



BlueCross BlueShield  
of Texas



# YOUR UT CONNECT MEDICAL PLAN GUIDE

2021 - 2022 YOUR HEALTH  
CARE BENEFIT PROGRAM

Effective **September 1, 2021**



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# UT CONNECT SCHEDULE OF COVERAGE

When you need to see a doctor, contact your primary care physician (PCP) or CONNECT customer service team (number on the back of your medical insurance card).



Your PCP will either treat you or refer you to a network specialist or facility for further care. Other than an OBGYN or behavioral health visit, if you visit a specialist without a referral from your PCP, your care may not be covered — even if it's at a network provider. As your primary care medical home, your PCP will ensure you are receiving the most efficient and effective treatment for all your health care needs.

**The plan doesn't cover care received out-of-network, except for urgent care or medical emergencies. If you receive non-emergency care from a doctor who is not in the network, the plan will not pay benefits for those services.**

## SCHEDULE OF BENEFITS

Coverage	Network Benefits*
Annual <u>Deductible</u> (applicable when <u>coinsurance</u> is required)	\$250/person \$750/family
Coinsurance Maximum	\$2,150/person \$6,450/family
Annual <u>Out-of-Pocket Maximum</u> **	\$8,550/person \$17,100/family (deductibles, coinsurance and copayments)
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No Limit
<b>OFFICE SERVICES</b>	
MDLIVE Virtual Visit	\$0
Preventive Care	Plan pays 100% (no copayment required)
Diagnostic Office Visit	PCP \$5 Copay; Specialist \$35 Copay <b>NOTE:</b> First PCP Copay Waived per patient, thereafter copay is applicable
Diagnostic Lab and X-Ray	Included in Office Visit Copay
Urgent Care	THR Urgent Care Centers \$30 Copay Non-THR Urgent Care Centers \$35 Copay
Other Diagnostic Tests	PCP \$5 Copay; Specialist \$35 Copay
Allergy Testing	PCP \$5 Copay; Specialist \$35 Copay
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)
<b>EMERGENCY CARE</b>	
Ambulance Service (if transported)	80% Plan/20% Member
Hospital Emergency Room	\$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services
Emergency Room Physician	80% Plan/20% Member after deductible



## SCHEDULE OF BENEFITS (continued)

Coverage	Network Benefits*
OUTPATIENT CARE	
Observation	80% Plan/20% Member
Surgery – Facility	\$50 Copay; then 80% Plan/20% Member
Surgery – Physician	80% Plan/20% Member
Diagnostic Lab and X-Ray	100% covered (except when billed with surgery; then 80% Plan/20% Member)
MRI/CT Scans	\$100 Copay <b>NOTE:</b> For related services, such as contrast materials or injections, 80% Plan/20% Member
Other Diagnostic Tests	80% Plan/20% Member
Outpatient Procedures	80% Plan/20% Member
INPATIENT CARE	
Hospital – Semiprivate Room and Board***	\$0 Copay; then 80% Plan/20% Member
Hospital Inpatient Surgery***	80% Plan/20% Member
Physician	80% Plan/20% Member
OBSTETRICAL CARE	
Prenatal and Postnatal Care Office Visits	PCP \$5 Copay; Specialist \$35 Copay (initial visit only)
Delivery – Facility/Inpatient Care***	\$0 Copay; then 80% Plan/20% Member
Obstetrical Care and Delivery – Physician	80% Plan/20% Member
THERAPY	
Physical Therapy/Chiropractic Care (max. 35 visits/year/condition)	\$35 Copay/Visit
Occupational Therapy (max. 35 visits/year/condition)	\$35 Copay/Visit
Speech and Hearing Therapy (max. 60 visits/year/condition)	\$35 Copay/Visit
EXTENDED CARE	
Skilled Nursing/Convalescent Facility*** (max. 180 visits)	80% Plan/20% Member
Home Health Care Services*** (max. 120 visits)	80% Plan/20% Member
Hospice Care Services***	80% Plan/20% Member
Home Infusion Therapy***	80% Plan/20% Member

Virtual Visits may not be available on all plans. Non-emergency medical service in Montana and New Mexico is limited to interactive online video. Non-emergency medical service in Arkansas and Idaho is limited to interactive online video for initial consultation.

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## SCHEDULE OF BENEFITS (continued)

Coverage	Network Benefits*
BEHAVIORAL HEALTH	
MDLIVE Virtual Visit	\$0 Copay
Serious Mental Illness – Office Visit	PCP \$5 Copay; Specialist \$35 Copay
Serious Mental Illness – Outpatient***	80% Plan/20% Member
Serious Mental Illness – Inpatient***	\$0 Copay; then 80% Plan/20% Member
Mental Illness – Office	PCP \$5 Copay; Specialist \$35 Copay
Mental Illness – Outpatient***	80% Plan/20% Member
Mental Illness – Inpatient*** (Other than Serious Mental Illness)	\$0 Copay; then 80% Plan/20% Member
Substance Use Disorder – Office	80% Plan/20% Member
Substance Use Disorder – Outpatient Treatment***	80% Plan/20% Member
Substance Use Disorder – Inpatient Treatment***	\$0 Copay; then 80% Plan/20% Member
OTHER SERVICES	
Durable Medical Equipment***	80% Plan/20% Member
Prosthetic Devices	80% Plan/20% Member
Hearing Aids (Adult) (\$1000 per ear; once every 3 years)	80% Plan/20% Member
Hearing Aids (through age 18; once every 3 years)	80% Plan/20% Member
Bariatric Surgery (pre-determination recommended)	<p>\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$3,000 bariatric surgery deductible, plan pays 100% of covered services— for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers.</p> <p><b>NOTE:</b> Individual must be enrolled in the UT SELECT and/or UT CONNECT plan for 36 continuous months prior to the date of the surgery to receive benefits.</p>

\* The plan doesn't cover care received out-of-network, except for medical emergencies. If you receive non-emergency care from a doctor who is not in the network, the plan will not pay benefits for those services.

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

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

# INTRODUCTION



This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies.

Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. 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.

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



**BlueCross BlueShield  
of Texas**

**UT CONNECT**

UT CONNECT 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.

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## Managed Health Care – In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at [www.bcbstx.com](http://www.bcbstx.com) to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. You may access our website, [www.bcbstx.com/utconnect](http://www.bcbstx.com/utconnect), for the most current listing to assist you in locating a Provider.

To receive In-Network Benefits for Behavioral Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll-free Behavioral Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Behavioral Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claim Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claim Administrator – not you – for services provided.

*The Provider has agreed to accept as payment in full the least of:*

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles and Coinsurance Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

## Managed Health Care – Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

*You will be responsible for paying:*

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles,
- Limited or non-covered services, and
- Failure to preauthorize penalty.



# IMPORTANT CONTACT INFORMATION



RESOURCE	CONTACT INFORMATION	ACCESSIBLE HOURS
CUSTOMER SERVICE (CONNECT TEAM)	1-888-399-8889	24 hours a day, 7 days a week (excluding Holidays)
MEDICAL PREAUTHORIZATION	1-800-441-9188	Monday – Friday 6:00 a.m. – 6:00 p.m.
BEHAVIORAL HEALTH HELPLINE/ SUBSTANCE USE DISORDER PREAUTHORIZATION HELPLINE	1-800-729-2422	24 hours a day 7 days a week
24/7 NURSELINE	1-888-315-9473	24 hours a day 7 days a week
BLUE CROSS AND BLUE SHIELD OF TEXAS WEBSITE	<a href="http://www.bcbstx.com/utconnect">www.bcbstx.com/utconnect</a>	24 hours a day 7 days a week

## CUSTOMER SERVICE HELPLINE

*Customer Service Representatives can:*

- Identify your Plan Service Area
- Give you information about Network and ParPlan Providers
- Distribute claim forms
- Answer your questions on claims
- Order replacement or additional Identification Cards
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers
- Coordinate referrals
- Schedule appointments

## BCBSTX WEBSITE

Visit the BCBSTX website at [www.bcbstx.com/utconnect](http://www.bcbstx.com/utconnect) for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

## BEHAVIORAL HEALTH/SUBSTANCE USE DISORDER PREAUTHORIZATION HELPLINE

To satisfy Preauthorization requirements for Participants seeking treatment for Behavioral Health Services for Behavioral Health Care Serious Mental Illness, and Substance Use Disorder, you, your Behavioral Health Practitioner, or a family member may call the Behavioral Health/Substance Use Disorder Preauthorization Helpline at any time, day or night.

## MEDICAL PREAUTHORIZATION HELPLINE

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

# WHO GETS BENEFITS



## Eligibility Requirements 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 or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee or any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the **Dependent Enrollment Period** section for a new Dependent of an Employee already having coverage under the Plan.

No eligibility rules or variations in rates will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

### EMPLOYEE ELIGIBILITY

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

### DEPENDENT ELIGIBILITY

If you apply for coverage, you may include your Dependents. Subject to the terms of this section, eligible Dependents are:

1. Your spouse;
2. A child under age 26;
3. A grandchild under age 26 who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
4. A child over the age of 26 who is determined by the Office of Employee Benefits at UT System Administration to be medically incapacitated and is unable to provide their own support.
5. Eligible surviving spouses (see UT System policy for more details).

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee retiree must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's/Retiree's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

## Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the plan is shown on your Identification Card. It may be different from the Eligibility Date.

### TIMELY APPLICATIONS

It is important that your application for coverage under the Plan is received timely by the Claim Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claim Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or
3. Become eligible after the Plan Effective Date and if the application is received by the Claim Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

### **EFFECTIVE DATES – LATE ENROLLEE**

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

### **LOSS OF OTHER HEALTH INSURANCE COVERAGE**

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
  - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
  - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
  - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective following the last day the Employee or Dependent held coverage under the prior Plan.

If all conditions described above are not met, you will be considered a Late Enrollee.



## LOSS OF GOVERNMENTAL COVERAGE

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

## HEALTH INSURANCE PREMIUM PAYMENT (HIPP) REIMBURSEMENT PROGRAM

An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claim Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

## DEPENDENT ENROLLMENT PERIOD

### 1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claim Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claim Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

### 2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

### 3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

### 4. Other Dependents

Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

## OTHER EMPLOYEE ENROLLMENT PERIOD

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage**, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.  
  
If you marry and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claim Administrator through the Plan Administrator.
2. If you are required to provide coverage for a child as described in **Court Ordered Dependent Children** above, and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage**, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

## Changes in Your Family

You should promptly notify the Claim Administrator through the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit an Enrollment Application/Change Form and the coverage of the Dependent will become effective as described in **Dependent Enrollment Period**.
- When you divorce, your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

**Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available.** If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claim Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

You have 31 days from the date of a qualifying change of status event to notify your institution Benefits Office and change your benefit selections. If you do not make your changes during the 31-day status change period, your changes cannot be made until the next Annual Enrollment in July, to be effective the following September 1.

Examples of qualified change of status events include:

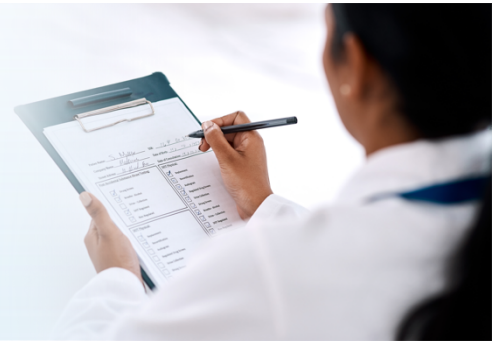
- Marriage, divorce, annulment, legal separation or spouse's death
- Birth, adoption, medical child support order, or dependent's death
- Significant change in residence if the change affects you or your dependents' current plan eligibility
- Starting or ending employment, starting or returning from unpaid leave of absence, or a change of job status (e.g., from part-time to full-time)
- Change in dependent eligibility
- Significant change in coverage or cost of other benefit plans available to you and your family.

Your benefit selection changes must be consistent with your change in status. An employee or retired employee...

- Whose dependent loses insurance coverage under the Medicaid or CHIP program as a result of loss of eligibility of either the employee or the dependent; or
- Whose dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll this dependent in UT CONNECT, as long as the dependent meets all other UT eligibility requirements and is enrolled within 60 days from the date of the applicable event. If enrollment of the dependent is conditioned on enrollment of the employee, the employee will also be eligible to enroll.

For questions regarding status changes, please contact your institution Benefits Office.

# HOW THE PLAN WORKS



## Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Expenses you incur under the Plan. The Claim Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claim Administrator, you will be responsible for amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles and Coinsurance Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claim Administrator.

## Case Management

Under certain circumstances, the Plan allows the Claim Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claim Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claim Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

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

## Use of Non-Contracting Providers

*Each time you need medical care, you can choose to:*

SEE A NETWORK PROVIDER	SEE AN OUT-OF-NETWORK PROVIDER
<ul style="list-style-type: none"> <li>• You receive the higher level of benefits (In-Network Benefits)</li> <li>• You are not required to file claim forms</li> <li>• You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services</li> <li>• Your Provider will preauthorize necessary services</li> </ul>	<p style="text-align: center;"><b>Out-of-Network Provider</b> <i>(Emergency and Urgent Care only)</i></p> <ul style="list-style-type: none"> <li>• Due to the managed care model of the UT CONNECT ACO plan, there are no benefits for out-of-network or out-of-area services except for urgent care and medical emergencies</li> </ul>



## IDENTIFICATION CARD

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- **Your Subscriber identification number.** This unique identification number is preceded by a three-character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claim Administrator.
- **Your group number.** This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- **Important telephone numbers.**



Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claim Administrator will provide a new Identification Card.

## UNAUTHORIZED, FRAUDULENT, IMPROPER, OR ABUSIVE USE OF IDENTIFICATION CARDS

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
  - a. Use of the Identification Card prior to your Effective Date;
  - b. Use of the Identification Card after your date of termination of coverage under the Plan;
  - c. Obtaining other benefits for persons not covered under the Plan;
  - d. Obtaining other benefits that are not covered under the Plan;
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
  - a. Denial of benefits;
  - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
  - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
  - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
  - e. Pre-approval of medical services for all Participants receiving benefits under your coverage;
  - f. Notice to proper authorities of potential violations of law or professional ethics.

## MEDICAL NECESSITY

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claim Administrator. Charges for services and supplies which the Claim Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

## SPECIALTY CARE PROVIDERS

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

# Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

## THE FOLLOWING TYPES OF SERVICES REQUIRE PREAUTHORIZATION:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- Motorized and customized wheelchairs and other durable medical equipment with a cost greater than \$5,000,
- Transplants,
- All inpatient Behavioral Health Care/ Serious Mental Illness including partial hospitalization programs and treatment received at Residential Treatment Centers, and,
- All inpatient treatment of Substance Use Disorder including partial hospitalization programs and treatment received at Residential Treatment Centers, and
- All inpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Substance Use Disorder, and Serious Mental Illness and Behavioral Health Care:
  - Applied Behavioral Analysis,
  - Outpatient Electroconvulsive therapy,
  - Intensive Outpatient Program, and
  - Repetitive Transcranial Magnetic Stimulation.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will Preauthorize services for you, when required.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled **Failure to Preauthorize**.

## **PREAUTHORIZATION FOR INPATIENT HOSPITAL ADMISSIONS**

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, you, your Physician, Provider of services, or a family member should call one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned not later than 24 hours after the call is received. We will follow-up with your Provider's office. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

### ***Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested***

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

## PREAUTHORIZATION FOR EXTENDED CARE EXPENSES AND HOME INFUSION THERAPY

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

The Claim Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claim Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claim Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

## PREAUTHORIZATION FOR BEHAVIORAL HEALTH CARE, AND SERIOUS MENTAL ILLNESS, AND TREATMENT OF SUBSTANCE USE DISORDER

In order to receive maximum benefits, all inpatient Behavioral Health Care, and treatment for Behavioral Health Care Serious Mental Illness, and Substance Use Disorder must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavior analysis, and outpatient electroconvulsive therapy. BCBSTX will notify your Provider if Preauthorization is required for Psychological Testing or Neuropsychological Testing. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the **Behavioral Health/Substance Use Disorder Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Behavioral Health/Substance Use Disorder Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.



## FAILURE TO PREAUTHORIZE

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient Behavioral Health Care, and treatment of Serious Mental Illness, and treatment of Substance Use Disorder is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
  - Inpatient Hospital Admission
  - Inpatient Behavioral Health Care, Serious Mental Illness, and treatment of Substance Use Disorder.
  - The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, Behavioral Health Care service, treatment of Behavioral Health Care, Serious Mental Illness, treatment of Substance Use Disorder or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or was Experimental/Investigational, benefits will be reduced or denied.

# Claim Filing and Appeal Procedures

## FILING OF CLAIMS REQUIRED

### *Claim Forms*

When the Claim Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claim Administrator for the Plan 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

Providers that contract with the Claim Administrator will submit your claims directly to the Claim Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

### *Contracting Providers*

When you receive treatment or care from a Provider that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

### *Non-Contracting Providers*

When you receive emergency or urgent care treatment or care from a health care Provider that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled Participant-Filed Claims below for instruction on how to file your own claim forms.

### **Participant-Filed Medical Claims**

If your Provider does not submit your claims, you will need to submit them to the Claim Administrator using a Subscriber-filed claim form provided by the Plan. You can obtain copies from the BCBSTX website at [www.bcbstx.com/utconnect](http://www.bcbstx.com/utconnect), or by calling Customer Service at the toll-free number on your Identification Card. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.



Visit the BCBSTX website for subscriber claim forms and other useful information  
[www.bcbstx.com/utconnect](http://www.bcbstx.com/utconnect)

### **WHERE TO MAIL COMPLETED MEDICAL CLAIM FORMS**

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

### **WHO RECEIVES PAYMENT**

Benefit payments will be made directly to contracting Providers when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Providers may require payment directly to them.

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.

Except as provided in the **section Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

#### ***Benefit Payments to a Managing Conservator***

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; and
- the Claim Administrator has not already paid any portion of the claim.
- In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claim Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claim Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

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

## WHEN TO SUBMIT CLAIMS

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

## RECEIPT OF CLAIMS BY THE CLAIM ADMINISTRATOR

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied, or the Claim Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claim Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

## REVIEW OF CLAIM DETERMINATIONS

### ***Claim Determinations***

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator. The Claim Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claim Administrator requires further information in order to process the claim, the Claim Administrator will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by the Claim Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

### ***If a Claim Is Denied or Not Paid in Full***

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for denial;
- A reference to the Health Benefit Plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by the Claim Administrator if you do not agree with the denial.

### ***Right to Review Claim Determinations***

You have the right to seek and obtain a full and fair internal review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

1. Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:



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

2. The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
3. You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.
4. If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

### **PREAUTHORIZATION APPEAL PROCEDURES**

If you or your Physician disagree with the determination of the Preauthorization prior to or while receiving services, you may appeal that decision by contacting the Claim Administrator's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Claim Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:



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

Once you have requested this review, you may submit additional information and comments on your Preauthorization decision to the Claim Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your Preauthorization decision held by the Claim Administrator.

Within 30 days of receiving your request to review, the Claim Administrator will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period.



## INTERPRETATION OF EMPLOYER'S PLAN PROVISIONS

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

### ***Claim Dispute Resolution***

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

## STANDARD EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination of a clinical appeal by an independent review organization (IRO). To obtain an authorization form, you or your representative may call toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card, or download the HIPAA Authorization Form to Disclose PHI from the [www.bcbstx.com/utconnect](http://www.bcbstx.com/utconnect) website within the section for Tools and Resources.

### **1. Request for external review.**

Within 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination, you or your authorized representative must file your request for standard external review.

### **2. Preliminary review.**

Within 5 business days following the date of receipt of the external review request, BCBSTX must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse internal benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- You have exhausted BCBSTX's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within 1 business day after BCBSTX completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSTX will outline the reasons it is ineligible in the notice.

### **3. Referral to Independent Review Organization.**

When an eligible request for external review is completed within the time period allowed, BCBSTX will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, BCBSTX will take action against bias and ensure independence. Accordingly, BCBSTX must contract with at least 3 IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within 5 business days after the date of assignment of the IRO, BCBSTX must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by BCBSTX to timely provide the documents and information must not delay the conduct of the external review. If BCBSTX fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within 1 business day after making the decision, the IRO must notify BCBSTX and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to BCBSTX. Upon receipt of any such information, BCBSTX may reconsider the adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by BCBSTX must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSTX decides, upon completion of its reconsideration, to reverse the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within 1 business day after making such a decision, BCBSTX must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSTX.
- In reaching a decision, the assigned IRO will review the claim de novo (independently) and not be bound by any decisions or conclusions reached during BCBSTX's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - a. Your medical records;
  - b. The attending health care professional's recommendation;
  - c. Reports from appropriate health care professionals and other documents submitted by BCBSTX, you, or your treating provider;
  - d. The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
  - e. Appropriate practice guidelines, which must include applicable evidence--based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
  - f. Any applicable clinical review criteria developed and used by BCBSTX, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
  - g. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSTX and you or your authorized representative.
- The notice of final external review decision will contain:
  - a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
  - b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence--based standards that were relied on in making its decision;
  - e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either BCBSTX or you or your authorized representative;
  - f. A statement that judicial review may be available to you or your authorized representative; and
  - g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by BCBSTX, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

#### **4. Reversal of plan's decision.**

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, BCBSTX must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

### **EXPEDITED EXTERNAL REVIEW**

#### **1. Request for expedited external review.**

BCBSTX must allow you or your authorized representative to make a request for an expedited external review with BCBSTX at the time you receive:

- An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

#### **2. Preliminary review.**

Immediately upon receipt of the request for expedited external review, BCBSTX must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. BCBSTX must immediately send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.

#### **3. Referral to independent review organization.**

Upon a determination that a request is eligible for external review following the preliminary review, BCBSTX will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. BCBSTX must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSTX's internal claims and appeals process.

#### **4. Notice of final external review decision.**

BCBSTX's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSTX and you or your authorized representative.

## EXHAUSTION

For standard internal review of a clinical appeal, you have the right to request external review once the internal review process has been completed and you have received the final internal adverse benefit determination from BCBSTX. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSTX waives the internal review process or BCBSTX has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by BCBSTX to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under law.

# Eligible Expenses, Payment Obligations, and Benefits

## ELIGIBLE EXPENSES

The Plan provides coverage for four categories of Eligible Expenses:

1. Inpatient Hospital Expenses,
2. Medical-Surgical Expenses,
3. Extended Care Expenses, and
4. Special Provisions Expenses.

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Plan Year benefit period basis unless otherwise stated. At the end of a Plan Year, a new benefit period starts for each Participant.

## COPAYMENT AMOUNTS

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage for your specific Plan information.

A Copayment Amount will be required for most Physician office visits, including lab and x-ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered Medical- Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- Surgery performed in the Physician's office;
- Physical therapy billed separately from an office visit;
- Occupational modalities in conjunction with physical therapy;
- Allergy injections billed separately from an office visit;
- Therapeutic injections;
- Any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- Services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each visit to a Retail Health Clinic.

A Copayment Amount will be required for each visit to an Urgent Care Center. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, shown on your Schedule of Coverage:

- Surgery performed in the Urgent Care center;
- Physical therapy billed separately from an Urgent Care visit;



- Occupational modalities in conjunction with physical therapy;
- Allergy injections billed separately from an Urgent Care visit;
- Therapeutic injections;
- Any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount and Coinsurance will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

## DEDUCTIBLES

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

- **Plan Year Deductible:** The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Plan Year. This Deductible will be applied to all Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses (unless otherwise indicated) before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

- If you have several covered Dependents, all charges used to apply toward a “per individual” Deductible amount will be applied toward the “per family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the “per family” Deductible amount.
- Eligible Expenses applied toward satisfying the “per individual” and “per family” Out-of-Network Deductible will apply toward both the Out-of-Network and the In-Network Deductible. However, Eligible Expenses applied toward satisfying the “per individual” and “per family” In-Network Deductible will not apply toward satisfying the Out-of-Network Deductible.

## OUT OF POCKET MAXIMUM AMOUNT

Most of your Eligible Expense payment obligations, are applied to the Out of Pocket maximum.

Your Out of Pocket Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by another Primary Plan when this Plan is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Penalties applied for failure to preauthorize.

### ***Individual Out of Pocket Maximums Amount***

When the Out of Pocket Maximum Amount for a Participant in a Plan Year equals the “per individual” “Out of Pocket Maximum Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Plan Year.

### ***Family Out of Pocket Maximum Amount***

When the Out of Pocket Amount for all Participants under your coverage in a Plan Year equals the “per family” “Out of Pocket Maximum Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Plan Year. No Participant will be required to contribute more than the individual Out of Pocket Maximum Amount to the family “Out of Pocket Maximum Amount.”

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

- There are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.
- Eligible Expenses applied toward satisfying the “per individual” and “per family” Out-of-Network Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and Out-of-Network Co-Share Stop-Loss Amount. However, Eligible Expenses applied toward satisfying the “per individual” and “per family” In-Network Co-Share Stop-Loss Amount maximum will not apply toward satisfying the Out-of-Network Co-Share Stop-Loss Maximum amount.

### **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 Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

## **Covered Medical Services**

### **INPATIENT HOSPITAL EXPENSES**

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits only for emergency and urgent care.

Refer to your Schedule of Coverage for information regarding Deductibles, Coinsurance percentages, and penalties for failure to preauthorize that may apply to your coverage.

### **MEDICAL-SURGICAL EXPENSES**

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” on your Schedule of Coverage in excess of your Co-Share Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical-Surgical Expense in excess of the Co-Share Amounts and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a professional recommendation should be obtained from the Physician.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic X-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:
  - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
  - b. Home air fluidized bed therapy.
  - c. Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition. For non- Emergency Care, professional local ground ambulance transportation or air ambulance transportation, when Medically Necessary, to or from a facility appropriately equipped and staffed for treatment of the Participant's condition. This includes but is not limited to transportation from one Hospital to another Hospital and from a Hospital to a rehabilitation facility or Skilled Nursing Facility. The Participant's condition must be such that any other form of transportation would be medically contraindicated.

Air ambulance transportation is only covered when (1) ambulance transportation is Medically Necessary, and (2) terrain, distance, your physical condition, or other circumstances require the use of air ambulance transportation rather than ground ambulance transportation.

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. 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.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Substance Use Disorder Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.
19. Elective Sterilizations.

## EXTENDED CARE EXPENSES

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the number of days or visits shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network or Emergency and Urgent Care Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

If shown on your Schedule of Coverage, the Plan Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

***Services and Supplies for Extended Care Expenses:***

1. For Skilled Nursing Facility:
  - a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
  - b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
  - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
  - a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
  - b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
  - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
  - d. Supplies and equipment routinely provided by the Home Health Agency.
  - e. 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 Infusion Therapy;
    - Durable medical equipment.
3. For Hospice Care:
  - a. Home Hospice Care:
    - Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a 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;
    - Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.
  - b. Facility Hospice Care:
    - All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a 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 by licensed therapists.

**SPECIAL PROVISIONS EXPENSES**

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

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

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

### ***Benefits for Maternity Care***

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the 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; and
- 96 hours following an uncomplicated delivery by caesarean section.

Inpatient hospital expenses incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's hospital admission for the delivery. These charges will be considered expenses of the child and may be subject to the benefit provisions and benefit maximums described in the Benefits Summary.

When using a Network facility: If the mother is a covered participant, she will be responsible for any applicable deductible and coinsurance. Deductible for newborn will be waived. Baby has coinsurance only regardless whether or not mother is covered.

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

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room. Your provider can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment to recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Coverage.

All treatment received following the onset of an accidental injury or emergency care will be eligible for Network Benefits. For a non-emergency, Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, no benefits will be available.

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

Benefits for eligible expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chronic villus sampling (CVS). These tests are eligible for coverage for the specific conditions listed:

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



### ***Benefits for Urgent Care/Retail Health Clinics***

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, Urgent Care visit or Emergency Care visit.

### ***Benefits for Preventive Care***

Benefits are available for the following preventive care services as indicated on your Schedule of Coverage:

- well-baby care (after the newborn's initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and X-ray;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under *Benefits for Screening Tests for Hearing Impairment*;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in Benefits for Childhood Immunizations for children under the age of six. Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expenses 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 Mammography Screening***

If a Participant incurs Medical-Surgical Expenses 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 Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Plan Year.

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

If a Participant is a *Qualified Individual*, Medical-Surgical Expense benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

*Qualified Individual means:*

- a. A postmenopausal woman not receiving estrogen replacement therapy;
- b. An individual with:
  - vertebral abnormalities,
  - primary hyperparathyroidism, or
  - a history of bone fractures; or
  - an individual who is: receiving long-term glucocorticoid therapy, or
  - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

### ***Benefits for Tests for Detection of Colorectal Cancer***

Benefits for Medical-Surgical Expenses incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are at normal risk for developing colon cancer, will be determined under Preventive Care as shown on your Schedule of Coverage for:

- A fecal occult blood; or
- A flexible sigmoidoscopy; or
- A colonoscopy.

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

Benefits will be determined on the same basis as for other Medical-Surgical Expenses as shown on your Schedule of Coverage, for each woman enrolled in the Plan who is 18 years of age or older, for Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

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

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

1. Physical examination for the detection of prostate cancer; and
2. Prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan 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 cancer risk factor.

### ***Benefits for Speech and Hearing Services***

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

### ***Benefits for Immunizations***

Benefits for Medical-Surgical Expenses 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 Allowable Amount. Deductibles and Co-Share Amounts will not be applicable.

Doses, recommended ages, and recommended populations vary. See the Advisory Committee on Immunization Practices' website for more information: [www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip). Injections for allergies are not considered immunizations under this benefit provision.

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

### ***Benefits for Certain Therapies for Children with Developmental Delays***

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations

The *Individualized Family Service Plan* must be submitted to the Claim Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of 3, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

*Developmental Delay* means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

*Individualized Family Service Plan* means an initial and ongoing treatment plan.

### ***Benefits for Autism Spectrum Disorder***

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the participant's physician or behavioral health practitioner in a treatment plan are available for a covered UT CONNECT participant.

Generally recognized services may include services such as:

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

Individuals providing treatment prescribed under that plan must be:

1. a Health Care Practitioner:
  - a. Who is licensed, certified, or registered by an appropriate agency of the state of Texas;
  - b. Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
  - c. Who is certified as a provider under the TRICARE military health system; or
2. an individual acting under the supervision of a Health Care Practitioner described in 1 above.

For purposes of this section, generally recognized services may include services such as:

- Evaluation and assessment services;
- Screening at 18 and 24 months;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy.

### ***Benefits for Screening Tests for Hearing Impairment***

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

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

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

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

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed for the treatment or correction of a congenital defect; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

### ***Benefits for Dental Services***

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by Accidental Injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues is limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

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

1. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
  - a. The transplant procedure is not Experimental/Investigational in nature; and
  - b. Donated human organs or tissue or an FDA-approved artificial device are used; and
  - c. The recipient is a Participant under the Plan; and
  - d. The transplant procedure is preauthorized as required under the Plan; and
  - e. The Participant meets all the criteria established by the Claim Administrator in pertinent written medical policies; and
  - f. The Participant meets all the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

2. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all the conditions cited above.

Benefits will be available for:

- a. A recipient who is covered under this Plan; and
  - b. A donor.
3. Covered services and supplies include services and supplies provided for the:
    - a. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
    - b. Removal of organs or tissues from living or deceased donors; and
    - c. Transportation and short-term storage of donated organs or tissues.
  4. No benefits are available for a Participant for the following services or supplies:
    - a. Donor search and acceptability testing of potential live donors;
    - b. Living and/or travel expenses of the recipient or a live donor;
    - c. Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
    - d. Purchase of the organ or tissue; or
    - e. Organs or tissue (xenograft) obtained from another species.

5. Preauthorization is required for any organ or tissue transplant. Review the PREAUTHORIZATION REQUIREMENTS subsection in this Benefit Booklet for more specific information about Preauthorization.
  - a. Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
  - b. At the time of Preauthorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.
6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational.

#### **Benefits for Treatment of Acquired Brain Injury**

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:

- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process(es) of restoring or improving a specific function.

*Service* means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

*Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

#### **Benefits for Treatment of Diabetes**

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for Diabetes Equipment and Diabetes Supplies (for which a Physician or Professional Other Provider has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items, when obtained for a Qualified Participant, shall include but not be limited to the following:

1. Diabetes Equipment
  - a. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
  - b. Insulin pumps (both external and implantable) and associated appurtenances, which include:
    - Insulin infusion devices,
    - Batteries,
    - Skin preparation items,
    - Adhesive supplies,
    - Infusion sets,
    - Insulin cartridges,
    - Durable and disposable devices to assist in the injection of insulin, and
    - Other required disposable supplies; and
  - c. Podiatric appliances, including up to two pairs of therapeutic footwear per Plan Year, for the prevention of complications associated with diabetes.

2. Diabetes Supplies
  - a. Test strips specified for use with a corresponding blood glucose monitor,
  - b. Visual reading and urine test strips and tablets for glucose, ketones, and protein,
  - c. Lancets and lancet devices,
  - d. Insulin and insulin analog preparations,
  - e. Injection aids, including devices used to assist with insulin injection and needleless systems,
  - f. Biohazard disposable containers,
  - g. Insulin syringes,
  - h. Glucagon emergency kits.
3. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
4. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
5. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician. Initial and follow-up instruction concerning:
  - a. The physical cause and process of diabetes;
  - b. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
  - c. Prevention and treatment of special health problems for the diabetic patient;
  - d. Adjustment to lifestyle modifications; and
  - e. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

*Diabetes Self-Management Training for the Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.



### ***Benefits for Physical Medicine Services***

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

### ***Benefits for Chiropractic Services***

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage.

However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In- Network or Out-of-Network Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

## **BEHAVIORAL HEALTH SERVICES**

### ***Benefits for Behavioral Health Care and Treatment of Substance Use Disorder***

Benefits for Eligible Expenses incurred for the treatment of Behavioral Health Care and treatment of Substance Use Disorder are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Behavioral Health Care provided as part of the Medically Necessary treatment of Substance Use Disorder will be considered for benefit purposes to be treatment of Substance Use Disorder until completion of the series of Substance Use Disorder treatments. (Behavioral Health Care treatment after completion of a series of Substance Use Disorder treatments will be considered Behavioral Health Care.)

Medically Necessary treatment of Substance Use Disorder and/or Behavioral Health Care in a Partial Hospitalization Treatment Program, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan and any Deductible as shown on your Schedule of Coverage will apply. Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Behavioral Health Care.

Intensive outpatient program means a freestanding or hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specializes in the treatment of co-occurring mental illness and Substance Use Disorder. with drug addiction, substance abuse or alcoholism. These programs Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions that are unlikely to benefit from treatment programs that focus solely on mental illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting

recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

All inpatient benefits used, including Hospital days and Physician/Behavioral Health Practitioner/Professional Other Provider visits, whether In-Network or Out-of-Network, apply to inpatient days or visits shown on your Schedule of Coverage under each level of benefits.

All outpatient Physician, Behavioral Health Practitioner and/or Professional Other Provider and other outpatient visit benefits used, whether In-Network or Out-of-Network, apply to outpatient visits shown on your Schedule of Coverage under each level of benefits.

# Medical Limitations and Exclusions

1. Any services or supplies which are not medically necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any experimental/investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the allowable amount as determined by Blue Cross and Blue Shield of Texas.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
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, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
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 the participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
  - As a result of war, declared or undeclared, or any act of war; or
  - While on active or reserve 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; or for completion of any insurance forms; or 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 and nutritional services, except as may be provided under UT CONNECT for preventive care services, or an inpatient nutritional assessment program provided in and by a hospital and approved by Blue Cross and Blue Shield of Texas, or benefits for treatment of diabetes as described in this Benefits Booklet.
13. Any services or supplies provided for custodial care, long term care, respite care (except as specifically mentioned under the hospice care program) and maintenance care.
14. Any services or supplies related the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions is subject to medical necessity.
15. Any services or supplies incurred for dental care and treatments, dental surgery, or dental appliances, except as provided under dental services and covered oral surgery in this Benefits Booklet.
16. Any services or supplies provided for cosmetic, reconstructive, or plastic surgery, except as provided for in this Benefits Booklet.
17. Any services or supplies provided for the correction of vision deficiencies, including, but not limited to, radial keratotomy, eye refraction, photo reflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in benefits for eyeglasses and vision services.
18. Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.
19. Any services or supplies provided for any medical social services (except as provided as an extended care expense), bereavement counseling (except as provided under hospice care), and vocational counseling.
20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a physician or other professional provider.
22. Any services or supplies provided primarily for environmental sensitivity; clinical ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or inpatient allergy testing or treatment.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
  - Sterilization reversal (male or female);
  - In vitro fertilization; and
  - 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 stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
25. Abortion, unless the participant's life would be endangered by continuing the pregnancy, there is a diagnosed fetal anomaly, or the pregnancy is caused by a criminal act such as rape or incest.
26. Any services or supplies in connection with:
  - Routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease, or
  - Foot care for flat feet, fallen arches, and chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Any services or supplies provided for the following treatment modalities:
  - Acupuncture;
  - Intersegmental traction;
  - Surface EMGs;
  - Spinal manipulation under anesthesia; and
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
29. Benefits for any covered services or supplies furnished by a contracting facility for which such facility has not been specifically approved to furnish under a written contract or agreement with Blue Cross and Blue Shield of Texas will be paid at the non-network benefit level.
30. 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.
31. Any services or supplies provided for reduction mammoplasty, except when medically necessary.
32. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages available for purchase over-the-counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. **Note:** This exclusion does not apply to podiatric appliances when provided as diabetic equipment.
33. Any benefits in excess of specified benefits maximums.
34. Any services and supplies provided to a participant incurred outside the United States if the participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
35. Replacement prosthetic appliances except those necessitated by growth due to maturity of the participant.
36. Inpatient private duty nursing services.
37. Outpatient drugs except as provided under the plan by the prescription drug program.
38. Outpatient contraceptive services, drugs and devices, except for contraceptive prescription drugs provided under the Prescription Drug Program portion of this plan.

39. 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.
40. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except: when medically necessary for the treatment of morbid obesity; or, when provided under preventive care for healthy diet/intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
41. The use of the procedures, supplies, or medications for treatment of psychological/psychogenic male sexual or erectile dysfunction/impotence.
42. Over-the-counter contraceptives.
43. Non-covered Durable Medical Equipment includes, but is not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
44. Services or supplies used primarily for patient convenience.
45. Most supplies available for purchase over the counter without a doctor's prescription.
46. Any tobacco cessation prescription drug products including, but not limited to, nicotine gum and nicotine patches, except as may be provided under the prescription drug program.
47. Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient.
48. Investigational services and supplies and all related services and supplies, except for routine patient care costs associated with investigational cancer treatment if those services or supplies would otherwise be covered under UT CONNECT. Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.
49. Long-term care service, respite care service (except as specifically mentioned under hospice care), and maintenance care.

# Prescription Drug Benefits

Your prescription drug benefits under UT CONNECT are administered by Express Scripts and require a \$100 annual deductible per plan participant, per plan year.

UT CONNECT Prescription Drug Benefits			
Annual Deductible (does not apply to medical plan annual deductible)	\$100/person/year*		
ACCESS OPTIONS	GENERIC DRUG COPAYMENT	PREFERRED DRUG COPAYMENT	NON-PREFERRED DRUG COPAYMENT
Retail Network Pharmacy: <ul style="list-style-type: none"> <li>Up to a 31-day supply</li> <li>Refills allowed as prescribed</li> <li>Good option for new prescriptions</li> </ul>	\$10	\$35	\$50
90-Day Day retail network at Walgreens or UT Pharmacy or Express Scripts Home Delivery: <ul style="list-style-type: none"> <li>Up to a 90-day supply</li> <li>Refills allowed as prescribed</li> <li>Best option for maintenance medication</li> </ul>	\$20	\$87.50	\$125

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

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

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

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

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

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

Cost of Brand Name Drug	\$150
Less Cost of Generic Equivalent	- \$55
Plus Cost of Generic Copayment	+ \$10
<b>YOUR PAYMENT</b>	<b>\$105</b>

The UT CONNECT Prescription Drug Plan allows you to utilize both the retail pharmacies and the mail order pharmacy. Most retail pharmacies participate in the nation-wide retail pharmacy network. If you fill a prescription at a non-network pharmacy, you will pay the full cost of your prescription and send a claim form and your receipt to Express Scripts. Your reimbursement will be based on your total cost, minus the UT System discount, the applicable annual deductible and copayment. You will be responsible for payment of any amount above the UT System contracted rate.

**If your retail pharmacy offers a price that is less than your plan's retail copayment, you will always pay the lesser amount.** Certain retail pharmacies that participate in Express Scripts' network offer a low, "usual and customary" price for some medications. You will pay either this price or your plan's retail copayment, whichever is less.

**You should still use your Express Scripts prescription drug ID card if you fill a prescription in a pharmacy that has a generic promotion program.** If you're purchasing a generic drug at retail pharmacy that has a generic promotion program, please present your prescription drug ID card to the pharmacist. Otherwise, we will not be able to check your prescription for potential interactions with your other medications. It also ensures that your payment will be applied to your plan's deductible or out-of-pocket maximum (if applicable).

**The best thing you can do is research your options.** Prices vary by retail store. **My Rx Choices** (available at [www.express-scripts.com](http://www.express-scripts.com)) can help you find out whether any of the medications that you're taking are on a generic program list. If they are on the list, review your plan's copayments and see whether you could save even more money.

## SMART90 RETAIL PRESCRIPTIONS

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

## PATIENT ASSURANCE PROGRAM

The Patient Assurance Programs provides UT members filling prescriptions for preferred program diabetic medications, including insulin, will pay no more than \$25 copay per 30-day supply; \$50 for 60 days, or \$75 for 90 days.

## DIABETIC SUPPLIES

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

## MY Rx CHOICES

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

- View a single presentation of medications with potential savings; Comparison-shop for available lower-cost alternatives;
  - Use the "Continue" option to have Express Scripts contact physicians on members' behalf to request approval for
  - equivalent conversions received through mail; and
  - Review options with your doctor and request prescriptions for lower-cost alternatives.
- Accessed via the web ([www.express-scripts.com/ut](http://www.express-scripts.com/ut)), via the new Express Scripts app or through the toll-free service line (1-800-818-0155), My Rx Choices features include
- Personal assessment of cost-saving opportunities;
  - Best-value alternatives based upon greatest cost savings to you presented in order from highest value to you; The most accurate, actionable drug pricing information available in the industry today;
  - Brand-to-generic and retail-to-mail comparison options,
  - Refill or renew prescriptions filled at the mail order pharmacy;
  - Get the order status of your prescription filled at the mail order pharmacy; Locate a pharmacy that is in your retail pharmacy network;
  - Easily transfer your retail prescriptions to the mail order pharmacy; See your full prescription history (going back up to 24 months) and Drug information.

## WORRY-FREE FILLS

Express Scripts has created the Worry-free Fills™ (WFF) program, so your prescriptions can be refilled automatically. If you elect to utilize WFF for your eligible prescriptions, there's no need to call or order your refills. As you near the end of your current supply, Express Scripts will automatically send your next refill using your existing address and payment information. To enroll in WFF, visit [Express-Scripts.com/ut](http://Express-Scripts.com/ut), or call Member Services at (800) 818-0155.

**Note:** For safety and other reasons, prescriptions for some medications are not eligible to be automatically filled. These prescriptions include specialty medications and controlled substances. When a prescription expires, you will need to get a new one and re-enroll that prescription in Worry-free Fills; the new prescription or a renewal of the earlier prescription will not be enrolled automatically.



## GAPS IN CARE ALERTS

Gaps in care, such as poor patient adherence with essential medication instruction have been associated with poorer clinical outcomes and higher total costs. Express Scripts now offers a new online safety feature that could help protect you and your family from gaps in care. It's already available at no cost to you as part of your UT CONNECT plan.

It's easy to use and works whether you get your medications at a retail pharmacy or by mail from the Express Scripts Pharmacy<sup>®</sup>. If you wish to access the Gaps in Care feature, register at [www.express-scripts.com/ut](http://www.express-scripts.com/ut).

After your one-time registration, any alerts will automatically be waiting for you whenever you log in to [Express-Scripts.com/ut](http://Express-Scripts.com/ut). These personalized alerts identify potential risks and enable you to respond quickly, which could help participants avoid unnecessary hospitalization, and prevent health setbacks to your health, staying on track with taking your medications as prescribed.

Alerts are based on established medical and scientific guidelines designed to help promote better health.

## MANUFACTURERS' COUPONS

Brand-name drugs often cost more than generic medications. And so, the brand manufacturers often use coupons to sway you into getting the more expensive product. If you decide to get a brand because you have a coupon from the manufacturer, then yes, you'll pay less for it, but the UT CONNECT plan will continue to pay the same high share of the drug's cost. That can quickly add up to thousands of dollars—possibly resulting in higher health care premiums or copayments in the future.

Certain retail pharmacies do accept manufacturers' coupons. UT System does not encourage coupon use, however, because it could lead to higher costs for you later. Coupons are not accepted through the mail order benefit, although you may be able to send your coupon to the manufacturer for a rebate or partial rebate after the fact, if the manufacturer allows it. If you have such a coupon, please review the information on it or on the manufacturer's website for instructions on requesting a rebate. These coupon offers are not available for patients enrolled in Medicare, Medicaid, or other federal programs, or where prohibited by law.

Ultimately, you and the UT CONNECT medical plan save the most when you fill prescriptions with generic drugs whenever possible. If a generic isn't available, consider using a Preferred brand-name drug that's less expensive. Visit [My Rx Choices<sup>®</sup>](#) to find potential lower-cost alternatives under your plan, and ask your doctor which alternative would be right for you. For medications you need to treat an ongoing condition, such as high blood pressure or high cholesterol, you'll typically pay even less by using your mail-order service, the [Express Scripts Pharmacy<sup>SM</sup>](#). All alternative options are available through [My Rx Choices<sup>®</sup>](#).

# Prescription Limitations

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

## PROGRAMS WITH LIMITATIONS INCLUDE:

**Prior Authorization:** Prior Authorization is a process requiring physician review to obtain additional clinical information for select drugs to determine qualification of coverage under the UT CONNECT Plan. To initiate a prior authorization, please contact Express Scripts. Your doctor can also contact Express Scripts directly through the Physician Prior Authorization process.

**Step Therapy:** Coverage under the Step Therapy Program may require that you try a generic drug or lower-cost brand-name alternative drug before using higher cost non-preferred drugs.

**Quantity Per Dispensing Event:** A medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period or per prescription.

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

If you submit a prescription for a drug that is subject to any of the above limitations, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Express Scripts Pharmacy<sup>SM</sup>, your doctor will be contacted directly. When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. Express Scripts will notify you and your doctor in writing of the decision. If coverage is approved, the amount of time for which coverage is valid will be communicated to you. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal. For additional information on the appeals process, please see the claims and appeals information in this document.

## WHAT'S NOT COVERED?

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

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

Note that these and certain other items may be covered under the medical portion of the UT CONNECT plan.

## Preventive Medications

The UT CONNECT Prescription Drug plan covers the following medications at a \$0 copayment when they are used for prevention as noted. To receive these medications at a \$0 copayment, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy.

- Aspirin – Generic Over-the-Counter (OTC) product for adults under 70 years of age for cardiovascular protection
- Statins – low to moderate dose generic statins for prevention of cardiovascular disease for adults >40 and < 75 years of age.
- Folic Acid – Over-the-Counter doses of 400 to 800 mcg/day for adults under the age of 51 who are pregnant or who are planning to become pregnant
- Fluoride – a prescription product for children age 6 months to 16 years to prevent dental cavities
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be administered at a network retail pharmacy if available. The cost of the vaccine is covered under the UT CONNECT pharmacy plan. See the summary of the medical plan for more details on vaccines administered in the doctor's office.
- Prescription and OTC Bowel Prep generic medications for colonoscopy for men and women age 49-76
- Tobacco Cessation Products for adults 18 and over
  - Nicotrol NS
  - Nicotrol Inhaler
  - Zyban
  - Chantix
  - Nicorette Gum/Lozenge
  - Nicotine Transdermal System
- Breast cancer prevention therapy with Tamoxifen, Raloxifene, Soltamox for adults 35 and over at high risk with copay review approval. Beginning 1/1/2021 this will include generic anastrozole and generic exemestane in addition to the other available products.
- HIV pre-exposure prophylaxis will be covered for emtricitabine/tenofovir disoproxil fumarate 200mg/300mg for persons at high risk of HIV acquisition.
- Contraceptives for individuals through the age of 50
- Prescription FDA-approved contraceptive agents (includes prescription IUDs—Mirena, Depo-Provera, patches, and oral agents)
- Emergency contraceptives (Plan B and Ella)
- OTC contraceptive devices and medications

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

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

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

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

## Specialty Pharmacy

### SPECIALTY DRUGS

Specialty drugs are medications that are typically high in cost and have one or more of the following characteristics:

- Complex therapy for complex disease
- Specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage
- Difficult to administer and may cause adverse reactions
- May have restrictions as determined by the US Food and Drug Administration
- Potential for significant waste due to the high cost of the drug

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.



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

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

### ACCREDO PHARMACY

Express Scripts provides specialty pharmacy services for patients with certain complex and chronic conditions through its wholly owned subsidiary, Accredo Health Group, Inc. (Accredo), with locations throughout the United States.

Accredo offers comprehensive therapy management solutions, including:

- Reimbursement services to review the patient's coverage and coordinate payment from the health plan and/or patient, as appropriate
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact
- Clinical services to assist the patient—under the supervision of his/her physician—in implementing the prescribed course of treatment
- Compliance programs to promote patient persistency and help the patient improve his/her quality of life
- Toll-free access to National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of your medications at no additional charge
- Registered nurses available for in-home medication administration, when clinically appropriate and as your plan allows
- Necessary supplies, such as needles and syringes, provided with your medications
- Refill reminder calls

Accredo is a specialty pharmacy program offered by Express Scripts, an independent company, that contracts directly with the University of Texas System to administer the prescription drug program for the University of Texas System.

Express Scripts does not offer Blue products or services and is solely responsible for the products and services that it provides.

## SaveOn SP

The plan is implementing a specialty pharmacy co-pay assistance program:

- Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum or deductible. A list of the program drugs can be found at [www.saveonsp.com/uts](http://www.saveonsp.com/uts).
- Although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum or deductible, the copay of the Program drugs will be reimbursed by the manufacturer with no financial responsibility for the participant.

# Prescription Drug Claims and Appeals

## INITIAL REVIEW

### *Non-Urgent Claims (Pre-Service and Post-Service)*

If you submit a prescription for a drug that is subject to any limitations such as prior authorization, step therapy, or quantity limitations, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use the Express Scripts Pharmacy<sup>SM</sup>, your doctor will be contacted directly. Express Scripts will need the following information:

- Your name benefit ID phone number
- The prescription drug for which benefit coverage has been denied
- The diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and
- Any additional information that may be relevant to your appeal.

You will be notified of the decision no later than 15 days after receipt of a pre-service claim that is not an urgent care claim if Express Scripts has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, if all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If Express Scripts does not have the necessary information needed to complete the review, Express Scripts will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

### *Urgent Claims (Expedited Reviews)*

In the case of an urgent care claim, the plan will notify you of its decision as soon as possible, but no later than 72 hours after receipt of the claim, unless there is insufficient information to decide the claim. If further information is needed, the plan will notify you within 24 hours of receipt of your claim that further information is needed and that you have 48 hours to submit the additional information. Additional information must be submitted within 48 hours of request. The plan will then notify you of its decision within 48 hours of receipt of the information. If the missing information is not received within the 48 hours for you to submit the missing information, the claim is deemed denied and you have the right to appeal the claim.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. Appeal of Adverse Benefit Determination

## APPEAL OF ADVERSE BENEFIT DETERMINATION

### *Non-Urgent Appeal*

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- Your name benefit ID phone number
- The prescription drug for which benefit coverage has been denied
- The diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and
- Any additional information that may be relevant to your appeal.

**This information should be mailed to:**

**Express Scripts, Inc.,  
P.O. Box 66588,  
St. Louis, MO 63166-6588**

**Attn: Appeals**

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre- service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. Additional assistance and notices are available in Spanish, Tagalog, Chinese, and Navajo by calling 1-800-818-0155.

If you are not satisfied with the coverage decision made on appeal, you may request a second level appeal. All second level appeals must be made in writing and be received by Express Scripts within 90 days of the receipt of notice of the decision. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- Your name benefit ID phone number
- The prescription drug for which benefit coverage has been denied
- The diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and
- Any additional information that may be relevant to your appeal.

**This information should be mailed to:**

**Express Scripts, Inc.,  
P.O. Box 66588,  
St. Louis, MO 63166-6588**

**Attn: Appeals**

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre- service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your “final adverse benefit determination”) you also have the right to submit your claim for review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

### ***Urgent Appeal (Expedited Review)***

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call 800-935-6103 or send a written request to: Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588, Attn: Appeals. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

## **INDEPENDENT EXTERNAL REVIEW**

### ***External Appeals Review***

Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, Express Scripts must receive your external review request within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: Express Scripts Attn: External Review Requests P.O. Box 66588, St. Louis, MO 63166-65887. Phone: 800-753-2851 Fax: 888-235-8551

### ***Non-Urgent External Review***

Once you have submitted your external review request, the Plan will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, your determination letter will contain contact information for applicable office of health insurance consumer assistance or ombudsman.

### ***Urgent External Review***

Once you have submitted your urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, your determination letter will contain contact information for applicable office of health insurance consumer assistance or ombudsman.



# Definitions

*The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.*

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

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

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

- **For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- **For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with the Claim Administrator in Texas** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- **For multiple surgeries** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.
- **For procedures, services, or supplies provided to Medicare recipients** – The Allowable Amount will not exceed Medicare's limiting charge.

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

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

- The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by the Claim Administrator, 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, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:
  - Individual, group, family, or conjoint psychotherapy,
  - Counseling,
  - Psychoanalysis,
  - Psychological testing and assessment,
  - The administration or monitoring of psychotropic drugs, or
  - Hospital visits or consultations in a facility listed in subsection 5, below;
  - Electroconvulsive treatment;
- Psychotropic drugs;
- Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

**Behavioral Health Practitioner** means a Physician or Professional Other Provider who renders services for Behavioral Health Care, Serious Mental Illness or Substance Use Disorder, only as listed in this Benefit Booklet.

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

**Care Coordination** means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

**Care Coordinator Fee** means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

**Certain Diagnostic Procedures** means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

**Substance Use Disorder** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

**Substance Use Disorder Treatment Center** means a facility which provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed as a substance use disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- Licensed, certified, or approved as a substance use disorder treatment program or center by any other state agency having 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.

**Claim Administrator** means Blue Cross and Blue Shield of Texas. BCBSTX, as part of its duties as Claim 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 kills 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); or
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

**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 acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- 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.

**Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claim Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

**Cosmetic, Reconstructive, or Plastic Surgery** means surgery that:

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

**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 Behavioral Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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

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

**Dependent** means your spouse as defined by applicable law, or any child covered under the Plan who is:

- Under the limiting age shown on your Schedule of Coverage;
- A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the Dependent limiting age).

*Child* means:

- Your natural child; or
- Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- Your stepchild; or
- Your foster child; or
- A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or
- A child not listed above:
  - whose primary residence is your household; and
  - to whom you are legal guardian or related by blood or marriage; and
  - who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

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

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

**Effective Date** means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

**Eligibility Date** means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the WHO GETS BENEFITS section of this Benefit Booklet.

**Eligible Expenses** mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

**Emergency Care** means health care services provided in a Hospital emergency facility (emergency room) 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 layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

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

**Employee** means a person who:

- Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
- Works a specified number of hours per week or month as required by the Employer; and
- Is recorded as an Employee on the payroll records of the Employer; and
- Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term Employee will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

**Employer** means the person, firm, or institution named on this Benefit Booklet.

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

- Controlled environment; or
- Sanitizing the surroundings, removal of toxic materials; or
- Use of special non-organic, non-repetitive diet techniques.

**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

*Approval* by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

*Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

**Extended Care Expenses** means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the Extended Care Expenses portion of this Benefit Booklet.

**Group Health Plan (GHP)** as applied to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

**Health Benefit Plan** means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

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

**Home Care Practitioner** means an Advanced Practice Nurse, Doctor of Medicine, doctor of Dentistry, Physician Assistant, doctor of Osteopathy, Doctor of Podiatry, or other licensed person prescription authority.

**Health Status Related Factor** means:

- Health status;
- Medical condition, including both physical and mental illness;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of family violence; and
- Disability.



**HIPAA** means the Health Insurance Portability and Accountability Act of 1996.

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

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

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

- 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; and
- Nursing services.

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

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

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

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

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

**Hospital** means a short-term acute care facility 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, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse; and
- Has in effect a Hospital Utilization Review Plan.

**Hospital Admission** means the period between the time of a Participant's entry into a Hospital or a Substance Use Disorder Treatment Center as a Bed patient and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. 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 by the Claim Administrator.

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

**Identification Card** means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

**Imaging Center** means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

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

**In-Network Benefits** means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claim Administrator.

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

- Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Provided by a Hospital or a Substance Use Disorder Treatment Center; and
- Furnished to and used by the Participant during an inpatient Hospital Admission.

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

- Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge is not an Eligible Expense.
- All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items are not an Eligible Expense.

Medically Necessary Behavioral Health Care or treatment of Serious Mental Illness in a Partial Hospitalization Treatment Program, a Crisis Stabilization Unit or Facility, Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

**Late Enrollee** means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

- The individual:
  - Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
  - Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
  - Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
    - Termination of employment;
    - Reduction in the number of hours of employment;
    - Termination of the other plan's coverage;
    - Termination of contributions toward the premium made by the Employer;
    - COBRA coverage has been exhausted;
    - Cessation of Dependent status;
    - The Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
    - In the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
  - Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
- The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
- A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
- A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
- A Dependent child is not a Late Enrollee if the child:
  - Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
  - The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
  - The child has lost coverage under Medicaid or CHIP; and
  - The request for enrollment is made not later than the 31st day after the date on which coverage under Medicaid or CHIP terminates.

**Marriage and Family Therapy** means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

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

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

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

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

- Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

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

- Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

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

**Medically Necessary or Medical Necessity** means those services or supplies covered under the Plan which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
- 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 medical staff of the Claim Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

**Negotiated National Account Arrangement** means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the Blue Cross Blue Shield Global Core Program.

**Network** means identified Physicians, Behavioral Health Practitioner, Professional Other 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 managed care arrangement.

**Network Provider** means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

**Non-Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

**Open Enrollment Period** means the 31-day period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

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

- **Facility Other Provider** – an institution or entity, only as listed:
  - Substance Use Disorder Treatment Center
  - Crisis Stabilization Unit or Facility
  - Durable Medical Equipment Provider
  - Home Health Agency
  - Home Infusion Therapy Provider
  - Hospice
  - Imaging Center
  - Independent Laboratory
  - Prosthetics/Orthotics Provider
  - Partial Hospitalization Treatment Program
  - Renal Dialysis Center
  - Residential Treatment Center for Children and Adolescents
  - Skilled Nursing Facility
  - Therapeutic Center
- **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
  - Advanced Practice Nurse
  - Doctor of Chiropractic
  - Doctor of Dentistry
  - Doctor of Optometry
  - Doctor of Podiatry
  - Doctor in Psychology
  - Licensed Acupuncturist
  - Licensed Audiologist
  - Licensed Chemical Dependency Counselor
  - Licensed Dietitian
  - Licensed Hearing Instrument Fitter and Dispenser
  - Licensed Marriage and Family Therapist
  - Licensed Clinical Social Worker
  - Licensed Occupational Therapist
  - Licensed Physical Therapist
  - Licensed Professional Counselor
  - Licensed Speech-Language Pathologist
  - Licensed Surgical Assistant
  - Nurse First Assistant
  - Physician Assistant
  - Psychological Associates who work under the supervision of a Doctor in Psychology

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

**Out-of-Network Benefits** means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

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

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

**Participant** means an Employee or Dependent whose coverage has become effective under this Plan.

**Partial Hospitalization Treatment Program:** A claim administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights

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

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

**Plan** means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

**Plan Administrator** means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

**Plan Anniversary Date** means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

**Plan Effective Date** means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

**Plan Month** means each succeeding calendar month period, beginning on the Plan Effective Date.

**Plan Service Area** means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

**Preauthorization** means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

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

- 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). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

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

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

**Provider Incentive** means an additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

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

**Residential Treatment Center:** A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

**Retail Health Clinic** means a participating Provider that has entered into a contractual agreement with BCBSTX to provide treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

**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;
- Schizo-affective disorders (bipolar or depressive); and
- Schizophrenia.

**Value-Based Program** means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

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

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

**Specialty Care Provider** means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

**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;
- A freestanding radiation therapy center; or
- A freestanding birthing centers.

**Waiting Period** means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.



# General Provisions

## AGENT

The Employer is not the agent of the Claim Administrator.

## AMENDMENTS

The Plan may be amended or changed at any time by agreement between TAC HEBP and the Claim Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

## 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, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

## CLAIMS LIABILITY

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

## DISCLOSURE AUTHORIZATION

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

## PARTICIPANT/PROVIDER RELATIONSHIP

The choice of a health care Provider should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care Provider. The Claim Administrator 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 sickness or injury treatment acceptable to the health care Provider.

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim Administrator 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.

## REFUND OF BENEFIT PAYMENTS

If the Claim Administrator pays benefits for Eligible Expenses incurred by you or your 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 Claim Administrator may deduct any refund due it from any future benefit payment.

## COORDINATION OF BENEFITS

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

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

### *Coordination of Benefits – Definitions*

- **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
  - Group or blanket insurance;
  - Franchise insurance that terminates upon cessation of employment;
  - Group hospital or medical service plans and other group prepayment coverage;
  - Any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
  - Governmental plans, or coverage required or provided by law.

**Plan** does *not* include:

- 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;
- A policy of health insurance that is individually underwritten and individually issued;
- School accident type coverage; or
- A state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

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.

- **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.
- **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan 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, This Plan 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.

- **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 Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- **We or Us** means Blue Cross and Blue Shield of Texas.

## 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.
- If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

### • Rules – This Plan determines its order of benefits using the first of the following rules which applies:

- **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:
  - secondary to the Plan covering the Participant as a Dependent and
  - 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 a Dependent.
- **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:
  - 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
  - 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.
- **Dependent Child/Parents Separated or Divorced.** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the Plan of the parent with custody of the child;
  - Then, the Plan of the spouse of the parent with custody, if applicable;
  - Finally, the Plan of the parent not having custody of the child.
  - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- **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 responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.
- **Active/Inactive Employee.** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee 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 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:
  - First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
  - Second, the benefits under the continuation coverage.
  - 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 f does not apply.
- **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 claim is made exceeds those Allowable Expenses in a Claim Determination Period.

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

When the benefits of This Plan are reduced as previously 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***

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We 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 us 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, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

## **SUBROGATION, REIMBURSEMENT AND THIRD-PARTY RECOVERY PROVISION**

### ***Subrogation***

If the plan pays or provides benefits for you or your dependents, the plan is subrogated to all rights of recovery which you or your dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the plan has paid or provided. That means the plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer. For the purposes of this provision, subrogation means the substitution of one person or entity (the plan) in the place of another (you or your dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

### ***Right of Reimbursement***

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

### ***Right to Recovery by Subrogation or Reimbursement***

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

## TERMINATION OF COVERAGE

### *Termination of Individual Coverage*

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

- Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
- You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
- The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
- A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See

**Continuation of Group Coverage – Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim 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 your Schedule of Coverage if the child continues to be both:

- *Disabled*, and
- Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

*Disabled* means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a Disabled Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

### *Termination of the Group*

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

## CONTINUATION OF GROUP COVERAGE – FEDERAL

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

### ***Minimum Size of Group***

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

### ***Loss of Coverage***

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

- Divorce from the covered Employee,
- Death of the covered Employee,
- The covered Employee becomes eligible for Medicare, or
- A covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

- The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
- The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
- The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
- The Group Health Plan is canceled.
- The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
- The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

### ***Extension of Coverage Period***

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

### ***Notice of COBRA Continuation Rights***

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.



# NOTICES



## UT CONNECT Medical Plan Opt Out of Certain Provisions of the Public Health Services (PHS) Act

Group health plans sponsored by State governmental employers, such as UT System must generally comply with certain requirements in title XXVII of the federal Public Health Services Act. However, the Act also permits State governmental employers that sponsor “self-funded” health plans (rather than provide coverage through a health insurance policy) to elect to exempt the self-funded plan from such requirements. UT System has elected to exempt the UT CONNECT Medical plan, which is self-funded, from the following requirements:

1. Standards related to benefits for mothers and newborns.
2. Parity in the application of certain limits to mental health benefits.
3. Required coverage for reconstructive surgery following mastectomies.
4. Coverage of dependent students on medically necessary leave of absence.

The exemption from these federal requirements will be in effect for the 2021-2022 plan year. The election may be renewed for subsequent plan years.

However, UT System currently voluntarily provides coverage that substantially complies with the requirements of the Newborn and Mother’s Protection Act and the WHCRA. Information about coverage available to newborns and mothers after delivery and coverage for reconstructive surgery can be found in the UT CONNECT Medical plan guide.

## HIPAA Privacy Notice

Title II of HIPAA requires self-funded health plans to comply with certain regulations concerning the privacy and security of personally identifiable health information that the plan collects or maintains about its enrollees. A copy of the privacy notice and policies that apply to UT CONNECT can be found on the **HIPAA and Privacy page** on the Office of Employee Benefits’ website, <http://www.utsystem.edu/offices/employee-benefits/hipaa-and-privacy>. A paper copy of the privacy notice is available to anyone upon request from OEB free of charge by calling 800-888-6824.

For more information, contact your institution Benefits Office.

## Patient Protection Disclosure

UT CONNECT generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UT CONNECT designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UT CONNECT at 888-372-3398 or <https://www.bcbstx.com/utconnect>.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from UT CONNECT or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact UT CONNECT at 888-372-3398 or <https://www.bcbstx.com/utconnect>.

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

## A. BLUECARD® PROGRAM

- Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.
- Whenever you access covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:
  - The billed covered charges for your covered services; or
  - The negotiated price that the Host Blue makes available to us.
- Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.
- Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.
- Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

## B. NEGOTIATED (NON-BLUECARD PROGRAM) NATIONAL ACCOUNT ARRANGEMENTS

- As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.
- The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

## C. NON-PARTICIPATING HEALTHCARE PROVIDERS OUTSIDE BCBSTX SERVICE AREA

- For non-participating healthcare providers outside our Plan Service Area please refer to the Allowable Amount definition in the **DEFINITIONS** section of this Benefit Booklet.

## D. VALUE-BASED PROGRAMS BLUECARD PROGRAM

- If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not bear any portion of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees of such arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Texas through average pricing or fee schedule incentive adjustments.
- Under the Agreement, Employer has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and Employer will not impose cost sharing for Care Coordinator Fees.

## E. BLUE CROSS BLUE SHIELD CORE PROGRAM

- If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the Blue Cross Blue Shield Core Program® when accessing Covered Services. The Blue Cross Blue Shield Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Core Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the Blue Cross Blue Shield Core Program service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.
- If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

### Inpatient Services

- In most cases, if you contact the Blue Cross Blue Shield Core Program Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Core Blue Shield Core Program Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact the Plan to obtain precertification for non-emergency inpatient services.

### Outpatient Services

- Outpatient Services are available for Emergency Care. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

### Submitting a BlueCard Worldwide Claim

- When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider’s itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan the BlueCard Worldwide Service Center or online at [www.bluecardworldwide.com](http://www.bluecardworldwide.com). If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

## Notice Regarding Professional Services

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided to you at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan.

# Continuation Rights Under COBRA

**NOTE:** Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

## INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**If you are an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

**If you are the spouse of an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced; Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

**Your dependent children** will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced; The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**If the Plan provides health care coverage to retired employees, the following applies:** Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

## WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

## YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

## HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

## DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

## SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

# Notice About Nondiscrimination and Accessibility Requirements

## DISCRIMINATION IS AGAINST THE LAW

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

### The UT System Office of Employee Benefits provides:

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

If you need these services, contact the UT System Office of Human Resources.

If you believe that the UT System Office of Employee Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The UT System Office of Human Resources, 210 W. 7th Street, Austin, Texas 78701, (512) 499-4587, (512) 499-4395, [esc@utsystem.edu](mailto:esc@utsystem.edu). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the UT Office of Human Resources is available to help you.

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

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

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

Complaint forms are available at [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).

## Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al

UT CONNECT Medical 1-888-399-8889

UT CONNECT Prescription Drug 1-800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

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UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539



## Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539 번으로 전화해 주십시오.

## Arabic

تظولم. ناچملا ب كل رفاوتنت قيوغلا قدعاسملا تامدخ ناف، عغلا ركذا تئحتت تنك اذا مقرب لصتا:

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UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Urdu

نیرک لاک - نیہ بایتسد نیم تقم تامدخ یک ددم یک نابز وک پآ وت، نیہ یتلوب ودر ا پآ رگا: رادریخ

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le

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UT CONNECT Prescription Drug 1- 800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Hindi

ध्यान दः यद आप हंद बोलते ह तो आपकेलए मु त म भाषा सहायता सेवाएं उपलब्ध ह।

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

पर कॉल कर।

## Persian (Farsi)

مهرف امش یارب ناگیار تروصب ینابز تالیهست، دینک یم وگننگ یسراف نابز هب رگا: هجوت اب. دشاب یم

UT CONNECT Medical 1-888-399-8889

UT CONNECT Prescription Drug 1- 800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

دیریگب سامت

## German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:

UT CONNECT Medical 1-888-399-8889

UT CONNECT Prescription Drug 1- 800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

## Gujarati

Gujarati: ધ્યાન આપો: જો તમે ગજરાતી ુ બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટ નિન:શલ્ક ુ ઉપલબ્ધ છે.

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UT CONNECT Prescription Drug 1- 800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

પર કોલ કરો

**Russian**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните

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UT CONNECT Prescription Drug 1- 800-818-0155

UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

**Japanese**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

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UT CONNECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)

UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

まで、お電話にてご連絡ください。

**Laotian**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າ ພາສາ ລາວ, ການ ນຳ ອິດກາງ ຊ່ວຍ ຄື ຫຼື ອ ດ ໂທ ສ

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UT CONNECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539



THE UNIVERSITY of TEXAS SYSTEM  
THIRTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

THE UNIVERSITY OF TEXAS SYSTEM  
OFFICE OF EMPLOYEE BENEFITS  
210 W. 7th STREET  
AUSTIN, TX 78701

## Claims Address

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

Customer Service

**888-399-8889**

24 hours/seven days a week\*

Online Provider Directory and Website

**[bcbstx.com/utconnect](http://bcbstx.com/utconnect)**

\* Customer service is available 24 hours/day, seven days/week, with the exception of BCBSTX observed holidays (New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the Day After, Christmas Day)

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