

UT SELECT 2007-2008 *Self-Funded Health Plan*

CHOOSE WELL



BlueCross BlueShield
of Texas

Effective September 1, 2007

Table of Contents

<u>Important Information</u>	<u>1</u>	<u>Extended Care and Home Infusion Therapy</u>	<u>24</u>
<u>Understanding Your Plan</u>	<u>3</u>	<u>Skilled Nursing Facility</u>	<u>25</u>
<u>About This Benefits Booklet</u>	<u>3</u>	<u>Home Health Care</u>	<u>26</u>
<u>Service Area</u>	<u>3</u>	<u>Home Hospice Care</u>	<u>26</u>
<u>Identification Card</u>	<u>4</u>	<u>Facility Hospice Care</u>	<u>26</u>
<u>Your UT SELECT Benefits</u>	<u>5</u>	<u>Other Benefit Provisions</u>	<u>26</u>
<u>In-Area Summary of Benefits</u>	<u>5</u>	<u>Prenatal Genetic and Chromosomal Metabolic Testing</u>	<u>26</u>
<u>Out-of-Area Summary of Benefits</u>	<u>11</u>	<u>Obstetrical Care</u>	<u>27</u>
<u>Who Gets Benefits</u>	<u>14</u>	<u>Special Beginnings Prenatal Care and Education</u>	<u>27</u>
<u>Eligibility for Coverage</u>	<u>14</u>	<u>Emergency Care and Treatment of Accidental Injury</u>	<u>28</u>
<u>Changes in Your Status</u>	<u>15</u>	<u>Ambulance Services</u>	<u>29</u>
<u>Certificates of Creditable Coverage</u>	<u>16</u>	<u>Mental Health Care</u>	<u>30</u>
<u>Address Changes</u>	<u>16</u>	<u>Chemical Dependency</u>	<u>30</u>
<u>How To Receive Benefits</u>	<u>17</u>	<u>Serious Mental Illness</u>	<u>30</u>
<u>Selecting a Provider</u>	<u>17</u>	<u>Mammography Screening</u>	<u>30</u>
<u>Network Benefits</u>	<u>17</u>	<u>Preventive Care</u>	<u>31</u>
<u>Out-of-Network Benefits</u>	<u>17</u>	<u>Prevention and Detection of Osteoporosis</u>	<u>31</u>
<u>Out-of-Area Benefits</u>	<u>17</u>	<u>Detection of Prostate Cancer</u>	<u>31</u>
<u>ParPlan/Traditional Indemnity Providers</u>	<u>18</u>	<u>Colorectal Cancer Screening</u>	<u>31</u>
<u>Preauthorization</u>	<u>18</u>	<u>Childhood Immunizations</u>	<u>32</u>
<u>Medical Services</u>	<u>18</u>	<u>Hearing Impairment</u>	<u>32</u>
<u>Mental Health Services</u>	<u>19</u>	<u>Hearing Aids</u>	<u>32</u>
<u>Disease Management</u>	<u>20</u>	<u>Savings on Hearing Aids</u>	<u>32</u>
<u>Case Management</u>	<u>21</u>	<u>Cosmetic, Reconstructive, or Plastic Surgery</u>	<u>33</u>
<u>Predetermination of Benefits</u>	<u>21</u>	<u>Covered Dental Care Services</u>	<u>33</u>
<u>BlueCard® Program</u>	<u>21</u>	<u>Organ and Tissue Transplants</u>	<u>33</u>
<u>BlueCard Worldwide®</u>	<u>22</u>	<u>Eyeglasses or Lenses</u>	<u>34</u>
<u>Medical Benefits Provided</u>	<u>23</u>	<u>Male Sexual Dysfunction</u>	<u>34</u>
<u>Eligible Expenses</u>	<u>23</u>	<u>Durable Medical Equipment</u>	<u>34</u>
<u>Deductible</u>	<u>23</u>	<u>Obesity</u>	<u>35</u>
<u>Out-of-Pocket Maximum</u>	<u>23</u>	<u>Limitations And Exclusions</u>	<u>36</u>
<u>Maximum Lifetime Benefits</u>	<u>24</u>		
<u>Changes in Benefits</u>	<u>24</u>		
<u>Inpatient Hospital Expense</u>	<u>24</u>		
<u>Medical-Surgical Expense</u>	<u>24</u>		

Table of Contents

<u>Notices</u>	<u>40</u>	<u>Claims Administration</u>	<u>52</u>
<u>HIPAA</u>	<u>40</u>	<u>Claims Liability</u>	<u>52</u>
<u>Women’s Health and Cancer Rights</u>	<u>41</u>	<u>Claim Filing Procedures</u>	<u>52</u>
<u>Continuation of Group Coverage (COBRA)</u>	<u>42</u>	<u>Receipt of Claims by the Plan</u>	<u>54</u>
<u>Other Blue Cross and Blue Shield Plans’ Separate Financial Arrangements with Providers</u>	<u>44</u>	<u>Interpretation of Plan Provisions</u>	<u>54</u>
		<u>Claim Determinations</u>	<u>54</u>
		<u>Appeal</u>	<u>55</u>
<u>General Information</u>	<u>45</u>	<u>Definitions</u>	<u>56</u>
<u>Participant/Provider Relationship</u>	<u>45</u>		
<u>Assignment and Payment of Benefits</u>	<u>45</u>		
<u>Subrogation, Reimbursement and Third Party Recovery Provision</u>	<u>45</u>		
<u>Coordination of Benefits</u>	<u>46</u>		
<u>UT SELECT and MEDICARE</u>	<u>49</u>		
<u>Refund of Benefit Payments</u>	<u>51</u>		
<u>Termination of Coverage</u>	<u>51</u>		



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

Enroll in Special Beginnings during your first trimester, and you will receive a \$50 reward card from Target after you complete program.

Important Information

UT SELECT Web site

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[®] [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. Posting this information online provides you with the most up-to-date information regarding UT SELECT BlueChoice[®] [providers](#). The UT SELECT Web site is updated monthly and available 24 hours a day.

The [Provider](#) Finder[®] 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.

Understanding Your Plan

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.



Choose Well: When you see this symbol, it denotes a Wellness benefit.

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[®] [Provider](#). You can locate BlueChoice[®] [Providers](#) in the UT SELECT [Provider](#) Directory, online at 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.

Understanding Your Plan

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


Your UT SELECT Benefits

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, New Mexico or Washington, D.C. 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](#).

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

Your UT SELECT Benefits

In-Area		
General Provisions	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Diagnostic Services (Office) (continued)		
Family Planning Services (birth control management)	\$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)	
Diagnostic Tests	\$25 copayment FCP \$30 copayment Specialist	
Infertility Diagnostic Testing		
 Preventive Care		
Periodic Physical Exam (one per plan year)	\$25 copayment FCP \$30 copayment Specialist	After deductible , plan pays 60%; you pay 40% of the Allowed Amount
Well Woman Exam (one per plan year)		
Mammogram (one per plan year)	Plan pays 100% (no copayment required)	
Well Child Care (under age 2)	\$25 copayment FCP \$30 copayment Specialist	
Immunizations (up to age 6, applies for injection only)	Plan pays 100% (no copayment required)	Plan pays 100% of the Allowed Amount
Immunizations (age 6 and older, applies for injection only)	\$25 copayment FCP \$30 copayment Specialist	After deductible , plan pays 60%; you pay 40% of the Allowed Amount

Your UT SELECT Benefits

In-Area		
General Provisions	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Obstetrical Care		
Initial Office Visit	\$25 copayment FCP \$30 copayment Specialist	
Delivery– Facility (preauthorization required) When using a Network facility: <i>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%	
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)	
Voluntary Sterilization– Facility (preauthorization required)	After \$100 copayment , plan pays 80%; you pay 20% after deductible	
Voluntary Sterilization– Physician	After deductible , plan pays 80%; you pay 20%	


Your UT SELECT Benefits

In-Area		
General Provisions	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Inpatient Care (<i>preauthorization</i> required)		
<u>Facility</u> <ul style="list-style-type: none"> • Preadmission Testing • Semi-private Room and Board • Intensive Care Unit (ICU) • Inpatient Hospital Care • Surgery 	After \$100 <u>copayment</u> per day (\$500 maximum <u>copayment</u> per admission), <u>plan</u> pays 80%; you pay 20% after <u>deductible</u>	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
<u>Physician</u>	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
<u>Outpatient Care</u>		
Observation <i>(a patient treated in a <u>hospital</u> or clinic instead of an in overnight room or ward)</i>	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Surgery– <u>Facility</u>	After \$100 <u>copayment</u> , <u>plan</u> pays 80%; you pay 20% after <u>deductible</u>	
Surgery– <u>Physician</u>	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
Lab and Radiology <i>Contrast material administered in conjunction with radiology services is subject to the applicable <u>deductible</u> and <u>coinsurance</u></i>	<u>Plan</u> pays 100% (no <u>copayment</u> required)	
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 <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
<u>Emergency Care</u>		
<u>Facility</u> –Emergency Room	\$100 <u>copayment</u> (waived if admitted)	
<u>Physician</u>	<u>Plan</u> pays 100% (no <u>copayment</u> required)	
Ambulance	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>

Your UT SELECT Benefits

In-Area		
General Provisions	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
Extended Care (<u>preauthorization</u> required)		
Skilled Nursing (subject to 180 day <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
<u>Home Health Care</u> (subject to 120 day <u>plan year</u> maximum)		
<u>Home Infusion Therapy</u>		
<u>Hospice Care</u> (subject to 90 visit <u>plan year</u> maximum)		
Therapy		
Physical Therapy (subject to 20 visit <u>plan year</u> maximum per condition if traditional physical therapy modalities billed)	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Occupational Therapy (subject to 20 visit <u>plan year</u> maximum per condition)		
Speech and Hearing Therapy (subject to 60 visit <u>plan year</u> maximum per condition)		
Respiratory Therapy		
Other		
Medical Supply/ <u>Durable Medical Equipment</u> (<u>preauthorization</u> required)/Prosthetic/Orthotics	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Hearing Aids (\$500 per ear; once every 4 years)	<u>Plan</u> pays 80%; you pay 20% (no <u>deductible</u>)	
<u>Serious Mental Illness</u> (<u>preauthorization</u> required) <i>The <u>Serious Mental Illness</u> Benefit is not part of, but is in addition to, the Mental Illness Benefit</i>		
Inpatient– <u>Facility</u>	After \$100 <u>copayment</u> per day (\$500 maximum <u>copayment</u> per admission), <u>plan</u> pays 80%; you pay 20% after <u>deductible</u>	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u>	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
Outpatient		
<u>Office Visit</u>	\$25 <u>copayment</u>	


Your UT SELECT Benefits

In-Area		
General Provisions	Network	Non-Network (Including ParPlan) Any charges over the Allowed Amount are the patient's responsibility
<u>Chemical Dependency</u> (preauthorization required; 3 episodes for treatment per lifetime)		
Inpatient– <u>Facility</u> (subject to 30 day <u>plan year</u> maximum)	After \$100 <u>copayment</u> per day (\$500 maximum <u>copayment</u> per admission), <u>plan</u> pays 80%; you pay 20% after <u>deductible</u>	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u> (subject to 30 visit <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
Outpatient (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)		
Office Setting (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	\$25 <u>copayment</u>	
 Smoking Cessation		
Outpatient/Office Setting (subject to 20 visit <u>plan year</u> maximum)	\$25 <u>copayment</u>	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
<u>Other Mental Illness</u> (preauthorization required)		
Inpatient– <u>Facility</u> (subject to 30 day <u>plan year</u> maximum)	After \$100 <u>copayment</u> per day (\$500 maximum <u>copayment</u> per admission), <u>plan</u> pays 80%; you pay 20% after <u>deductible</u>	After <u>deductible</u> , <u>plan</u> pays 60%; you pay 40% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u> (subject to 30 visit <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 80%; you pay 20%	
Outpatient (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)		
Office Setting (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	\$25 <u>copayment</u>	

Your UT SELECT Benefits

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, New Mexico or Washington, D.C. 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](#).**

Out-of-Area	
General Provisions	Any charges over the Allowed Amount are the patient’s responsibility
Deductible (per plan year) <ul style="list-style-type: none"> • Individual • Family 	\$250 \$750
Out-of-Pocket Maximum (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 <ul style="list-style-type: none"> • Individual • Family 	\$1,750 \$5,250
Diagnostic Services (Office)	
Office Visit	After deductible , plan pays 75%; you pay 25% of the Allowed Amount
Chiropractic Care (subject to 20 visit plan year maximum per condition if traditional physical therapy modalities billed)	
Infertility Diagnostic Testing	
 Preventive Care	
Periodic Physical Exam (one per plan year)	After deductible , plan pays 75%; you pay 25% of the Allowed Amount
Well Woman Exam (one per plan year)	
Mammogram (one per plan year)	
Well Child Care (under age 2)	
Immunizations	
Obstetrical Care	
Delivery (preauthorization required)	After deductible , plan pays 75%; you pay 25% of the Allowed Amount
Voluntary Sterilization	

Your UT SELECT Benefits

Out-of-Area	
General Provisions	Any charges over the Allowed Amount are the patient's responsibility
Inpatient Care (<u>preauthorization</u> required)	
<ul style="list-style-type: none"> • Preadmission Testing • Semi-private Room and Board • Intensive Care Unit (ICU) • Inpatient Hospital Care • Surgery 	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
<u>Outpatient Care</u>	
Including Observation, Surgery, Labs, Radiology and Diagnostic Testing	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
<u>Emergency Care</u>	
<u>Facility</u> and <u>Physician</u> —Emergency Room	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Ambulance	
Extended Care (<u>preauthorization</u> required)	
Skilled Nursing (subject to 180 day <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
<u>Home Health Care</u> (subject to 120 day <u>plan year</u> maximum)	
<u>Home Infusion Therapy</u>	
<u>Hospice Care</u> (subject to 90 visit <u>plan year</u> maximum)	
Therapy	
Physical Therapy (subject to 20 visit <u>plan year</u> maximum per condition if traditional physical therapy modalities billed)	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Occupational Therapy (subject to 20 visit <u>plan year</u> maximum per condition)	
Speech and Hearing Therapy (subject to 60 visit <u>plan year</u> maximum per condition)	
Respiratory Therapy	
Other	
Medical Supply/ <u>Durable Medical Equipment</u> (<u>preauthorization</u> required)/Prosthetic/Orthotics	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Hearing Aids (<i>\$500 per ear; once every 4 years</i>)	

Your UT SELECT Benefits

Out-of-Area	
General Provisions	Any charges over the Allowed Amount are the patient's responsibility
<u>Serious Mental Illness</u> (<u>preauthorization</u> required) <i>The <u>Serious Mental Illness</u> Benefit is not part of, but is in addition to, the Mental Illness Benefit</i>	
Inpatient– <u>Facility</u>	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u>	
Outpatient	
<u>Office Visit</u>	
<u>Chemical Dependency</u> (<u>preauthorization</u> required; 3 episodes for treatment per lifetime)	
Inpatient– <u>Facility</u> (subject to 30 day <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u> (subject to 30 visit <u>plan year</u> maximum)	
Outpatient (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	
Office Setting (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	
 Smoking Cessation	
Outpatient/Office Setting (subject to 20 visit <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
<u>Other Mental Illness</u> (<u>preauthorization</u> required)	
Inpatient– <u>Facility</u> (subject to 30 day <u>plan year</u> maximum)	After <u>deductible</u> , <u>plan</u> pays 75%; you pay 25% of the <u>Allowed Amount</u>
Inpatient– <u>Physician</u> (subject to 30 visit <u>plan year</u> maximum)	
Outpatient (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	
Office Setting (subject to 20 visit <u>plan year</u> maximum for outpatient and office combined)	

Who Gets Benefits

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

Who Gets Benefits

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

Who Gets Benefits

- 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

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. 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, New Mexico or Washington, D.C. 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 and Traditional Indemnity [providers](#) may be located online at 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

How to Receive Benefits

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® [Provider](#), it is your responsibility to ensure that your chosen [Provider](#) is still in the [BlueChoice® 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® 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®, 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

How to Receive Benefits

Mental Health Services

When using a BlueChoice[®] [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[®] [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 may be responsible for the full cost of the services, until the [Medical Necessity](#) of your treatment can be determined. Benefits may be denied if the treatment is not [Medically Necessary](#).

How to Preauthorize

When you use a BlueChoice[®] [Provider](#), he will be responsible for the [Preauthorization](#).

If you do not use a BlueChoice[®] [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](#).

Medical Preauthorization Numbers

In Dallas: (972) 783-4475

Outside of Dallas: 1-800-441-9188

INROADS Behavioral Health Services Telephone Numbers

In Dallas: (972) 766-5204

Outside of Dallas: 1-800-528-7264

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.

How to Receive Benefits



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
- 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. On behalf of [Blue Cross and Blue Shield of Texas](#), LifeMasters, a disease management company, may also contact you directly to see if you would be interested in participating in a disease management 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.

How to Receive Benefits

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[®] Program

BlueCard[®] 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[®] 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, New Mexico and Washington, D.C. As a reminder, membership identification cards for UT SELECT [Subscribers](#) who are designated as [In-Area](#) contain the BlueCard[®] 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[®] program can be located on the web at www.bluecares.com. You can also contact BlueCard[®] 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](#).

How to Receive Benefits

BlueCard Worldwide®

When you travel or live abroad, always carry your UT SELECT Identification Card. Through the BlueCard Worldwide® 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® 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® 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® 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® [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® Access Service Center. The claim form is available online at 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® claim form completely and accurately and attach it to your bills. Any missing information will delay claim processing.

Medical Benefits Provided

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.

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](#)

Medical Benefits Provided

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:

- Three episodes for [Chemical Dependency](#) treatment

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® [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.

Medical Benefits Provided

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.)

Medical Benefits Provided

- 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

Medical Benefits Provided

- 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*.

Special Beginnings Prenatal Care and Education

Special Beginnings is a voluntary program for participating [plan](#) members who are expecting a baby. The program helps expectant mothers and their babies get off to a healthy start by providing prenatal and postnatal health education, pregnancy risk assessment, educational materials and follow-up monitoring from pregnancy to six week after delivery. There is no cost to enroll.

Enroll in Special Beginnings and Receive a \$50 Reward Card from Target

Prenatal education, regular obstetrical check-ups and lifestyle awareness are key factors in helping pregnant women deliver healthy babies. That's why [Blue Cross and Blue Shield of Texas](#) is pleased to offer a \$50 reward card from Target for women who enroll in and complete the Special Beginnings program. If you're in your first trimester, you may call **1-800-462-3275**, Monday through Friday, 8:30 a.m. – 4:30 p.m. (CT) to enroll in Special Beginnings. Your \$50 Target reward card for completing the program will be mailed to your home or mailing address within 60-90 days after your baby's birth.

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 Subscriber) 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.

Medical Benefits Provided

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 preauthorized 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[®] [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[®] [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[®] [Provider](#). The referral must be authorized by [BCBSTX](#).

Medical Benefits Provided

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.

Medical Benefits Provided

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 preauthorized 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](#).

Medical Benefits Provided



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:

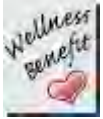
- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk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

Medical Benefits Provided



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[®] 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.

Savings on Hearing Aids

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

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

**The relationship between [Blue Cross and Blue Shield of Texas](#) and TruHearing is that of independent contractors.

Medical Benefits Provided

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](#).
- Orthognathic surgery.

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

Medical Benefits Provided

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 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

Medical Benefits Provided

- 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

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.

Limitations and Exclusions

13. Any services or supplies provided for Custodial Care.
14. Any items of [Medical-Surgical Expense](#) incurred for dental care and treatments, dental surgery, or dental appliances, except as explained in [Other Benefit Provisions](#).
15. Any services or supplies provided for [Cosmetic](#), [Reconstructive](#), or Plastic Surgery, except as explained in [Other Benefit Provisions](#).
16. 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](#).
17. Any services or supplies for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and oppositional disorders.
18. Any services or supplies provided for:
 - Any [Medical Social Services](#) (except as provided as an [Extended Care Expense](#))
 - Bereavement counseling (except as provided under [Hospice Care](#))
 - Vocational counseling
 - [Marriage and family therapy](#) and/or counseling
19. 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.
20. Travel, whether or not recommended by a [Physician](#) or [Other Professional Provider](#), except as expressly described by the [Plan](#).
21. 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](#)
22. Any services or supplies in conjunction with chelation therapy, except for treatment of acute metal poisoning.
23. 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.

Limitations and Exclusions

24. 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
25. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
26. 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](#).
27. 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
28. 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.
29. Any benefits in excess of specified benefit maximums.
30. Any services or supplies not specifically defined as [Eligible Expenses](#) in the [Plan](#).
31. Outpatient drugs except as provided under the [Plan](#) by the Prescription Drug Program.
32. 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](#).
33. 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.
34. Any services or supplies provided for reduction mammoplasty, except when [Medically Necessary](#).
35. 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

Limitations and Exclusions

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](#).

36. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except when [Medically Necessary](#) for the treatment of morbid obesity.
37. The use of the procedures, supplies, or medications for treatment of psychologic/psychogenic male sexual or erectile dysfunction/impotence is not eligible for benefits.
38. 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.
39. 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.
40. Arch supports, elastic stockings and garter belts not related to diabetes.
41. Services or supplies used primarily for patient convenience.
42. Most supplies purchased over the counter without a doctor's prescription.
43. Telephone calls between [physicians](#) and telephone call discussions between a [physician](#) and a patient.
44. 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.
45. 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

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/benefits/hipaa/. A paper copy of the privacy notice is provided to all new enrollees and is available to anyone upon request from the Office of Employee Benefits.

For more information contact your Campus Benefits Office or visit www.utsystem.edu/benefits.

Notices

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.

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.

Notices

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 Benefits Office if you have any questions about COBRA.

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

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

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[®] [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 Subscriber, as [BCBSTX](#) elects. Payment to either party discharges the [Plan](#)'s responsibility to the Subscriber 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 Subscriber 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 Subscriber or covered person retains an attorney, then the Subscriber 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 Subscriber 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 Subscriber 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 Subscriber or covered person and their attorney, if applicable. The Subscriber 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

General Information

the Subscriber or covered person, then the Subscriber 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 Sponsor](#) 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 Subscriber or covered person takes no action to recover any money from any source, the Subscriber 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.

General Information

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.

General Information

- **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.

General Information

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

If you and/or your dependents do not enroll in Medicare Part B when eligible, [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 and/or your dependents 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.

General Information

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

Provider Accepts Medicare Assignment Y/N	BCBSTX In-Network Provider Y/N	Service Covered by Medicare Y/N	Medicare Pays	UT SELECT Pays	Member Pays
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

General Information

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.

Claims Administration

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® [Provider](#) Claims or Other Claims Submitted on Your Behalf or on Behalf of Your Dependents:

- When you receive treatment or care from a BlueChoice® [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® 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® 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® [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.

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.

Claims Administration

- 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.

Claims Administration

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

Claims Administration

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:

*Office of Employee Benefits
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

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 [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.

Definitions

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® 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)

Definitions

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.

Definitions

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.

Definitions

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.

Definitions

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.

Definitions

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](#).

Definitions

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, New Mexico and Washington, D.C., are considered in-area.

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

Definitions

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

Definitions

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

Definitions

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, New Mexico or Washington, D.C., 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](#).

Definitions

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, New Mexico and Washington, D.C.

Out-of-Area Benefits are available to eligible employees and retirees residing outside of Texas, New Mexico and Washington, D.C., 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](#).

Definitions

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, 2007.

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](#)

Definitions

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® [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.

Definitions

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.

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 and Website

www.bcbstx.com/ut

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, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

48273.0607