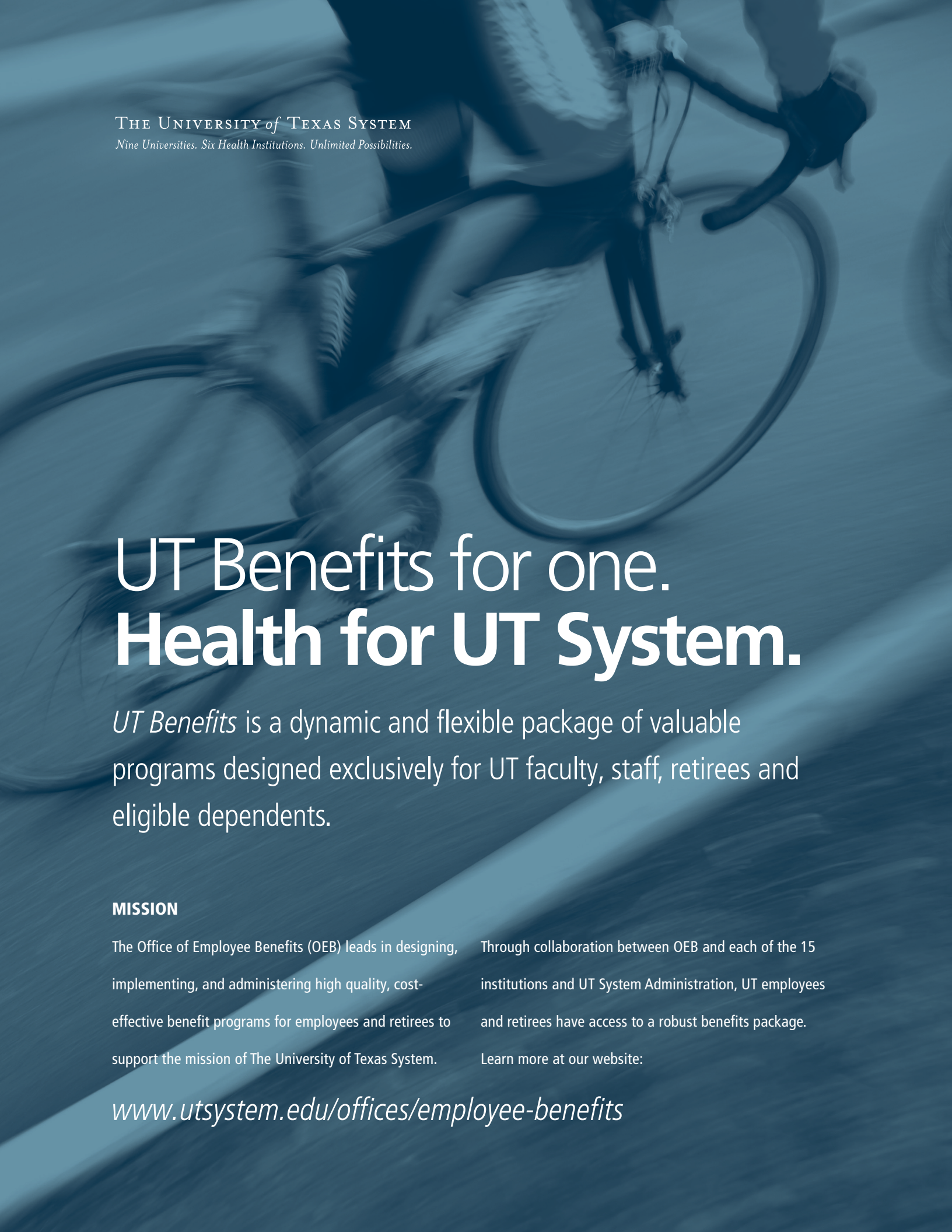
UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

Retired Employees

2014-2015 Benefits Handbook



THE UNIVERSITY of TEXAS SYSTEM

Nine Universities. Six Health Institutions. Unlimited Possibilities.

UT Benefits for one. **Health for UT System.**

UT Benefits is a dynamic and flexible package of valuable programs designed exclusively for UT faculty, staff, retirees and eligible dependents.

MISSION

The Office of Employee Benefits (OEB) leads in designing, implementing, and administering high quality, cost-effective benefit programs for employees and retirees to support the mission of The University of Texas System.

Through collaboration between OEB and each of the 15 institutions and UT System Administration, UT employees and retirees have access to a robust benefits package. Learn more at our website:

www.utsystem.edu/offices/employee-benefits

UT BENEFITS HANDBOOK

FOR RETIRED EMPLOYEES

SEPTEMBER 1, 2014 - AUGUST 31, 2015

Welcome

Your quality of life is very important to all of us at the UT System Office of Employee Benefits (OEB). That's why we're pleased to offer UT Benefits, a dynamic and flexible package of valuable programs. Through UT Benefits, you and your family have access to comprehensive health insurance, financial protection through life and disability insurance, a variety of tax-deferred and post-tax retirement savings options, and numerous resources to support your overall well-being.

Your UT Benefits Handbook for Retired Employees has been designed to help you understand all of the available options so that you can make the best possible benefits decisions for yourself and your family.

This handbook is provided as an overview of terms and conditions of the insurance, retirement and wellness programs for The University of Texas System. OEB maintains plan guides and the OEB Administrative Manual, which contain more detailed information. These publications can be found online at **www.utsystem.edu/offices/employee-benefits/forms-and-publications** or may be obtained by request from your institution's Benefits Office. Please consult the plan guides and your institution Benefits Office for specific benefit information. Contact information for your institution Benefits Office is located in the back of this handbook.

The University of Texas System reserves the right to amend, change or terminate the health and welfare benefit plans, any underlying contracts or any other programs, at any time and without notice, at its sole discretion, according to the terms of the applicable plans or programs.

Effective September 1, 2014 this Booklet supersedes all previous editions. The University of Texas System reserves the right to interpret the provisions of the Booklet and to amend any provisions thereof. The controlling document is the version found online at: www.utsystem.edu/offices/employee-benefits/forms-and-publications. If there is any ambiguity or inconsistency between a printed copy of the document and the online version, the terms of the online document shall control. However, to the extent that any provision in this booklet conflicts with applicable law, the applicable law shall control. You may request a printed copy of the latest edition at any time.

If you are an active employee, please see the UT Benefits Handbook for Employees.

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☐ **Review plan information in this handbook**

☐ **Review the Legal Notices Section of this handbook including:**
- ☐ Uniform Summary of Benefits and Coverage
- ☐ UT SELECT Medical Plan Opt Out of Certain Provisions of the Public Health Services (PHS) Act
- ☐ Medicare Part D Notice of Creditable Coverage
- ☐ COBRA
- ☐ Genetic Information Non-Discrimination (GINA)
- ☐ HIPAA Notice of Privacy Practices
- ☐ CHIPRA – I**f you or your dependents are eligible to enroll in Medicaid or CHIP** (page 34)

☐ **View information on the Office of Employee Benefits (OEB) website. Contact your institution's Benefits Office, the plan vendor, or OEB with questions**

☐ **Enroll or make changes by contacting your institution's Benefits Office**

☐ **Complete evidence of insurability (EOI) if necessary**

☐ **Submit dependent documentation if necessary**

☐ **Keep a copy of your enrollment confirmation statement to be sure your coverage is correct, or review in *My UT Benefits***

☐ **Add, update, or confirm beneficiary information for life insurance**

☐ **Look for new ID cards within two weeks of your effective date if you have enrolled in new coverage or made changes to existing coverage**

☐ **Register for online resources – see vendor information at the back of this handbook**

☐ **Update contact information if it changes by contacting the benefits office at the institution from which you retired**

☐ **Enroll in Medicare Parts A and B when you become eligible as a non-working Retired Employee (See more in the UT SELECT Medical Section of this handbook).**

Group Insurance Benefits

ELIGIBILITY AND ENROLLMENT

Eligibility

Retired Employees

1. An individual who was employed at a UT System institution in a benefits-eligible position on August 31, 2003, and subsequently retires from the System is eligible for benefits as a retired employee if:

(a) The individual meets the Rule of 80 (total of age plus years of creditable state service equals or exceeds 80), or the individual is at least age 55 with five (5) years of creditable state service; and

(b) The individual has at least three (3) years of service with the System for which the individual was eligible to participate in the Program; and

(c) The individual's last place of state employment before retirement was with a System institution; and

(d) The individual retires from System under the jurisdiction of the Teacher Retirement System of Texas (TRS); the Employees Retirement System of Texas (ERS); or the Optional Retirement Program (ORP) established by Chapter 830, Government Code or any other federal or state statutory retirement program to which the System has made employer contributions.

2. An individual whose first date of employment at a UT System institution in a benefits-eligible position was on or after September 1, 2003 is eligible for benefits as a retired employee if:

(a) The individual meets the Rule of 80 (total of age plus years of state service credit equals or exceeds 80) with at least ten (10) years of creditable state service, or is at least age 65 with ten (10) years of total state service credit; and

(b) The individual has at least ten (10) years of service with the System; and

(c) The individual's last state employment before retirement was with an institution of the System; and

(d) The individual retires under the jurisdiction of the Teacher Retirement System of Texas (TRS); the Employees Retirement System of Texas (ERS); or the Optional Retirement Program (ORP) established by Chapter 830, Government Code or any other federal or state statutory retirement program to which the System has made employer contributions.

Individuals, regardless of age and years of service credit, who worked in a benefits-eligible position with UT and are members of the Teacher Retirement System of Texas (TRS) and qualify for disability retirement may also qualify to participate in the UT Benefits program. Individuals who are participants in the Optional Retirement Program (ORP) may also qualify for disability retirement.

The criteria above cover most, but not all, of the situations under which someone is eligible for retired employee benefits. For more information about retired employee benefits eligibility, refer to the Office of Employee Benefits Administrative Manual, Policy 220 on the OEB website.

Dependents

You may enroll your eligible dependents for certain UT Benefits coverage.

Eligibility to participate in certain UT Benefits coverage as a dependent is determined by law. Because of changes made by the federal Affordable Care Act (ACA), your children (including stepchildren and adopted children) are eligible for the UT SELECT Medical plan, regardless of marital status, until they reach the age of 26. Eligibility of dependents who do not qualify as your spouse or child (such as eligible grandchildren), ends at age 25 for all UT Benefits coverage, including the UT SELECT Medical plan. Eligible dependents are:

- Your spouse, as defined by Texas Family Code;
- Your children, including stepchildren and adopted children, who are:
  - under age 26 regardless of marital status for the UT SELECT Medical plan,
  - unmarried and under age 25 for other UT Benefits (Dental, Vision, Life);
- Your unmarried grandchild(ren) under age 25, provided the child meets the requirements which includes proof that you claim the child as your dependent for federal tax purposes;
- Certain children over age 25 (over age 26 for the UT SELECT Medical plan), who are determined by OEB to be medically incapacitated and are unable to provide their own support; and

- Children for whom you are named a legal guardian by a court or who are the subject of a medical support order requiring such coverage.

Examples of dependents that are not eligible for *UT Benefits* include:

- your former spouse;
- your married child (for coverage other than UT SELECT Medical);
- your child over age 25 (age 26 for UT SELECT Medical), if not medically incapacitated and unable to provide their own support;
- your grandchild, if they are married or over age 25;
- foster children covered by another government program, unless coverage is required by law or court order;
- any dependent insured by another UT employee or retired employee;
- any dependent insured by another plan that receives State of Texas premium contributions; or
- any dependent who is on active duty in the armed forces of any country (for coverage other than UT SELECT Medical).

Surviving Dependent Benefits

The surviving spouse or other benefits-eligible dependent of an employee or retired employee who, on the date of the employee's death, had at least five (5) years of Teacher Retirement System of Texas (TRS) or Texas Optional Retirement Program (ORP) creditable service, including at least three (3) years with UT as a benefits-eligible employee at the time of death, is eligible for benefits as a surviving dependent if the dependent had been participating in UT Benefits at the time of the employee or retired employee's death.

A surviving spouse may continue *UT Benefits* coverage for the remainder of the surviving spouse's life. A dependent child may continue until the child loses his or her status as a dependent child. The dependent of an individual who has not met the service requirements at the time of death may elect COBRA coverage for a period not to exceed 36 months.

Dependent Documentation

UT requires supporting documentation when you request to add a dependent to your plan. Be prepared to provide proof of eligibility such as your marriage certificate, your child(ren)'s birth certificates, appropriate adoption paperwork, federal tax forms or other documents that support the dependent relationship. For medically incapacitated dependents, proof of the incapacitating condition and dependency must be submitted within 31 days of initial eligibility for enrollment of an incapacitated dependent. This paperwork is required not only to support the coverage of eligible dependents but also to support a mid-year change of status such as marriage or birth of a child.

During Annual Enrollment, completed dependent documentation must be submitted electronically by August 15. If you've added a dependent and you are not able to complete electronic dependent documentation, you may submit the documentation to your local HR/Benefits office by the same deadline of August 15.

Misrepresentation of benefit eligibility requirements constitutes a violation of OEB's official policy. A verified misrepresentation by an employee or retired employee shall be reported by OEB to the appropriate institution for investigation and possible sanctions. Possible sanctions for such a violation range from a reprimand to dismissal. In addition, reimbursement may be required for any benefits paid to an ineligible individual. Deliberate misrepresentation of dependent eligibility by an employee or retired employee may constitute criminal fraud and may result in a referral to a law enforcement office. Any ineligible dependent may be terminated from plan participation upon discovery of ineligibility.

Enrollment

Initial Period of Eligibility for Retired Employees

An individual must enroll in the program as a retired employee within **31 days** of the date upon which the individual retires. An individual who fails to enroll within the 31 day period may not enroll until:

(a) the next Annual Enrollment period; or

(b) the occurrence of a qualified change of status event.

You may enroll in or make changes to benefits during your initial period of eligibility through your institution's Benefits Office.

Waiting Period for Retired Employees

An Employee who terminates employment without retiring and later applies for Retired Employee insurance will not be eligible to participate in UT SELECT Health coverage until the first day of the calendar month that begins after the 90th day after the date the individual retires. There is no waiting period for enrollment in optional coverages which are paid in full by the Retired Employee.

Annual Enrollment

Annual enrollment is the period of time during which you may make changes to benefit elections for you and your eligible dependents. Outside of annual enrollment, you may only make changes if you have a qualified change of status event. UT System holds annual enrollment each summer, usually during the month of July. Prior to Annual Enrollment, you will receive a letter or email titled "Your UT Benefit Enrollment Options" that lists your current coverage and future coverage options and informs you if any action is required on your part. During this

time you may change your group insurance benefit elections and add, update or remove dependents from coverage using the *My UT Benefits* online system.

Your Annual Enrollment elections become effective each September 1st after the annual enrollment period. If a coverage requires EOI, and EOI is not approved by September 1, that coverage will be effective on the EOI approval date (Voluntary Life Insurance) or the first of the month following the approval date (all other coverage). If EOI is denied, the change in coverage will not take effect. If dependent documentation is not received or approved, the dependent's coverage will not take effect

Change of Status

You have **31 days** from the date of a qualified change of status event to notify your institution Benefits Office and complete changes to your benefits that are consistent with that event. If you do not make your eligible changes during the 31-day status change period, your changes cannot be made until the next Annual Enrollment in July, to be effective the following September 1.

The list below includes common examples of qualified change of status events:

- marriage, divorce, annulment, 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;
- change of job status affecting eligibility;
- change in dependent's eligibility (e.g., reaching age 26 for UT SELECT Medical, marriage or reaching age 25 for all coverage other than UT SELECT Medical, or gaining or losing eligibility for any other reason); or
- significant change in coverage or cost of other benefit plans available to you and your family.

A retired employee

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

may enroll this dependent in the basic coverage under UT Benefits, as long as the dependent meets all other UT eligibility requirements and is enrolled within 60 days from the date of the applicable event. If enrollment of the dependent is conditioned on enrollment of the retired employee, the retired employee will also be eligible to enroll.

Note: EOI and dependent documentation may be required for some benefit changes following a qualified change of status event.

You may enroll in or make changes to benefits within the required time frame through your institution HR/Benefits office.

Evidence of Insurability (EOI)

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

Increase, add, or reinstate retired employee or spouse voluntary group life insurance coverage;

Add long term care coverage for yourself or family member enrollment in long-term care coverage.

During Annual Enrollment, completed EOI must be submitted electronically by August 15. If you are not able to complete electronic EOI, the form may be printed and mailed by the deadline to the insurance company for review.

During the initial period of eligibility or following a change of status, EOI must be submitted within 31 days of the change event date. Coverage subject to EOI will become effective on the EOI approval date (Voluntary Life Insurance) or the first of the month following the approval date (all other coverage). If EOI is denied, the change in coverage will not take effect.

Beneficiary Information

It is important to designate beneficiaries for all of your insurance and retirement accounts that require them. If you don't, state laws may cause death benefits to be distributed differently than you had planned, may result in additional taxes, and may unnecessarily delay the process of finalizing payment to your loved ones. You should regularly review and, if necessary, update your beneficiary designations.

For your UT Benefits group term life insurance (which you receive even if you only have the basic coverage), you can review your beneficiary information and make updates any time online by accessing the Dearborn National Online Beneficiary Management system through *My UT Benefits* at **www.utsystem.edu/myutbenefits**. If you have not completed a beneficiary designation or you need to revise your designation, you should complete or update your designation as soon as possible. If you have questions or are unable to access the online system, please contact Dearborn National Customer Service at (866) 628-2606 (available Monday through Friday from 7 a.m. to 7 p.m. central time) for assistance.

If you are a member of the Teachers Retirement System (TRS), you should download the TRS beneficiary designation form and return the form directly to TRS. For more information, go to the TRS website at **www.trs.state.tx.us/** or call 1-800-223-8778.

If you are a participant in the Optional Retirement Program (ORP), or the voluntary UTSaver Tax-Sheltered Annuity (TSA) or UTSaver Deferred Compensation Plan (DCP), you should always be sure that a current beneficiary is on file for each of these retirement accounts. You can download the appropriate beneficiary designation form and return the completed form directly to your specific retirement provider. For more information, please see the retirement plan section of the OEB website.

Termination of Coverage

If employee eligibility for coverage ends, the effective date of the termination of coverage is generally the end of the month in which eligibility ends. Failure to pay premium within 45 days of the due date will result in cancellation of coverage retroactive to the first of the month following the last month that premium payment was made. An individual whose coverage is cancelled for nonpayment of premium is not eligible for coverage under COBRA.

PLAN INFORMATION

Premium Sharing

As a retired employee, UT and the State of Texas will pay 100% of your premiums for the basic coverage package, and up to 50% of the premiums for your dependents' medical coverage. You are responsible for all optional coverage premiums.

If you are a benefits-eligible retired employee with coverage under another group health plan and elect to waive the basic coverage package you are eligible to use 50% of the state premium sharing to purchase Dental and/or Vision Coverage. If you waive, you will not be enrolled in Basic Group Life Insurance or be eligible for the Living Well Program as those are a part of the Basic Coverage Package.

Basic Coverage Package

UT Benefits includes the following basic coverage package for eligible retired employees:

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

Optional Coverage

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

- UT SELECT Medical Plan, with Prescription Drug Coverage, for your eligible dependents
- UT SELECT Dental Insurance
- UT SELECT Dental Plus Insurance
- DeltaCare USA Dental HMO
- Superior Vision Insurance
- Superior Vision Plus Insurance
- Voluntary Group Term Life Insurance
- Long-Term Care (LTC)

UT SELECT Living Well Health & Wellness Program

The Living Well program provides an opportunity for you to take an active role in your health care decisions and help improve your quality of life. From providing critical information about preventing or managing serious disease to developing a personalized health improvement plan, you will find a variety of powerful and easy-to-use tools for you and your eligible dependents to take charge of your health and develop your own personal wellness program. All employees, retired employees, and dependents age 18 and older enrolled in the UT SELECT Medical plan are eligible to participate in this comprehensive program.

The Living Well Health Platform powered by Provant!

Wellness is important, and we want to help you take an active role in the quality of your life and offer you a reward for taking charge. The Office of Employee Benefits has teamed up with Provant Health Solutions, an independent health and wellness company, to provide the new health platform to UT SELECT Medical plan members.

This year, our program includes:

- A confidential online health assessment, which only takes about 15 minutes to complete and offers personalized recommendations on how to best maintain and improve your health.
- A comprehensive online health platform with calorie trackers, meal and exercise plans, wellness workshops, a nurse hotline, and much more, all available 24/7.
- Incentives and rewards. We are excited to announce our New Amazon Electronic Gift Card. You will have instant delivery of incentive and broadest product selection.

Getting started is easy.

- **Go to livingwell.provantonline.com**
- Log in or click on "Register New Account"
- Under the Health heading, click "Health Assessment"
- Complete all the pages of the survey
- When you're finished, you will receive a personal health risk report and personalized wellness plan to help you achieve your health goals. Enjoy your $25 gift card when you complete the Health Assessment and receive your annual preventive exam. The gift card is considered taxable income.

To earn your gift card for the 2014 -2015 plan year, you should complete the preventive exam and health assessment by August 31, 2015.

The health assessment is a 15-minute, confidential survey that asks questions about your current health, diet, fitness, safety and lifestyle. If you have questions about creating an account, email **livingwell@provanthealth.com** or call at 1-877-239-3557.

For more details about our Living Well: Make it a Priority programs and services, visit **www.livingwell.utsystem.edu**. Find your local Institution's program website at **www.livingwell.utsystem.edu/institutionprograms.htm**.

Tobacco Premium Program (TPP)

The use of tobacco is one of the leading preventable health risks worldwide. Because UT System is committed to promoting a culture of wellness and disease prevention, and also recognizes the costs associated with treating tobacco related health conditions, members enrolled in the UT SELECT Medical plan pay a monthly surcharge in addition to the premium normally charged for UT SELECT Medical plan coverage of $30 per month if they use tobacco. All members will be required to provide a declaration regarding their tobacco use as a condition of enrollment in UT SELECT.

What is the TPP and to whom does the TPP apply?

- An additional out-of-pocket premium of $30 per month for UT SELECT members who use tobacco products
- Applies to any tobacco user (age 16 and over) enrolled in the UT SELECT Medical plan

TPP Premium Rate(s)

Tobacco User	Monthly Out-of-Pocket Cost
Member	$30 per month
Spouse	$30 per month
Children	$30 per month*

*The premium for dependent children is $30 per month regardless of how many covered dependent children use tobacco. The maximum premium is $90 per family per month.

Members must declare if they are tobacco users. A "tobacco user" is defined as a person who has used tobacco products within the past sixty (60) days.

Members who declare they are non-tobacco users must not have used tobacco products within the pasty sixty (60) days from the day this declaration is signed.

All types of tobacco products are included as part of the Tobacco Premium Program, including, but not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip, or any other product that contains tobacco), clove cigarettes and any other smoking devices that use tobacco such as hookahs. E-cigarettes, which contain nicotine, are considered a tobacco product.

How can the UT SELECT Medical plan help me quit using tobacco?

The UT System is committed to helping tobacco users quit by offering our UT SELECT covered members specialized programs at no cost including Smoking/Tobacco Cessation Programs, Pharmaceutical Therapy and Nicotine Replacement Therapy (NRT). Learn more about programs available at our Living Well website at **www.livingwell.utsystem.edu/tobacco.htm**.

Exception to Tobacco Use Premium

An exception to the tobacco premium may apply for a tobacco user who has been diagnosed with an uncontrolled health factor and whose physician advises against stopping the use of tobacco. Tobacco users who qualify under this provision, should submit a statement from their treating physician in order to waive the tobacco premium. The Physician Statement Form can be submitted anytime during the year to your institution HR/ Benefits Office, and the tobacco premium will be waived beginning the first of the month following submission of the form.

Important: A member is responsible to submit a Physician Statement Form every plan year to avoid charges of the Tobacco Premium Program.

UT SELECT Medical Plan

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

Choice of Doctors Each Time You Need Health Care

When you enroll in UT SELECT, you can receive care from any licensed doctor you choose; no referrals are required. If you use a network doctor, you will receive the highest level of benefits, pay less out-of-pocket, and will usually not have to file any claims. If you use an out-of-network doctor, you will still be covered, but your out-of-pocket costs for health care services will be substantially higher.

IN-AREA BENEFITS – Benefits available to UT SELECT participants living in Texas, New Mexico and Washington, D.C.

OUT-OF-AREA – Out–of-Area benefits apply only to those UT SELECT participants whose residence of record is outside of Texas, New Mexico and Washington, D.C. Deductible and coinsurance applies to all out-of-area services except for preventive care unless the covered member has Medicare as their primary insurance. If a service is out-of-network for an out-of-area member, any amount charged above the allowable amount may be billed to the member.

IN-NETWORK – Network benefits are available for services performed by providers or in facilities that have a network contract agreement with BCBSTX. Network benefits may be available when services are rendered by providers outside of Texas if that provider has a network contract agreement with the Blue Cross and Blue Shield plan in the state where services were rendered. Network providers have agreed to charge only up to the BCBSTX allowed amount. You are responsible for applicable deductibles, copays and/or coinsurance.

OUT-OF-NETWORK – Out-of-network benefits are available for services from providers who do not have a network contract agreement with BCBSTX. When receiving services from out-of-network providers, you will be responsible for applicable deductibles, copays and/or coinsurance, as well as any amounts exceeding the BCBSTX allowed amount. The amounts exceeding the allowed amount are often significant. Always ask for an estimate of your financial responsibility before receiving services from an out-of-network provider.

Preventive Care

Preventive care services are offered at no out-of-pocket cost. Eligible services are outlined in the federal regulations based on U.S. Preventive Service Task Force Recommendations.

To view a list of preventive care benefits offered through the UT SELECT Medical plan as well as information on preventive care benefits as required by the Affordable Care Act (healthcare reform), go to **www.healthcare.gov**. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your doctor bills for services that are not preventive.

UT SELECT BENEFIT SUMMARY CHART

September 1, 2014 - August 31, 2015

Members with Medicare as their primary insurance should also see the section on UT SELECT and Medicare.

Coverage	In-Network		Out-of-Network*
	In-Area	Out-of-Area* (outside of TX, NM, or Washington DC)	
Annual Deductible (applicable when coinsurance is required)	$350/person $1,050/family	$350/person $1,050/family	$750/person $2,250/family
Annual Out-of-Pocket Maximum	$2,500/individual $7,500/family (deductible and coinsurance) $6,350/individual $12,700/family (deductible and coinsurance, and copayments)	$2,500/individual $7,500/family (deductible and coinsurance)	$5,000/person $15,000/family
Pre-existing Condition Limitation	None	None	None
Lifetime Maximum Benefit	No Limit	No Limit	No Limit
OFFICE SERVICES			
Preventive Care	Plan pays 100% (no copayment required)	Plan pays 100% (no copayment required if provider is in-network)	60% Plan/40% Member
Diagnostic Office Visit	FCP or Behavioral Health Provider $30 Copay; Specialist $35 Copay; 100% covered after copay	75% Plan/25% Member	60% Plan/40% Member
Diagnostic Lab and X-Ray	Included in Office Visit Copay	75% Plan/25% Member	60% Plan/40% Member
Non-Emergency MRI/CT Scans	$100 Copay (may be waived by contacting the BVA before services)	75% Plan/25% Member	60% Plan/40% Member
Other Diagnostic Tests	FCP $30 Copay; Specialist $35 Copay	75% Plan/25% Member	60% Plan/40% Member
Allergy Testing	FCP $30 Copay Specialist $35 Copay	75% Plan/25% Member	60% Plan/40% Member
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	75% Plan/25% Member	60% Plan/40% Member
EMERGENCY CARE			
Ambulance Service (if transported)	80% Plan/20% Member	75% Plan/25% Member	80% Plan/20% Member
Hospital Emergency Room	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)
Emergency Physician Services	Plan pays 100% (no copayment required)	75% Plan/25% Member	Plan pays 100% (no copayment required)
OUTPATIENT CARE			
Observation	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Surgery – Facility	$100 Copay; then 80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member

Coverage	In-Network		Out-of-Network*
	In-Area	Out-of-Area* (outside of TX, NM, or Washington DC)	
Surgery – Physician	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Diagnostic Lab and X-Ray	100% covered	75% Plan/25% Member	60% Plan/40% Member
Other Diagnostic Tests	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Outpatient Procedures	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
INPATIENT CARE			
Hospital - Semi private Room and Board**	$100 Copay/Day ($500 max/ admission); then 80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Hospital Inpatient Surgery**	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Physician	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
OBSTETRICAL CARE			
Prenatal and Postnatal Care Office Visits	FCP $30 Copay; Specialist $35 Copay (initial visit only)	75% Plan/25% Member	60% Plan/40% Member
Delivery – Facility/Inpatient Care**	$100 Copay ($500 max/admis- sion); then 80% Plan /20% Member	75% Plan/25% Member	60% Plan/40% Member
Obstetrical Care and Delivery - Physician	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
THERAPY			
Physical Therapy/ Chiropractic Care (max. 20 visits/yr)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Occupational Therapy (max. 20 visits/yr)	80% Plan/20% Member	75% Plan/25% Memberr	60% Plan/40% Member
Speech and Hearing Therapy (max. 60 visits/yr)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Respiratory Therapy	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
EXTENDED CARE			
Skilled Nursing/ Convalescent Facility** (max.180 visits)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Home Health Care Services** (max.120 visits)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Hospice Care Services**	80% Plan / 20% Member	75% Plan/25% Member	60% Plan/40% Member
Home Infusion Therapy**	80% Plan / 20% Member	75% Plan/25% Member	60% Plan/40% Member
BEHAVIORAL HEALTH			
Serious Mental Illness – Office Visit	$30 Copay	75% Plan/25% Member	60% Plan/40% Member
Serious Mental Illness – Outpatient**	80% Plan / 20% Member	75% Plan/25% Member	60% Plan/40% Member

Continued...

Coverage	In-Network		Out-of-Network*
	In-Area	Out-of-Area* (outside of TX, NM, or Washington DC)	
Serious Mental Illness – Inpatient**	$100 Copay/Day ($500 max/ admission) then 80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Mental Illness – Office (max. 20 visits/yr. for outpatient and office combined)	$30 Copay	75% Plan/25% Member	60% Plan/40% Member
Mental Illness Outpatient** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Mental Illness – Inpatient** (Other than Serious Mental Illness) **Max. 30 days/yr.**	$100 Copay/Day ($500 max/ admission) then 80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Chemical Dependency – Office (max. 20 visits/ yr. for outpatient and office combined)	$30 Copay	75% Plan/25% Member	60% Plan/40% Memberr
Chemical Dependency – Outpatient Treatment** (max. 20 visits/yr. for outpatient and office combined)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Chemical Dependency - Inpatient Treatment** (max. 30 days/yr; 3 episodes of treatment per lifetime)	$100 Copay/Day ($500 max/ admission) then 80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
OTHER SERVICES			
Durable Medical Equipment**	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Prosthetic Devices	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Hearing Aids ($500 per ear, once every 4 years)	80% Plan/20% Member	75% Plan/25% Member	60% Plan/40% Member
Bariatric Surgery (pre-determination recommended)	$5,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After $5,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers.		$5,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After $5,000 bariatric surgery deductible, plan pays 100% up to the allowable amount. The member pays charges exceeding the allowable amount which can be a significant difference.

* Any charges over the allowable amount are the patient's responsibility.
**These services require preauthorization to establish medical necessity.

Key Terms and Examples

Allowed Amount – Maximum amount on which payment is based for covered health care services. Sometimes, this is referred to as "eligible expense", "payment allowance", or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference (balance billing) which can be significant. In-Network providers agree to the allowed amount for covered services.

Annual Deductible – The amount of out-of-pocket expense the member pays in a plan year (September 1 – August 31) for health care services before the plan begins to pay. The deductible does not apply to all services, and copayments are not applied to the deductible met.

Annual Out-of-Pocket Maximum – The amount of out-of-pocket expense the member pays for eligible expenses in a plan year (September 1 – August 31). This limit never includes your premium, balance-billed charges or health care the plan doesn't cover. The bariatric and prescription drug expenses also do not count toward this limit.

The $2,500/$7,500 limit includes deductible and coinsurance only (no copayments). As a provision of the Affordable Care Act, there's an additional limit including copayments such that in no case will the eligible in-network out-of-pocket expenses including deductible, coinsurance, and copayments be greater than $6,350 for employee only coverage or $12,700 for employee plus dependent coverage (Subscriber plus spouse, subscriber plus child(ren), or subscriber plus family).

Benefits Value Advisor (BVA) – A Benefits Value Advisor is a health care expert who uses data, cost estimators, provider-finders and other tools to provide consumers with choices that allow them to maximize their health care benefits. Contact the BVA at 866-882-2034. Calling this number prior to a non-emergency office or outpatient MRI or CT Scan will allow the $100 copayment to be waived.

Coinsurance – The member share of the costs of a covered service, calculated as a percent of the allowed amount for the service. The member pays coinsurance after any deductible is met, and the plan pays the rest of the allowed amount. Some services also require a copayment.

EXAMPLE (Coinsurance): Avi begins physical therapy with an In-Network provider. He has not met any of his deductible. The provider submits a claim to insurance for $150. The allowed amount is $70. Avi pays $70 because he has not met any of his deductible. The UT SELECT Plan pays $0, but it has saved Avi money by negotiating the allowed amount with the provider.

If Avi continues to go to physical therapy and does not incur any other expenses which apply to his deductible, he will meet his In-Network deductible with his fifth visit (5 x $70 = $350). On his sixth visit: The provider submits the claim to insurance for $150. The allowed amount is $70.

Avi has met his deductible, so he pays 20% of the allowed amount of $70, or $14. The UT SELECT Plan pays 80% of $70, or $56.

Copayment – A fixed amount you pay for a covered health care service, usually at the time you receive the service. Some services also require deductible and coinsurance. Copayments are not applied to the deductible met.

EXAMPLE (Copayment): Justine goes to a network provider for an office visit when she has pink eye. The provider submits a claim to insurance for $210. The allowed amount is $100. Justine pays a $30 copayment for the In-Network Diagnostic Office Visit. The UT SELECT Plan pays the difference of $70 to the Provider.

FCP – Family Care Physician; Includes Family Practice, Internal Medicine, OB/GYN, and Pediatrics.

UT SELECT and Medicare

Active Employees

In most cases, an active employee or dependent of an active employee enrolled in UT SELECT should enroll in Medicare Part A and decline Parts B and D once eligible, typically at age 65. Once you retire, you and your Medicare-eligible dependent(s) should then enroll in Part B without penalty and continue to waive Part D. In most instances, if you are eligible for Medicare and are working at UT in a benefits-eligible position for at least 20 hours per week, your UT medical plan will be primary for you and your covered dependent, regardless of age, and Medicare will be secondary. Medicare may be primary for some Medicare-eligible active employees or their dependents with certain medical conditions such as end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS). Consult with your local Social Security Administration office to learn what illnesses qualify for Medicare coverage prior to turning age 65.

Retired Employees

When you or your covered dependent(s) become eligible for Medicare, you and your Medicare-eligible dependents should enroll in Part A (typically inpatient coverage) and Part B coverage (typically office visits and doctor fees) and decline Part D (prescription drug coverage) in most cases. **The University of Texas System urges all retired employees and dependents to enroll in Medicare Parts A and B when they become eligible at age 65, or earlier if they are eligible due to a disability such as end stage renal disease.** Retired employees, or soon-to-be retired employees, or their dependents who are eligible for Medicare must have Medicare Parts A and B to receive the maximum benefits available from the UT SELECT plan.

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

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

If you decline Part B, you will have to pay a higher premium if you ever re-apply for Medicare coverage. **As a retired employee, if you or your Medicare-eligible dependent have declined Medicare Part B, UT SELECT Medical will reduce your claim payment by the benefit that would have been available to you under Medicare Part B (usually 80%), and then pay the remaining claim amount under the terms of your health plan.**

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

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

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

If your doctor does not accept Medicare assignment

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

If a service is normally not covered by UT SELECT or is subject to limitations (such as the 20 visit limit on physical therapy), the service beyond plan limitations and exclusions will not be covered. See the summary chart beginning on page 10.

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

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

1 Provider who does not participate with Medicare may not bill more than the Medicare Limiting Charge (115% of MC Allowed).
2 Allowed charges are the lesser of the Medicare Limiting Charge or the Blue Cross and Blue Shield allowed amount. If the Blue Cross and Blue Shield allowed amount is less, the member may be billed the difference.

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

Special rules are mandated by federal law when coordinating benefits between UT SELECT, Medicare and another coverage.

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

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

1. UT SELECT
2. Medicare
3. ABC Company

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

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

1. Medicare
2. UT SELECT
3. XYZ Company

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

EXAMPLE C
Meredith is 72 and has UT SELECT as a retired employee. During her phased retirement, she returns to teach for the Fall semester, from September 1 through January 15. She is covered by her husband's medical plan through his active employment. During the semester that Meredith has returned to a benefits-eligible position at UT, her claims are paid in this order:

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

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

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

It is important to inform your providers and health plan carriers of all the insurances in which you are enrolled. Understanding correct coordination of benefits will help to ensure timely and accurate claims payments. If you have questions regarding your specific insurance situation, please contact your institution Benefits Office, the UT System Office of Employee Benefits, or your health care administrator.

For more information on UT SELECT and Medicare, please see the Important Notices section of this handbook. You may also request a copy from your institution Benefits Office.

Your Health Care Benefits Travel With You

Your UT SELECT Medical ID card features the Blue Cross and Blue Shield symbols and the PPO in a suitcase logo telling providers that you are part of the BlueCard program. This means you and your covered dependents have access to Blue Cross and Blue Shield network providers throughout the United States and around the world. To receive the network (highest) level of benefits when you need to seek care, please call **1-800-810-BLUE (2583)** printed on your Medical ID card.

Transitional Benefits

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

Transitional benefits are subject to approval. To request transitional benefits, complete a "Transitional Benefits Form" available from your institution Benefits Office or online at **www.bcbstx.com/ut.**

UT SELECT Prescription Drug Plan Benefits

Your prescription drug benefits under UT SELECT are administered by Express Scripts and require a $100 annual deductible per plan participant, per plan year separate from the medical plan deductible.

UT SELECT 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: Up to a 30-day supply. Refills allowed as prescribed. (good option for new prescriptions)	$10	$35	$50
Home Delivery Pharmacy: Up to a 90-day supply. Refills allowed as prescribed. (best option for maintenance medication)	$20	$87.50	$125

If you purchase a preferred or non-preferred drug when a less expensive generic alternative drug is available, 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 annual deductible. Sometimes the cost difference is quite large. Below is an example of how this type of claim would process if you had already met your $100 annual deductible:

Cost of brand name drug-	$150
Less cost of generic equivalent-	-$55
Plus cost of generic copayment-	+ $10
Your payment	**$105**

The generic, preferred, or non-preferred list of covered drugs is reviewed periodically resulting in changes to the prescription drug list throughout the year. If you are taking a medication that is affected by one of these changes, Express Scripts will mail a letter to your address on file to alert you of the change in benefits. Please refer to the Express Scripts website (**www.express-scripts.com/ut**) or call Express Scripts Customer Service (1-800-818-0155) for current information on specific medications.

Specialty Pharmacy (Accredo)

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.

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.

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

Your Prescription Drug Plan and Medicare Part D

The Federal Medicare program provides a Medicare-approved prescription drug benefit – Medicare Part D. The University of Texas System continues to offer your current UT SELECT prescription drug benefit, and enrollment in Medicare Part D will have a negative financial impact for most UT participants.

UT strongly urges you NOT to enroll in the Medicare Part D program. UT is committed to providing your prescription drug coverage now and in the future and to helping you make informed choices about your prescription drug benefit. For a relatively small number of very low-income UT retirees, enrolling in Medicare Part D may save money if the retiree also qualifies for a "low income subsidy" provided as part of the Medicaid Part D Program. Please see the Medicare Part D Notice of Creditable Coverage in the Legal Notices section of this handbook. For more information about the low income subsidy, call **1-800-772-1213** or visit **www.socialsecurity.gov.**

Dental

UT Benefits and Delta Dental Insurance Company provide three plan options for retired employees and their families.

Dental PPO Plans

UT Benefits offers two dental PPO plans for you to choose from based on the level of benefits your family needs. Both dental PPO plans allow you the freedom to choose from any licensed dentist although you will save when you use a Delta Dental DPO or Delta Premier network provider.

- **UT SELECT Dental Plan** (Standard Self-Funded Dental PPO Plan) – good for standard dental insurance needs
- **UT SELECT Dental Plus Plan** (Enhanced Self-Funded Dental PPO Plan) – greater benefits than the standard UT SELECT Dental Plan

Dental PPO Plan Comparison

Benefits and Covered Services	UT SELECT Dental*	UT SELECT Dental Plus*
Service Area**	Use any licensed dentist, but save with the Delta Dental DPO or Delta Premier networks	
Deductible	$25	$0
Maximum Benefits (per enrollee per plan year)	$1,250	$3,000
Orthodontic Maximum Benefits (Lifetime)	$1,250	$3,000
Diagnostic & Preventive Services (D&P) Exams, cleanings, x-rays, sealants	100%	100%
Basic Services Fillings, stainless steel crowns	80%	100%
Endodontics (root canals) Covered Under Basic Services	80%	100%
Periodontics (periodontal scaling, Root planning, and treatment of gum disease) Covered Under Basic Services	80%	100%
Oral Surgery Covered Under Basic Services	80%	100%
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	50%	80%
Orthodontic Benefits Adults and dependent children	50%	80%

* Limitations may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees. Fees are based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists, and Premier contracted fees for non-Delta Dental dentists.

** Visit deltadentalins.com/universityoftexas to locate a network provider.

DeltaCare USA Dental HMO Plan

(Fully-Insured Dental HMO Plan) Available in Austin, Dallas/ Ft. Worth, Galveston, Houston, and San Antonio. There is also limited availability in El Paso, Tyler, and part of the Rio Grande Valley. Plan eligibility is based on your zip code. Ask your benefits office if you are eligible to enroll in the DeltaCare Dental HMO. You must select and receive services from a DeltaCare plan dentist to use the benefits under this plan.

DeltaCare USA plans feature:

- Set copayments.
- No annual deductibles and no maximums for covered benefits.
- Low out-of-pocket costs for many diagnostic and preventive services (such as professional cleanings and regular dental exams).

Choosing your DeltaCare USA dentist

When you enroll, you choose a DeltaCare USA Primary Family Dentist to receive benefits under your plan. You must visit your selected DeltaCare USA dentist to receive benefits under your plan. To find the most current listing of DeltaCare USA network dental offices:

- Visit the Delta Dental website at **www.deltadentalins.com/universityoftexas** and go to the "Find a Dentist" box on the home page.
- Select "DeltaCare USA" as your plan network, click "Search", and follow the instructions.

You can also call Customer Service for help in finding a dentist. If you do not select a dentist, Delta Dental will select a dentist for you. Family members may select a different dentist for treatment within the covered service area. Refer to your plan booklet for details.

Vision

Fully insured Vision Care benefits are offered by Superior Vision Services. You have two vision plan options to choose from:

- Superior Vision (Standard Plan)
- Superior Vision Plus (Enhanced Plan)

Both plans feature the following copayments:

- Exam: $35
- Materials: $0
- Contact Lens Fitting: $35

Services/Frequency limits for both plans:

- Exam: 1 per plan year
- Frames: 1 per plan year
- Contact Lens Fitting: 1 per plan year
- Lenses: 1 per plan year
- Contact Lenses: 1 per plan year

Services	Superior Vision (Standard Plan)		Superior Vision Plus (Enhanced Plan)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Exam (MD)	Covered in full[1]	Up to $42	Covered in full[1]	Up to $42
Exam (OD)	Covered in full[1]	Up to $37	Covered in full[1]	Up to $37
Frames	$140 retail allowance	Up to $53	$150 retail allowance	Up to $53
Contact Lens Fitting (standard[2])	Covered in full[1]	Not covered	Covered in full[1]	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance[1]	Not covered	$50 retail allowance[1]	Not covered
Lenses (standard) per pair:				
Single Vision	Covered in full	Up to $32	Covered in full	Up to $32
Bifocal	Covered in full	Up to $46	Covered in full	Up to $46
Trifocal	Covered in full	Up to $61	Covered in full	Up to $61
Polycarbonate (dependent children up to age 25)	Not Covered	Not covered	Covered in full	Not covered
Scratch coat (factory, single sided)	Not Covered	Not covered	Covered in full	Not covered
Ultraviolet coat	Not Covered	Not covered	Covered in full	Not covered
Progressive lens	See description[3]	Up to $61[1]	$120 retail allowance[5]	Up to $61
Elective Contact lenses[4]	$125 retail allowance	Up to $100	$150 retail allowance	Up to $100

[1] After co-pays. Co-pays apply to in-network benefits only.
[2] See your benefits materials for definitions of standard and specialty contact lens fittings
[3] Covered at the provider's in-office retail price for a standard lined trifocal; member pays difference between the progressive and the trifocal, plus applicable co-pay
[4] Contact lenses are in lieu of eyeglass lenses and frames benefit
[5] Overages on standard progressive lenses will be the member's responsibility

Additional discounts are available on LASIK, lens options and upgrades and mail-order contacts.

All costs and allowances are retail; you are responsible for any charges in excess of the retail allowances. All final determinations of benefits, administrative duties, and definitions are governed by the certificate of insurance for your specific benefits.

Group Term Life Insurance

Group term life (GTL) insurance can help ensure financial security for your family and loved ones upon your death. UT System, through the vendor Dearborn National, provides eligible retired employees with basic GTL as part of the basic coverage package. Eligible retired employees also have the opportunity to purchase additional coverage at group rates.

Basic Group Term Life (GTL) Benefits

Basic group term life insurance in the amount of $6,000 is a part of the basic coverage package.

Voluntary Group Term Life Options

Coverage Level	Benefit Amount
Retired Employee Voluntary GTL	$7,000 $10,000 $25,000 $50,000
Dependent Spouse Voluntary GTL*	$3,000

*Retired employee must be enrolled in retired employee voluntary GTL benefits in order to elect benefits for a spouse.

When you first move from active employment to a retired employee without a break in service, you are guaranteed coverage up to the amount of voluntary GTL coverage you had in force as an active employee not to exceed a maximum of $50,000.

After your initial eligibility period to elect voluntary GTL coverage as a retired employee, evidence of insurability is required for any increase in voluntary GTL benefits during annual enrollment or following a qualified change in status event.

Evidence of insurability is required on all spouses of retired employees who elect to enroll for voluntary GTL insurance. However, this requirement will be waived if your spouse was enrolled for voluntary GTL insurance on the last day you were an active employee and there is no break in coverage.

Group Long-Term Care (LTC)

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

The LTC plan is available to you and your dependent spouse. Your spouse may apply without your having applied for coverage. Evidence of insurability (EOI) is required.

LTC coverage is portable, so if you are a return to work retired employee and you leave your employment with UT System, you can keep your LTC coverage.

Long-Term Care Benefit Summary

Daily Maximum Facility Care Benefit	$100	$125	$150	$200	$250
Daily Maximum Home Care	$50	$72.50	$75	$100	$125
Lifetime Maximum Benefit	$109,500	$136,875	$164,250	$219,000	$273,750

To help counter the effects of inflation, you may elect either the guaranteed benefit increase option (GBO), which will offer periodic opportunities to increase (buy-up) your existing coverage, or the optional lifetime automatic benefit increase (ABI). If ABI is chosen, on each anniversary of your coverage effective date CNA will increase each benefit amount in effect by 5%.

Enrollment in LTC cannot be done through *My UT Benefits*. You must enroll with CNA enrollment materials. For information or to order a complete package of information including enrollment materials, please call CNA Customer Service at **(888) 825-0353**. Additional information is also available at **www.ltcbenefits.com/uts** or your institution Benefits Office.

If you were enrolled in a LTC plan through UT System before September 1, 2013, please contact CNA for information about your LTC plan policy.

Retirement Program Information for Retired Employees

WHAT YOU NEED TO KNOW

TRS Retired Employees

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

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

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

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

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

ORP Retired Employees

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

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

VOLUNTARY RETIREMENT PROGRAMS

Your UTSaver Voluntary Programs at a Glance

UTSaver Voluntary Programs

U.T. System offers two voluntary retirement savings programs: The UTSaver 403(b) Tax Sheltered Annuity (TSA) and the 457(b) Deferred Compensation plan (DCP).

Notes to Remember:

Anyone receiving a salary can participate, even graduate student employees and retiree rehires.

You can enroll at any time. (Subject to certain Payroll/Benefits processing timelines.)

	UTSaver TSA		UTSaver DCP
	Traditional	**Roth**	
Eligibility	All employees	All employees	All employees
Employee contribution	Pre-tax dollars	After-tax dollars	Pre-tax Dollars
Employer Contribution	None	None	None
Employee withdrawals	Taxable when withdrawn	Tax free when withdrawn as a "qualified" distribution	Taxable when withdrawn
General contribution limits	$17,500 IRS maximum (2014) for both traditional and Roth sources. (Each dollar of a Roth contribution reduces the amount that can be contributed pretax, and vice versa.[1]		$17,500 IRS maximum (2014)
Over age 50 catch-up contribution	$5,500 combined with Roth	$5,500 combined with Traditional	$5,500
15-year catch-up contribution	$3,000 combined with Roth	$3,000 combined with Traditional	N/A
Three years prior to retirement catch-up (special catch-up)[2]	N/A	N/A	Up to $17,500 (may not be used simultaneously with age 50 catch-up)
Distributions Upon Separation of Employment	Distributions made prior to age 59 ½ will be subject to ordinary income tax and a possible 10% penalty	"Nonqualified" distributions made prior to age 59 ½ will be subject to ordinary income tax on earnings and possibly a 10% penalty	Distributions will be subject to ordinary income tax only.

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

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

For one or more of the employee's last three calendar years ending before the year in which the employee attains normal retirement age. The special catch-up amount is $17,500 for 2014. May not be used simultaneously with the age 50 and over catch-up.

Your UTRetirement Programs Authorized Providers

Authorized Provider	FIDELITY (800) 343-0860 www.fidelity.com/ut	VOYA FINANCIAL (Formerly ING) (866) 506-2199 www.ingretirementplans.com/utexas	LINCOLN (800) 454-6265 *8 www.lfg.com/ut	TIAA-CREF (800) 842-2776 www.tiaa-cref.org/utexas	VALIC (800) 448-2542 www.valic.com/utsystem
Products	MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.
SERVICES AVAILABLE AT NO COST TO THE EMPLOYEE					
Face-to-face counseling	Yes. On campus or at our local Fidelity Investor Centers.	Yes	Yes	Yes	Yes. By on-staff VALIC financial advisor.
Discuss UT Retirement Plan Options	Yes	Yes	Yes	Yes	Yes
Assess employee risk tolerance and retirement goals	Yes. Educational resources and guidance tools are available online as well as by phone or in person.	Yes	Yes	Yes	Yes. Educational materials and financial analysis online or in person.
Consider outside assets with no advice on those assets	Yes	Yes	Yes	Yes	Yes. Online aggregator helps track assets. Rollover help on request.
Provide asset allocation models and the list of available company funds	Yes. Guidance help available with online tools as well as over the phone or in person.	Yes	Yes	Yes	Yes. Allocation modeling and investment planning online or in person.
Advice on fund selection	Yes. Online or in person.	Yes	Yes	Yes	Yes. Online or in person.
Free financial planning services	Yes. On campus or at our local Fidelity Investor Centers.	Yes	Yes. Receive retirement analysis at no cost from local Retirement Consultants.	Yes	Yes. Receive retirement analysis at no cost from on-staff advisor.
Online tools, interactive calculators, & mobile apps	Yes	Yes	Yes	Yes	Yes
Financial workshops and seminars	Yes. Online, on campus, & at local Fidelity Investor Centers.	Yes	Yes, online or in person at no additional cost.	Yes. Online or in person.	Yes. Online or in person.
Investment fund enrollment	Yes. Online enrollment or downloadable forms on our website.	Yes. Online enrollment or downloadable forms on our website.	Yes. Online enrollment or downloadable forms on our website.	Yes. Online enrollment or downloadable forms on our website.	Easy enrollment online or with a VALIC financial advisor.
SERVICES AVAILABLE FOR A FEE TO THE EMPLOYEE					
Actively manage company accounts	No	Yes - mutual funds only	No	Yes	Yes

Resources

In addition to the robust UT Benefits, additional resources are available to help you stay financially and physically healthy. If you have specific questions about any of these resources, please feel free to contact customer service for the sponsoring plan vendor.

WELLNESS RESOURCES

Employee Assistance Program (EAP)

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

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

24/7 Nurseline (BCBSTX)

Health concerns don't always follow a 9-to-5 schedule. Fortunately, you can call the toll-free Nurseline 24 hours a day, seven days a week to get the information you need. In addition to speaking with a registered nurse, you also have the option to access an audio library of more than 1,000 health topics—from allergies to women's health—with more than 600 topics available in Spanish. Call the 24/7 Nurseline toll-free at **(888) 315-9473**.

Condition Management (BCBSTX)

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

Lifestyle Management (BCBSTX)

For participants who want to lose weight or stop smoking, UT SELECT coverage also features lifestyle management programs, composed of licensed masters level social workers and licensed professional counselors, who promote wellness through a holistic approach of behavioral coaching, clinical coaching, education and condition management. To enroll in a lifestyle management program, please call toll-free at **(800) 462-3275.**

Gaps in Care Alerts (Express Scripts)

While advances in the pharmaceutical treatment of disease have greatly improved clinical outcomes for patients with chronic and complex medical conditions, the significant potential for essential medications to improve patient health is often not achieved due to gaps in patient care. For example, gaps in care, such as poor adherence with essential medication, are associated with poorer clinical outcomes and higher total costs.

Now there's a new online safety feature that could help protect you and your family. It's already available at no cost to you as part of your UT SELECT plan.

It's easy to use and works whether you get your medications at a retail pharmacy or by mail from the **Express Scripts Pharmacy®**. All you need to do is register at **www.express-scripts.com/ut.**

After your one-time registration, any alerts will automatically be waiting for you whenever you log in. These personalized alerts identify potential risks and enable you to take action quickly. They could help you avoid unnecessary hospitalization, prevent setbacks to your health, and stay on track with taking your medications as prescribed by your doctor.

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

This protection works for people who take medications regularly (typically 3 months or more) for an ongoing condition, such as high blood pressure, high cholesterol, or diabetes. People with one or more chronic conditions are more likely to require medical care and hospitalization if they do not take their medications as prescribed, so having this added protection could make a difference.

You will need your prescription drug ID card and a recent prescription number. If you are already registered, your new online safety feature is already activated and your protection is working.

Superior Vision's SmartAlert Program (Superior Vision)

Superior Vision's SmartAlert provides an easy way to foster communication between you, your Superior Vision eye care provider and your primary care physician or specialist.

This tool is the My Vision Lifestyle Update* form and is located on the Superior Vision website at **www.superiorvision.com/ut** in the member portal. You should print a copy of the form, review and answer the questions carefully, then share this form with your Superior Vision provider during your next eye exam appointment.

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

WISE CONSUMER RESOURCES

Benefits Value Advisor (BVA)

Blue Cross and Blue Shield of Texas wants you to know that you have a choice when selecting where to go for health care. Many times you can choose between different providers or facilities and receive the same procedure at a lower cost.

This is where Benefits Value Advisor (BVA) comes in. You can call a BVA and get cost comparison information from providers in your area for:

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

A BVA can also help you:

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

One call can result in big savings!
Just call **866-882 2034** to talk to a Benefits Value Advisor.

Knee Replacement Providers:
Provider A - Knee Replacement Cost: **$16,912** Provider B- Knee Replacement Cost: **$47,066**
Which provider will you choose? The same procedure performed in the same area can vary in cost by more than $30,000 depending on where you go!* *Example cost data from Travis County

Call customer service to preauthorize MRIs and CAT/CT scans through a Benefits Value Advisor to avoid a $100 penalty.

My Rx Choices (Express Scripts)

An industry-leading prescription savings program, **My Rx Choices** is offered as an enhancement to your benefit plan. Here you can view a single presentation of medications with potential savings and comparison shop for available lower cost alternatives. You also have the option to have Express Scripts contact physicians on your behalf to review options with your doctor and request approval for **equivalent** conversions received through mail.

Personalized Medicine Program (Express Scripts)

Your prescription drug coverage includes the Personalized Medicine Program, a program that incorporates genetic testing to optimize prescription drug therapies for certain conditions. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available and are included in the program. The Personalized Medicine Program is available to participants meeting a specified clinical profile who are prescribed qualifying medications. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at **www.express-scripts.com/ut** or by calling an Express Scripts customer service representative at **(800) 818-0155.**

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

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

Worry-free Fills (Express Scripts)

Express Scripts has created the Worry-free Fills™ (WFF) program, so your prescriptions can be refilled automatically. When you enroll your eligible prescriptions in WFF, there's no need to call or order your refills. As you near the end of your current supply, we'll automatically send your next refill using your existing address and payment information. To enroll in WFF, visit **www.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 prescrip-

tions include specialty medications, controlled substances, and over-the-counter medications. 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.

Blue Access for Members℠ (BCBSTX)

Go to **www.bcbstx.com/ut,** log onto Blue Access for Members, and:

- Check the status of a claim and your claims history
- Confirm who in your family is covered under your plan
- View and print an explanation of benefits (EOB)* for a claim
- Locate a doctor or hospital in the Network
- Sign up to receive claim status email alerts
- Request email notification of finalized claims
- Request a new or replacement ID card or print a temporary ID card

*BCBSTX no longer mails an explanation of benefits (EOB) statement to UT SELECT participants unless they specifically request that their EOBs be mailed. Always review your EOBs following medical treatment to ensure the accuracy of provider billing and payment.

Cost Estimator (BCBSTX)

When your physician has recommended a medical procedure, you can easily find and review the outcome history of procedures previously performed at hospitals using the **Cost Estimator t**ool. You can also use this tool to estimate your costs for common medical procedures.

The costs displayed are estimates for the selected service or procedure and are not a guarantee of charges, payments or benefits. Costs may vary depending on the services performed as part of undergoing treatment. Always confirm that the facility you choose is a network provider and that the procedure is covered under your benefits plan.

To use the Cost Estimator, log into Blue Access for MembersSM within **www.bcbstx.com/ut**, then click the My Coverage tab and select **Estimate Treatment Costs**.

DISCOUNTS/VALUE ADDED SERVICES

Blue365 (BCBSTX)

blue365deals.com/BCBSTX

Blue365 has a range of new features and greater discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. Once you register on the Blue365 website at blue365deals.com/BCBSTX, you will receive weekly "Featured Deals," which will offer additional discounts from leading health companies and online retailers that are available for a short period of time.

Jenny Craig®

877-JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight-loss goals. You will get one-on-one support given by a trained weight-loss expert. Your consultant will give you a tailored program based on the essential components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program.

Procter & Gamble (P&G) Dental Products

877-333-0121

Get savings on dental packages containing the latest in Oral B®' power toothbrushes and Crest®' products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electric toothbrush, mouth rinse, floss, and many more.

TruHearing

800-687-4617

Save on digital hearing aids through TruHearing. Get a hearing test at no extra charge when performed to fit a hearing aid. Enjoy a 45-day, money-back guarantee and a three-year warranty. Also get a choice of hearing aid styles at a number of price levels and enough batteries to last a year when you buy a hearing aid.

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

International SOS (UT System)

When traveling abroad, coverage is provided for your medical needs through your UT SELECT program; however, additional services are available through the UT System-wide International SOS program. This is a comprehensive, 24-hour medical response organization that provides international assistance services worldwide through the use of multilingual alarm centers on duty 24 hours a day, 365 days a year. International SOS responds to calls for help and advice from students, travelers and expatriates, managing issues from the simplest task of a doctor referral to the most complex emergency evacuation. Membership is included for no charge for staff, faculty and students when traveling abroad on official UT business, and is available at a discount when traveling for a personal trip. You may obtain a membership card from your institution travel office. All UT-related travel abroad not booked using one of the University's contracted travel agencies should be reported to International SOS in advance. This can be done via the UT System SOS portal at **www.internationalsos.com** (use UT System Membership # **11BSGC000037** to log on). International SOS is not a Uniform Group Insurance Program benefit.

Legal Notices

UNIFORM SUMMARY OF BENEFITS AND COVERAGE

The uniform Summary of Benefits and Coverage (SBC) provision of the Affordable Care Act requires all insurers and group health plans to provide consumers with an SBC to describe key plan features in a mandated format, including limitations and exclusions. The provision also requires that consumers have access to a uniform glossary of terms commonly used in health care coverage. The UT SELECT SBCs are available online. To review an SBC for UT SELECT PPO or Out-of-Area coverage, visit the website, **www.bcbstx.com/ut.** You can view the glossary at **www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.** To request a copy of these documents free of charge, you may call the SBC Hotline at 1-855-756-4448.

UT SELECT MEDICAL PLAN OPT OUT OF CERTAIN PROVISIONS OF THE PUBLIC HEALTH SERVICE (PHS) ACT

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

- Protection against limiting stays in connection with the birth to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section. (Newborn and Mother's Health Protection Act)
- Certain requirements to provide benefits for reconstructive surgery following a mastectomy. (Women's Health & Cancer Rights Act (WHCRA) of 1988)
- Protection against having benefits for mental health and substance abuse disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
- Continued coverage for up to one year for a dependent child who is covered under a plan solely based on student status, who takes a medically necessary leave of absence from a post-secondary educational institution. (Michelle's Law)

The exemption from these federal requirements will be in effect for the 2014-2015 plan year. The election may be renewed for subsequent plan years.

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

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from The University of Texas System Office of Employee Benefits About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The University of Texas System and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The University of Texas System Office of Employee Benefits has determined that the prescription drug coverage offered by the UT SELECT Medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Enrollees of the UT SELECT Medical plan are automatically enrolled in prescription drug coverage. It is not possible to enroll in UT SELECT Medical coverage and decline or waive the prescription drug portion of the coverage. If you decide to join a Medicare drug plan, you are not required to drop your current UT SELECT Medical plan coverage. If you elect part D coverage in addition to your UT SELECT Medical coverage, the pharmacy benefits you are eligible for under your UT SELECT Medical will coordinate with your Part D coverage.

If you do decide to join a Medicare drug plan and drop your current UT SELECT Medical plan coverage, be aware that you and your dependents will be able to get this coverage back during annual enrollment or following a qualified change of status event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the UT SELECT Medical plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In

addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact your institution Benefits Office for additional information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the UT SELECT Medical plan changes. You also may request a copy of this notice at any time from The Office of Employee Benefits or your institution Benefits Office.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage, visit **www.medicare.gov.**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at **1-800-772-1213 (TTY 1-800-325-0778).**

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

CONTINUATION OF GROUP COVERAGE (COBRA)

You are receiving this notice because you have recently become a participant in group health coverage offered by UT System (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Benefits Guide or contact the HR or Benefits Office at your UT Institution..

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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'll 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're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to 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 lose coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (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."

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 UT System, 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. 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 continuation 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, 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 appropriate UT Institution's HR or Benefits office within 60 days after the qualifying event occurs and provide appropriate documentation of the qualifying event, such as a copy of a finalized divorce decree.

How long will continuation coverage last?

For medical, dental, and vision coverage:

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 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. The COBRA Application shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,

- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of

the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or

- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason that would result in the termination of coverage of a participant or beneficiary under the Plans who is not receiving continuation coverage (such as fraud).

For UT FLEX Health Care Reimbursement Accounts (HCRAs):

Employees experiencing a qualifying event may elect to continue an eligible UT FLEX HCRA through the end of the plan year for which the account was originally elected by making after tax monthly contributions to the account. Only UT FLEX HCRAs with a remaining balance at the time of your qualifying event that is equal to or greater than the total of all required monthly contributions for the rest of the plan year are eligible for continuation.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage for medical, dental, and vision coverage may be available as described in the two following paragraphs if a qualified beneficiary is disabled or if a second qualifying event occurs during the continuation period. You must notify each specific plan administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of medical, dental, and vision COBRA coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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. A copy of your SSA disability determination letter along with a written request to extend the COBRA period must be provided directly to each specific plan administrator (medical, dental, and/or vision) prior to the end of the initial 18-month period of coverage in order to extend the maximum period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second qualifying event

An additional 18-month extension of medical, dental, and vision coverage may be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum total period of continuation coverage available when a second qualifying event occurs is 36 months. Second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage

options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

For more information

This notice does not fully describe continuation coverage or other rights under the UT Benefits Plans. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the HR or Benefits Office at the UT Institution where you (or your family member) are employed. Contact information for each UT institution's Benefits Office is included on page one of this notice.

Employees seeking more information about COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa.

Keep your Plan informed of address changes

In order to protect your and your family's rights, you should keep Plan Administrators informed of any changes in your address and the addresses of family members. To do this, you should update your contact through the HR or Benefits Office at your UT Institution while you are employed and through the specific plan administrators if you enroll in continuation of coverage under COBRA. You should also keep a copy, for your records, of any coverage related forms or notices that you send to the Plan Administrator.

CONTACT INFORMATION FOR INSTITUTION BENEFITS OFFICES

UT Institution	Telephone Number
UT Arlington	(817) 272-5554 or (817) 272-5558
UT Austin	(512) 471-4772 or Toll Free: (800) 687-4178
UT Brownsville	(956) 882-8205
UT Dallas	(972) 883-2221
UT El Paso	(915) 747-5202
UT Health Science Center at Tyler	(903) 877-7784
UT Health Science Center Houston	(713) 500-3960
UT Health Science Center San Antonio	(210) 567-2600
UT MD Anderson Cancer Center ***Employees should refer to Intranet site.**	(713) 745-6947
UT Medical Branch Galveston	(409) 772-2630, Option '0' or Toll Free (866) 996-8862
UT Pan American	(956) 381-2451
UT Permian Basin	(915) 552-2751
UT San Antonio	(210) 458-4250
UT Southwestern	(214) 648-9830
UT System Administration	(512) 499-4660
UT Tyler	(903) 566-7358

GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, UT System will generally never require a UT System benefits participant to provide any genetic information when responding to any request for medical information in connection with enrollment in any UT System benefits plan or accessing any of your UT System plan benefits. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. There may be circumstances where your health care provider may recommend that an individual undergo genetic testing for health reasons and in some cases a UT System plan may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. For more information about GINA see **www.dol.gov/ebsa/faqs/faq-GINA.html.**

UNIVERSITY OF TEXAS SYSTEM NOTICE OF PRIVACY PRACTICES

REVISION EFFECTIVE AS OF September 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

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

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

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

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

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

C. **Health Care Operations.** System may use or disclose your medical information in order to conduct "health care operations." Health care operations are activities that federal law considers important to System's successful operation. As examples, System may use your complying with contracts and applicable laws. In addition, System may contact you to give you information about treatment alternatives or other health-related services that may interest you. System may also disclose your medical information to a health care provider or other health plan that is involved with your health care, as needed for that person's quality-related medical information to evaluate the performance of participating providers in a Plans' networks, and System may disclose your medical information to an auditor who will make sure that a third party administrator of a Plan is health care operations.

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

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

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

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

H. **Disclosure to You.** System may disclose your medical information to you or to a third party to whom you request us in writing to disclose your medical information.

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

J. **Disclosures to Business Associates.** System may contract or otherwise arrange with other entities or System offices to perform services on behalf of the Plans. System may then disclose your medical information to these "Business Associates," and these Business Associates will use or disclose your medical information only to the extent System would be able to do so under the terms of this Section II. These Business Associates are also required to comply with federal law that regulates your medical information privacy. To the extent that System offices serve as Business Associates to other institutions within The University of Texas System that are Covered Entities, those offices will comply with those institutions' Privacy Policies and Notices of Privacy Policies as to those institutions' PHI they maintain, access or use as their Business Associates of those institutions.

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

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

M. **Written Authorization.** System may use or disclose your medical information under circumstances that are not described above only if you provide permission by "written authorization." After you provide

written authorization, you may revoke that authorization, in writing, at any time by sending notice of the revocation to the Privacy Officer identified in Section IV of this Notice. If you revoke an authorization, System will no longer use or disclose your medical information under the circumstances permitted by that authorization. However, System cannot take back any disclosures already made under that authorization.

III. RESTRICTIONS. You have the following rights associated with your medical information:

A. System will not use your medical information for fundraising purposes.
B. System will never use your genetic medical information about you for underwriting purposes. Using or disclosing your genetic information is prohibited by federal law.
C. System does not use your medical information for marketing purposes. "Marketing" does not include face to face communications with you, or any communications for which the Plan receives no remuneration such as refill reminders, treatment plans, alternatives to treatment, case management, value added services provided in connection with a Plan, and other purposes related to treatment and health operations care. "Marketing" also excludes promotional gifts of nominal value provided by the Plan nor does it include refill reminders.
D. System does not sell your medical information.

IV. YOUR RIGHTS CONCERNING YOUR MEDICAL INFORMATION

You have the following rights associated with your medical information:

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

as the information is kept by or for System. You must make your request in writing to the Privacy Officer, and you must give a reason that supports your request. If System denies your request for an amendment, System will explain to you its reasons for denial and your appeal rights following denial.

E. **Right to an Accounting of Disclosures:** You have the right to request a list of disclosures of your medical information that have been made by System and its Business Associates. OEB does not have to list the following disclosures:
   - Disclosures for treatment;
   - Disclosures for payment;
   - Disclosures for health care operations;
   - Disclosures of a limited data set for health care operations, research, or public health activities;
   - Disclosures to you;
   - Disclosures to individuals involved with your health care;
   - Disclosures to authorized federal officials for national security activities;
   - Disclosures that occur incidentally with other permissible uses and disclosures;
   - Disclosures made under your written authorization; and
   - In certain circumstances, disclosures to law enforcement officials or health oversight agencies.

   You must make your request in writing to the Privacy Officer. Your request must state the time period during which the disclosures were made, which may not include dates more than six years prior to the request. System may charge you a fee for the list of disclosures if you request more than one list within 12 months.

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

G. **Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this Notice, even if you have received this Notice electronically. You may make your request to the Privacy Officer.

V. BREACH NOTIFICATIONS

System makes every effort to secure your health information, including the use of encryption whenever possible. In the event that any of your medical information that has not been encrypted is the subject of a breach, System will provide you with a written or electronic about the breach as required by federal law.

VI. WHOM TO CONTACT REGARDING SYSTEM'S PRIVACY POLICIES

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

Privacy Officer c/o
Office of General Counsel
The University of Texas System
201 West 7th Street, Suite 600
Austin, Texas 78701-2902
(512) 499-4462
Email: Privacyofficer@utsystem.edu

B. Department of Health and Human Services. To obtain further information about the federal privacy rules or to submit a complaint to the Department of Health and Human Services, you may contact the Department by telephone at 1 800 368 1019, by electronic mail at (ocrmail@hhs.gov), or by regular mail addressed to:

Regional Manager, Region IV
Office of Civil Rights
US Department of Health and Human Services
1301 Young Street
Dallas, TX 75202
214 767-4056
TDD 214 767-8940

C. Electronic Copy of This Notice. You may obtain an electronic copy of the most current version of this Notice at the following website: **www.utsystem.edu/offices/employee-benefits/hipaa-and-privacy**.

VII. SYSTEM'S RIGHT TO REVISE THIS NOTICE

System reserves the right to change the terms of this Notice at any time. System also reserves the right to make the revised notice effective for medical information System already has about you as well as any information OEB receives while such notice is in effect. Within 60 days of a material revision to this Notice, System will provide the revised notice to all individuals then covered by a Plan. If you want to make sure that you have the latest version of this Notice, you may contact the Privacy Officer.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2014. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: **www.medicaid.alabama.gov**
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: **health.hss.state.ak.us/dpa/programs/medicaid/**
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: **www.azahcccs.gov/applicants**
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid
Medicaid Website: **www.colorado.gov/**
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: **www.flmedicaidtplrecovery.com/**
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: **dch.georgia.gov/**
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: **healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx**
Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid
Website: **www.in.gov/fssa**
Phone: 1-800-889-9948

IOWA – Medicaid
Website: **www.dhs.state.ia.us/hipp/**
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: **www.kdheks.gov/hcf/**
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: **chfs.ky.gov/dms/default.htm**
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: **www.lahipp.dhh.louisiana.gov**
Phone: 1-888-695-2447

MAINE – Medicaid
Website: **www.maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: **www.mass.gov/MassHealth**
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: **www.dhs.state.mn.us/**
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
Website: **www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid
Website: **medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml**
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: **www.ACCESSNebraska.ne.gov**
Phone: 1-800-383-4278

NEVADA – Medicaid
Medicaid Website: **dwss.nv.gov/**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: **www.dhhs.nh.gov/oii/documents/hippapp.pdf**
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
www.state.nj.us/humanservices/dmahs/clients-medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: **www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: **www.nyhealth.gov/health_care/medicaid/**
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid and CHIP
Website: **www.ncdhhs.gov/dma**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: **www.nd.gov/dhs/services/medicalserv/medicaid/**
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: **www.insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: **www.oregonhealthykids.gov**
www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: **www.dpw.state.pa.us/hipp**
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: **www.ohhs.ri.gov**
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: **www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: **dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: **www.gethipptexas.com/**
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: **health.utah.gov/upp**
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: **www.greenmountaincare.org/**
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: **www.dmas.virginia.gov/rcp-HIPP.htm**
Medicaid Phone: 1-800-432-5924
CHIP Website: **www.famis.org/**
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: **hrsa.dshs.wa.gov/premiumpymt/Apply.shtm**
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: **www.dhhr.wv.gov/bms/**
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: **www.badgercareplus.org/pubs/p-10095.htm**
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: **health.wyo.gov/healthcarefin/equalitycare**
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

BENEFITS COST WORKSHEET FOR RETIRED EMPLOYEES
PLAN YEAR 2014-2015

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

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

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

MEDICAL OUT-OF-POCKET COST PER MONTH Full-Time Employees:				BLUE CROSS BLUE SHIELD OF TEXAS	
Plan Available – Worldwide	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	**MEDICAL TOTAL**
UT SELECT	$0	$227.07	$237.49	$447.17	
Prescription benefit coverage + $6,000 Life					**$**

TOBACCO PREMIUM PROGRAM (TPP)					
Tobacco User(s)	**Non-user**	**Subscriber**	**Spouse**	**Child(ren)**	**TPP TOTAL[2]**
Tobacco User(s) Cost	$0	$30.00	$30.00	$30.00[1]	**$**

1 Maximum cost of $30 per month regardless of how many covered dependent children use tobacco.
2 Maximum cost per family is $90 per month

DENTAL OUT-OF-POCKET COST PER MONTH				DELTA DENTAL	
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
NATIONWIDE					
UT SELECT Dental	$32.40	$61.51	$67.80	$96.40	
UT SELECT Dental Plus	$55.85	$106.06	$117.03	$166.74	**DENTAL TOTAL**
CERTAIN AREAS IN TEXAS					
DeltaCare Dental HMO	$8.89	$16.90	$18.68	$26.67	**$**

VISION OUT-OF-POCKET COST PER MONTH				SUPERIOR VISION	
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	**VISION TOTAL**
Superior Vision	$7.00	$11.00	$11.24	$17.84	
Superior Vision Plus	$11.00	$17.18	$18.40	$26.00	**$**

LIFE OUT-OF-POCKET COST PER MONTH		DEARBORN NATIONAL	
Enter Elected Coverage Amount: • Select from the following options and enter here (see[1] below). $7,000 $10,000 $25,000 $50,000 Note: For those Retired Employees of the UT System who retired through the 1993 one-time retirement option, enter the amount of coverage currently in place.		A	
Divide total in **A** by 1,000 to determine units of $1,000 for premium calculation. Enter here.		B	
Refer to Retiree Rate Chart below. Enter the rate that corresponds with your age on September 1, 2014.		C	
To determine the premium cost per month, multiply **B x C**.		D	

The remainder of the Life Out-of-Pocket calculation section relates to eligible spouse of a Retired Employee.
Dependent children of Retirees are not eligbile for Life coverage.

If you are electing the $3,000 Spouse Coverage option, enter $1.83 (see[2] below). Otherwise, enter zero.		E	**LIFE TOTAL**
To determine total Life premium cost per month, add **D + E.** Otherwise, enter zero.		F	**$**

RETIREE RATE CHART	
AGE OF SUBSCRIBER ON 9/01/14	**RATE PER $1,000 COVERAGE**
< 35	**$0.038**
35 - 39	**$0.048**
40 - 44	**$0.065**
45 -49	**$0.100**
50 -54	**$0.155**
55 -59	**$0.240**
60 -64	**$0.375**
65 -69	**$0.670**
70 and over	**$0.752**

1 If you are increasing your Life coverage amount, Evidence of Insurability (EOI) is required.
2 To elect Spouse Life coverage, EOI may be required. Contact your institution Benefits Office for assistance.

LONG TERM CARE (LTC) OUT-OF-POCKET COST PER MONTH *

CNA

AGE	PLAN A – Basic Benefit with Guaranteed Benefit Increase Option					PLAN B – Basic Benefit with Lifetime Automatic Benefit Increase Option (Inflation Protection)				
	$100 BENEFIT	$125 BENEFIT	$150 BENEFIT	$200 BENEFIT	$250 BENEFIT	$100 BENEFIT	$125 BENEFIT	$150 BENEFIT	$200 BENEFIT	$250 BENEFIT
<=24	6.46	8.07	9.69	12.92	16.15	40.73	50.92	61.10	81.47	101.83
25	6.78	8.47	10.16	13.55	16.94	41.43	51.78	62.14	82.85	103.57
26	6.96	8.71	10.45	13.93	17.41	42.20	52.76	63.31	84.41	105.51
27	7.21	9.01	10.81	14.41	18.02	43.35	54.19	65.03	86.70	108.38
28	7.49	9.36	11.23	14.97	18.71	44.79	55.99	67.19	89.59	111.99
29	7.80	9.75	11.70	15.60	19.50	46.54	58.18	69.82	93.09	116.36
30	8.13	10.17	12.20	16.27	20.33	48.49	60.61	72.73	96.97	121.22
31	8.51	10.64	12.77	17.02	21.28	50.73	63.41	76.09	101.45	126.81
32	8.91	11.14	13.37	17.83	22.29	53.13	66.42	79.70	106.27	132.83
33	9.35	11.68	14.02	18.69	23.37	55.67	69.58	83.50	111.33	139.16
34	9.83	12.29	14.75	19.66	24.58	58.43	73.04	87.65	116.86	146.08
35	10.35	12.94	15.53	20.70	25.88	61.28	76.59	91.91	122.55	153.19
36	10.92	13.65	16.37	21.83	27.29	64.17	80.22	96.26	128.35	160.43
37	11.53	14.41	17.29	23.05	28.81	67.03	83.79	100.55	134.07	167.58
38	12.16	15.20	18.24	24.32	30.41	69.69	87.11	104.54	139.38	174.23
39	12.83	16.04	19.24	25.66	32.07	72.18	90.22	108.27	144.36	180.44
40	13.50	16.88	20.25	27.01	33.76	74.35	92.93	111.52	148.69	185.87
41	14.23	17.78	21.34	28.45	35.56	76.46	95.58	114.69	152.92	191.15
42	14.98	18.73	22.47	29.96	37.45	78.41	98.01	117.61	156.81	196.02
43	15.81	19.77	23.72	31.63	39.53	80.46	100.57	120.69	160.91	201.14
44	16.70	20.88	25.06	33.41	41.76	82.50	103.12	123.75	165.00	206.25
45	17.69	22.11	26.54	35.38	44.23	84.74	105.93	127.12	169.49	211.86
46	18.78	23.48	28.17	37.56	46.95	87.22	109.02	130.83	174.44	218.05
47	19.96	24.95	29.94	39.92	49.90	89.95	112.43	134.92	179.89	224.87
48	21.16	26.45	31.74	42.32	52.90	92.43	115.54	138.64	184.85	231.07
49	22.34	27.93	33.52	44.69	55.86	94.42	118.03	141.64	188.85	236.06
50	23.52	29.40	35.28	47.03	58.79	95.97	119.96	143.96	191.94	239.93
51	24.78	30.97	37.16	49.55	61.94	97.49	121.87	146.24	194.98	243.73
52	26.13	32.66	39.20	52.26	65.33	99.01	123.76	148.51	198.01	247.52
53	27.65	34.56	41.47	55.29	69.12	100.80	126.00	151.20	201.60	252.00
54	29.41	36.76	44.11	58.82	73.52	103.10	128.88	154.66	206.21	257.76
55	31.41	39.26	47.11	62.81	78.51	105.87	132.34	158.80	211.74	264.67
56	33.72	42.15	50.58	67.44	84.30	109.39	136.73	164.08	218.77	273.46
57	36.40	45.50	54.60	72.81	91.01	113.76	142.20	170.64	227.52	284.40
58	39.18	48.97	58.77	78.36	97.94	118.12	147.65	177.18	236.24	295.30
59	41.83	52.29	62.75	83.67	104.59	121.78	152.23	182.67	243.56	304.45
60	44.50	55.63	66.76	89.01	111.26	125.19	156.49	187.79	250.38	312.97
61	47.40	59.25	71.10	94.80	118.51	128.98	161.23	193.47	257.96	322.46
62	50.61	63.26	75.91	101.21	126.51	133.19	166.49	199.79	266.38	332.98
63	54.36	67.95	81.54	108.72	135.89	138.45	173.06	207.67	276.90	346.12
64	58.71	73.39	88.07	117.43	146.78	144.79	180.98	217.18	289.57	361.97
65	63.88	79.85	95.82	127.76	159.70	152.42	190.52	228.62	304.83	381.04
66	70.06	87.57	105.08	140.11	175.14	161.69	202.11	242.53	323.38	404.22
67	77.28	96.61	115.93	154.57	193.21	172.42	215.53	258.63	344.84	431.05
68	85.58	106.97	128.37	171.16	213.94	184.42	230.52	276.63	368.84	461.05
69	94.85	118.56	142.28	189.70	237.13	197.29	246.61	295.94	394.58	493.23
70	104.87	131.09	157.31	209.74	262.18	210.48	263.09	315.71	420.95	526.19
71	115.65	144.56	173.48	231.30	289.13	223.90	279.87	335.85	447.80	559.75
72	127.12	158.90	190.68	254.24	317.80	237.46	296.82	356.19	474.91	593.64
73	139.35	174.19	209.03	278.70	348.37	251.25	314.06	376.87	502.50	628.12
74	152.03	190.03	228.04	304.06	380.07	264.83	331.04	397.25	529.67	662.08
75	165.21	206.51	247.81	330.42	413.02	278.38	347.97	417.57	556.76	695.95
76	178.99	223.74	268.49	357.98	447.48	292.29	365.37	438.44	584.59	730.73
77	193.00	241.25	289.50	386.00	482.50	306.10	382.63	459.15	612.20	765.25
78	207.92	259.90	311.88	415.85	519.81	321.45	401.81	482.17	642.90	803.62
79	223.65	279.56	335.48	447.30	559.12	338.16	422.70	507.24	676.32	845.40
80	240.40	300.50	360.59	480.79	600.99	356.75	445.94	535.12	713.50	891.87
81	257.50	321.88	386.26	515.01	643.76	375.96	469.94	563.93	751.91	939.89
82	275.24	344.05	412.86	550.48	688.11	396.35	495.44	594.52	792.70	990.87
83	293.20	366.50	439.81	586.41	733.01	416.64	520.80	624.96	833.28	1041.60
84	310.87	388.58	466.30	621.74	777.17	436.46	545.57	654.69	872.92	1091.14
85	328.62	410.78	492.94	657.25	821.56	455.80	569.75	683.70	911.60	1139.50
86	345.99	432.49	518.98	691.98	864.97	473.66	592.07	710.49	947.32	1184.15
87	362.76	453.45	544.14	725.51	906.89	489.00	611.25	733.50	977.99	1222.49
88	378.91	473.64	568.37	757.83	947.28	502.44	628.05	753.66	1004.88	1256.10
89	395.56	494.45	593.34	791.12	988.90	515.41	644.27	773.12	1030.82	1288.53
90	412.23	515.29	618.34	824.46	1030.57	528.07	660.08	792.10	1056.13	1320.17

LTC TOTAL

$

ESTIMATED TOTAL MONTHLY OUT-OF-POCKET (Add ALL boxes and enter total) **$**

* EOI is not required for new Employees who enroll during their initial period of eligibility. EOI is required for all other new enrollees.

Notes

Notes

Contact Information

INSURANCE PLAN ADMINISTRATORS

UT SELECT Medical
(Blue Cross and Blue Shield of Texas)
Group: 71778

P.O. Box 660044
Dallas, TX 75266-0044

(866) 882-2034
M-F 8:00 AM-6:00 PM CT
www.bcbstx.com/ut

UT SELECT Prescription
(Express Scripts)
Group: UTSYSRX

Express Scripts
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

(800) 818-0155
24hrs a day 7 days a week
www.express-scripts.com/ut

Living Well Health Platform
(Provant Health Solutions)

(888) 703-2296
M-F 6 AM - 5 PM CT
livingwell.provantonline.com

UT SELECT Dental and
UT SELECT Dental Plus
(Delta Dental)
Group: 5968

P.O. Box 1809
Alpharetta, GA 30023

(800) 893-3582
M-F 6:15 AM-6:30 PM CT
www.deltadentalins.com/universityoftexas

DeltaCare USA Dental HMO
(Delta Dental)
Group: 6690

P.O. Box 1809
Alpharetta, GA 30023

(800) 893-3582
M-F 7:00 AM-8:00 PM CT
www.deltadentalins.com/universityoftexas

Superior Vision
Group: 26856

P.O. Box 967
Rancho Cordova, CA 95741-0967

(800) 507-3800
M-F 7:00 AM-8:00 PM CT
Sat 10:00 AM-3:30 PM CT
www.superiorvision.com/ut

Group Term Life
(Dearborn National)
Group: GFZ71778

1020 31st Street
Downers Grove, IL 60515

(866) 628-2606
M-F 7:00 AM-7:00 PM CT
www.dearbornnational.com/ut

Long-Term Care
(CNA)
Group: 0010025IS

Continental Casualty
Attn: LTC Claims
P.O. Box 946760
Maitland, FL 32794-6760

(888) 825-0353
M-F 7:00 AM-5:00 PM CT
www.ltcbenefits.com/uts

RETIREMENT PROVIDERS

Fidelity Investments

P.O. Box 770002
Cincinnati, OH 45277-0090

(800) 343-0860
M-F 7:00 AM-11:00 PM CT
www.fidelity.com/ut

Voya Financial (formerly ING)
One Orange Way
Windsor, CT 06095-4774

(866) 506-2199
M-F 7:00 AM-9:00 PM CT
Sat 7:00 AM-3:00 PM CT
www.ingretirementplans.com/utexas

Lincoln Financial Group

Lincoln Financial Group
Attn: UT Retirement Servicing
1300 South Clinton Street
Fort Wayne, IN 46801

(800) 454-6265 * 8
M-F 7:00 AM-7:00 PM CT
www.lfg.com/ut

TIAA-CREF

TIAA-CREF (Products, Services)
P.O. Box 1259
Charlotte, NC 28201

TIAA-CREF Mutual Funds
P.O. Box 8009
Boston, MA 02266-8009

(800) 842-2776
TDD (800) 842-2755
M-F 7:00 AM-9:00 PM
Sat 8:00 AM-5:00 PM CT
www.tiaa-cref.org/utexas

VALIC

VALIC Document Control
P.O. Box 15648
Amarillo, TX 79105-5648

(800) 448-2542
M-F 8:00 AM-7:00 PM CT
www.valic.com/utexasorp

Contact Information

INSTITUTION BENEFITS OFFICES

UT Arlington

Office of Human Resources
J. D. Wetsel Bldg.
1225 W. Mitchell, Ste. 212
Arlington, TX 76019

(817) 272-5558 Benefits Line or
(817) 272- 5554
Fax: (817) 272-5798
benefits@uta.edu

UT Austin

The University of Texas at Austin
Human Resource Services
101 E. 27th St. STOP J5600
Austin, TX 78712-1573

(512) 471-4772 or
Toll Free: (800) 687-4178
Fax: (512) 232-3524
HRSC@austin.utexas.edu

UT Brownsville

Human Resources UTB
451 E. Alton Gloor
Brownsville, TX 78526

(956) 882-8205
Fax: (956) 882-6599
benefits@utb.edu

UT Dallas

Office of Human Resources
Mail Station AD 10
800 W. Campbell Rd.
Richardson, TX 75080

(972) 883-2221
Fax: (972) 883-2156
benefits@utdallas.edu

UT El Paso

Administration Building, Room 216
500 West University Ave.
El Paso, TX 79968

(915) 747-5202
Fax: (915) 747-5815
benefits@utep.edu

UT Health Science Center Tyler

11937 US Highway 271
Tyler, TX 75708-3154

(903) 877-7784
Fax: (903) 877-5394
benefits@uthct.edu

UT Health Science Center Houston

7000 Fannin
The University Center Tower (UCT)
10th Floor
Houston, TX 77030

(713) 500-3935
Fax: (713) 500-0342
benefits@uth.tmc.edu

UT Health Science Center San Antonio

7703 Floyd Curl Drive, MSC 7972
San Antonio, TX 78229-3900

(210) 567-2600
Fax: (210) 567-6791
ben-admin@UTHSCSA.EDU

UT Health Science Center Tyler

11937 US Highway 271
Tyler, TX 75708-3154

(903) 877-7784
Fax: (903) 877-5394
benefits@uthct.edu

UT MD Anderson Cancer Center

Physical Address:
7007 Bertner
Human Resources Benefits
Houston, TX 77030-3907

Mailing Address:
HR Benefits Unit 1614
PO Box 301407
Houston, TX 77230-1407

(713) 745-6947
Fax: (713) 745-7160
hrbenefits@mdanderson.org

UT MD Anderson Cancer Center

Physicians Referral Service (PRS)
Physical Address:
7007 Bertner, Suite 1MC9.2359
Houston, TX 77030

Mailing Address:
Physicians Referral Service (PRS)
PO Box 301407, Unit 1660
Houston, Texas 77230-1407

(713) 792-7600
Fax: (713) 794-4812
prsfacbensrvs@mdanderson.org

UT Medical Branch at Galveston

301 University Blvd.
Galveston, TX 77555-0840

(409) 772-2630, Option "0"
Toll Free: (866) 996-8862
Fax: (409) 772-2754
benefits.services@utmb.edu

UT Pan American

Human Resources
1201 W. University Dr.
Edinburg, TX 78541

(956) 665-2451
Fax: (956) 665-3289
hrbenefits@utpa.edu

UT Permian Basin

4901 East University Blvd.
Odessa, TX 79762

(432) 552-2751
Fax: (432) 552-3747

UT San Antonio

One UTSA Circle
San Antonio, TX 78249

(210) 458-4250
Fax: (210) 458-7890
benefits@utsa.edu

UT Southwestern Medical Center

5323 Harry Hines Blvd
Dallas, TX 75390-9023

(214) 648-9830
Fax: (214) 648-9881
benefits@utsouthwestern.edu

UT System

Office of Employee Services
Claudia Taylor Johnson Hall
210 W. 6th Street, Suite B.140.E
Austin, TX 78701

(512) 499-4660
Fax: (512) 499-4380
esc@utsystem.edu

UT Tyler

Office of Human Resources
3900 University Blvd. ADM 108
Tyler, TX 75799

(903) 566-7480
Fax: (903) 565-5690
aclem@uttyler.edu

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