimbursement Costs**

In order to qualify for travel reimbursement, a Provider or facility must not be available in the Participant's area (within 100 miles) that can treat the specific condition. Expenses for out-of-state transportation/travel is allowed, but subject to the same limitations. Expenses which may be reimbursed include: lodging, gas/mileage, air transportation, and food for the patient and one companion. Itemized receipts are required for all transportation/travel reimbursement costs except mileage. Expenses in excess of established State of Texas per diem rates are not eligible for reimbursement. All transportation/travel reimbursements are subject to a \$10,000 lifetime maximum.

### **Benefits for Eyeglasses or Lenses**

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

### **Benefits for Treatment of Male Sexual Dysfunction**

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

- Inflatable or Non-inflatable Penile Implants (Prostheses)
- Vacuum Erection Devices
- Intracavernosal Injection Therapy
- (Trans)urethral Suppository Method

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

## **Benefits for Durable Medical Equipment**

Durable Medical Equipment consists of items which:

- Are prescribed by your attending physician (i.e. the physician who is treating your illness or injury)
- Are medically necessary
- Are primarily and customarily used only for medical purpose
- Are generally useful a person with an illness or injury
- Are designed for prolonged use; and
- Serve a specific therapeutic purpose in the treatment of an illness or injury

The cost of rental or purchase, including repair and adjustment, of durable medical equipment is covered.

Most supplies purchased over the counter without a doctor's prescription are not a covered benefit.

## **Benefits for the Treatment of Obesity**

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

- It is determined to be Medically Necessary; and
- It satisfies the criteria established in the Claims Administrator's medical policy guidelines

## Limitations and Exclusions

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The benefits as described in this booklet are not available for:

1. Services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of an injury, condition, disease, bodily malfunction, or sickness.
2. Any Experimental/Investigational services or supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowed Amount as determined by BCBSTX.
4. Any services or supplies for any illness or injury arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of, or in conjunction with, any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to a Participant by blood or marriage.
8. Any services or supplies provided for treatment of injuries or sickness:
  - as a result of war or act of war (declared or undeclared)
  - while on active or reserve military duty in the armed forces of any country or international authority
9. Any charges:
  - Resulting from the failure to keep a scheduled visit with a Physician or Other Professional Provider
  - For completion of any insurance forms
  - For acquisition of medical records
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary or Nutritional Services, except for a nutritional assessment program for Diabetic Management provided in and by a Hospital and approved in

advance by BCBSTX or for Diabetic Management Services as described in the *DEFINITIONS*. Dietary or Nutritional Services may also be covered for the following conditions: Inborn metabolic disorders, chronic renal failure, chronic liver failure, severe dyslipidemia, lactose deficiency, celiac disease (sprue), severe food allergies or in situations where the prescription for nutritional supplements indicates it is being prescribed as the sole source of nutrition.

13. Any services or supplies provided for Custodial Care.
14. Any services or supplies provided for orthognathic surgery unless the child has been covered by a UT health plan since birth. Orthognathic surgery includes, but is not limited to, correction of congenital, development or acquired maxillofacial skeletal deformities of the mandible and maxilla.
15. Any items of Medical-Surgical Expense incurred for dental care and treatments, dental surgery, or dental appliances, except as explained in *Other Benefit Provisions*.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as explained in *Other Benefit Provisions*.
17. Any services or supplies provided for the correction of vision deficiencies including, but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, eye refraction, photo reflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in *Other Benefit Provisions*.
18. Any services or supplies for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and oppositional disorders.
19. Any services or supplies provided for:
  - Any Medical Social Services (except as provided as an Extended Care Expense)
  - Bereavement counseling (except as provided under Hospice Care)
  - Vocational counseling
20. Any occupational therapy services that do not consist of traditional physical therapy modalities and which are not part of an active multidisciplinary physical rehabilitation program designed to restore lost or impaired body functions.
21. Travel, whether or not recommended by a Physician or Other Professional Provider, except as expressly described by the Plan.
22. Any services or supplies provided primarily for:
  - Inpatient allergy testing or treatments
  - Clinical ecology or any similar testing or treatment not recognized by the American Academy of Allergists and Immunologists
  - Environmental Sensitivity
23. Any services or supplies in conjunction with chelation therapy, except for treatment of acute metal poisoning.

24. Any services or supplies provided for, in preparation for, or in conjunction with:
- Sterilization reversal (male and female)
  - Transsexual surgery
  - Sexual dysfunction, except as explained in *Other Benefit Provisions*
  - In vitro fertilization
  - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct-intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stages transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
25. Any services or supplies for routine foot care, such as:
- The cutting or removal of corns or calluses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients
  - Any services performed in the absence of localized illness, injury, or symptoms involving the foot
  - Any treatment of a fungal (mycotic) infection of the toenail in the absence of:
    - Clinical evidence of mycosis of the toenail
    - Compelling medical evidence documenting that the patient either:
      - I. Has a marked limitation of ambulation requiring active treatment of the foot; or
      - II. In the case of a non-ambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment
  - Excision of a nail without using an injectable or general anesthetic
26. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
27. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase, other than injectable drugs administered by or under the direct supervision of a Physician or Other Professional Provider.
28. Any services or supplies provided for the following treatment modalities:
- Acupuncture
  - Videofluoroscopy
  - Intersegmental traction
  - Surface EMGs
  - Manipulation under anesthesia
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron
29. Any smoking cessation prescription drug products including, but not limited to, nicotine gum and nicotine patches, except as may be provided under the Prescription Drug Program.
30. Any benefits in excess of specified benefit maximums.
31. Any services or supplies not specifically defined as Eligible Expenses in the Plan.

32. Outpatient drugs except as provided under the Plan by the Prescription Drug Program.
33. Any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX.
34. Any services or supplies furnished by a Non-contracting Facility (except that for accidents, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital, including a governmental facility) shall be subject to benefits as provided in this booklet.
35. Any services or supplies provided for reduction mammoplasty, except when Medically Necessary.
36. Any services or supplies provided for the non-surgical and/or non-diagnostic treatment of, or related to services to, the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery, as described in the definition of Covered Oral Surgery.
37. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except when Medically Necessary for the treatment of morbid obesity.
38. The use of the procedures, supplies, or medications for treatment of psychologic/psychogenic male sexual or erectile dysfunction/impotence is not eligible for benefits.
39. Non-covered Durable Medical Equipment includes, but is not limited to, air conditions, air purifiers, blood pressure cuff, breast pump, cryogenic machine, humidifiers, physical fitness equipment, and whirlpool bath equipment.
40. Orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, removable orthotic inserts, cast shoes designed to support the arch or affect changes in the foot or foot alignment that are not related to diabetes.
41. Arch supports, elastic stockings and garter belts not related to diabetes.
42. Services or supplies used primarily for patient convenience.
43. Most supplies purchased over the counter without a doctor's prescription.
44. Telephone calls between physicians and telephone call discussions between a physician and a patient.
45. Investigational Services and Supplies and all related services and supplies, except for routine patient care costs associated with Investigational cancer treatment if those services or supplies would otherwise be covered under the Plan if not provided in connection with an approved clinical trial program.

46. The following services are not covered under your Plan:

- Long Term Care Service
- Respite Care Service, except as specifically mentioned under the Hospice Care Program
- Inpatient Private Duty Nursing Service
- Maintenance Care

## Notices

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# HIPAA

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

- Limitations on a pre-existing condition exclusion period
- 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
- 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 (OEB) has elected to exempt 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.

UT SELECT does not have plan year or lifetime maximums, other than those mentioned in the Benefit Booklet. Serious Mental Illness (as defined in the Texas Insurance Code, Chapter 1601 and Article 3.51-14) will be treated as any other illness under UT SELECT.

Although The University is exempt from the HIPAA provisions relating to Hospital stays for mothers and newborns, it is our intent to satisfy all the requirements for obstetrical 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 that the plan collects or maintains about its enrollees. A copy of the privacy note and policies that apply to UT SELECT can be found on the OEB Web site at [www.utsystem.edu/egi/hipaa/](http://www.utsystem.edu/egi/hipaa/). A paper copy of the privacy notice is provided to all new enrollees and is available to anyone upon request from Employee Group Insurance.

For more information contact your Campus Benefits Office or visit [www.utsystem.edu/egi](http://www.utsystem.edu/egi).

## Notices

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# Women's Health and Cancer Rights

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for all plans renewed on or after October 21, 1998. This benefit is included as part of your coverage.

In the case of a Participant receiving benefits under their Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Deductibles, Coinsurance and Copayment Amounts will be the same as those applied to other covered medical services, such as surgery and prosthesis.

## Notices

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# Continuation of Group Coverage

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

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

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

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

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

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

1. Death of the employee;
2. Divorce or legal separation from the employee;
3. Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without group health coverage); or
4. Children who lose coverage due to eligibility provisions (for example: reaching age 25 or marriage).

### **Who is eligible for the continuation option?**

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

### **How do the Participants apply?**

1. If a qualifying event is either: (a) the divorce of an employee; or (b) a child becoming ineligible for coverage, the eligible Participants notify the employer in writing. Then, the employer will give written notice to the Participants of the continuation option. If the qualifying event is the employee's death, Medicare eligibility, or termination of employment (or reduction of hours), the employer will give written notice to the Participants of the continuation option.
2. The eligible Participants have 60 days to give written notice to the employer of their desire to continue coverage. The election must specify names of covered individuals and the reason for and date of the qualifying event.
3. A Participant's coverage shall terminate upon the occurrence of any of the following:
  - a. The maximum time period expires;
  - b. A continued Participant obtains coverage after the date of election under any other group health Plan (as an employee or otherwise) which does not contain an applicable exclusion for any Preexisting Condition of the Participant;
  - c. A continued Participant becomes covered by any Medicare benefits after the date of election;

- d. The employer no longer provides group health coverage for employees; or
- e. The required payment to continue coverage is not made on a timely basis.

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

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

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

Contact your employer if you have any questions about COBRA.

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

## Notices

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

### BlueCard

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

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

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

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

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

# General Information

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## **Participant/Provider Relationship**

You or your covered dependents are solely responsible for the choice of a health care Provider. BCBSTX does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. BCBSTX, as the Claims Administrator, is not liable for any act or omission by any health care Provider. BCBSTX does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for illness or injury treatment acceptable to the health care Provider.

BCBSTX, BlueChoice<sup>®</sup> Providers, and/or other contracting Providers are independent contractors with respect to each other. BCBSTX in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. BCBSTX does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

## **Assignment and Payment of Benefits**

Rights and Benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, BCBSTX reserves the right to make benefit payments to the Provider or the Employee, as BCBSTX elects. Payment to either party discharges the Plan's responsibility to the Employee or dependent for benefits available under the Plan.

## **Subrogation, Reimbursement and Third Party Recovery Provision**

**When This Provision Applies:** If you, your covered spouse, or one of your covered dependents, is injured and entitled to receive money from any source, including but not limited to any party's liability or auto insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the medical Plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the health Plan.

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

The Employee or covered person agrees to sign any documents requested by the Plan including, but not limited to, reimbursement and/or subrogation agreements to the Plan or its agent(s) may request. Also, the Employee or covered person agrees to furnish any information as the Plan or its agent(s) may request him. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from

exercising its rights to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided between the Employee or covered person and their attorney, if applicable. The Employee or covered person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Employee or covered person, then the Employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the Employee or covered person takes no action to recover any money from any source, the Employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

### **Coordination of Benefits**

The availability of benefits specified in UT SELECT is subject to Coordination of Benefits (COB) as described below. This COB provision applies to UT SELECT when a Participant has health care coverage under more than one Plan.

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

### **Coordination of Benefit Definitions**

**Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes (a) group or blanket insurance; (b) franchise insurance that terminates upon cessation of employment; (c) group Hospital or medical service plans and other group prepayment coverage; (d) any coverage under labor-management trusted arrangements, union welfare arrangements, or employer organization arrangements; (e) governmental plans, or (f) coverage required or provided by law.

Plan does not include: (a) any coverage held by the Participant for hospitalization and/or Medical-Surgical Expense which is written as a part of or in conjunction with any automobile-casualty insurance policy; (b) a policy of health insurance that is individually underwritten and individually issued; or (c) school accident type coverage.

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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

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

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

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

## **Order of Benefit Determination Rules**

### ***General Information***

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

### ***Rules***

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

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

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

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

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

- c. ***Dependent Child/Parents Separated or Divorced*** – If two or more Plans cover a Participant as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
1. First, the Plan of the parent with custody of the child
  2. Then, the Plan of the spouse of the parent with custody, if applicable
  3. Finally, the Plan of the parent not having custody of the child

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

- ***Joint Custody*** – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is primarily responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.
- ***Active/Inactive Employee*** – The benefits of a Plan, which covers a Participant as an Employee who, is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a dependent of a person covered as a retiree and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph e does not apply.
- ***Continuation Coverage*** – If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:
  1. The COBRA continuation coverage Plan that covers member as a subscriber/policyholder is the primary Plan.
  2. Secondary liability is the Plan that covers the UT SELECT subscriber as a dependent.
- g. ***Longer/Shorter Length of Coverage*** – If none of the above rules determine the order of benefits, the benefits of the Plan, which covered an Employee, member or subscriber longer, are determined before those of the Plan, which covered that Participant for the shorter period of time.

### **Effect on the Benefits of this Plan**

#### ***When This Section Applies***

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

#### ***Reduction in This Plan's Benefits***

The benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of

This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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

***Right to Receive and Release Needed Information***

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

***Facility of Payment***

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, BCBSTX may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under This Plan. BCBSTX will not have to pay that amount again.

***Right to Recovery***

If the payments the Plan makes are more than should have been paid under this COB provision, BCBSTX may recover the excess from one or more of:

- the persons paid or for whom payment has been made
- insurance companies
- Hospitals, Physicians, or Other Providers
- any other person or organization

**UT SELECT and MEDICARE**

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

If you do not enroll in Medicare Part B when eligible, BCBSTX will assume that Medicare paid 80% of the Medicare Allowed Amount when processing your claim. BCBSTX will calculate the benefits payable for the allowable expense under UT SELECT as if they were the primary payer. UT SELECT will pay up to this amount, but not more than the difference between the Medicare allowable and the Medicare paid amount. You may be responsible for Deductibles, Copayments or Coinsurance Amounts in some cases.

If you are enrolled in Medicare Part B and go to a Physician that accepts Medicare assignment and services are covered by Medicare, you will not be responsible for Deductibles, Copayments or Coinsurance Amounts. UT SELECT will reimburse up to 100% of the Medicare Allowed Amount for approved services.

Please review the Medicare Coordination of benefits table on the following page.

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

<b>Provider Accepts Medicare Assignment Y/N</b>	<b>BCBSTX In-Network Provider Y/N</b>	<b>Service Covered by Medicare Y/N</b>	<b>Medicare Pays</b>	<b>UT SELECT Pays</b>	<b>Member Pays</b>
Y	Y	Y	80% MC Allowed	20% MC Allowed	0
Y	N	Y	80% MC Allowed	20% MC Allowed	0
Y	Y	N	0	80% of BCBS Allowed After \$250 UT SELECT Deductible or 100% after Copay, whichever is applicable	20% of BCBS Allowed After \$250 UT SELECT Deductible or Copay, whichever is applicable
Y	N	N	0	60% of BCBS Allowed after \$500 UT SELECT Deductible	\$500 UT SELECT Deductible + 40% of BCBS Allowed+ Difference between Billed Charge and BCBS Allowed
N	Y	Y	80% MC Limiting Charge	20% MC Limiting Charge after \$250 UT SELECT Deductible	\$250 UT SELECT Deductible
N	N	Y	80% MC Limiting Charge	20% MC Limiting Charge after \$500 UT SELECT Deductible	\$500 UT SELECT Deductible
N	Y	N	0	80% of BCBS Allowed After \$250 UT SELECT Deductible or 100% after Copay, whichever is applicable	20% of BCBS Allowed After \$250 UT SELECT Deductible or Copay, whichever is applicable
N	N	N	0	60% of BCBS Allowed after \$500 UT SELECT Deductible	\$500 Deductible + 40% of BCBS Allowed + Difference between Billed Charge and BCBS Allowed

## **Refund of Benefit Payments**

If the Plan pays benefits for Eligible Expenses incurred by you or your covered dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Plan may deduct any refund due it from any future benefit payment.

## **Termination of Coverage**

BCBSTX is not required to give you notice of termination of coverage; however, you will most likely receive a Certificate of Creditable Coverage indicating your termination date. The Plan will not always know of the events causing termination until after the events have occurred.

### ***Termination of Individual Coverage***

Coverage under the Plan for you and/or your dependents will automatically terminate when:

- Your portion of the group contribution is not received timely by the Plan
- The last day of the month in which you lose eligibility to participate in the Plan occurs
- The Plan is amended to terminate the coverage of the class of Employees to which you belong
- A dependent ceases to be a dependent as defined in the Plan
- The date you or your dependent enters into active full-time military service

The Plan Administrator may refuse to renew the coverage of an eligible Employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

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

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

### ***Termination of the Plan***

The coverage of all Participants will terminate if the Plan is terminated in accordance with its terms.

# Administration of UT SELECT Claims

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## Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

## Claim Filing Procedures

### *Notice of Claims:*

All claims for benefits under the Plan must be submitted by you or your Provider within 12 months of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within this 12-month period will not be considered for payment of benefits.

### *Claim Forms:*

BCBSTX must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

### *Who Files Claims*

BlueChoice<sup>®</sup> Provider Claims or Other Claims Submitted on Your Behalf or on Behalf of Your Dependents:

- When you receive treatment or care from a BlueChoice<sup>®</sup> Provider or Other Professional Provider who contracts with BCBSTX, you will not be required to file claims.
- The Provider will submit the claims directly to BCBSTX for you. To assist them in filing your claims, you should always carry your identification card with you.

## **BLUECHOICE<sup>®</sup> PROVIDERS AND PARTICIPATING PROVIDERS MUST SUBMIT YOUR CLAIMS DIRECTLY TO THEIR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.**

### *Other Health Care Providers:*

When you receive treatment or care from a health care Provider that does not participate in BlueChoice<sup>®</sup> or does not contract with BCBSTX, you may be required to file your own claim forms. However, some Providers may do this for you as further explained:

### *Provider-filed claims:*

Providers that are not BlueChoice<sup>®</sup> Providers but who do contract with BCBSTX under a direct-payment arrangement may submit your claims directly to BCBSTX for services and supplies provided to you or any of your covered dependents.

At the time any services are provided to you or your dependents, you should inquire if they will file claim forms for you. *To assist Providers in filing your claims, always carry your identification card with you.*

### *Participant-filed claims:*

If your Provider does not submit your claims, you must submit them to BCBSTX using the appropriate form provided by BCBSTX. In order for BCBSTX to process your claims quickly and accurately, complete and accurate information must be submitted on every claim. Claim forms are available from your Campus Benefits Office, through your Customer Service Help line, or online at [www.bcbstx.com/ut](http://www.bcbstx.com/ut).

The information needed to process your claim promptly is explained below:

- Use a separate claim form for each individual. Do not combine expenses for family members on one claim form. Each Participant's claim must be filed separately.
- Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim.
  - Patient's name
  - Subscriber's identification number, including alpha prefix.
  - Correct address
  - Diagnosis (preferably as indicated by your Provider on the itemized bill for your services)
  - Date of injury, illness, or pregnancy
  - Information about any other group health insurance coverage the patient may have
- Attach the Provider's itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim:
  - Name and address of the facility or Provider providing the service or supplies
  - Date of service
  - Type of service
  - Charge for each service
  - Patient's name
  - Diagnosis

Non-contracting Providers and/or Subscribers should mail the completed medical claim form with attachments to:

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

### ***Who Receives Payment***

Payments are generally made directly to the BlueChoice® Providers or contracting Providers when they bill the Plan. Written agreements by BCBSTX with some Providers require that payments be made directly to them.

If you utilize an Out-of-Network Provider or Noncontracting Provider, payments will be made to you unless other arrangements are made. Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

If the Plan has not paid any portion of the claim, benefits for services provided to your minor dependent child may be paid to a third party, if the third party is named in a court order as managing or possessory conservator of the child. In order for benefits to be payable to a managing or possessory conservator of a child, this person must submit the claim form with bills and receipts, proof of payment of the expenses and a certified copy of the court order naming such person the managing or possessory conservator.

If you or your Provider owes the Plan any sums, the Plan may deduct from its benefit payment the amount that the Plan is owed. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to the Plan will be considered satisfaction of the Plan's obligations to you.

An Explanation of Benefits summary is sent to you so you will know what has been paid.

## **Receipt of Claims by the Plan**

A claim cannot be considered received for processing until BCBSTX actually receives the claim at the proper address and with all of the required information. If the claim is not complete, BCBSTX will return it. On claims that need further information for proper processing, BCBSTX may contact either you or the Provider for the additional information. The claim cannot be processed until BCBSTX receives the requested information.

## **Interpretation of Plan Provisions**

The operation and administration of the Plan require uniform interpretation of the intent of the Plan and the Plan provisions. The Plan Sponsor has full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits.

BCBSTX has been given authority to make determinations as to whether:

- Services, care, treatment or supplies are Medically Necessary
- Surgery is Cosmetic, Reconstructive or Plastic Surgery
- Charges are allowable
- Surgery, medical treatment or drugs are Experimental/Investigational

## **Claim Determinations**

***Claims Processing:*** When a claim is submitted correctly and received by BCBSTX, it will be processed to determine if and in what amount benefits should be paid. BCBSTX has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. Some claims take longer to process than others because they require additional information, such as medical records or operative reports.

After processing the claim, BCBSTX will notify the Participant by way of an Explanation of Benefits summary form.

***If a Claim Is Denied or Not Paid in Full:*** On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why the claim may be denied or not paid in full. First read the Explanation of Benefits summary, and then review this booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the Plan's decision, it should be sent to BCBSTX with a request for a review of the decision.

### ***Request for Reconsideration of Claim Determination***

You have the right to seek and obtain a full and fair review of any determination of a claim, or request for inpatient Preauthorization, Extended Care and Home Infusion Therapy Preauthorization, or any other determination made by BCBSTX of your and your dependent's benefits under the Plan.

If you believe all or part of your benefits were incorrectly denied and want to obtain review of the benefit determination, you must:

- Submit a written request for review mailed to BCBSTX. The request must contain your name, the Participant's name, your group and subscriber numbers, and the claim you want reviewed.
- The written request must contain the questions and comments you have concerning the determination and you must submit all additional information (especially medical information) that supports why you believe the determination was incorrect. Mail your appeal to:

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

On the basis of the comments, questions, and information received in the request for review, together with any information available to it, BCBSTX will review your claim.

You will be notified of BCBSTX's decision and the reasons for the decision within 60 days of BCBSTX's receipt of the request for review.

### **Appeal to the UT System**

In the event your Request for Reconsideration is denied by BCBSTX in writing, you may further appeal to the UT System (your Plan Sponsor) at the address below:

*Employee Group Insurance  
The University of Texas System  
702 Colorado Street, Room 6.300  
Austin, TX 78701*

The appeal must be submitted in writing and accompanied by supporting written documents. The UT System has the discretion to make an administrative decision regarding your appeal or to forward the appeal for a hearing by The University of Texas System Claims Review Committee. If you are not satisfied with an administrative decision of the UT System, you may further appeal to the Committee. The decision of the University of Texas Claims Review Committee is final.

## Definitions

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**Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Other Professional Provider within 30 days after the occurrence.

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

- **Hospitals and Other Facility Providers, Physicians and Other Professional Providers contracting with BCBSTX or any other participating Blue Cross and/or Blue Shield Plan** – The Allowed Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.
- **Hospitals and Other Facility Providers not contracting with BCBSTX or any other Blue Cross and/or Blue Shield Plan** – The Allowed Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Other Facility Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Other Facility Providers where fee schedules or rate payments are not appropriate, the Allowed Amount will be the lesser of billed charge or a per diem established by BCBSTX.
- **Procedures, services, or supplies provided in Texas by Physicians and Other Professional Providers not contracting with BCBSTX** – The Allowed Amount will be the lesser of the billed charge or the amount BCBSTX would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Other Professional Provider with similar experience and/or skill.

If BCBSTX does not have sufficient data to calculate the Allowed Amount for a particular procedure, service, or supply, BCBSTX will determine an Allowed Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

- **Procedures, services, or supplies performed outside of Texas by Physicians or Other Professional Providers not contracting with BCBSTX or any other Blue Cross and/or Blue Shield Plan** – BCBSTX will establish an Allowed Amount using Texas regional or state Allowed Amounts applicable to procedures, services, or supplies of Physicians or Other Professional Providers with similar skills and experience.
- **Multiple Surgeries** – The Allowed Amount for all surgical procedures performed on the patient on the same day will be the amount for the single procedure with the highest Allowed Amount plus one-half of the Allowed Amount for each of the other procedures performed.
- **Drugs administered by a Home Infusion Therapy Provider** – The Allowed Amount will be the lesser of (a) the actual charge, or (b) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by BCBSTX.

- **For procedures, services, or supplies provided to Medicare recipients**, the Allowed Amount will not exceed Medicare's limiting charge.

**Ambulance Service** involves the use of a specially designed and equipped automotive or other vehicle, licensed by the state, and regulated by local, state and federal laws, to transport the ill or injured. Ambulances can be classified as either basic life support or advanced life support depending upon how the vehicle is equipped. This in turn regulates the level of care that can be provided in the actual transport.

**Annual Enrollment Period** means a specified period of time preceding the next Plan Anniversary Date during which Employees and dependents may enroll for coverage.

**BlueChoice<sup>®</sup> Network** means identified Physicians, Other Professional Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a PPO arrangement.

**Blue Cross and Blue Shield of Texas (BCBSTX)** means the Claims Administrator. As part of its duties, the Claims Administrator may use an authorized representative or (in some instances) other Blue Cross and/or Blue Shield Plans who have contracted with the Claims Administrator to provide Network services that would not generally be available.

**Bundling** means the process that identifies a medical procedure (i.e. lab, radiology, surgery, anesthesiology, etc.) that is incidental to another billed procedure and is therefore included in that charge and not eligible for separate benefits. The process has developed in conjunction with physician specialists from across the country. When you use a BlueChoice or ParPlan provider, they must "write-off" charges that bundle with other services. If provider is a non-ParPlan provider, the Participant is responsible for these bundled charges.

**Chemical Dependency** means the abuse of or psychological or physical dependence on, or addiction to alcohol or a Controlled Substance.

**Chemical Dependency Treatment Center** means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written Health Benefit Treatment Plan approved by the INROADS Behavioral Health. The facility must be:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations
- Licensed, certified or approved as a Chemical Dependency treatment program or center by an agency of the State of Texas having legal authority to license, certify or approve
- If outside of Texas, licensed, certified or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve

**Chiropractic Services** means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

**Claims Administrator** means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

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

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

**Coinsurance** means your share of Eligible Expenses incurred during a Plan Year, not counting, among other expenses, the Deductible or Copayment amounts. It is usually a percentage (20%, 25% or 40% for example) of the Allowed Amount.

**Complications of Pregnancy** means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
  - Nephritis
  - Nephrosis
  - Cardiac decompensation
  - Missed abortion
  - Similar medical and surgical conditions of comparable severity

But shall not include:

- False labor
  - Occasional spotting
  - Physician-prescribed rest during the period of pregnancy
  - Morning Sickness
  - Hyperemesis gravidarum
  - Pre-eclampsia
  - Eclampsia
  - Similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- Termination of pregnancy by non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

**Coordinated Home Care Program** means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

**Contracting Facility** means a Hospital, a Other Facility Provider, or any other facility or institution with which BCBSTX (or any other Blue Cross and/or Blue Shield Plan) have executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available

under the Plan. However, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Noncontracting Facility regardless of the existence of a written contract with any Blue Cross and/or Blue Shield Plan.

**Copayment** means the dollar amount the Participant must pay for medical services at the time they are provided. The \$25 amount a Participant must pay for a Network Physician office visit is an example of a *Copayment Amount*.

**Cosmetic Surgery** means that surgery which:

- Can be expected or is intended to improve the physical appearance of a Participant; or
- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

**Covered Oral Surgery** means maxillofacial surgical procedures limited to:

- Excision of nondental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and nondental related procedures of the accessory sinuses;
- Appliances, as well as surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint), as a result of an accident, a trauma, a congenital defect, a development defect, or a pathology, and
- Surgical removal of complete/bony and partial/bony impacted teeth.

**Covered Services and Supplies** means the Allowed Amount for services or supplies that are specifically covered under UT SELECT.

**Crisis Stabilization Unit or Facility** means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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

**Deductible** means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be payable.

**Dental Care Services** (although no benefits are available for dental services, the following definition is included for clarification purposes) means the professionally recognized dental services, supplies, or appliances which are provided to a Participant by a Physician or Other Professional Provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a Provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental Care Services include,

but are not limited to cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alternation of the alveolar or periodontium process of the maxilla and the mandible.

**Diabetic Equipment and Supplies** means those items, covered under the Prescription Drug portion of your plan, associated with the treatment of diabetes. Such items, when obtained for a *Qualified Participant*, shall include the following:

- *Diabetic Equipment*: Blood glucose monitors (including monitors for the blind), insulin pumps and necessary accessories, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.
- *Diabetic Supplies*: Test strips for blood glucose monitors, visual reading and urine test stripes, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels and glucagons emergency kits.

A *Qualified Participant* means an individual eligible for coverage under the Plan who has been diagnosed with:

- Insulin dependent or non-insulin dependent diabetes,
- Elevated blood glucose levels induced by pregnancy, or
- Another medical condition associated with elevated blood glucose levels.

**Diabetic Management Services** means Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the diabetic patient. Such management is limited to the following services when rendered by or under the direction of a Physician:

Initial and follow-up instruction concerning:

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

**Dietary and Nutritional Services** means the education, counseling, or training of a Participant (including printed material) regarding:

- Diet
- Regulation or management of diet
- The assessment or management of nutrition.

**Durable Medical Equipment** means therapeutic supplies and rehabilitative equipment required for therapeutic use, such as a wheelchair, Hospital-type bed, artificial respirator or similar equipment.

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

**Durable Medical Equipment Provider** means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Health Care Organizations.

**Effective Date** means the date the Participant's coverage begins under the Plan or any portion for which the Participant has enrolled.

**Eligibility Date** means the date the Participant satisfies the definition of a(n):

- Employee,
- Retiree,
- Dependent, or
- Spouse

And is in a class eligible for coverage under the Plan.

**Eligible Expenses** means Inpatient Hospital Expense, Medical-Surgical Expense, or Extended Care Expense, all as specified in this benefit booklet.

**Emergency Care** means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to get immediate care could result in:

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

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

- Controlled environment
- Sanitizing the surroundings, removal of toxic materials
- Use of special nonorganic, nonrepetitive diet techniques

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

**Experimental/Investigational** means procedures, drugs, devices, services and/or supplies which:

- Are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or
- Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and
- Specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

**Extended Care Expense** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the subsection entitled Benefits for Extended Care Expense.

**Facility** is licensed to provide services and supplies that are covered by UT SELECT, and that is approved by BCBSTX. Facilities include:

- Alcohol or Drug Treatment
- Birthing Center
- Chemical Dependency
- Crisis Stabilization Unit
- Durable Medical Equipment
- Home Health Agency
- Home Infusion Therapy
- Hospice
- Imaging Center
- Independent Laboratory
- Orthotic
- Outpatient Surgical
- Prosthetic
- Psychiatric Day Treatment
- Radiation Therapy Center
- Renal Dialysis Center
- Residential Treatment Center
- Rural Health Clinic
- Skilled Nursing
- Therapeutic Center

**Family Deductible** means three individuals in the family must each meet a Plan year Deductible under one UT SELECT subscriber identification number.

**Food and Drug Administration (FDA)** is a federal agency responsible for drug oversight (i.e., approval and dispensing protocols)

**Home Health Agency** means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located and is certified by Medicare as a supplier of Home Health Care.

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

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

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

Over-the-counter products which do not require a Physician's or Other Professional Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included in this definition.

**Home Infusion Therapy Provider** means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

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

- Licensed in accordance with state law (where the state law provides for such licensing)
- Certified by Medicare as a supplier of Hospice Care

**Hospice Care** means services for which benefits are provided under the Plan when provided by a Hospice Agency to patients confined at home or in a Hospice facility due to a terminal illness or terminal injury requiring skilled health care services.

**Hospital** means a short-term acute care facility which:

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

**Hospital Admission** means the period between the time of a Participant's entry into a Hospital, or a Chemical Dependency Facility as a bed patient and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Other Professional Provider, whichever first occurs. The day of entry, but not the day of discharge or departure shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission.

*Bed patient* means confinement in a bed accommodation of a Chemical Dependency Facility on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than Chemical Dependency Facility) designed, staffed, and operated to provide long-term institutional care on a residential basis.

**Immediate Family Member** means a person related by blood or marriage who is a spouse, parent, child, mother-in-law, father-in-law, brother, sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, cousin, grandparent or grandchild.

**Imaging Center** means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the appropriate state Radiation Control Agency.

**In-Area** means a geographic location selected by The University of Texas System that is served by the UT SELECT network. All of Texas and New Mexico are considered in-area.

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

**Inpatient Hospital Expense** means charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

- Furnished at the direction or prescription of a Physician or Other Professional Provider
- Provided by a Hospital or a Chemical Dependency Facility
- Furnished to and used by the Participant during a Hospital Admission.

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

- Room accommodation charges provided that if the Participant is confined in a private room, the excess of the room accommodation charge over the Hospital's average semi-private room accommodation charge will not be considered under the Plan for any purpose.
- All other care in the nature of usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. Personal items are not included as Eligible Expenses under the Plan.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, or a Crisis Stabilization Unit or Facility, or a Residential Treatment Center, in lieu of hospitalization, shall be deemed to be Inpatient Hospital Expense.

**Legend Drugs** means drugs, biological, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

**Licensed Midwife** means a "licensed" nurse midwife (i.e. Advanced Nurse Practitioner (ANP)). Although there may be other designations/certifications that midwives may obtain, UT SELECT will only allow benefits for ANP.

Other common designations not covered that you may encounter include: (1) Certified Midwife – an individual who has obtained a State issued certificate from the State Midwifery Agency; and (2) Certified Professional Midwife – a professional certification that can be obtained from the National Association of Registered Midwives.

**Long Term Care Services** mean those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self care because of chronic illness, injury or condition.

**Marriage and Family Therapy** means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the

evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

**Maintenance Care** means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

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

- Social and emotional factors related to the Participant's illness, need for care, response to treatment and adjustment to care
- Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources

**Medical-Surgical Expense** means the Allowed Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

- Furnished by or at the direction or prescription of a Physician or Other Professional Provider
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan

A service or supply is furnished at the direction of a Physician or Other Professional Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician or Other Professional Provider
- Provided at the usual place of business of the directing Physician or Other Professional Provider
- Billed to the patient by the directing Physician or Other Professional Provider

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

Medical-Surgical Expense shall include:

- Services of Physicians or Other Professional Providers
- Services of a certified registered nurse-anesthetist
- Services of a licensed professional physical, speech, hearing, respiratory or occupational therapist
- Physical Therapy (includes modalities done by a Doctor of Chiropractic); up to the maximum number of visits per Participant each Plan Year as shown on your *Summary of Benefits*
- Diagnostic x-ray and laboratory procedures
- Radiation therapy
- Rental or purchase (at the discretion of BCBSTX) of Durable Medical Equipment required for therapeutic use
- Professional local ground Ambulance Service or Air Ambulance Service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition
- Anesthetics and administration thereof when performed by someone other than the operating Physician or Other Professional Provider
- Oxygen and its administration provided the oxygen is actually used
- Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Participant
- Prosthetic Appliances required for the alleviation or correction of conditions arising out of Accidental Injury occurring or illness commencing after the Participant's Effective Date of coverage under the Plan, excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant
- Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any

part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint

- Services of a Physician or Other Professional Provider to restore loss of or correct an impaired speech or hearing function
- Services or supplies used by the Participant during an outpatient visit to a Hospital or a Therapeutic Center or Chemical Dependency Facility
- Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases
- Diabetic Equipment
- Diabetic Management Services
- Certain Outpatient Procedures
- Infertility, diagnostic testing only
- Occupational Therapy

**Medically Necessary or Medical Necessity** means those services or supplies covered hereunder which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- Not primarily for the convenience of the Participant, his Physician, the Hospital or Other Provider
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The Claims Administrator for the Plan shall determine whether a service or supply is Medically Necessary and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Other Professional Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

**Mental Health Care** means any one or more of the following:

- The diagnosis or treatment of a mental disease, disorder, or condition as listed in the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by BCBSTX, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin
- The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Other Professional Provider (or by any person working under the direction or supervision of a Physician or Other Professional Provider) when the Eligible Expense is:
  - Individual, group, family or conjoint psychotherapy
  - Counseling
  - Psychoanalysis
  - Psychological testing and assessment
  - The administration or monitoring of psychotropic drugs
  - Hospital visits or consultations in a facility listed in last bullet of this definition
- Electroconvulsive treatment
- Psychotropic drugs

- Any of the services listed in items above, performed in or by a Hospital, Other Facility Provider, or other licensed facility or unit providing such care.

**Network Benefits** apply to eligible Employees and Retirees who reside in Texas or New Mexico and their covered dependents. This level of benefits is also available to certain active employees and their dependents residing in the Washington, D.C., area. When Participants see Network Providers, they receive Network Benefits which are reimbursed at a higher level. Out-of-Network Benefits are available when Participants choose to see Out-of-Network Providers.

**Network Provider** means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX or other Blue Cross and/or Blue Shield Plan to participate as a PPO Provider.

**Noncontracting Facility** means a Hospital, an Other Facility Provider, or any other facility or institution which has not executed a written contract with BCBSTX or other Blue Cross and/or Blue Shield Plan for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Other Facility Provider, or any other facility or institution with a written contract with BCBSTX which has expired or has been canceled is a Noncontracting Facility.

**Obstetrical Care** means routine care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

**Office Visit** means a visit performed by a Physician for a covered service, in which the reimbursement for the charge is not included in any other procedure already considered for benefits.

**Other Provider** means a person or entity, other than a Hospital or Physician that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses.

**Other Professional Provider** means a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

- Advanced Nurse Practitioner
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage and Family Therapist
- Licensed Master Social Worker-Advanced Clinical Practitioner
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Licensed Surgical Assistant

- Physician's Assistant
- Psychological Associate (working under the supervision of a Doctor in Psychology)

In states where there is a licensure requirement, such Other Providers must be licensed by the appropriate state administrative agency.

**Out-of-Area** means geographic locations outside of Texas and New Mexico.

**Out-of-Area Benefits** are available to eligible employees and retirees residing outside of Texas and New Mexico and their covered dependents.

**Out-of-Network Benefits** means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider without referral by a PPO Network Provider or through the Mental Health Help Line.

**Out-of-Network Provider** means a Hospital, Physician, or Other Provider, who has not entered into an agreement with BCBSTX or other participating Blue Cross and/or Blue Shield Plan as a PPO Provider.

**Out-of-Pocket Maximum** means your share of Eligible Expenses including the Deductible. It does not include the Copayment Amounts.

**Outpatient Care** means care that is ordered by a doctor and provided in a Hospital (as defined in this section), with a stay of less than 24 hours.

**ParPlan Provider** means a Physician or other Provider who has signed an agreement with BCBSTX to do the following:

- Accept the BCBSTX Allowed Amount for Plan Participants
- File claims for Participants covered by BCBSTX
- Not bill Participants for services determined by BCBSTX to be not Medically Necessary, or Experimental/Investigational

**Participant** means an employee, or retiree or a dependent whose coverage has become effective according to the requirements of the Plan.

**Physical Medicine Services** means those modalities, procedures, tests, and measurements listed in the Physicians' Current Procedural Terminology Manual (Procedure Codes 97010 -97799), whether the service or supply is provided by a Physician or Other Professional Provider and includes, but is not limited to, physical therapy, hot and cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

**Physician** means a person, when acting within the scope of his license who is a Doctor of Medicine or Doctor of Osteopathy.

**Plan** means UT SELECT.

**Plan Anniversary Date** means the month, day, and year that is twelve (12) months following the Plan Effective Date and each succeeding year thereafter, unless otherwise changed by the Plan Sponsor.

**Plan Effective Date** means the date on which coverage for the Employer's Plan begins, September 1, 2005.

**Plan Service Area** means the geographical area designated by the Employer that is used to determine eligibility for Managed Health Care Plan benefits.

**Plan Sponsor** means The University of Texas System.

**Plan Year** means the period of time beginning September 1 through August 31 during which time benefits are provided.

**Preauthorization** means advance approval that is required from BCBSTX. Preauthorization determines Medical Necessity of the care a Participant receives. It is required for:

- 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
- Intermediate Care Facilities
- Residential Treatment Centers
- Crisis Stabilization Units
- Psychiatric Day Treatment Facilities

**Predetermination** means a review by BCBSTX of proposed services and supplies to determine Medical Necessity and the availability of benefits under UT SELECT, prior to services and supplies being provided. Predeterminations do not guarantee payment.

**Preferred Provider Organization (PPO)** means a health care program that organizes a selected group of health care Providers for participation in a managed care arrangement. In a PPO Managed Care Plan, the Participant is given the opportunity to receive medical services and supplies through the PPO Network of participating Providers or to receive medical services and supplies from Providers outside the PPO Network.

There is an incentive to the Participant to choose BlueChoice<sup>®</sup> Providers through a higher reimbursement level and lower Out-of-Pocket Maximum expense. Out-of-Network Benefits are usually at a lower reimbursement level with higher Out-of-Pocket Maximum expense to the Participant and the Participant is responsible for Preauthorization, claim filing, etc.

**Private-duty Nursing Service** means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or a licensed vocational nurse (L.V.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing service does not include Custodial Care Service.

**Proof of Loss** means written evidence of a claim including:

- The form on which the claim is made
- Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and correct diagnosis code(s) and procedure code(s) for the services and items

**Prosthetic Appliances** means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses).

**Prosthetic/Orthotics Provider** means a certified prosthetics that supplies both standard and customized prostheses and orthotic supplies.

**Provider** means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses in the Plan.

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Health Care Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

**Reconstructive Surgery** means that surgery which:

- Can be expected or is intended to improve the physical appearance of a Participant; or
- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

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

**Residential Treatment Center** means an institution, which is appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provision of Mental Health Care services for emotionally disturbed individuals.

**Respite Care Service** means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

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

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

**Skilled Nursing Facility** means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

**Skilled Nursing Service** means those services provided by a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.) which require the clinical skill and professional training of a R.N. or L.V.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non professional personnel. Skilled Nursing Service does not include Custodial Care Service.

**Specialty Care Provider** means a Physician or Other Professional Provider that has entered into an agreement for the provision of specialty care services to Participants in a managed care arrangement.

**Subscriber** means the employee or retiree who is also the primary policy holder.

**The University of Texas System** means your Employer and is also the Plan Sponsor.

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

- An ambulatory (day) surgery facility; or
- A freestanding radiation therapy center; or
- A freestanding birthing center.

# Prescription Drug Program

The Prescription Drug Program is administered by Medco Health Solutions, Inc. (Medco) through a participating network retail pharmacy program and a home delivery pharmacy program.

## Covered Prescription Drug Charges

Covered Prescription Drug Charges mean charges which are:

1. Due to sickness or injury;
2. Incurred while you and your Dependents are covered under the Prescription Drug Program;
3. For drugs and medications that require a Physician's written prescription order while a Participant is not confined in a Hospital;
4. Dispensed by a licensed pharmacist; and
5. Diabetic Supplies with a written prescription.

<b>SUMMARY OF BENEFITS</b>			
<b>Annual Deductible</b> \$50 person/ year (Deductible does not apply to medical plan deductible)			
<b>Access Options</b>	<b>Generic Prescription</b>	<b>Preferred Drug</b>	<b>Non-Preferred Drug</b>
Retail Pharmacy: <ul style="list-style-type: none"> <li>• Up to a 30-day supply*</li> <li>• Refills allowed as prescribed</li> <li>• Good option for new prescriptions</li> </ul>	\$10	\$25	\$40
Home Delivery Pharmacy <ul style="list-style-type: none"> <li>• Up to a 90-day supply*</li> <li>• Refills allowed as prescribed</li> <li>• Best option for maintenance medications</li> </ul>	\$20	\$50	\$80
Out-of-Network Pharmacy <ul style="list-style-type: none"> <li>• Up to a 30-day supply</li> <li>• Refills allowed as prescribed</li> </ul>	You pay full cost of prescription and submit claim form to Medco for reimbursement. Your reimbursement will be paid as follows: <b>Total Cost – (minus the) UT Discount – (minus the) Applicable Copayment = Your Reimbursement</b>		
<p><b>Important Plan Feature:</b> If you choose to use a brand name drug (Preferred or Non-Preferred) for which there is a generic equivalent, you must pay the difference between the cost of the brand name and the generic drug plus the generic Copayment. In some circumstances, this cost could be substantial. Please ask your Physician to dispense generics when available. If your Physician prescribed a brand name medication, you can determine the cost by visiting <a href="http://www.medco.com">www.medco.com</a> or by calling Medco at 1-800-818-0155.</p> <p><b>Participant's Out-of-Pocket Cost Example:</b>            Cost of Brand Name Drug: <b>\$150</b>            Less, cost of Generic Drug Equivalent: <b>\$55</b>            Plus, Cost of Generic Drug Copayment: <b>\$20</b>            Total Out-of-Pocket Cost: <b>\$115 (for brand)</b>  <b>(Compared to Total Out-of-Pocket Cost for Generic of \$20.)</b></p>			

\* Copayments are not prorated when less than the maximum 30- or 90-day supply is dispensed

## How to Obtain Covered Prescription Drugs

A \$50 per person per plan year deductible must be met before prescription drug benefits are available. Charges in connection with the Prescription Drug Program are covered as provided in the *Summary of Benefits*, using one of the three methods:

1. **Home Delivery Pharmacy** – Prescription or refills for covered medications may be sent to the Home Delivery Pharmacy. It must include the Deductible (if applicable) and copayment shown in the *Summary of Benefits* and a complete Order Form. Refills can be obtained on the internet at [www.medco.com](http://www.medco.com), by phone at 1-800-4REFILL, 1-800-473-3455, or by mail. Refill forms are available in your Campus Benefits Office. This is most beneficial for medications taken on a regular basis.

Some Home Delivery Pharmacy prescriptions cannot be dispensed in quantities greater than a 30-day supply due to Federal narcotic classification or shelf-life (stability) of medication. Contact Medco Customer Service for more details on this limitation.

2. **Network Retail Pharmacy** – Prescriptions may be purchased at a Network Retail Pharmacy by presenting your UT SELECT identification card. You will be charged the appropriate deductible (if applicable) and copayment as shown in the *Summary of Benefits*.
3. **Non-Network Retail Pharmacy** – Prescriptions may be purchased at any retail pharmacy, and the charges submitted to Medco using a reimbursement claim form. You will be reimbursed for the charge as shown in the *Summary of Benefits*.

To obtain first time **Home Delivery** Prescription Drugs, a prescription order form can be obtained via [www.medco.com](http://www.medco.com) or by calling toll free 1-800-818-0155 or asking your physician to fax a prescription for you. To obtain a fax form, please ask your physician to call 1-888-EASYRX1 or 1-888-3237-9791. After completing this form, they should fax the form back to the number on the fax form. Forms should be sent to:

*Medco Health Solutions, Inc.*  
*P. O. Box 650322*  
*Dallas, TX 75265-0322*

Be sure the prescription is complete and contains:

- Patient's name
- Physician's name
- Exact strength of medication
- Exact daily dosage
- Exact quantity
- Exact instructions

To file for reimbursement for **Non-Network Retail Pharmacy** claims, a claim form and a copy of the pharmacy receipt which includes the pharmacy address and phone number should be sent to:

*Medco Health Solutions, Inc.*  
*P. O. Box 2187*  
*Lee's Summit, MO 64063-2187*

Additional forms or information can be obtained from your Campus Benefits Office. Call Medco at 1-800-818-0155 for questions concerning the Prescription Drug Program.

## Limitations

The Prescription Drug Program contains benefit limitations which either limits the amount of medication (Quantity Limits per Copayment) that is covered for one copayment or require authorization for the medications (Managed Prior Authorization).

**Quantity Level Limits** – is a program which allows access to a limited supply of medication for each Copayment. Members are responsible for a copayment for each order filled. Medications under this program include migraine medications.

**Medications Requiring Prior Authorization** – are specific to products where confirmation of diagnosis is required prior to the pharmacy dispensing medication. Medications which require prior authorization include, but are not limited to, antiobesity preparations, dermatologicals, immune globulins, growth hormones, and hormone agents. In addition, onychomycosis therapy (antifungals), some antidepressants and smoking cessation medications require authorization to obtain additional supplies.

Note: Should your doctor feel there are circumstances which may qualify you for coverage of a medication noted above, you may contact Medco to obtain the special toll free phone number your doctor can call to request a coverage review.

Formulary First Coverage Review- is a program that promotes Generic and Preferred brand medications as the first line of therapy. Therapeutically equivalent Generic and Preferred brands are required before Non-Preferred drugs, *unless the physician provides clinical support for the Non-Preferred drug*. This program focuses on prescriptions written for the following medications:

- |                                     |  |
|-------------------------------------|--|
| ▪ Non-Preferred Drug: Aciphex       | Preferred Drug: omeprazole (generic), Nexium, & Protonix       |
| ▪ Non-Preferred Drug: Prevacid      | Preferred Drug: omeprazole (generic), Nexium, & Protonix       |
| ▪ Non-Preferred Drug: Prilosec 40mg | Preferred Drug: omeprazole (generic), Nexium, & Protonix       |
| ▪ Non-Preferred Drug: Pravachol     | Preferred Drug: lovastatin (generic), Zocor, Lipitor & Vytorin |

## Exclusions

Under the Prescription Drug Program, no benefits will be paid for:

1. Charges a Participant is not required to pay or charges made only because coverage exists (subject to the right, if any, of the United States government to recover Maximum Allowable Charges for care provided in a military or veteran's Hospital).
2. An Illness or Injury:
  - a. For which benefits are paid or payable under Worker's Compensation or any occupational disease or similar law whether such benefits are insured or self-insured; or
  - b. That is caused by, or connected in any way to, employment of the Participant. This includes self-employment or employment by others. It applies whether or not Worker's Compensation or any occupational disease or similar law covers the charges incurred. It applies whether the charges are covered on an insured or uninsured basis.

3. Therapeutic devices or appliances.
4. Medications that may be obtained without a written prescription.
5. Immunization agents, biological sera, blood or blood plasma (including the giving of these items).
6. Drugs Labeled: “Caution – limited by federal law to investigation use”, or experimental drugs, even though a charge is made to the Participant.
7. Any charge for the administration of prescription drugs or injectable insulin.
8. Any medication which is consumed or administered at the place where it is dispensed (Physician’s office or clinic).
9. Drugs that may be received at no charge under local, state, or federal programs (not applicable to drugs covered by Medicaid).
10. Drugs and medicines to be taken by or given to a Participant while he is confined in a hospital, or other facility.
11. Any prescription or refill in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician’s original order.
12. Drugs prescribed for illness or injury resulting from war or acts of war.
13. Certain prescription drugs, including, but not limited to:
  - a. Retin-A for Participants over age 35
  - b. Fertility Drugs
  - c. Over-the-Counter Products
  - d. Renova
  - e. Allergy serum
14. Ostomy supplies.
15. Topical fluoride preparations.
16. Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
17. Non-Federal Legend Drugs.

## **Specific Definitions**

**Copayment** means patient’s cost share or the amount shown in the *Summary of Benefits* that a participant must pay for each Prescription Drug before the prescription can be filled. The copayment cannot be applied toward the Deductible under the medical portion of your Plan.

**Deductible** means the amount that must be paid by the participant before prescription drug benefits are allowed. Example: Each covered individual will pay the first \$50 in drug costs. After the \$50 is

reached, you will only be responsible for the copayments listed above. The Prescription Drug Deductible does not apply to the medical plan deductible.

**Generic Drug** means medications sold under a generic name, often unfamiliar names, but by law must have the same active ingredients and are subject to the same rigid 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.

**Home Delivery Pharmacy** means the Medco Health Mail Order Pharmacy.

**Home Delivery Prescription Drugs** means drugs, generally maintenance medications, ordered from a mail order drug company which has agreed to provide its services to participants under this Plan.

**Maintenance Medication** means drug products usually prescribed to treat conditions of a long-term or chronic nature, such as diabetes, arthritis and high blood pressure.

**Network Retail Pharmacy** means a retail pharmacy which has contracted with Medco to offer discounts on medication dispensed under this Outpatient Prescription Drug Program.

**Non-Network Retail Pharmacy** means a licensed retail establishment where legally licensed pharmacists dispense prescription drugs, but which does not participate in Medco's pharmacy network.

**Non-Preferred Drugs** means medications which are not on the Preferred Drug List.

**Preferred Drugs** means a list of brand name medications preferred for their clinical effectiveness and opportunities to help contain the Plan's cost. The list of preferred medications is available online at [www.utsystem.edu/egi](http://www.utsystem.edu/egi) and [www.medco.com](http://www.medco.com).

**Prescription Drug** means any medical substance, the label of which the federal Food Drug and Cosmetic Act requires to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

**Short-term Medications** means those Prescription Drugs prescribed for shorter, common illnesses (such as colds, flu, infections, and injuries).

### **Additional Information**

- For general Plan information and mail order forms or to determine if your medication is on the Preferred Drug List, contact Medco at 1-800-818-0155 or [www.medco.com](http://www.medco.com)
- To order new mail order prescriptions, mail your completed home delivery form to:

*Medco Health Solutions, Inc.  
P. O. Box 650322  
Dallas, TX 75265-0322*

- To order refills, call 1-800-473-3455 or go to [www.medco.com](http://www.medco.com)
- Group Number: UTSYSRX

## Medications Requiring Prior Authorization

Medications requiring authorization prior to initial prescription (Contact Medco to request a Coverage Review)	
Asthma	Xolair
Viral	Synagis, RespiGam
Rheumatological	Humira, Enbrel, Arava, Remicade, Kinert
Osteoporosis	Forteo
Oncology	Gleevec, Iressa
Human Growth Hormones	Protropin, Humatrope, Geref, Genotropin, Norditropin, Nutropin, Saizen, Serostim
Hormone Agents	Crinone 8%, Lupron, Factrel, Lutrepulse, Synarel
Irritable Bowel Syndrome	Zelnorm, Lotrenox
Immune Globulins	Gamimune, Gammagard, Gammar-IV, Sandoglobulin, Venoglobulin
Cholesterol lowering	Zetia
Anti-Obesity Agents	Xenical, Meridia, Tenuate & generics, phentermine, Topamax, Zonegran
Acromegaly	Somavert
Acne & other dermatologicals	Accutane, Retin-A, Avita, Altinac, Raptiva
Medications requiring authorization to obtain additional supplies (Contact Medco to request a Coverage Review)	
Onychomycosis Therapy	Sporanox, Lamisil, Diflucan
Antidepressant Therapy	Wellbutrin SR, Lexapro
Smoking Deterrents	Zyban, Prostep, Nicotrol NS, Habitrol

Should your doctor determine you qualify for coverage of a medication listed above, you may contact Medco for information about the special toll free phone number your doctor can call to request a coverage review.

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**CLAIMS ADDRESS**

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

**CUSTOMER SERVICE**

1-866/882-2034  
8 a.m. to 5 p.m. (Central Time) Monday–Friday

**ONLINE PROVIDER DIRECTORY**

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

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