



THE UNIVERSITY of TEXAS SYSTEM

EMPLOYEE **ENROLLMENT** **GUIDE**

2019/20 BENEFITS GUIDE FOR
NEW EMPLOYEES

A PUBLICATION OF
THE OFFICE OF EMPLOYEE BENEFITS

UT Benefits Enrollment Guide

FOR PLAN YEAR BEGINNING SEPTEMBER 1, 2019

After you become benefits eligible, you will have orientation or a meeting with a benefits representative at your institution. They will help you with the following important information about your benefits enrollment.

Date of hire/initial benefits eligibility date

Deadline for enrolling in benefits (31 days after initial eligibility)

My basic coverage is effective

My voluntary coverage is effective

My Benefits ID Number is

For help with enrollment or eligibility, to update information for you or covered dependents, or to make benefits changes due to a change of status event (within 31 days), contact:

NAME OF BENEFITS REPRESENTATIVE

PHONE

EMAIL

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Welcome to UT Benefits

Insurance, Wellness, and Retirement programs offered to you through the UT System Administration Office of Employee Benefits

The UT Benefits program operates under Texas Insurance Code and complies with state laws and statutes pertinent to employee benefits for The UT System. Chapter 1601 of the Code governs all UT group insurance programs. The Office of Employee Benefits (OEB) is responsible for the overall administration of contracts for the group insurance and voluntary retirement programs for all UT institutions.

Each institution may provide its own additional programs and resources outside of the group insurance to meet the needs of that institution's employees. The Benefits and Human Resources Offices at each location are the primary point of contact for all employees and retired employees. They maintain and administer all employment records and information related to your UT employment including eligibility and payroll.

For plan-specific details and services, our insurance and retirement program vendors are the best resource.

Below is a summary of who to contact for information on various topics. Contact information for OEB (UT Benefits), your institution's HR/Benefits Office, and plan vendors is located at the back of this guide.

CAMPUS BENEFITS OFFICE

Address Change
Life Events / Change of Status
Eligibility
Payroll / Premium Billing

UT SYSTEM OFFICE OF EMPLOYEE BENEFITS (OEB)

Periodic Newsletters
Legal Notices
Plan Guides
Annual Enrollment

INSURANCE VENDORS

Plan Details
ID Cards
Value Added Benefits
Claim Issues
Customer Service

This handbook provides an overview of terms and conditions of the insurance, retirement, and wellness programs for The University of Texas System. The Office of Employee Benefits along with our vendors maintains a wealth of information regarding the programs and services offered through group insurance. All plan information can be accessed through the OEB website. Here is an overview of specific information available to you:

Chapter 1601 – The Chapter in the Texas Insurance Code that governs the Uniform Group Insurance Programs for the employees of The University of Texas System and Texas A&M University.

OEB Administrative Manual – Contains the policies and procedures for the Office of Employee Benefits (OEB) at The University of Texas System (System).

Plan Guides – Detailed plan information for each insurance type—may also be known as “the certificate.”

Legal Notices – Federally required notices related to your insurance benefits.

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.

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, 2019 this Booklet supersedes all previous editions, including undated mailings and revisions as well as all other University of Texas System policies either written or oral that refer to UT Benefits. 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 will control and are final. If there is any ambiguity or inconsistency between this document and Chapter 1601 or current policy, the current policy or terms of Chapter 1601 control and are final. You may request a printed copy of the latest edition at any time.

Enrollment Checklist

- ☐ Review plan information in this guide
- ☐ Review the Legal Notices at the back of this book:
 - Uniform Summary of Benefits and Coverage
 - UT SELECT Medical Plan Opt Out of Certain Provisions of the Public Health Services (PHS) Act
 - UT CONNECT Medical Plan Opt Out of Certain Provisions of the Public Health Services (PHS) Act
 - Special Enrollment Rights Notice
 - Patient Protection Disclosure
 - HIPAA Notice of Privacy Practices
 - Medicare Part D Notice of Creditable Coverage
 - CHIPRA – If you or your dependents are eligible to enroll in Medicaid or CHIP
 - Non-Discrimination and Accessibility Notice
- ☐ Attend orientation and view presentations on the OEB website
- ☐ Contact your institution's Benefits Office, the plan vendor, or OEB for questions
- ☐ Enroll within 31 days of your date of hire
- ☐ Complete evidence of insurability (EOI), if necessary, within 31 days of the initial period of eligibility
- ☐ Submit dependent documentation, if necessary, within 31 days of the initial period of eligibility
- ☐ Keep a copy of your enrollment summary
- ☐ Check your first paycheck after your benefits effective date to be sure your coverage is correct
- ☐ Complete beneficiary information for life, accidental death and dismemberment (AD&D), voluntary retirement accounts, and TRS/ORP
- ☐ Look for new ID cards and a FLEX Debit Card (if enrolled in HCRA) within two weeks of your effective date
- ☐ Register for online resources – see vendor information at the back of this handbook
- ☐ Review Voluntary Retirement Program information and select a provider. You may add or change your voluntary retirement program at any time.
- ☐ Contact your institution's Benefits Office within 31 days of a change of status event if you need to make changes to your benefits during the year.





Group Insurance Benefits Eligibility and Enrollment

Eligibility

EMPLOYEES

In general, under state law, you are eligible for benefits as a **full-time employee** if:

1) You work at least 40 hours per week or have a full-time appointment, **2)** your appointment is expected to continue for at least 4 ½ months, **3)** you are eligible to participate in TRS or ORP, and **4)** you are not currently insured by another state-sponsored medical insurance plan.

A UT institution may designate an employee who is expected to work at least 30 hours per week as full-time. Please check with your institution's HR or Benefits Office for additional information if you think you may be eligible.

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

1) You work at least 20 but less than 40 hours per week, or have at least a 50% appointment, **2)** your appointment is expected to continue for at least 4 ½ months, **3)** you are eligible to participate in TRS or ORP, and **4)** you are not currently insured by another state-sponsored medical insurance plan.

This enrollment guide specifically refers to the above group of eligible employees. Although certain provisions highlighted in this guide may apply to other groups of employees, there may be instances in which, due to your appointment, some details may not apply to your specific situation.

Certain non-employee Post-Doctoral Fellows and qualifying Graduate Students who are not otherwise eligible for UT Benefits may be eligible for some or all components of UT Benefits. Contact your institution's benefits office for more information.



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. Eligible dependents are:

- Your spouse;
- Your children under age 26 regardless of their marital status, including:
 - biological children;
 - stepchildren and adopted children;
 - grandchildren you claim as dependents for federal tax purposes;
 - children for whom you are named a legal guardian or who are the subject of a medical support order requiring such coverage; and
 - certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support.

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

- your former spouse;
- foster children covered by another government program, unless coverage is required by law or court order;
- any dependent insured in the same plan type by another UT employee or retired employee; or
- any dependent insured by another plan that receives State of Texas premium contributions.

PREMIUM SHARING

Premium Sharing refers to the funds contributed by the State and your institution to pay for some or all of the cost of the Basic Coverage Package (Medical, Basic Life and Basic AD&D insurance for employees).

The amount of Premium Sharing depends on your employment appointment, and in most cases is:

For full-time employees: 100% of employee premiums for the basic coverage package and 50% of the premiums for your dependents' medical coverage.

For benefits-eligible part-time employees: 50% of employee premiums for the basic coverage package and 25% of the premiums for your dependents' medical coverage.

If you are a part-time employee who is eligible for benefits because of your status as a graduate student, UT and the State of Texas will pay 50% of your premiums for the basic coverage package, and up to 25% of the premiums for your dependents' medical coverage. Your

institution may also choose to supplement premiums for its graduate student employees. For more information, contact your institution's Benefits Office.

If you are a benefits-eligible employee with coverage under another group health plan and elect to waive the basic coverage package, you are eligible to use state premium sharing (50% if you are full-time and 25% if you are part-time) to purchase one or more of the following optional coverages that are paid on a pre-tax basis: Dental, Vision, and Voluntary Accidental Death and Dismemberment (AD&D). If you waive, you will not be enrolled in Basic Group Life Insurance or Basic Accidental Death and Dismemberment (AD&D) insurance.

Important: Those who wish to waive the Basic Coverage Package and receive partial Premium Sharing for eligible optional coverages, must submit proof of other group health insurance to their employing institution.

Rates are available in the back of this booklet.

SURVIVING DEPENDENT BENEFITS

A surviving spouse or other benefits-eligible dependent may continue limited participation in the UT Benefits program following the death of a participating employee or retired employee, provided the employee has at least five (5) years of creditable service with either Teacher Retirement System of Texas (TRS) or the Texas Optional Retirement Program (ORP), including at least three (3) years as a benefits-eligible employee with UT System.

A surviving spouse may only continue UT Benefits Medical, Dental, or Vision coverage they are enrolled in at the time of the employee's or retired employee's death. They may not add coverage at that time, and

if the coverage is ever dropped or terminated for any reason, it may not be reinstated. Surviving dependents are not eligible for Premium Sharing. Coverage may continue 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.



OVERAGED INCAPACITATED DEPENDENTS

A dependent child age 26 or older who is determined to be medically incapacitated at the time a subscriber first becomes benefits eligible may be enrolled in the plan if the child was covered by the subscriber's previous health plan with no break in coverage. Enrolled children may be eligible for UT Benefits as an incapacitated dependent if they are determined to be medically incapacitated at the time they age out of eligibility for coverage as a child under the program at age 26. Please contact your institution's Human Resources or Benefits Office for additional information about covering incapacitated dependent children.

WHEN BOTH SPOUSES WORK FOR UT

If you and your spouse both work for UT, you need to make some choices on how you enroll in benefits. Below are some tips to help you make these enrollment decisions and avoid enrollment errors.

BASIC COVERAGE PACKAGE

In general, it is best to enroll separately in UT medical so that each person can take advantage of your premium sharing and to get the \$40,000 Life and AD&D coverage that is included in the basic employee package.

Note: It is not permissible for one UT covered spouse to enroll in the other UT spouse's UT medical coverage in order to waive their UT medical coverage for the option of using half of the premium sharing for optional coverage.

DENTAL, VISION, VOLUNTARY LIFE, AND VOLUNTARY AD&D

You may not be enrolled as both the employee AND dependent spouse on the same plan type and dependent children may not be enrolled twice in the same plan type. Here are some dual UT spouse enrollment considerations:

- For the lowest overall premium cost, one spouse should cover the whole family, including the other spouse and child(ren), for dental and vision.
- For the greatest benefit, each spouse should enroll in their own Voluntary Life and AD&D coverage.
- Only one spouse may add dependent child Voluntary Life/AD&D coverage since the child(ren) cannot be enrolled more than once in the same plan.

FLEX FLEXIBLE SPENDING ACCOUNTS

Health Care Reimbursement Accounts (HCRA) – For qualified healthcare expenses

Each spouse may enroll in HCRA up to the full annual limit for HCRA and use the money on eligible healthcare expenses for any eligible dependent.

****If both spouses enroll in HCRA make sure you don't file for reimbursement for the same claim.**

EXAMPLE 1: Pat and Rene both work for UT. They have 5 children and many healthcare expenses so they both enroll in the maximum allowed HCRA. Child Talia gets sick and has a doctor visit and needs a prescription. Pat uses the UT FLEX Debit Card to pay for these items. Rene may not submit a claim for reimbursement for these same expenses.

EXAMPLE 2: Cindy and Todd both work for UT. They each elect \$1,000 in HCRA. Cindy has to have some unexpected dental work and exhausts her UT FLEX election early in the plan year. Todd takes advantage of his wellness program and is able to stop taking some medications so he has more UT FLEX money remaining than he was expecting. He can use some of his HCRA for Cindy's eligible healthcare expenses.

Dependent Daycare Reimbursement Accounts (DCRA) – For daycare expenses

The IRS limits the amount that can be contributed to DCRA. Married individuals who file separate tax returns are limited to a \$2,500 contribution annually. You may contribute up to \$5,000 if you are married and file a joint tax return, provided both you and your spouse each earn more than \$5,000 annually. If one of you earns less than \$5,000 during the year, you are limited to a maximum spending account contribution equal to the earned income of the lowest-earning spouse.



Enrollment

INITIAL PERIOD OF ELIGIBILITY FOR EMPLOYEES

You have 31 days from your hire date (initial period of eligibility) to complete benefits enrollment. Employees moving from a non-benefits eligible status to a benefits-eligible status also have 31 days from their change of status (initial period of eligibility) to complete benefits enrollment. Enrolling in certain insurance coverage may require evidence of insurability (EOI) or dependent documentation.

If elections are not made within the 31-day initial period of eligibility, you will be required to wait until the next Annual Enrollment or a qualified change of status event to make changes, including adding or dropping coverage. Annual enrollment occurs each July 15 – 31.

Your institution's Benefits Office will provide you with information on how to enroll or make changes to your benefits.

WAITING PERIOD

Newly hired employees and their dependents may be required to satisfy a waiting period before enrollment in the UT SELECT Medical plan is allowed. The waiting period can be up to 90 days depending on the date your employment begins.

You may enroll in voluntary coverage within your initial period of eligibility and begin receiving voluntary plan benefits either on your date of hire or the first of the following month. If EOI is required and approved, the coverage will begin the first of the month following approval of your application.

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:

- Add short-term or long-term disability coverage or any amount of employee voluntary life insurance coverage during annual enrollment;
- Increase, add, or reinstate employee voluntary group term life insurance greater than 3 times annual salary at any time; or
- Increase, add, or reinstate additional spouse voluntary group life insurance coverage.

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 children's birth certificates, appropriate adoption paperwork, federal tax forms or other documents that support the dependent relationship. For overaged incapacitated dependents, proof of other current coverage, an application for coverage, including medical files documenting incapacitating condition and dependency must be submitted within 31 days of initial eligibility for enrollment of an incapacitated dependent. Following receipt of this information, a review of all applicable materials will determine if the overage dependent is eligible for coverage in the UT Benefits program.

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.



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 and AD&D insurance (which you receive even if you only have the basic coverage), you can review your current beneficiary information by contacting Dearborn National Customer Service at (866) 628-2606 (available Monday through Friday from 7 a.m. to 7 p.m. central time) If you have not designated a beneficiary or you need to revise your designation, you will need to complete a beneficiary designation form, available at: www.dearbornnational.com/ut/lang_en/forms/employee_forms.html. Complete the form and mail it to the address listed on the bottom of the form.

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 go to www.utsystem.edu/offices/employee-benefits/approved-providers.

CHANGE OF STATUS

You have **31 days** from the date of a qualified change of status event to notify your institution's 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;
- starting or ending employment, starting or returning from FMLA, or other change of job status (e.g., from non-benefits eligible part-time to full-time) affecting eligibility;
- change in dependent's eligibility (e.g., reaching age 26 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.

Special rules apply for an 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
- becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

This dependent may be enrolled in certain UT Benefits coverage provided the dependent meets all other UT eligibility requirements and is enrolled within **60 days** from the date of the applicable event. If enrollment of the dependent is conditioned on enrollment of the employee, the employee will also be eligible to enroll.

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 applicable time frame through your institution's HR/Benefits Office. Please refer to "Legal Notices" section at the back of this booklet for more information on "Special Enrollment Rights".



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Plan Information

BASIC COVERAGE PACKAGE

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

UT SELECT MEDICAL PLAN,
WITH PRESCRIPTION DRUG COVERAGE

\$40,000 BASIC GROUP LIFE INSURANCE

\$40,000 BASIC ACCIDENTAL DEATH AND
DISMEMBERMENT (AD&D)

OPTIONAL COVERAGE

Benefits-eligible employees may select the following Optional Coverage(s) for themselves and their eligible dependents, unless stated otherwise:

UT SELECT MEDICAL PLAN,
WITH PRESCRIPTION DRUG COVERAGE
FOR YOUR ELIGIBLE DEPENDENTS (ENROLLMENT
IN THIS PLAN IS AUTOMATIC FOR FULL-TIME
EMPLOYEES)

UT CONNECT ACO MEDICAL PLAN,
WITH PRESCRIPTION DRUG COVERAGE
FOR YOURSELF AND YOUR ELIGIBLE DEPENDENTS
(FOR ELIGIBLE DALLAS/FORT WORTH AREA
MEMBERS ONLY)

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

VOLUNTARY ACCIDENTAL DEATH &
DISMEMBERMENT (AD&D) INSURANCE

SHORT-TERM DISABILITY (STD) INSURANCE
(FOR EMPLOYEES ONLY)

LONG-TERM DISABILITY (LTD) INSURANCE
(FOR EMPLOYEES ONLY)

UT FLEX HEALTH CARE REIMBURSEMENT
ACCOUNT (HCRA)

UT FLEX DEPENDENT CARE REIMBURSEMENT
ACCOUNT (DCRA) – TO BE USED FOR DAYCARE
EXPENSES FOR DEPENDENT CHILDREN UP TO AGE
13 OR YOUR SPOUSE OR DEPENDENT WHO IS
PHYSICALLY OR MENTALLY UNABLE TO CARE FOR
HIM OR HERSELF.



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, a monthly surcharge applies for tobacco users enrolled in the UT SELECT Medical plan. This \$30 charge is in addition to the regular monthly premium costs and will be applied separately for the employee and spouse as well as for any dependent children aged 16 and over who use tobacco, up to a maximum of \$90 per family per month. As a condition of enrollment in the UT SELECT Medical plan, members must provide a declaration regarding tobacco use as described below.

Members must declare whether they are tobacco users, which is defined as a person who has used tobacco products within the past sixty (60) days.

Those who declare they are non-tobacco users must not have used tobacco products within the past sixty (60) days prior to the day this declaration is completed.

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.

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 in this situation is responsible for submitting a Physician Statement Form every plan year to avoid Tobacco Premium Program charges.



UT SELECT Medical Plan

The UT Benefits program includes UT SELECT Medical, a self-funded 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.

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 - Available to UT SELECT participants living in Texas, New Mexico, and Washington, D.C.

Out-of-Area - Apply only to those UT SELECT participants whose residence of record is outside of Texas, New Mexico, and Washington, D.C.

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. 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 Parts A/B 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 ALS. Consult with your local Social Security Administration office to learn what illnesses qualify for Medicare coverage prior to turning age 65.



UT SELECT Benefit Summary Chart

SEPTEMBER 1, 2019 - AUGUST 31, 2020

IN-AREA PLAN

In-Area Benefits apply to any eligible Employees, Retirees, and their dependents whose residence of record is in the State of Texas, New Mexico, or Washington, D.C.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	\$350/individual \$1,050/family	\$750/individual \$2,250/family
ANNUAL MEDICAL COINSURANCE MAXIMUM	\$2,150/individual \$6,450/family (does not include deductible)	N/A
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,900/individual \$15,800/family (All member medical and prescription drug allowed cost share)	N/A
OFFICE SERVICES		
VIRTUAL VISIT WITH MDLIVE	\$0 copay	\$0 copay
PREVENTIVE CARE	Plan pays 100% (no copayment required)	60% Plan/40% Member
DIAGNOSTIC OFFICE VISIT (FAMILY CARE PHYSICIAN (FCP) IS FAMILY PRACTICE INTERNAL MEDICINE OB/GYN PEDIATRICS)	FCP \$30 Copay; Specialist \$35 Copay	60% Plan /40% Member
URGENT CARE	\$35	60% Plan /40% Member
EMERGENCY CARE		
AMBULANCE SERVICE (IF TRANSPORTED)	80% Plan/20% Member	
HOSPITAL EMERGENCY ROOM	\$150 Copay plus 20% coinsurance (copay waived if admitted) If admitted, ER services are added to claims for inpatient services	
OUTPATIENT CARE		
OUTPATIENT FACILITY SERVICES	\$100 Copay; then 80% Plan /20% Member	60% Plan/40% Member
NON-EMERGENCY MRI/CT SCANS	\$100 Copay (may be waived by contacting the Health Advocate before services) Note: For related services, such as contrast materials or injections, 80% Plan/20% Member	\$100 Copay plus 60% Plan/40% Member (copay may be waived by contacting the Health Advocate before services)
INPATIENT CARE		
SEMI PRIVATE ROOM AND BOARD**	\$100 Copay/Day (\$500 max/admission); then 80% Plan/20% Member	60% Plan/40% Member
THERAPY		
PHYSICAL THERAPY/CHIROPRACTIC CARE, OCCUPATIONAL THERAPY (MAX. 20 VISITS/YR)	\$35 Copay	60% Plan/40% Member
SPEECH AND HEARING THERAPY (MAX. 60 VISITS/YR)		

BEHAVIORAL HEALTH		
VIRTUAL VISIT WITH MDLIVE	\$0 copay	\$0 copay
OFFICE VISIT	\$35 Copay	60% Plan/40% Member
OUTPATIENT**	80% Plan /20% Member	60% Plan/40% Member
INPATIENT**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
OTHER SERVICES		
BARIATRIC SURGERY* (PRE-DETERMINATION RECOMMENDED)	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After \$3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers.	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After \$3,000 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.

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

UT HEALTH NETWORK FOR UT SELECT PARTICIPANTS

An additional benefit tier known as the UT Health Network offers an enhanced plan design for UT SELECT Medical participants receiving services from certain UT physicians and certain UT medical facilities. You will pay lower copays and coinsurance when seeing a participating UT physician at a participating UT-owned facility, and you can also save on physician charges when treatment is received from a participating UT physician at a non-UT-owned facility. Benefits of the new UT Health Network along with several claims examples are illustrated below.

	UT HEALTH NETWORK BENEFIT	STANDARD UT SELECT IN-NETWORK BENEFIT
PRIMARY CARE	\$20 copay	\$30 copay
SPECIALIST	\$25 copay	\$35 copay
EMPLOYEE CLINIC*	\$10 copay	\$30 copay
DEDUCTIBLE	\$350	\$350
COINSURANCE	10%	20%
INPATIENT COPAY*	\$0 / day	\$100 / day (max \$500)

Current points of service for the UT Health Network include:

- UT Medical Branch Galveston facilities & providers;
- UT Health Northeast (Tyler) facilities & providers;
- UT Rio Grande Valley providers and facilities; and
- UT Austin, UT Health Houston, and UT Health San Antonio Employee & Nursing Clinics.

For additional information, including details about available Employee & Nursing Clinics, please see the individual city links under "UT Health Network" in the navigation menu of the OEB website. You can also log into Blue Access for Members to access the Provider Finder specific to UT SELECT Medical, where participating providers and facilities are clearly marked as being part of the UT Health Network. You must be logged in to see the "UT Health Network" designation.

The UT Health Network benefit is not available at this time for services received from UT Southwestern, or UT MD Anderson Cancer Center physicians or facilities. Your regular UT SELECT Medical in-network benefits apply for these providers and locations.

BENEFITS EXAMPLES

Your UT Health Network benefit applies depending on the status of the provider and facility as shown below.

- Visit to a Participating Employee Health Clinic* (at any UT Facility) for urgent care needs: Member pays \$10 copay.
*Note: Employee Health Clinics may be run by a UT medical or nursing practice. Employee Health Clinics are not Primary Care or Specialty offices).
- Office Visit with a UT Provider at a UT-owned or non-UT-owned Facility: Member pays office visit copay of \$20 (primary care) or \$25 (specialist).



- Inpatient or Outpatient Services with a UT Provider at a participating UT Facility: Member pays regular \$350 deductible, 10% coinsurance on provider and facility charges, and a \$0 inpatient/\$100 outpatient copay.
- Inpatient or Outpatient Services with a UT Provider at a non-participating Facility: Member pays regular \$350 deductible, 10% coinsurance on provider charges, 20% coinsurance on facility charges, and \$100 facility copay per day.

OUT-OF-AREA PLAN

Out-of-Area benefits apply to any eligible Employees, Retirees, and their dependents whose residence of record is outside of the State of Texas, New Mexico, or Washington, D.C. The Out-of-Area plan covers the same services as the In-Area Plan, and the prescription drug plan benefits are the same.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	\$350 / individual \$1,050 / family	\$750 / individual \$2,250 / family
ANNUAL MEDICAL COINSURANCE MAXIMUM	\$2,150 / individual \$6,450 / family (does not include deductible)	\$4,250 / individual \$12,750 / family (does not include deductible)
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,900 / individual \$15,800 / family (All member medical and prescription drug allowed cost share)	N/A
PREVENTIVE CARE	Plan pays 100% (no copayment required)	60% Plan / 40% Member
VIRTUAL VISIT WITH MDLIVE	\$0 copay	\$0 copay
OTHER COVERED MEDICAL SERVICES	75% Plan / 25% Member	60% Plan / 40% Member
BARIATRIC SURGERY (PRE-DETERMINATION RECOMMENDED)	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After \$3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers.	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum). After \$3,000 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.

UT SELECT KEY TERMS

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 and do not balance bill.

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 expenses also do not count toward this limit.

The \$2,150/\$6,450 limit includes medical coinsurance only (no copayments or prescription plan costs). There’s an additional limit

including copayments and prescription costs such that in no case will the eligible in-network out-of-pocket expenses including medical and prescription deductible, coinsurance, and copayments be greater than \$7,900 for employee only coverage or \$15,800 for employee plus dependent coverage (Subscriber plus spouse, subscriber plus child(ren), or subscriber plus family).

Health Advocate – Health advocates serve as a personal assistant for your health care needs. You may contact a health advocate to address your medical benefits questions. They can help you and your covered family members:

- Get personal assistance with your health care matters
- Understand your health benefits
- Talk to a BCBSTX clinician about health questions
- Sort out a new diagnosis and what to do next
- Shop for quality, lower-cost health care

It’s easy to reach a health advocate. Call 1-866-882-2034, weekdays 7 a.m. to 7 p.m. CT.

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

YOUR HEALTH CARE BENEFITS TRAVEL WITH YOU

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” online at www.bcbstx.com/ut.



UT CONNECT Medical Plan

UT CONNECT is a benefit option available to University of Texas System benefits-eligible employees, non-Medicare retirees, and their families living in Dallas/Fort Worth Metroplex. It gives you a choice for coverage that combines a focus on both quality and value.

Southwestern Health Resources, the network established by UT Southwestern Medical Center and Texas Health Resources, is the foundation of this benefits option. As a result, this coverage links you and your family to a full range of care—from annual physicals and primary prevention programs to groundbreaking treatment capabilities for major illnesses.

UT CONNECT offers members access to some of the most highly regarded physicians, caregivers, health care leaders and specialists throughout North Texas:

- UT Southwestern Medical Center
- Texas Health Resources
- Pediatric Hospitals in the Dallas/Fort Worth Metroplex

CHOOSING YOUR PRIMARY CARE PHYSICIAN (PCP)

Having a PCP brings together the advantages UT CONNECT offers. That's why you'll need to select a PCP for each member of your family at the time you enroll.

IN-NETWORK CARE

UT CONNECT provides access to physicians, caregivers, outpatient facilities and hospitals in the network. There is no coverage for out-of-network care, except for true emergencies and a few other specific situations. If needed, we'll be available to assist you in getting the care you need within network, including referrals to specialists and pre-authorizations.

Physicians, caregivers, and hospitals participating in the network are listed online at www.bcbstx.com/utconnect.

UT CONNECT Benefit Summary Chart

SEPTEMBER 1, 2019 - AUGUST 31, 2020

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

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

NETWORK BENEFITS	
ANNUAL DEDUCTIBLE (APPLICABLE WHEN COINSURANCE IS REQUIRED)	\$250/individual \$750/family
COINSURANCE MAXIMUM	\$2,150/individual \$6,450/family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,900/individual \$15,800/family (medical and prescription deductible, coinsurance, and copayments)
PRE-EXISTING CONDITION LIMITATION	None
LIFETIME MAXIMUM BENEFIT	No limit
OFFICE SERVICES	
VIRTUAL VISIT WITH MDLIVE	\$0 Copay
PREVENTIVE CARE	Plan pays 100% (no copayment required)
DIAGNOSTIC OFFICE VISIT	PCP \$15 Copay; Specialist \$25 Copay NOTE: First PCP Copay Waived per patient, thereafter copay is applicable
DIAGNOSTIC LAB AND X-RAY	Included in Office Visit Copay
URGENT CARE	\$35 Copay
OTHER DIAGNOSTIC TESTS	PCP \$15 Copay; Specialist \$25 Copay
ALLERGY TESTING	PCP \$15 Copay; Specialist \$25 Copay
ALLERGY SERUM/INJECTIONS (IF NO OFFICE VISIT BILLED)	Plan pays 100% (no copayment required)
EMERGENCY CARE	
AMBULANCE SERVICE (IF TRANSPORTED)	80% Plan/20% Member
HOSPITAL EMERGENCY ROOM	\$150 Copay/then 20% Member coinsurance (copay waived if admitted) If admitted, ER services are added to claims for inpatient services
EMERGENCY PHYSICIAN SERVICES	80% Plan/20% Member

OUTPATIENT CARE	
OBSERVATION	80% Plan/20% Member
SURGERY – FACILITY	\$50 Copay; then 80% Plan/20% Member
SURGERY – PHYSICIAN	80% Plan/20% Member
DIAGNOSTIC LAB AND X-RAY	100% covered (except when billed with surgery; then 80% Plan/20% Member)
MRI/CT SCANS	\$100 Copay NOTE: For related services, such as contrast materials or injections, 80% Plan/20% Member
OTHER DIAGNOSTIC TESTS	80% Plan /20% Member
OUTPATIENT PROCEDURES	80% Plan /20% Member
INPATIENT CARE	
HOSPITAL - SEMI PRIVATE ROOM AND BOARD**	Deductible then 80% Plan/20% Member
HOSPITAL INPATIENT SURGERY**	80% Plan/20% Member
PHYSICIAN	80% Plan/20% Member
OBSTETRICAL CARE	
PRENATAL AND POSTNATAL CARE OFFICE VISITS	PCP \$15 Copay; Specialist \$25 Copay (initial visit only)
DELIVERY – FACILITY/INPATIENT CARE**	Deductible then 80% Plan/20% Member
OBSTETRICAL CARE AND DELIVERY - PHYSICIAN	80% Plan/20% Member
THERAPY	
PHYSICAL THERAPY/CHIROPRACTIC CARE (MAX. 20 VISITS/YR)	\$25 Copay / Visit
OCCUPATIONAL THERAPY (MAX. 20 VISITS/YR)	\$25 Copay / Visit
SPEECH AND HEARING THERAPY (MAX. 60 VISITS/YR)	\$25 Copay / Visit
EXTENDED CARE	
VIRTUAL VISIT WITH MDLIVE	\$0 Copay
SKILLED NURSING/CONVALESCENT FACILITY** (MAX. 180 VISITS)	80% Plan/20% Member
HOME HEALTH CARE SERVICES** (MAX. 120 VISITS)	80% Plan/20% Member
HOSPICE CARE SERVICES**	80% Plan/20% Member
HOME INFUSION THERAPY**	80% Plan/20% Member
BEHAVIORAL HEALTH	
SERIOUS MENTAL ILLNESS – OFFICE VISIT	PCP \$15 Copay; Specialist \$25 Copay
SERIOUS MENTAL ILLNESS – OUTPATIENT**	80% Plan /20% Member
SERIOUS MENTAL ILLNESS – INPATIENT**	Deductible then 80% Plan/20% Member
MENTAL ILLNESS – OFFICE	PCP \$15 Copay; Specialist \$25 Copay
MENTAL ILLNESS – OUTPATIENT**	80% Plan/20% Member
MENTAL ILLNESS – INPATIENT**	Deductible then 80% Plan/20% Member

CHEMICAL DEPENDENCY – OFFICE	PCP \$15 Copay; Specialist \$25 Copay
CHEMICAL DEPENDENCY – OUTPATIENT TREATMENT**	80% Plan/20% Member
CHEMICAL DEPENDENCY – INPATIENT TREATMENT**	Deductible then 80% Plan/20% Member
BEHAVIORAL HEALTH	
DURABLE MEDICAL EQUIPMENT**	80% Plan/20% Member
PROSTHETIC DEVICES	80% Plan/20% Member
HEARING AIDS (ADULT) (\$1000 PER EAR; ONCE EVERY 3 YEARS)	80% Plan/20% Member
HEARING AIDS (THROUGH AGE 18; ONCE EVERY 3 YEARS)**	80% Plan/20% Member
BARIATRIC SURGERY (PRE-DETERMINATION RECOMMENDED)	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. NOTE: Individual must be enrolled in the UT SELECT plan for 36 continuous months prior to the date of the surgery to receive benefits.

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

**These services require preauthorization to establish medical necessity.

UT CONNECT KEY TERMS

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 and do not balance bill.

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) including medical and prescription drug deductibles, copayments and coinsurance

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

EMERGENCY BENEFITS WHILE YOU TRAVEL

In an emergency, go to the nearest facility for care, in or out of the network. Emergency care is always covered in a true emergency situation (e.g., heart attack, broken bones, head injuries, severe pain, severe bleeding, etc.). UT CONNECT uses the same network for international services as UT SELECT.

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” online at www.bcbstx.com/utconnect.



Prescription Drug Plan for UT SELECT and UT CONNECT

Your prescription drug benefits under UT SELECT and UT CONNECT are administered by Express Scripts and require a \$100 annual deductible per plan participant, per plan year. This deductible is separate from the medical plan deductible. The deductible and allowed member cost share (copayment) apply to the whole plan out-of-pocket limit.

UT SELECT PRESCRIPTION DRUG PLAN 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 31-DAY SUPPLY. REFILLS ALLOWED AS PRESCRIBED. (GOOD OPTION FOR NEW PRESCRIPTIONS)	\$10	\$35	\$50
HOME DELIVERY PHARMACY / Smart90 Retail at Walgreen's or UT Pharmacies: 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. 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.

YOUR PRESCRIPTION DRUG PLAN AND MEDICARE PART D

The Federal Medicare program provides a Medicare-approved prescription drug benefit – Medicare Part D that might be available to certain UT SELECT participants. The University of Texas System continues to offer your current UT SELECT prescription drug benefit, and enrollment in a private Medicare Part D plan will have a negative financial impact for most UT participants. UT strongly urges active benefits-eligible employees NOT to enroll in a private Medicare Part D program or Advantage plan, if eligible.

All retired UT plan participants are enrolled in a UT sponsored Medicare Part D Plan so anyone already enrolled in a separate UT Part D or Advantage plan will have to choose to drop UT SELECT plan coverage (including medical) or drop their other plan because no one may be enrolled in more than one Medicare plan. Please note also, that depending on the amount of your modified adjusted gross income when you are enrolled in a Medicare Part D Plan, you may be subject to a Part D income-related monthly adjustment amount (Part D-IRMAA). Social Security will contact you if you are responsible for Part D-IRMAA. The Part

D-IRMAA amount goes directly to Medicare, not to your plan. To view a chart listing the D-IRMAA amount by income, see www.Medicare.gov and search for the page titled "Monthly Premium for Drug Plans" where D-IRMAA is also discussed. If you are notified by Social Security that you are responsible for D-IRMAA and you disagree (for example, if your income goes down), you should contact Social Security directly and let them know you wish to appeal their determination.

Only for a relatively small number of very low-income UT SELECT participants, enrolling in Medicare Part D may save money if the participant also qualifies for a "low income subsidy" provided as part of the Medicare 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

Delta Dental Insurance Company administers two self-funded dental plans for UT participants and provides a fully-insured dental HMO plan.

DENTAL PPO PLANS

You can choose from two dental PPO plans depending on the level of benefits your family needs. Both dental PPO plans allow you the freedom to choose from any licensed dentist though you will save when you use a Delta Dental DPO or Delta Premier network provider. Non-network dentists are not limited in the amounts they can charge you. The difference in plan payment to these providers and what you owe (balance billing) may be significant.

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	Plan pays deductible
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 (ENDODONTICS, PERIODONTICS, AND ORAL SURGERY)	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.

DENTAL HMO PLAN

The **DeltaCare USA Dental HMO Plan** (fully-insured) is 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 institution's 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 for most common services.
- 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. You must visit your selected dentist to receive benefits under your plan. 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.

To find the most current listing of 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.



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:		SERVICES/FREQUENCY LIMITS FOR BOTH PLANS:	
EXAM	\$35	EXAM	1 per plan year
MATERIALS	\$0	FRAMES	
CONTACT LENS FITTING	\$35	CONTACT LENS FITTING	
		LENSES	
		CONTACT LENSES	

VISION PLANS COMPARISON

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	\$165 retail allowance	Up to \$81
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 26)	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	\$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 and Accidental Death and Dismemberment Insurance

Group term life (GTL) insurance can help ensure financial security for your family and loved ones upon your death. Accidental death and dismemberment (AD&D) insurance gives you added financial protection by paying full benefits in the case of accidental death and partial benefits for certain losses due to accidental injury. UT System provides eligible employees with basic GTL and AD&D as part of the basic coverage package. Benefits-eligible employees also have the opportunity to purchase additional voluntary employee and dependent coverage at group rates. Both basic and voluntary GTL and AD&D insurance are provided by Dearborn National.

BASIC GROUP TERM LIFE (GTL) BENEFITS

Basic group term life insurance in the amount of \$40,000 is a part of the basic coverage package. Full time eligible employees enrolled in the UT SELECT Medical plan are automatically enrolled in the basic GTL at no cost and without Evidence of Insurability (EOI).

VOLUNTARY GROUP TERM LIFE OPTIONS

COVERAGE LEVEL	BENEFIT AMOUNT
EMPLOYEE VOLUNTARY GTL (AVAILABLE WITH OR WITHOUT BASIC GTL)	1 to 10 times annual compensation (to a maximum total of \$2,000,000)
DEPENDENT VOLUNTARY GTL*	\$10,000 (Benefit amount for spouse and each eligible dependent child)
ADDITIONAL SPOUSE VOLUNTARY GTL*	\$15,000 or \$40,000 in addition to the \$10,000 Dependent Voluntary GTL

*Employee must be enrolled in Employee Voluntary GTL benefits in order to elect benefits for spouse and/or dependent children.

The dependent voluntary GTL premium provides coverage of \$10,000

for each eligible dependent regardless of how many dependents are covered. Employee Voluntary GTL and Additional Spouse Voluntary GTL premium is based on the enrolled person's age and benefit coverage level. Please see the rates in the Resources section of this guide.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Basic accidental death and dismemberment (AD&D) insurance in the amount of \$40,000 is part of the basic coverage package. Full time eligible employees enrolled in the UT SELECT Medical plan are automatically enrolled in the basic AD&D at no cost and without evidence of insurability (EOI).

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT OPTIONS

COVERAGE LEVEL	BENEFIT AMOUNT
EMPLOYEE VOLUNTARY AD&D (AVAILABLE WITH OR WITHOUT BASIC AD&D)	Increments of \$10,000 up to \$2 million or 10 times annual compensation, whichever is less.
SPOUSE VOLUNTARY AD&D*	Increments of \$10,000 up to one-half of the employee voluntary AD&D benefit in force or \$1,000,000 whichever is less.
DEPENDENT CHILD COVERAGE*	\$10,000 (benefit per eligible child)

*Employee must have at least \$20,000 Employee Voluntary AD&D coverage in order to elect Voluntary AD&D coverage for spouse and/or dependent children.

All amounts of AD&D coverage are guaranteed issue. No EOI is ever required for any increases in AD&D benefits during annual enrollment or following a qualified change in status event during the plan year.



Disability Insurance

Disability insurance replaces a portion of your income if you suffer a prolonged illness or non-work related injury that prevents you from doing your job. Dearborn National provides short-term disability (STD) and long-term disability (LTD) insurance benefits for active benefits-eligible UT System employees. This benefit is not available for dependents.

Benefits under STD and LTD will be reduced by deductible sources of income or disability benefits received from other sources. Your total disability pay, including other sources of income, cannot be more than 60% of your weekly earnings.

SHORT-TERM DISABILITY (STD)

WEEKLY BENEFIT	60% of weekly earnings up to a maximum benefit of \$693 per week (subject to reduction by deductible sources of income or disability earnings)
ELIMINATION PERIOD	Accident/Injury: Fourteen (14) days or until sick leave has been exhausted Sickness: Fourteen (14) days or until sick leave has been exhausted
SICK LEAVE	You must exhaust all of your accrued sick leave before benefits are payable.
MAXIMUM PERIOD PAYABLE	22 Weeks; 4 weeks for pre-existing conditions

LONG-TERM DISABILITY (LTD)

MONTHLY BENEFIT	60% of your monthly earnings up to a maximum gross monthly benefit of \$12,025 per month, subject to deductible sources of income or other disability earnings.	
ELIMINATION PERIOD	90 days from onset of disability, during which you are continuously disabled.	
SICK LEAVE	You must exhaust all of your accrued sick leave before benefits are payable.	
MAXIMUM PERIOD PAYABLE	Age at Disability Less than age 60 Age 60 through 64 Age 65 through 69 Age 70 and over	Maximum Period Payable To age 65, but not less than 5 years 5 years To age 70, but not less than 1 year 1 year

Note: The LTD program does not cover long-term care services.

IMPORTANT

You may enroll in up to three (3) times your salary in Voluntary Life Insurance coverage or Disability coverage without Evidence of Insurability (EOI) during your newly eligible enrollment window or following a change of status.

If you try to add this coverage at another time, you may be considered a late entrant and be required to pass EOI.

UT FLEX

A flexible spending account (FSA) - Health Care Reimbursement Account (HCRA) or Day Care Reimbursement Account (DCRA) is a way to set aside money from your earnings before taxes are withheld that can be used to pay certain out-of-pocket health care expenses and qualifying dependent day care expenses.

As you incur health care or dependent day care expenses throughout the plan year, you will be reimbursed with tax-free dollars from your UT FLEX account(s). This reduces the amount you pay in taxes and increases your spendable income. If you are enrolled in HCRA, you also have the added convenience of the UT FLEX Debit Card to pay for eligible expenses at the point of service.

Here is an example of how you might save:

	WITH AN FSA	WITHOUT AN FSA
ANNUAL SALARY	\$40,000	\$40,000
HEALTH CARE FSA CONTRIBUTION (PRE-TAX)	(\$1,500)	(\$0)
DEPENDENT CARE FSA CONTRIBUTION(PRE-TAX)	(\$4,000)	(\$0)
TAXABLE INCOME AFTER CONTRIBUTION AMOUNT	\$34,500	\$40,000
ESTIMATED TAXES WITHHELD (22.65%)*	(\$7,814)	(\$9,060)
POST-TAX INCOME	\$26,686	\$30,940
MONEY SPENT AFTER TAX ON HEALTH CARE AND DEPENDENT DAY CARE EXPENSES	(\$0)	(\$5,476)
TAKE HOME PAY	\$26,686	\$25,464
SAVINGS	\$1,222	\$0

*Based on 7.65% FICA and 15% tax bracket.

Note: Please be advised that this example is for illustrative purposes only. These projections are only estimates and should not be assumed to be tax advice. Be sure to consult a tax advisor to determine the appropriate tax advice for your situation.

MAESTRO HEALTH UT FLEX TOOLS

Maestro Health has planning tools available at learn.myutflex.com. Click on - "UT FLEX Resources"

IMPORTANT INFORMATION ABOUT UT FLEX

"USE IT OR LOSE IT."

To qualify as a tax-exempt plan, the UT FLEX flexible spending accounts must comply with all applicable Internal Revenue Service requirements, including forfeiture of unreimbursed funds. In other words, these UT FLEX spending account plans are "use it or lose it" plans. Any amounts you do not use throughout the plan year (and during the grace period for health-related expenses) will be forfeited, so it is very important to plan carefully. Review your prior year's expenses to estimate your health care and dependent day care expenses for the upcoming plan year. Be conservative and plan only for predictable expenses.

COORDINATION WITH FEDERAL CHILD AND DEPENDENT CARE EXPENSES TAX CREDIT

If you plan to use a combination of the UT FLEX DCRA and the "Credit for Child and Dependent Care Expenses" on your federal income tax return, the amount you deposit in your DCRA will offset dollar-for-dollar the amount of expenses you are eligible to claim as a tax credit on your federal income tax return. You should carefully review the benefits of the federal income tax credit with the benefits of the UT FLEX DCRA. If you are not sure how this may impact you, consult your personal tax advisor before making your elections.



Plan Carefully

Any amount left in your account after the claims run-out period will be forfeited.

Important: The IRS limits maximum amounts for contributions to dependent day care accounts (January 1 through December 31). Your contributions are tracked by UT FLEX and your employing institution on a fiscal year (September 1 through August 31) basis. You (and your spouse, if applicable) - not UT FLEX or your institution - are responsible for making sure you do not exceed the IRS limits during each calendar year.

UT FLEX BENEFIT SUMMARY

	Health Care Reimbursement Account (HCRA)	Dependent Day Care Reimbursement Account (DCRA)
WHAT CAN BE REIMBURSED?*	Medically necessary health care expenses, including dental and vision related expenses incurred and paid during your period of coverage. Expenses paid by insurance are not eligible for reimbursement.	For children under age 13 or qualified disabled dependents of any age who are claimed as dependents for federal income tax purposes. Dependent day care expenses that are necessary for you and your spouse (if married) to work or attend school full-time, such as child care services in a home, licensed day care, and adult day care.
HOW MUCH CAN I CONTRIBUTE?	\$15 minimum contribution per month. Total contributions cannot exceed \$2,700 per plan year per employee for federal income tax filing purposes.	\$15 minimum per month up to a maximum of \$5,000 per plan year; or up to a maximum of \$2,500 per plan year if married filing separate federal income tax returns.
ADMINISTRATIVE FEE	\$0	\$0
DEBIT CARD FEE	No fee	N/A; debit card is not available for DCRA
HOW DO I GET REIMBURSED FOR ELIGIBLE EXPENSES?	Mobile app: Apple iOS or Android Store - mSAVE (Maestro Health) Pay with a UT FLEX debit card File Online at myUTFLEX.com Mail or fax a paper claim	Mobile app: Apple iOS or Android Store - mSAVE (Maestro Health) File Online at myUTFLEX.com Mail or fax a paper claim
WHEN CAN I GET REIMBURSED?	The first day of your enrollment in the plan.	As soon as your first contribution is deducted from your pay and put into your account. Reimbursement can be made only up to your available account balance.
LAST DAY TO INCUR EXPENSES	November 15 after the end of the plan year	August 31 (The last day of the plan year)
CLAIM FILING DEADLINE	November 30 after the end of the plan year	November 30 after the end of the plan year

*A detailed list of eligible and ineligible expenses is available at learn.myutflex.com/#ITEMS

IMPORTANT

The UT FLEX Plan Year is **September 1 to August 31**, which is different from most other FSA plans that operate on a calendar year. Please pay close attention to key dates:

August 31 | Deadline to incur DCRA expenses.

November 15 | Grace period ends. Last day to incur expenses on the HCRA from the previous plan year.

November 30 | Claim filing deadline for both DCRA and HCRA.

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Living Well: Health & Wellness Program

The UT System Living Well program provides a variety of resources to enable employees, retirees, and dependents enrolled in the UT SELECT Medical plan to take charge of their health and develop their own personal wellness program.

Our mission is to improve the health and well-being of Texans by helping University of Texas System employees, retirees, and dependents at all institutions achieve optimal performance levels.

Learn more about all of these programs at our Living Well website: www.livingwell.utsystem.edu

NATURALLY SLIM

Naturally Slim is an online program that helps you lose weight, plus improve your overall health -- all while eating the foods you love. With Naturally Slim, you'll learn that you don't have to starve yourself or count calories to be healthy, lose weight and keep it off forever. To add yourself to the waitlist to be notified when the next application period opens, visit www.naturallyslim.com/livingwell

UT SYSTEM ACTIVITY CHALLENGES

Team up with your institution for the UT System-wide wellness challenge. You'll work toward the challenge goal to earn rewards and help your institution win the traveling trophy. For even more fun, team up with colleagues for a friendly competition.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) can help you resolve problems that affect your personal life or job performance. Learn more about this free program at: www.utsystem.edu/offices/employee-benefits/lw/eap

REIMBURSEMENT FOR EXERCISE EXPENSES

Individuals with medical conditions that can be improved by physical activity are able to receive reimbursement from their healthcare reimbursement flexible spending account (UT FLEX) to pay for some exercise programs or equipment. A Letter of Medical Necessity is required for all exercise referrals.



ONSITE HEALTH CHECKUPS

This checkup, similar to what you might receive at your doctor's office, is designed to identify issues that may affect your health and help you get them under control before they become serious. Participating institutions will be communicating the dates via email and posters.

ONSITE FLU SHOTS

Flu Shots may be available at your institution at no cost to you. Details will be sent via email and our "A Matter of Health" newsletter during September/October.

24/7 NURSELINE

Get answers to your health care questions, information about major medical issues, chronic illness support, and lifestyle change support. Call BCBSTX toll-free at **1-866-882-2034**, 24 hours a day, 7 days a week.

HEALTH ADVOCACY SOLUTION

All UT SELECT medical plan members have access to a health advocate through the Health Advocacy Solution. Health advocates can assist with questions about your benefits and help manage complicated or chronic conditions, such as coronary artery disease, asthma, and diabetes.

FINANCIAL WELLNESS

UT System provides many resources to help you learn about personal finances and how to plan for your retirement. We've partnered with five of the leading investment companies in the nation to provide representatives on your campus to help you as you consider your future financial health.

SPECIALIST PHARMACISTS

If you take medications to treat high cholesterol, diabetes, or one of several other conditions, specialist pharmacists can answer your questions and offer improvements in the quality and affordability of your pharmacy care. Learn more by contacting Express Scripts at 1-800-818-0155.

FREE RESOURCES TO HELP YOU QUIT TOBACCO

The UT SELECT medical plan offers members a variety of tobacco cessation resources at no out-of-pocket cost. These resources include professional counseling and pharmaceutical therapy. See the Living Well website for details: www.livingwell.utsystem.edu.

FITNESS DISCOUNT PROGRAM

UT SELECT offers a fitness program through BCBSTX. This program offers discounts to several gyms throughout the state. For information, log on to Blue Access for Members, and select the icon for the Fitness Program.

CENTERED APP

The Centered app (for iPhone) by BCBSTX is designed to reduce stress by helping users add mindful activity to their daily routines. Through the app, you can set goals for mindful minutes, choose from a variety of guided activities and track how your mood is impacted by meditation and activity.

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If Employment or Eligibility Ends

If you or your dependents lose benefits eligibility (termination, change in hours, divorce, or reaching the dependent age limit), coverage you have in place will continue through the end of the month in which the eligibility ends. You have options to continue certain coverage as outlined in this section.

Your Rights to Continuation of Coverage Under COBRA

MEDICAL, DENTAL, VISION, AND UT FLEX HEALTH CARE REIMBURSEMENT ACCOUNTS

THIS NOTICE CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS TO CONTINUE YOUR HEALTH CARE COVERAGE IN THE UNIVERSITY OF TEXAS (UT) SYSTEM GROUP MEDICAL, DENTAL, AND VISION PLANS AND YOUR UT FLEX HEALTH CARE REIMBURSEMENT ACCOUNT, IF APPLICABLE.

PLEASE REVIEW THIS NOTICE CAREFULLY AND SHARE WITH YOUR COVERED SPOUSE (IF APPLICABLE).

You are receiving this notice because you have recently become a participant in group health coverage offered by UT System (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under one or more of the Plans. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** 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. It can also become available to other members of your family who are covered under one or more of the Plans when they would otherwise lose their 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. Please see contact information for the HR/Benefits Offices at each UT Institution at the back of this guide.



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 CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise have ended because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event occurs, 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes 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 any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes 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 with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, 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 31 days after the qualifying event occurs and provide appropriate documentation of the qualifying event, such as a copy of a finalized divorce decree.

HOW IS COBRA COVERAGE PROVIDED?

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

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 the 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 the plan administrator prior to the end of the initial 18-month period of coverage in order to extend the maximum period for medical, dental and/or vision coverage. 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 at the back of this enrollment guide.

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.

Life Insurance

If you or your dependents lose eligibility for life insurance, your coverage may be converted or ported if your application is submitted to the life insurance vendor within 31 days of the end date of your coverage. For more information, including complete details, rates and forms, please contact the vendor Dearborn National or see the information provided on their website.

CONVERSION

You and your dependents may be eligible to convert your life insurance to an individual whole life policy. You must have been enrolled in coverage for at least five years.

PORTABILITY

You and your dependents may be eligible to port your coverage, or continue the coverage under the same group policy, if you have been enrolled in the policy for at least one year. You may not port coverage when you retire. The maximum age for ported coverage is 65.

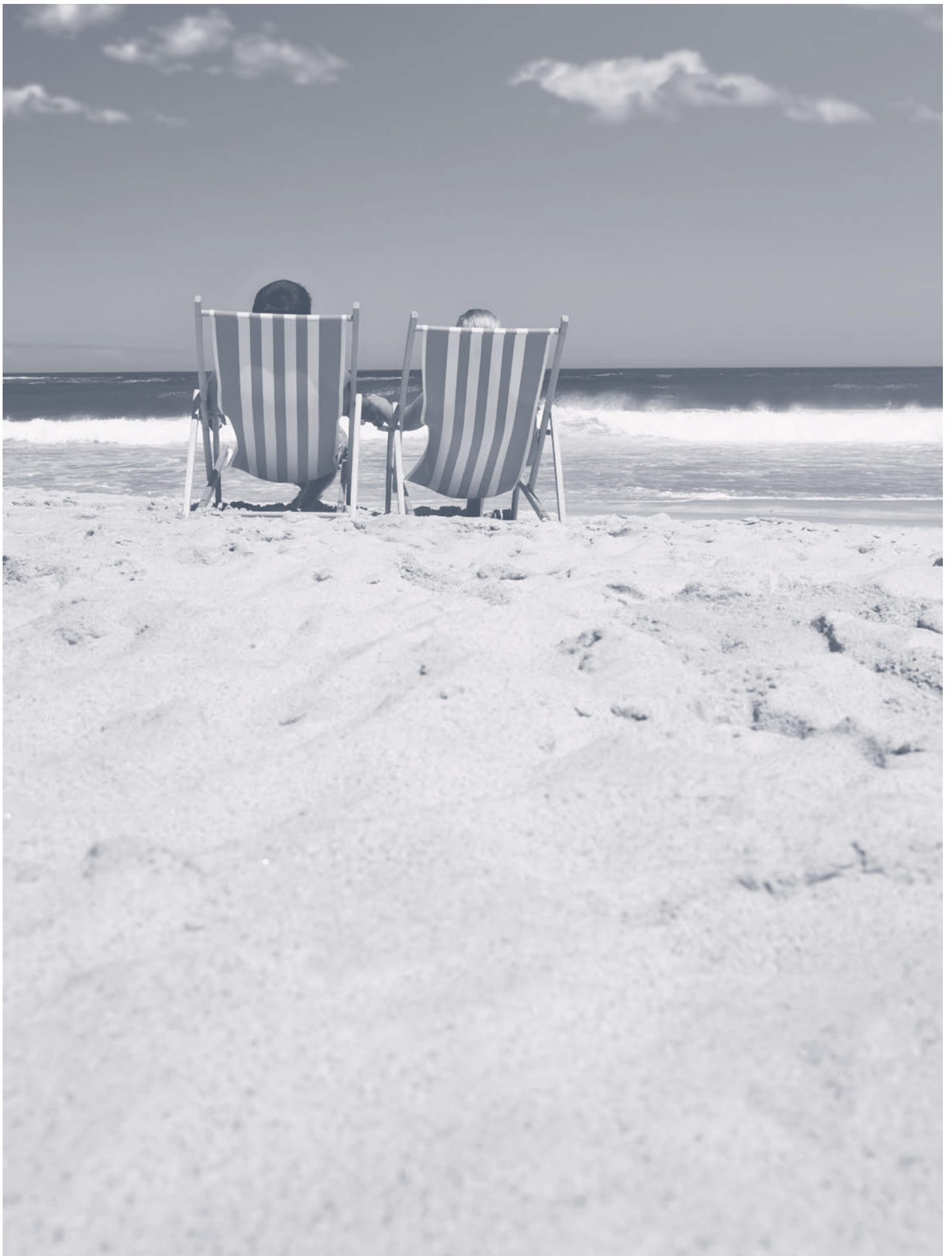
Long Term Disability

Conversion of Long-Term Disability (LTD) coverage is offered through Reliance Standard Life Insurance Company. The conversion plan allows you to convert your group LTD coverage provided by The University of Texas System, to a plan of LTD conversion coverage. Benefits and amounts of insurance under the LTD conversion coverage may differ from those under The University of Texas System's group LTD policy. You are responsible for payment of all LTD conversion coverage premiums under this plan. This conversion coverage is intended to be a "transition" LTD plan if you have no other group LTD coverage option at the time of termination. The Long-Term Disability Conversion Plan coverage extends for up to one (1) year. Complete details, rates and forms are available from the vendor Dearborn National.

UT FLEX

Your participation in the UT FLEX plans ends at the end of the month in which your employment or benefits eligibility ends unless you extend the Health Care Reimbursement Account through COBRA. COBRA is not available for the Dependent Day Care Reimbursement Account. You may only incur expenses through the end of the month in which your participation ends, but your claims filing deadline is still November 30. If your termination date is 8/31, you are eligible for the HCRA grace period and can incur expenses through November 15 following that termination date.

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Retirement Program for Active Employees

Your Future, Your Choice

The University of Texas System provides a number of vehicles you can use to save for your retirement future.

MANDATORY PLANS

TEACHER RETIREMENT SYSTEM OF TEXAS (TRS)

OPTIONAL RETIREMENT PROGRAM (ORP)
(For eligible employees)

VOLUNTARY PLANS

UTSAVER 403(B)
TAX SHELTERED ANNUITY PROGRAM (TSA)

UTSAVER 457(B)
DEFERRED COMPENSATION PLAN (DCP)

Anyone who is not a contract employee and is receiving a salary can participate in a voluntary plan. This includes graduate student employees, temporary or part time employees, and retiree rehires. Enrollment in the UTSAver TSA or UTSAver DCP can be done at any time of the year.

NOTICE

This handbook is not intended to provide a complete representation of all plan provisions. It is intended for general informational purposes only. You should not consider it tax, legal or investment advice. In the event anything in this handbook conflicts with the UT System Retirement Programs plan documents, UT System policies, or state or federal law, the UT System Retirement Programs plan documents, UT System policies, and state and federal law will govern. Please consult with your tax, legal or investment advisor for assistance with your personal situation.



Mandatory Retirement Programs

THE TEACHER RETIREMENT SYSTEM OF TEXAS (TRS)

WHAT IS TRS?	TRS is a defined benefit retirement plan governed by Internal Revenue Code Section 401(a). All eligible employees of The University of Texas System are automatically enrolled in TRS on their first day of employment unless they are eligible for and elect to enroll in ORP.
WHO IS ELIGIBLE FOR TRS?	Texas law requires all benefits-eligible employees to be automatically enrolled in TRS at the time they are hired. Benefits eligible means expected to work at least 20 hours per week for at least 4 ½ months or more, excluding students employed in positions that require student status as a condition of employment.
HOW DOES TRS WORK?	Employee and employer contributions go into a large trust fund managed by knowledgeable professionals.
WHAT DOES "DEFINED BENEFITS PLAN" MEAN?	Benefits available from TRS are determined by a formula using a combination of years of service credit in TRS, annual salary and a multiplier established by state law.
WHEN CAN I RECEIVE A BENEFIT?	A TRS member has the right to receive a lifetime annuity after 5 years of service credit with TRS and upon meeting age and service requirements.
HOW CAN I EARN SERVICE CREDIT IN TRS?	The greater the number of creditable years of service, the greater the retirement benefit will be. For TRS purposes, your year begins every September 1 st , and you will generally have attained credit for that year after working 90 work days.
CAN I BUY ADDITIONAL SERVICE CREDIT IN TRS?	You can purchase previously unreported TRS-eligible service, substitute service, out-of-state service, military service, developmental leave and previously withdrawn service to increase your creditable years of service. In some cases, purchases may be made with money rolled over directly from another qualified retirement account, such as your UTSAver Tax Sheltered Annuity or UTSAver Deferred Compensation Plan. Please contact TRS for more information regarding types of special service purchases, cost and payment options.
DOES TRS HAVE DEATH OR DISABILITY BENEFITS?	TRS offers both disability retirement and death benefits effective on your first day of employment. The disability retirement is dependent upon the number of years of service credit with TRS at the time of the disability. Your beneficiary is eligible for a lump sum death benefit of twice your annual salary up to \$80,000 on your first day of employment.
I USED TO WORK UNDER THE EMPLOYEES RETIREMENT SYSTEM. WHAT DOES THAT DO FOR MY TRS ACCOUNT?	Service credited under the Employees Retirement System of Texas (ERS) can be transferred to TRS. Likewise, eligible members of ERS may transfer their TRS-credited service credit to ERS. Under both situations, you must have three years of creditable service with the receiving system. The transfer of service that has been actively maintained or reinstated takes place under the rules of the system to which the credit is transferred. Such transfer may only take place when the member retires or at the time that a pre-retirement death benefit becomes payable. Interested individuals should contact TRS for more information.
WHAT IF I WANT A REFUND OF MY TRS ACCOUNT?	If you terminate your employment in public education in Texas, you can request a refund of your TRS contribution amounts. When you refund your account, you lose the service credit, which could impair your ability to obtain retiree health benefits.
WHAT IF I HAVE MORE QUESTIONS?	For more information regarding your TRS account, please visit the TRS website at www.trs.state.tx.us or call (800) 223-8778.

THE OPTIONAL RETIREMENT PROGRAM (ORP)

WHAT IS ORP?	The Optional Retirement Program (ORP) may be chosen by certain qualified employees as an alternative to TRS based on their appointment to certain positions. This program is a defined contribution plan governed by Internal Revenue Code Section 403(b).
WHO IS ELIGIBLE FOR ORP?	Eligibility for ORP is determined by the job performed. Your institution Benefits Office will notify you if you are in an ORP-eligible position. To be eligible to participate in ORP, an employee must: (1) initially be appointed on a full-time basis for 4 ½ months or more; and (2) be appointed to a position otherwise eligible to participate in ORP. Employees who are eligible to participate in a retirement program who are not eligible to participate in ORP must participate in TRS. Examples of eligible positions include faculty positions, specialized professional positions such as physicians, engineers or attorneys, and executive-level administrative positions.
WHEN CAN I ELECT TO PARTICIPATE IN ORP?	You have 90 days from the date you first become eligible for the ORP to make your enrollment decision. If you are reclassified or assume a new job and become ORP-eligible for the first time after your initial employment date, the 90-day election period begins on the day your reclassification becomes effective. The decision to elect ORP is a once-per-lifetime, irrevocable decision.
HOW DOES ORP WORK?	Rather than contributing to TRS, a set percentage of your salary is directed to whichever of the five authorized retirement providers you chose to work with. Your contributions and the state matching funds are then invested according to your directions at that authorized provider. After vesting (one year and one day of participation), the benefit you receive at the time of retirement is your personal contributions and state matching funds, plus or minus any investment returns.
WHAT DOES "DEFINED CONTRIBUTION PLAN" MEAN?	ORP is called a "defined contribution plan" because the retirement benefit is based on the actual amount contributed to the individual participant's account and the rate of return on investment rather than a formula. At the time of retirement, you are eligible to receive your accumulated contributions and state matching funds plus or minus investment returns.
IF ELIGIBLE, HOW DO I CHOOSE ORP OR TRS?	All ORP-eligible employees should receive An Overview of TRS and ORP . A copy can be found at: www.utsystem.edu/offices/employee-benefits/optional-retirement-program You may also wish to discuss both options with your local benefits office, a representative of TRS, or one of the five authorized providers.
HOW DO I ENROLL IN ORP?	To enroll in ORP, follow these steps: Choose your retirement provider(s) from the currently authorized provider list. You may select more than one vendor for your ORP participation. Go to www.utsystem.edu/offices/employee-benefits/enroll-retirement-manager and follow the link to UTRetirement Manager. Log in and click on ORP Enroll/Change and follow the prompts. Complete the appropriate retirement provider application(s) to open an account with that company and mail the application(s) directly to the provider. Complete TRS Form 28 (Notice to Elect to Participate in Optional Retirement Program and/or Refund) and mail it to your institution Benefits Office.



Voluntary Retirement Programs

YOUR UTSAVER VOLUNTARY PROGRAMS AT A GLANCE

UTSAVER VOLUNTARY PROGRAMS UT System offers two voluntary retirement savings programs: The UT Saver 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*	\$19,000 IRS maximum (2019) for both traditional and Roth sources. (Each dollar of a Roth contribution reduces the amount that can be contributed pretax, and vice versa.		\$19,000 IRS maximum (2019)
	OVER AGE 50 CATCH-UP CONTRIBUTION	\$6,000 combined with Roth	\$6,000 combined with Traditional	\$6,000
	15-YEAR CATCH-UP CONTRIBUTION	\$3,000 combined with Roth (lifetime total of \$15,000)	Off-set by Roth contributions	N/A
	THREE YEARS PRIOR TO YEAR OF RETIREMENT CATCH-UP (SPECIAL CATCH-UP)**	N/A	N/A	Up to \$19,000 (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.

* Contribution limits shown are IRS maximums for 2019. The 2018 limit was \$18,500.

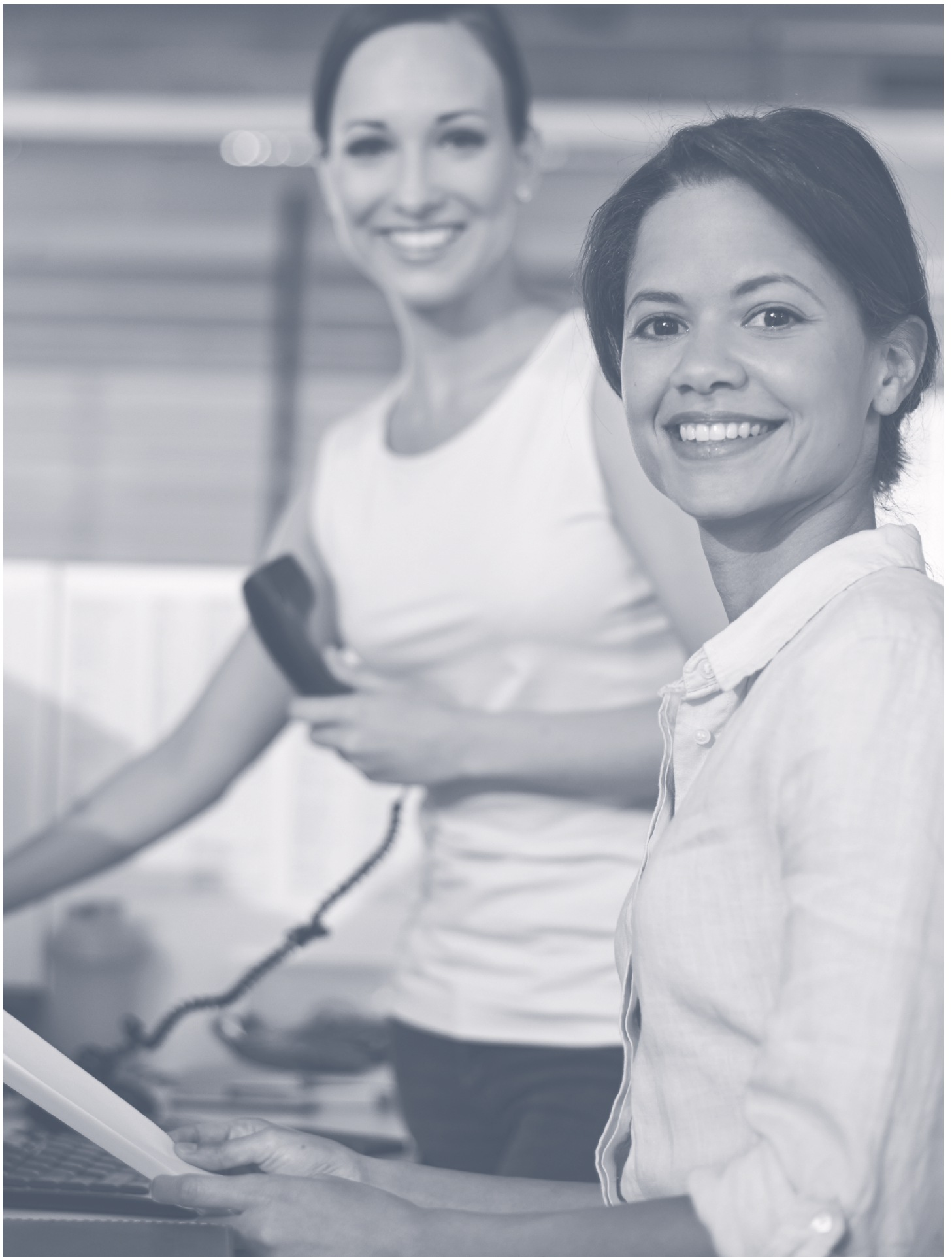
** A "qualified" distribution occurs when the Roth account has been in place for five taxable years (from the year of first contribution) and one of the following events has occurred: (1) attainment of age 59 ½; (2) disability; or (3) death.

Contribution limits 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 each voluntary program.

Your UTRetirement Programs Authorized Providers

AUTHORIZED PROVIDER	FIDELITY (800) 343-0860 www.netbenefits.com/ut	VOYA (866) 506-2199 utexas.prepare4myfuture.com	LINCOLN (800) 454-6265 *8 www.lfg.com/ut	TIAA (800) 842-2776 www.tiaa.org/public/tcm/ utexas/home	AIG RETIREMENT (800) 448-2542 www.valic.com/utsystem
PRODUCTS	MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS	ANNUITIES MUTUAL FUNDS LIFESPAN MODELS 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	Yes	Yes	Yes. On campus or at our local offices in Austin, Houston, Dallas.	Yes. By on-staff VALIC financial advisor.
DISCUSS UT RETIREMENT PLAN OPTIONS	Yes	Yes	Yes	Yes. By phone or in person.	Yes
ASSESS EMPLOYEE RISK TOLERANCE AND RETIREMENT GOALS	Yes	Yes	Yes	Yes. Comprehensive services and tools are available online, by phone, or in person.	Yes. Educational materials and financial analysis online or in person.
CONSIDER OUTSIDE ASSETS WITH NO ADVICE ON THOSE ASSETS	Yes	Yes	Yes	Yes. The Advice tool/ service considers outside assets, which can also be tracked via our 360 Degree Net Worth tool on the participant website.	Yes. Online aggregator helps track assets. Rollover help on request.
PROVIDE ASSET ALLOCATION MODELS AND THE LIST OF AVAILABLE COMPANY FUNDS	Yes	Yes	Yes	Yes. Objective Advice and allocation recommendations available online, by phone, or in person.	Yes. Allocation modeling and investment planning online or in person.
ADVICE ON FUND SELECTION	Yes. Online or in person.	Yes	Yes	Yes. Objective Advice is available online, by phone, or in person.	Yes. Online or in person.
FREE FINANCIAL PLANNING SERVICES	Yes	Yes	Yes. Receive retirement analysis at no cost from local Retirement Consultants.	Yes. Full Financial and Wealth Planning services at no additional cost.	Yes. Receive retirement analysis at no cost from on-staff advisor.
INTERACTIVE CALCULATORS	Yes	Yes	Yes, www.lfg.com	Yes. www.tiaa-cref.org/utexas	Yes, www.valic.com/utsystem
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 at no cost.	Yes. Online or in person. No cost.
ACCESS, MANAGE, FOLLOW	Online, mobile apps, Facebook, and Twitter	Yes	Online, Facebook, Twitter	Online, mobile apps, Facebook, and Twitter	Online, mobile apps, Facebook, Twitter
INVESTMENT FUND ENROLLMENT	Online enrollment or downloadable forms at www.netbenefits.com/ut	Online or by downloadable form at: https://utexas.prepare4myfuture.com/	Forms may be downloaded at: www.lfg.com/ut	Online from the TIAACREF UT site at: www.tiaa-cref.org/utexas	Easy enrollment online at: www.valic.com/utsystem 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.

Wise Healthcare Consumer Resources

COST COMPARISON

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 **Health Advocate** comes in for UT SELECT members.

UT SELECT members can call a Health Advocate and get cost comparison information from providers in your area for:

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

A Health Advocate can also help you:

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

CALL A HEALTH ADVOCATE AND SAVE!

UT SELECT members may call customer service to preauthorize MRIs and CAT/CT scans through a Health Advocate to avoid the \$100 Copay for those services.

Just call to talk to a **Health Advocate**

UT SELECT: 866-882-2034

UT CONNECT members may call CUSTOMER SERVICE

UT CONNECT: 888-399-8889 (FOR ELIGIBLE DALLAS/FORT WORTH AREA MEMBERS ONLY)



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.

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 prescriptions 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 MEMBERSSM (BCBSTX)

UT SELECT: www.bcbstx.com/ut

UT CONNECT: www.bcbstx.com/utconnect

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)

UT SELECT: www.bcbstx.com/ut

UT CONNECT: www.bcbstx.com/utconnect

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 tool. 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 then click the My Coverage tab and select Estimate Treatment Costs.

Discounts & Value-Added Services

BLUE365

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.

UT SELECT and UT CONNECT are 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)

This is a comprehensive, 24-hour emergency 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.

IDENTITY PROTECTION SERVICES

As a value-added service, Blue Cross and Blue Shield of Texas (BCBSTX) provides employees, retirees and their families who are covered under the UT SELECT or the UT CONNECT Medical Plan (both administered by BCBSTX) the opportunity to enroll in identity protection services.

These services are intended to give you some additional peace of mind. They are intended to protect health and personal information. Provided by Experian – at no cost to you – these services complement the security and data protection measures BCBSTX already has in place.

The services offered at no cost to you include features such as credit monitoring, fraud resolution, and identity theft insurance for adults and a selection of services for minor dependent children. Please note, that under the terms of this value added program, you will be required to re-enroll annually.

To enroll in this free program, you should log into your Blue Access for Members (BAM) account at www.bcbstx.com/ut (for UT SELECT participants) or www.bcbstx.com/utconnect (for UT CONNECT participants). Once logged in, please look for the “Identity Protection” link in the “Quick Links” section on the left side of the page.

NOTE: If you have not previously registered with Blue Access for Members (BAM), you will need to do so in order to access the link to sign up for free Identity Protection services. Your Benefits Identification number (or BID) is an 8 character unique identifier used for all of your UT Benefits coverage which can be found on your Blue Cross and Blue Shield of Texas ID card. The “Identification Number” requested during registration for BAM includes the leading “0” on your BCBSTX ID card plus your 8 character BID.



Enrollment Tools

PLAN YEAR 2019-2020

This is NOT an enrollment form. You must enroll online using My UT Benefits during Annual Enrollment or, for new Employees at institutions not participating in My UT Benefits Initial Enrollment, 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.

BENEFITS COST WORKSHEET FOR EMPLOYEES

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 (FULL-TIME) TOTAL
UT SELECT (OUT-OF-POCKET)	\$0	\$270.41	\$282.81	\$532.51	
UT CONNECT (OUT-OF-POCKET) DALLAS-FORT WORTH AREA ONLY	\$0	\$243.37	\$254.53	\$479.26	
PREMIUM SHARING (PAID BY STATE OF TEXAS AND YOUR UT INSTITUTION)	\$628.05	\$957.27	\$838.70	\$1,169.89	
Medical Plan Rates include: Prescription benefit coverage + \$40,000 Life + \$40,000 AD&D			Full-time = Appointed for at least 30 hours per week		\$

OR

MEDICAL OUT-OF-POCKET COST PER MONTH		Part-Time Employees:			BLUE CROSS BLUE SHIELD OF TEXAS
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	MEDICAL (PART-TIME) TOTAL
UT SELECT (OUT-OF-POCKET)	\$314.02	\$749.04	\$702.16	\$1,117.45	
UT CONNECT (OUT-OF-POCKET) DALLAS-FORT WORTH AREA ONLY	\$314.02	\$749.04	\$702.16	\$1,117.45	
PREMIUM SHARING (PAID BY STATE OF TEXAS AND YOUR UT INSTITUTION)	\$314.03	\$478.64	\$419.35	\$584.95	
Medical Plan Rates include: Prescription benefit coverage + \$40,000 Life + \$40,000 AD&D					\$

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	DENTAL TOTAL
NATIONWIDE					
UT SELECT Dental	\$28.51	\$54.13	\$59.66	\$84.83	
UT SELECT Dental Plus	\$61.39	\$116.59	\$128.65	\$183.29	
CERTAIN AREAS IN TEXAS					
DeltaCare Dental HMO	\$8.80	\$16.73	\$18.49	\$26.40	\$
VISION OUT-OF-POCKET COST PER MONTH					SUPERIOR VISION
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	VISION TOTAL
Superior Vision	\$5.90	\$9.30	\$9.52	\$15.10	
Superior Vision Plus	\$9.00	\$14.08	\$15.08	\$21.30	\$
LIFE OUT-OF-POCKET COST PER MONTH					DEARBORN NATIONAL
Enter your basic annual earnings (or contract salary) rounded up to the next \$1,000 increment (e.g. \$51,454 = \$52,000).					A
Select from 1-10 times basic annual earnings and enter how many times your earnings you desire for coverage amount. Enter a number from 1 to 10 (see ¹ below).					B
Enter Elected Coverage Amount: Multiply A x B and enter amount here. If C is greater than \$2 million, enter \$2 million.					C
Divide total in C by 1,000 to determine units of \$1,000 for premium calculation. Enter here.					D
Refer to Employee Rate Chart below. Enter the rate that corresponds with your age on September 1, 2019.					E
To determine the premium cost per month, multiply D x E.					F
The remainder of the Life Out-of-Pocket calculation section relates to eligible dependents of Employees.					
If you are electing the \$10,000 Family Coverage option, enter \$2.87 (see ² below). Otherwise, enter zero.					G
If you are eligible and choose to elect Spouse Coverage of \$25,000, enter \$15,000 (see ¹ below); OR If you are eligible and choose to elect Spouse Coverage of \$50,000, enter \$40,000 (see ¹ below); OR Enter zero if you do not choose to elect Spouse Coverage.					H
Divide total in H by 1,000 to determine units of \$1,000 for premium calculation. Otherwise, enter zero.					I
Refer to Spouse Rate Chart below. Enter the rate that corresponds to your Spouse's age on September 1, 2019. Otherwise, enter zero.					J
To determine the total Spouse Coverage premium cost per month, multiply I x J. Otherwise, enter zero.					K
To determine total Dependent Coverage premium cost per month, add G + K. Otherwise, enter zero.					L
Add F + L					LIFE TOTAL \$



EMPLOYEE RATE CHART	
AGE OF SUBSCRIBER ON 9/01/19	RATE PER \$1,000 COVERAGE
15 - 34	\$0.037
35 - 39	\$0.047
40 - 44	\$0.063
45 - 49	\$0.097
50 - 54	\$0.150
55 - 59	\$0.233
60 - 64	\$0.364
65 - 69	\$0.650
70 - 74	\$0.752
75 - 79	\$0.932
80 and over	\$1.634

SPOUSE RATE CHART	
AGE OF SPOUSE ON 9/01/19	RATE PER \$1,000 COVERAGE
15 - 24	\$0.053
25 - 29	\$0.054
30 - 34	\$0.057
35 - 39	\$0.072
40 - 44	\$0.101
45 - 49	\$0.154
50 - 54	\$0.241
55 - 59	\$0.376
60 - 64	\$0.574
65 - 69	\$0.857
70 - 74	\$1.167
75 - 79	\$1.446
80 and over	\$2.536

1 If you are increasing your Life coverage amount (coverage amounts 4-10x annual salary) or are electing Spouse, Evidence of Insurability (EOI) is required.

2 The Family Coverage option provides coverage of \$10,000 for each covered Dependent.

ACCIDENTAL DEATH & DISMEMBERMENT OUT-OF-POCKET COST PER MONTH		DEARBORN NATIONAL
<p>Enter desired coverage amount in \$10,000 increments.</p> <p>Coverage is available up to 10 times your basic annual earnings or contract salary. Basic annual earnings should be rounded up to the next \$1,000 increment (e.g. \$51,454 would be rounded to \$52,000, maximum coverage amount of \$520,000).</p> <p>Total employee coverage cannot exceed \$2,000,000.</p>		A
<p>Enter desired Spouse coverage amount in increments of \$10,000. The maximum Spouse coverage is 50% of the amount in item A (rounded down to nearest \$10,000). Employee must have \$40,000 Voluntary AD&D coverage to elect Spouse AD&D coverage.</p>		B
<p>If you desire Dependent child(ren) coverage, enter \$10,000 in item C.</p> <p>Employee must have \$20,000 Voluntary AD&D coverage to elect Dependent AD&D coverage. All of your eligible children are covered for one monthly premium cost.</p> <p>If not electing Dependent coverage, enter zero.</p>		C
<p>Enter the sum of A plus the greater of B or C</p>		D
<p>Multiply amount in D x \$.000014 for Total AD&D</p>		AD&D TOTAL \$

SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH		DEARBORN NATIONAL
<p>Multiply Basic MONTHLY earnings (cannot exceed \$5,000) x \$0.0027.</p>		STD TOTAL
<p>To calculate basic MONTHLY earnings, divide <u>annual</u> contract salary (including longevity and hazardous duty pay) by 12 months.</p> <p>Evidence of Insurability (EOI) is required for enrollment during Annual Enrollment.</p>		\$

LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH		DEARBORN NATIONAL
<p>Multiply Basic MONTHLY earnings (cannot exceed \$20,042) x \$0.0038.</p>		LTD TOTAL
<p>To calculate basic MONTHLY earnings, divide <u>annual</u> contract salary (including longevity and hazardous duty pay) by 12 months.</p> <p>Evidence of Insurability (EOI) is required for enrollment during Annual Enrollment.</p>		\$

UT FLEX SALARY REDUCTIONS PER MONTH				MAESTRO HEALTH	
Type of Account	Minimum	Maximum	Monthly Contribution		FLEX TOTAL A + B
Health Care Reimbursement Account ¹	\$15 per month	\$2,700 Annual Election		A	
Dependent Day Care Reimbursement Account ²	\$15 per month	\$5,000 Annual Election If <u>single</u> or <u>married filing jointly</u> on your Federal Income Tax Return		B	
		\$2,500 Annual Election If <u>married filing separately</u> on your Federal Income Tax Return			
				\$	

¹ Health Care Reimbursement Account (HCRA):

Maximum Election – HCRA deductions cannot exceed \$2,700 per employee per plan year (September 1 - August 31) for federal income tax filing purposes.

² Dependent Day Care Reimbursement Account (DCRA):

Maximum Election - In any given calendar year (January 1 - December 31), the DCRA deductions cannot exceed \$5,000 for federal income tax filing purposes.

ESTIMATED TOTAL MONTHLY OUT-OF-POCKET (Add ALL boxes and enter total)	\$
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REQUIRED DOCUMENTATION FOR DEPENDENT ENROLLMENT

TYPE OF DEPENDENT	REQUIRED DOCUMENTS
SPOUSE	<ul style="list-style-type: none"> Valid marriage certificate between subscriber and spouse issued by any state; OR Declaration of Informal Marriage of subscriber and spouse issued by a Texas clerk or utilizing the form promulgated by Texas Department of Health and Human Services; OR Declaration of Informal Marriage issued by another state; OR Other documentation deemed acceptable by OEB
BIOLOGICAL CHILD	<ul style="list-style-type: none"> Birth Certificate of Child proving relationship to Subscriber; OR Certification of Vital Records proving relationship to Subscriber; OR Verification of Birth Facts Form* proving relationship to Subscriber; OR Valid Medical Support Order requiring Subscriber to provide medical coverage; OR Paternity test* accompanied by Court Order, Medical Support Order, or reissued Birth Certificate
ADOPTED CHILD	<ul style="list-style-type: none"> Valid Court Order of Adoption; OR Valid Pre-Adoption Placement Order issued by a Licensed Child Placement Agency; OR Valid Court Order naming Subscriber as Managing Conservator of Child; OR Birth Certificate of Child with Adoptive Parent(s); OR Valid Medical Support Order requiring Subscriber to provide medical coverage
STEPCHILD	<ul style="list-style-type: none"> Birth Certificate of Child; AND Marriage Certificate of Subscriber and Spouse (Biological Parent)
FOSTER CHILD	<ul style="list-style-type: none"> Valid Court Order establishing a parent-child relationship between Subscriber and Foster Child
GRANDCHILD	<ul style="list-style-type: none"> Birth Certificate of Grandchild or Verification of Birth Facts Form* proving relationship to Subscriber; AND Birth Certificate of Biological Parent; AND Grandchild Certification Form*; AND Most recent tax return indicating Grandchild is the financial dependent of Subscriber
INCAPACITATED OVER AGE DEPENDENT	<ul style="list-style-type: none"> Valid Document (e.g., birth certificate, adoption papers) proving relationship to Subscriber; AND Application For Coverage of Incapacitated Over Age Dependent Form*; AND Supporting Medical Records Less Than One Year Old* Most recent tax return indicating financial dependence may also be required.
WARD	<ul style="list-style-type: none"> Valid Court Order naming Subscriber as Guardian or Conservator
IMPORTANT	<ol style="list-style-type: none"> A Power of Attorney is not adequate legal documentation for establishing a Dependent relationship. A complete copy (all pages) of a Court Order may be required to be provided, depending on eligibility and documentation requirements. If Subscriber is unable to provide the above document(s) but has other documentation that may establish a Dependent relationship, the institution HR Manager should review and determine that the alternative documentation is adequate. A document in a language other than English must be accompanied by a notarized, sworn affidavit by an independent third party indicating the document has been reviewed and translated.





UT SELECT Value Added Services

HEALTH ADVOCACY SOLUTIONS (HAS)

Get coordinated help and personal health care support from a team of experts. Features include:

- Help with understanding your care options & benefits;
- Help finding network providers & scheduling appointments;
- Ability to speak to the same health advocate for follow-up questions and discussions; and
- Coordinated help from your health advocate and other experts to connect you with the resources you need, when you need them.

You can contact a **Health Advocate** at **(866) 882-2034** or you can chat live either **online** (bcbstx.com/ut) or via the **BCBSTX app** (bcbstx.com/mobile)

MDLIVE: VIRTUAL DOCTOR VISITS - \$0 COPAYMENT

Care when and where you need it, at no cost to you, through MDLIVE – available 24 hours a day, seven days a week, 365 days a year. Features include:

- Physicians with expertise in primary care, pediatrics, & more;
- Treatment for many non-emergency medical conditions, including: colds and flu, fever (age 3+), sinus infections, ear problems (age 12+), allergies, etc.; and
- Behavioral health services (by appointment and with video connection only).

Visit mdlive.com/bcbstx for more information and to activate your account.

HINGE HEALTH

A new approach to help you conquer chronic pain without surgery or drugs. Features include:

- At-home exercise therapy and behavioral coaching program for chronic back and knee pain based on proven, non-surgical care guidelines;
- Delivered remotely using mobile & wearable technology provided at no cost to you;
- Programs for chronic hip, shoulder, and neck pain available beginning January 1, 2020; and
- No out-of-pocket cost.

Visit hingehealth.com/UTS for more information.

OMADA

Clinically proven to help reduce the risk of Type 2 diabetes and help participants lose weight. Features include:

- Core 16-week program includes wireless smart scale, weekly online lessons, and a health coach and focuses on nutrition, physical activity, and behavioral change with
- Researched curriculum paired with professional health coaches; and
- No out-of-pocket cost.

Visit omadahealth.com/UTS for more information

LIVONGO

Simplified new approach to diabetes management, for those living with Type 1 or Type 2. Features include:

- Unlimited support, strips & lancets;
- 24/7 support from Certified Diabetes Educators; and
- No out-of-pocket cost.

Visit welcome.livongo.com to learn more

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Legal Notices

You have the right to obtain a printed copy free of charge of any or all of these notices at any time by contacting the Office of Employee Benefits at benefits@utsystem.edu or (512) 499-4616.

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 insurance SBCs are available online.

UT SELECT PPO or Out-of-Area coverage:

www.bcbstx.com/ut/coverage

UT CONNECT coverage:

www.bcbstx.com/utconnect/coverage

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:

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

The exemption from these federal requirements will be in effect for the 2019-2020 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.

UT CONNECT 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 CONNECT Medical plan, which is self-funded, from the following requirements:

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

The exemption from these federal requirements will be in effect for the 2019-2020 plan year. The election may be renewed for subsequent plan years.

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

Group Health Plan Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Please also refer to the "Enrollment" section of this guide for additional information.

To request special enrollment or obtain more information, contact your campus HR Benefits office. Contact information for each campus HR Benefits office can be found on the last page of this guide.

Patient Protection Disclosure

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

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

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



University of Texas System Notice of Privacy Practices

Revised Effective August 1, 2018

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 CONNECT, UT SELECT Dental and Dental Plus and UT FLEX Self-funded Group Health Plans ("the Plans") which are funded by The University of Texas System and administered by the Office of the Employee Benefits (OEB) 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 VI), and System's right to revise this Notice (see Section VII). 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 SYSTEM 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 medical information 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 the 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 complying with contracts and applicable laws.
- 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' Protected Health Information (PHI) they maintain, access or use as their Business Associates.
- 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 VI 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

- 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 care operations. "Marketing" also excludes promotional gifts of nominal value provided by the Plan.

- 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 the 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 Confidential Communications.** 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 notification 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
Systemwide Compliance Office
The University of Texas System
210 West 7th Street
Austin, Texas 78701-2902
(512) 852-3264
Email: Privacyofficer@utsystem.edu**

mail addressed to:
**Regional Manager
Office of Civil Rights
US Department of Health and Human Services
1301 Young Street
Dallas, TX 75202
(800) 368-1019
TDD (800) 537-7697**

- c. **Electronic Copy of This Notice.** You may obtain an electronic copy of the most current version of this Notice at the following website: <https://www.utsystem.edu/documents/docs/hipaa/hipaa-notice-privacy-practices>.

- 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

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.

Medicare Part D Notice of Creditable Coverage

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.

Medicare-eligible retirees and their Medicare-eligible dependents covered under the UT medical plans are automatically enrolled in the UT SELECT PDP Employer Group Waiver Plan (EGWP), also known as UT SELECT Part D. Active employees and retirees working in a benefits-eligible position at a UT institution, as well as their dependents, who are covered under the UT medical plans are enrolled in the UT prescription drug plan (non-Medicare) regardless of Medicare eligibility. If you are considering enrolling in a Medicare Part D plan or an Advantage Plan with prescription drug coverage that is not affiliated with UT, you should compare your current coverage through UT, including which drugs are covered at what cost, with the coverage and costs of the Medicare plans available to you. Information about where you can get help with making decisions about your prescription drug coverage is included 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 coverage offered by the UT prescription drug 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?

For participants in the UT prescription drug plan (non-Medicare), you are not required to drop your UT medical and prescription plan coverage if you choose to join a Part D plan not affiliated with UT. Your UT prescription drug benefits will coordinate with your outside Part D coverage.

For participants in the UT SELECT Part D plan, enrollment in a Medicare Part D or Advantage plan not affiliated with UT will conflict with your UT SELECT Part D coverage. You will need to choose either a UT or non-UT plan, then take further action to disenroll from the other. Failure to do so may result in automatic disenrollment from the plan of your choice or a disruption in your coverage.

If you do decide to join a Medicare drug plan and drop or lose your current UT 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 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 and if this coverage changes through the UT medical plans. 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). 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).

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're 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 aren't eligible for Medicaid or CHIP, you won't 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, 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, 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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: myalhipp.com/
Phone: 1-855-692-5447

ALASKA – The AK Health Insurance Premium Payment Program

Website: myakhipp.com/ Phone 1-866-251-4861
Email: CustomerService@MyAKHIP.com
Medicaid Eligibility:
dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA – Medicaid

Website: flmedicaidtprecovery.com/hipp
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: www.medicaid.georgia.gov
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64:
Website: www.in.gov/fssa/hip
All other Medicaid:
Website: www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid

Website: www.dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS – Medicaid

Website: www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: chfs.ky.gov

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MAINE – Medicaid

Website: www.maine.gov/dhhs/ofi/public-assistance/index.htm

Phone: 1-800-442-6003 TTY Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/eohhs/gov/departments/masshealth

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/seniors/health-care/healthcare-programs/programs-and-services/medical-assistance.jsp

Phone: 1-800-657-3739 or (651) 431-2670

MISSOURI – Medicaid

Website:

www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 1-573-751-2005

MONTANA – Medicaid

Website:

dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: (402) 473-7000

Omaha: (402) 595-1178

NEVADA – Medicaid

Website: dhcfp.nv.gov

Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/

Phone: 1-603-271-5218

Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

www.state.nj.us/humanservices/dmahs/clients/medicaid

Medicaid Phone: 1-609-631-2392

CHIP Website: www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: dma.ncdhhs.gov

Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid

Website: www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: healthcare.oregon.gov/Pages/index.aspx

www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.eohhs.ri.gov/

Phone: 1-855-697-4347

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

Medicaid: medicaid.utah.gov

CHIP: health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT– Medicaid

Website: www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:

www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website:

www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website:

www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: mywvhipp.com

Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid

Website:

www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/

Phone: 1-307-777-7531

To see if any more States have added a premium assistance program since January 31, 2019, 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, Menu Option 4, Ext. 61565

Nondiscrimination Notice

Discrimination is Against the Law

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

The UT System Office of Employee Benefits provides:

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters, and
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Free language services to people whose primary language is not English, such as:

- Qualified interpreters, and
- Information written in other languages.

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file.

Accessibility Requirements Notice

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#) 번으로 전화해 주십시오

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#) पर कॉल कर।

Laotian

ປິດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)

Persian (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فر

اهم باشد. با تماس بگیر ید. [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#)

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Gujarati

ચુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#).

Japanese

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。..... [UT SELECT Medical](#) [UT SELECT Prescription Drug](#) [UT SELECT Medicare Part D](#) まで、お電話にてご連絡ください。

UT SELECT Medical 1-866-882-2034
UT CONNECT Medical 1-888-372-3398
UT SELECT Prescription Drug 1-800-818-0155
UT SELECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231)
UT SELECT Dental 1-800-893-3582
UT FLEX 1-844-887-3539

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Fax: (512) 232-3524
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Fax: (972) 883-2156
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UT HEALTH SAN ANTONIO

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

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Fax: (903) 877-5394
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Fax: (713) 794-4812
prsfacbensrvs@mdanderson.org

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Fax: (432) 552-3747
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and Innovation
(512) 499-4587
Fax: (512) 499-4380
ohr@utsystem.edu

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Fax: (903) 565-5690
humanresources@uttyler.edu

Plan Administrators

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UT SELECT PART D PRESCRIPTION

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24hrs a day 7 days a week
www.express-scripts.com/ut

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