



BlueCross BlueShield
of Texas

UT SELECT



YOUR UT SELECT HEALTH BENEFITS

2022 - 2023

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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

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WELCOME



Meeting Your Health Care Needs

This booklet is a guide to your UT SELECT Medical Plan (UT SELECT) benefits administered by Blue Cross and Blue Shield of Texas (BCBSTX) under the direction of *The University of Texas System (UT System)*, Office of Employee Benefits (OEB). It includes definitions of terms you should know and detailed information about your UT SELECT plan. Tips on how to use the **plan** effectively, answers to frequently asked questions, and a comprehensive table of contents to help you locate information you need are also included. If you have questions, call Customer Service at **1-866-882-2034**, refer to the website (bcbstx.com/ut), or contact your institution Benefits Office.

This booklet is intended to be an information source only. It is not a contract or a policy.

The terms “you” and “your” as used in this Benefits Booklet refer to the employee or retiree. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise. Underlined words are defined terms. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

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



**BlueCross BlueShield
of Texas**

UT SELECT

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

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Important Phone Numbers and Websites

UT SELECT Health Advocate
1-866-882-2034

UT SELECT and Online Provider Directory
bcbstx.com/ut

Express Scripts, Inc.
Prescription Drug Program –
Customer Service
1-800-818-0155
express-scripts.com/ut

Express Scripts Medicare (PDP) for
UT SELECT members with Medicare Primary
1-800-860-7849

UT CARE™ Medicare PPO Customer Service
1-877-842-7562 (TTY 711)
Help is available 24 hours per day, 7 days per week.
bcbstx.com/retiree-medicare-ut

Websites
Office of Employee Benefits
utsystem.edu/offices/employee-benefits

Wellness Resources
utsystem.edu/offices/employee-benefits/livingwell

Identification Cards

The ID card issued to you by Blue Cross and Blue Shield of Texas identifies you as a participant in the UT SELECT medical plan. (You will receive a separate ID card from Express Scripts for your pharmacy benefits under UT SELECT.) Your ID card contains important information about you, your employer group, and the benefits to which you are entitled.



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

Any change in family status may require a new ID card be issued to you.

Unauthorized, Fraudulent, Improper, or Abusive Use of ID cards

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

- Use of the ID card prior to your **effective date**
- Use of the ID card after your date of termination of coverage under UT SELECT

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

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

How to Request ID Cards

Blue Cross and Blue Shield of Texas and Express Scripts will issue separate ID cards for the Medical and Prescription Drug plans. The cards will be mailed to your home address on file. There is no charge for ID cards. To request additional cards or to replace lost or damaged cards:

- **Medical:** Call Blue Cross and Blue Shield of Texas Customer Service at **1-866-882-2034**, or log onto Blue Access for Members through **bcbstx.com/ut** to order Medical ID cards online or print a temporary ID card.
- **Non-Medicare Prescription Drug:** Call Express Scripts Customer Service at **1-800-818-0155** or you can print one through the Express Scripts website, **express-scripts.com**. A virtual card is also available through the Express Scripts app (application) via your mobile phone.
- **Medicare Prescription Drug:** Call Express Scripts Medicare Part D Customer Service at **1-800-860-7849** or you can print one through the Express Scripts website, **express-scripts.com**. A virtual card is also available through the Express Scripts app (application) via your mobile phone.
- **UT CARE Medicare PPO:** Call Customer Service at **1-877-842-7562 (TTY 711)** or log into Blue Access for Members through **bcbstx.com/retiree-medicare-ut**.

Blue Access for Members Website Features

You can access helpful information and administrative forms through the UT SELECT website. Go to bcbstx.com/ut to find:

- Doctors and Hospitals (Provider Finder®)
- Forms
- Benefits Booklet
- Medical Policies
- Healthy Living Information
- Blue Access for Members (view claims)
- Contact Information
- Frequently Asked Questions

Many of the most frequently requested features appear directly on the UT SELECT home page. The website appearance and content are subject to change at any time.



How to Find Blue Access for Members

Go to bcbstx.com/ut

Click on **Log In**

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

Registered Blue Access for Members can:

- Check the status of a claim.
- Confirm who is covered under your plan.
- View and print detailed claim history and Explanation of Benefits (EOB). **EOBs are available online. To receive copies by mail, you must log into Blue Access for Members to elect to receive paper copies or call Customer Service for assistance.**
- Locate a physician or other provider in your network that meets your needs.
- Shop and compare provider costs for common procedures and treatments.
- Sign up to receive e-mail notifications of new claim activity.
- Request a new or replacement ID card or print a temporary ID card.

Express Scripts Website Features

- Check order status
- Refill and renew prescriptions
- Check prices and coverage
- Find convenient pharmacies, including an in-network 90-day maintenance location
- View your Rx claims and balances
- Pay your balance using a variety of payment options
- Transfer retail prescriptions to home delivery. Just click Add to Cart for eligible prescriptions and check out. We'll contact your provider on your behalf and take care of the rest. Check Order Status to track your order.
- Much more

To access the member website:

- Log in to express-scripts.com
- Register if it is your first visit. Just have your member ID or SSN handy.

Many of the most frequently requested features appear directly on the home page. The website appearance and content are subject to change at any time.

YOUR UT SELECT MEDICAL BENEFITS



In-Area Summary of Benefits

In-Area Network and Non-Network benefits apply to eligible employees, retirees and their covered dependents residing in Texas, New Mexico or Washington, D.C. Payment for non-network (including **ParPlan**) services is limited to the **allowable amount** as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the **allowable amount**. **Any charges over the allowable amount for non-network services are the patient's responsibility and are in addition to deductible, coinsurance and out-of-pocket maximums.**

Members with Medicare as primary should see the UT SELECT and Medicare section of this guide.

IN-AREA		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network*
Annual <u>Deductible</u> (applicable when <u>coinsurance</u> is required)	\$600/person** \$1,800/family	\$1,800/person \$5,400/family
Coinsurance Maximum	\$3,500/person \$10,500/family	Unlimited
Annual <u>Out-of-Pocket Maximum</u> ***	\$8,700/person \$17,400/family (includes medical and prescription drug deductibles, copayments, and coinsurance)	Unlimited
Pre-existing Condition Limitation	None	None
Lifetime Maximum Benefit	No Limit	No Limit
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 – Office Setting Family Care Physician (FCP) Family Practice Internal Medicine OB/GYN Pediatrics	FCP \$30 Copay	60% Plan/40% Member
Specialist Office Visit	\$50 Copay	60% Plan/40% Member
Urgent Care	\$50 Copay	60% Plan/40% Member
Diagnostic Lab and X-Ray	Included in Office Visit Copay	60% Plan/40% Member
Other Diagnostic Tests	FCP \$30 Copay; Specialist \$50 Copay	60% Plan/40% Member
Allergy Testing	FCP \$30 Copay; Specialist \$50 Copay	60% Plan/40% Member
Allergy Serum/Injections (if no office visit billed)	Plan pays 100% (no copayment required)	60% Plan/40% Member

IN-AREA (continued)		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network*
EMERGENCY CARE		
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member
Hospital Emergency Room, Including Physician Services	\$500 Copay/visit If admitted, ER services are added to claims for inpatient services	\$500 Copay/visit If admitted, ER services are added to claims for inpatient services
OUTPATIENT CARE		
Observation	80% Plan/20% Member	60% Plan/40% Member
Surgery – Facility	\$200 Copay; then 80% Plan/20% Member	60% Plan/40% Member
Surgery – Physician	80% Plan/20% Member	60% Plan/40% Member
Diagnostic Lab and X-Ray	100% covered (except when billed with surgery; then 80% Plan/20% Member)	60% Plan/40% Member
MRI/CT Scans	\$150 copay per procedure	\$150 copay per procedure, then 40% Member
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member
INPATIENT CARE		
Hospital – Semiprivate Room and Board****	\$200 Copay/Day (\$1,000 max/admission); then 80% Plan/20% Member	60% Plan/40% Member
Hospital Inpatient Surgery****	80% Plan/20% Member	60% Plan/40% Member
Physician	80% Plan/20% Member	60% Plan/40% Member
OBSTETRICAL CARE		
Prenatal and Postnatal Care Office Visits	FCP \$30 Copay; Specialist \$50 Copay (initial visit only)	60% Plan/40% Member
Delivery – Facility/Inpatient Care****	\$200 Copay/Day (\$1,000 max/admission); then 80% Plan/20% Member	60% Plan/40% Member
Obstetrical Care and Delivery – Physician	80% Plan/20% Member	60% Plan/40% Member
THERAPY		
Physical Therapy/Chiropractic Care (max. 35 visits/year/condition)	\$50 Copay/Visit	60% Plan/40% Member
Occupational Therapy (max. 35 visits/year/condition)	\$50 Copay/Visit	60% Plan/40% Member
Speech and Hearing Therapy (max. 60 visits/year/condition)	\$50 Copay/Visit	60% Plan/40% Member
Applied Behavior Analysis****	FCP \$30 Copay, Specialist \$50 Copay 80% Plan/20% Member Outpatient or Home Health Services	60% Plan/40% Member
EXTENDED CARE		
Skilled Nursing/Convalescent Facility**** (max. 180 visits)	80% Plan/20% Member	60% Plan/40% Member
Home Health Care Services**** (max. 120 visits)	80% Plan/20% Member	60% Plan/40% Member
Hospice Care Services****	80% Plan/20% Member	60% Plan/40% Member
Home Infusion Therapy****	80% Plan/20% Member	60% Plan/40% Member

IN-AREA (continued)		
Coverage	BCBSTX In-Network	BCBSTX Out-of-Network*
BEHAVIORAL HEALTH		
Virtual Visit with MDLIVE	\$0 Copay	\$0 Copay
Serious Mental Illness – Office Visit	FCP \$30 Copay; Specialist \$50 Copay	60% Plan/40% Member
Serious Mental Illness – Outpatient****	80% Plan/20% Member	60% Plan/40% Member
Serious Mental Illness – Inpatient****	\$200 Copay/Day (\$1,000 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Office	FCP \$30 Copay; Specialist \$50 Copay	60% Plan/40% Member
Mental Illness – Outpatient****	80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Inpatient****	\$200 Copay/Day (\$1,000 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Substance Use Disorder – Office	FCP \$30 Copay; Specialist \$50 Copay	60% Plan/40% Member
Substance Use Disorder – Outpatient Treatment****	80% Plan/20% Member	60% Plan/40% Member
Substance Use Disorder – Inpatient Treatment****	\$200 Copay/Day (\$1,000 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
OTHER SERVICES		
Durable Medical Equipment****	80% Plan/20% Member	60% Plan/40% Member
Prosthetic Devices	80% Plan/20% Member	60% Plan/40% Member
Hearing Aids (Adult) (\$1,000 per ear; once every 3 years)	80% Plan/20% Member Deductible does not apply	80% Plan/20% Member Deductible does not apply
Hearing Aids (pediatric; once every 3 years)	80% Plan/20% Member Deductible does not apply	80% Plan/20% Member Deductible does not apply
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. (For non-network providers, after \$3,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount). Individual must be enrolled in the UT SELECT or UT CONNECT plan for 36 continuous months prior to the date of the surgery to receive benefits.	
Fertility and Family Building Benefit	2 Smart Cycles covered per lifetime. The person(s) receiving fertility treatment must be an employee or covered spouse enrolled for 12 months continuously in an employee health plan offered through the University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Get started and activate your benefit by contacting Progyny at 1-844-535-0711 .	

*For services provided out-of-network, any charges over the allowable amount are the patient's responsibility.

** J Visa holders have a \$500 individual deductible and a \$1,500 family deductible.

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

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

The UT Health Network

The 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 UT Health Network along with several claims examples are illustrated below.

	UT HEALTH NETWORK BENEFIT	CURRENT UT SELECT NETWORK BENEFIT*
PRIMARY CARE	\$20 copay	\$30 copay
SPECIALIST	\$40 copay	\$50 copay
URGENT CARE	\$40 copay	\$50 copay
EMPLOYEE CLINIC	\$10 copay	\$30 copay
DEDUCTIBLE	\$600	\$600
COINSURANCE	10%	20%
INPATIENT	Deductible plus 10% coinsurance	\$200/day (\$1,000 max) plus 20% coinsurance
OUTPATIENT	Deductible plus 10% coinsurance	\$200/day plus 20% coinsurance

*See the Summary of Benefits charts for Out of Network details.

Current points of service for the UT Health Network include:

- UT Medical Branch Galveston facilities & providers
- UT Rio Grande Valley facilities & providers
- UT Tyler Health Science Center facilities & providers
- UT Health Houston facilities & providers
- University Hospital System in San Antonio
- Employee and Nursing Clinics at UT Austin, UT Health Houston, UT Health San Antonio and UT Rio Grande Valley

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.

Out-of-Area Summary of Benefits

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. Payment for services is limited to the allowable amount as determined by Blue Cross and Blue Shield. ParPlan (Texas) and Traditional Indemnity Network (outside of Texas) providers accept the allowable amount. To maximize your benefits and to avoid charges over the allowable amount, seek care through a BCBSTX provider when possible. **Any charges over the allowable amount are the patient's responsibility and will be in addition to deductible, coinsurance and out-of-pocket maximums.**

COVERAGE	OUT-OF-AREA*
Annual Deductible (applicable when coinsurance is required)	\$600/Person; \$1,800/Family
Coinsurance Maximum	\$3,500/Person; \$10,500 Family
Annual Out-of-Pocket Maximum**	\$8,700/Person \$17,400/Family (includes medical and prescription drug deductibles, copayments, and coinsurance)
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	75% Plan/25% Member
Diagnostic Lab and X-Ray	75% Plan/25% Member
Other Diagnostic Tests	75% Plan/25% Member
Allergy Testing	75% Plan/25% Member
Allergy Serum (if no office visit billed)	75% Plan/25% Member
EMERGENCY CARE	
Ambulance Service (if transported)	75% Plan/25% Member
Hospital Emergency Room	75% Plan/25% Member
Emergency Physician Services	75% Plan/25% Member
OUTPATIENT CARE	
Observation	75% Plan/25% Member
Surgery – Facility	75% Plan/25% Member
Surgery – Physician	75% Plan/25% Member
Diagnostic Lab and X-Ray	75% Plan/25% Member
Other Diagnostic Tests	75% Plan/25% Member
Outpatient Procedures	75% Plan/25% Member
INPATIENT CARE	
Hospital – Semiprivate Room and Board***	75% Plan/25% Member
Hospital Inpatient Surgery***	75% Plan/25% Member
Physician	75% Plan/25% Member
OBSTETRICAL CARE	
Prenatal and Postnatal Care Office Visits	75% Plan/25% Member
Delivery – Facility/Inpatient Care***	75% Plan/25% Member
Obstetrical Care and Delivery – Physician	75% Plan/25% Member

COVERAGE (continued)	OUT-OF-AREA* (continued)
THERAPY	
Physical Therapy/Chiropractic Care (max. 35 visits/year/condition)	75% Plan/25% Member
Occupational Therapy (max. 35 visits/year/condition)	75% Plan/25% Member
Speech and Hearing Therapy (max. 60 visits/year/condition)	75% Plan/25% Member
EXTENDED CARE	
Skilled Nursing/Convalescent Facility*** (max. 180 visits)	75% Plan/25% Member
Home Health Care Services*** (max. 120 visits)	75% Plan/25% Member
Hospice Care Services***	75% Plan/25% Member
Home Infusion Therapy***	75% Plan/25% Member
BEHAVIORAL HEALTH (Mental Illness, Serious Mental Illness, and Substance Use Disorder)	
Virtual Visit with MDLIVE	\$0 Copay
Serious Mental Illness – Office Visit	75% Plan/25% Member
Serious Mental Illness – Outpatient***	75% Plan/25% Member
Serious Mental Illness – Inpatient***	75% Plan/25% Member
Mental Illness – Office	75% Plan/25% Member
Mental Illness – Outpatient***	75% Plan/25% Member
Mental Illness – Inpatient***	75% Plan/25% Member
Substance Use Disorder – Office	75% Plan/25% Member
Substance Use Disorder – Outpatient Treatment***	75% Plan/25% Member
Substance Use Disorder – Inpatient Treatment***	75% Plan/25% Member
OTHER SERVICES	
Durable Medical Equipment***	75% Plan/25% Member
Prosthetic Devices	75% Plan/25% Member
Hearing Aids (Adult) (\$1,000 per ear; once every 3 years)	75% Plan/25% Member
Hearing Aids (pediatric; once every 3 years)	75% Plan/25% Member
Bariatric Surgery* (pre-determination recommended)	After \$3,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount. (individual must be enrolled in the UT SELECT or UT CONNECT plan for 36 continuous months prior to date of the surgery to receive benefits.)
Fertility and Family Building Benefit	2 Smart Cycles Covered per Lifetime. The person(s) receiving fertility treatment must be an employee or covered spouse enrolled for 12 months continuously in an employee health plan offered through the University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Contact Progyny at 1-844-535-0711 to activate fertility benefits.

*For services provided out-of-network and out-of-area, any charges over the allowable amount are the patient's responsibility.

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

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

HOW YOUR UT SELECT MEDICAL PLAN WORKS



Freedom of Choice

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

See a Network Provider	See a Non-Network Provider	
	ParPlan Provider	Non-Network Provider that is not a contracting provider
<ul style="list-style-type: none"> You receive the highest level of benefits (network benefits) You are not required to file claim forms You are not balance billed; network providers will not bill for costs exceeding the BCBSTX allowable amount for covered services Your provider will preauthorize necessary services 	<ul style="list-style-type: none"> You receive the lower level of benefits (non-network benefits) You are not required to file claim forms in most cases; ParPlan providers will usually file claims for you You are not balance billed; ParPlan providers will not bill for costs exceeding the BCBSTX allowable amount for covered services In most cases, ParPlan providers will preauthorize necessary services 	<ul style="list-style-type: none"> You receive non-network benefits (the lowest level of benefits) You are required to file your own claim forms You may be billed for charges exceeding the BCBSTX allowable amount for covered services You must preauthorize necessary services

Network vs. Non-Network Providers

If You Need To:	Network	Non-Network (Including ParPlan)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the allowable amount as determined by BCBSTX. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount.
Visit a doctor or specialist	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the applicable copayment Pay any deductible and coinsurance Your doctor or other provider cannot charge more than the allowable amounts for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the office visit File a claim and get reimbursed for the visit minus any deductible and coinsurance Your costs will be based on allowable amounts; the non-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
Receive preventive care	<ul style="list-style-type: none"> Visit any network doctor or specialist Plan pays 100% for certain age-specific and gender-specific preventive care services; see the Preventive Care section of this guide Your doctor or other provider cannot charge more than the allowable amounts for covered services 	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the preventive care visit File a claim and get reimbursed for the visit minus any deductible and coinsurance Your costs will be based on allowable amounts; the non-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX

If You Need To:	Network	Non-Network (Including ParPlan)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the allowable amount as determined by BCBSTX. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount.
Receive emergency care	<ul style="list-style-type: none"> • Call 911 or go to any hospital or doctor immediately; you will receive network benefits for emergency care • Pay the copayment (waived if admitted) and coinsurance • Pay any deductible and coinsurance (if admitted) (see Emergency Care) 	
Be admitted to the hospital	<ul style="list-style-type: none"> • Your network doctor will preauthorize your admission • Go to the network hospital • Pay any applicable copayment, deductible and coinsurance 	<ul style="list-style-type: none"> • You, a family member, your doctor or the hospital must preauthorize your admission • Go to any licensed hospital • Pay any deductible and coinsurance each time you are admitted • Your costs will be based on allowable amounts; the non-network doctor/facility from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
Receive behavioral health or substance use disorder services	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider, or go to any network hospital or facility • Pay any applicable copayment, deductible and coinsurance 	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider, or go to any licensed hospital or facility • Pay any deductible and coinsurance • Your costs will be based on allowable amounts; the non-network doctor or other provider from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
File a claim	Claims will be filed for you	You may need to file the claim yourself

What is a ParPlan provider?

ParPlan providers have agreed to accept the Blue Cross and Blue Shield of Texas allowable amount and/or negotiated rates for covered services. When using ParPlan providers, benefits for covered services are reimbursed at the lower (non-network) level. In most cases, ParPlan providers will file the member's claims and preauthorize necessary services. The member is not responsible for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services when ParPlan providers are used.

What happens if care is not available from a network provider?

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider **prior to the visit**, network benefits will be paid. Otherwise, non-network benefits will be paid, and the claim will have to be resubmitted for review and adjustment, if appropriate.

Need to locate a network or ParPlan doctor or hospital?

Log onto [bcbstx.com/ut](https://www.bcbstx.com/ut) and click on Doctors & Hospitals. You can always call Customer Service at **1-866-882-2034** to confirm network status.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas (a non-contracting provider), you receive non-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the Blue Cross and Blue Shield of Texas non-contracting allowable amount, which in most cases is less than the allowable amount applicable for Blue Cross and Blue Shield of Texas contracted providers. The non-contracted provider is not required to accept the Blue Cross and Blue Shield of Texas non-contracting allowable amount as payment in full and may balance bill you for the difference between the Blue Cross and Blue Shield of Texas non-contracting allowable amount and the non-contracting provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under UT SELECT and any applicable deductibles, coinsurance amounts, and copayment amounts.

Allowable Amount

The allowable amount is the maximum amount of benefits Blue Cross and Blue Shield of Texas will pay for eligible expenses you incur under UT SELECT. Blue Cross and Blue Shield of Texas has established an allowable amount for medically necessary services, supplies and procedures provided by providers that have contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan and providers that have not contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan. When you receive services, supplies, or care from a provider that does not contract with Blue Cross and Blue Shield of Texas, you will be responsible for any difference between the Blue Cross and Blue Shield of Texas allowable amount and the amount charged by the non-contracting provider. You will also be responsible for charges for services, supplies and procedures limited or not covered under UT SELECT, copayment amounts, deductibles, any applicable coinsurance, and out-of-pocket maximum amounts.

How is the allowable amount determined?

For hospitals and other facility providers, physicians, and other health care providers contracting with

Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan – The allowable amount is based on the terms of the provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For hospitals and other facility providers, physicians, and other health care providers not contracting with Blue Cross and Blue Shield of Texas in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting allowable amount) – The allowable amount will be the lesser of the provider's billed charges or the Blue Cross and Blue Shield of Texas non-contracting allowable amount. Except for home health care, the non-contracting allowable amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim. The non-contracting allowable amount for home health care is developed from base Medicare national per visit amounts for low utilization payment adjustment, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and shall be updated on a periodic basis. When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the allowable amount for non-contracting providers will represent an average contract rate in aggregate for network providers adjusted by a predetermined factor established by Blue Cross and Blue Shield of Texas. Such factor shall be not less than 75% and shall be updated not less than every two years.

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

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Texas within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare services, or its successor.

The non-contracting allowable amount does not equate to the provider's billed charges and participants receiving services from a non-contracting provider will be responsible for the difference between the non-contracting allowable amount and the non-contracting provider's billed charge, and this difference may be considerable. To find out the Blue Cross and Blue Shield of Texas non-contracting allowable amount for a particular service, participants may call the toll-free Customer Service number shown on their UT SELECT ID card.

For multiple surgeries – The allowable amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest allowable amount plus a determined percentage of the allowable amount for each of the other covered procedures performed.

For procedures, services, or supplies provided to Medicare recipients – The allowable amount will not exceed Medicare's limiting charge.

Predetermination of Benefits

As participants in UT SELECT, you and your covered dependents are entitled to a review by the Blue Cross and Blue Shield of Texas Medical Division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if Blue Cross and Blue Shield of Texas considers the service to be medically necessary and, therefore, eligible for benefits. To have a predetermination conducted, have your physician provide a letter of medical necessity and any pertinent medical records supporting this position to Blue Cross and Blue Shield of Texas. After a decision is reached, you and your physician will be notified in writing. **Predetermination is not a guarantee of payment.**

Facility Fees

Some medical centers charge a separate facility fee for doctor visits or other procedures and services performed in an outpatient or inpatient facility. If your services take place at a medical center that charges a facility fee, you may be charged for outpatient or inpatient services. These fees can be up to a few hundred dollars for each visit—even if the provider is in the network. When making an appointment, always ask your provider's office if a separate facility fee will be charged for your visit.

Continuity of Care

In the event a participant is under the care of a network provider at the time such provider stops participating in the network and at the time of the network provider's termination, the participant has special circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Blue Cross and Blue Shield of Texas will continue providing coverage for that provider's services at the in-network benefit level.

Special circumstances means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the participant. *Special circumstances* shall be identified by the treating physician or health care provider, who must request that the participant be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the participant of any amounts for which the participant would not be responsible if the physician or provider were still a network provider.

The continuity of coverage will not extend for more than ninety (90) days, or more than nine (9) months if the participant has been diagnosed with a terminal illness, beyond the date the provider's termination from the network takes effect. However, for participants past the 24th week of pregnancy at the time the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Transitional Benefits

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in UT SELECT and your provider is not in the PPO network, ongoing care with the current provider may be requested for a period of time.

Transitional care benefits may be available if being treated for any of the following conditions by a non-network provider:

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care

Transitional care benefits are subject to approval. To request transitional care benefits, complete a **Transitional Benefits Form** available from your institution Benefits Office or at utsystem.edu/offices/employee-benefits. Instructions for submitting the request to Blue Cross and Blue Shield of Texas are on the form. If the transitional care request is approved, you or your covered dependent may continue to see the non-network provider and receive the network level of benefits from the UT SELECT plan. If the transitional care request is denied, you may still continue to see your current provider, but benefits will be paid at the non-network level.

If your provider is in the network, you do not have to complete a Transitional Benefits Form.

Preauthorization Requirements

UT SELECT requires advance approval (preauthorization) by Blue Cross and Blue Shield of Texas for certain services. Preauthorization establishes in advance the medical necessity of certain care and services covered under UT SELECT. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements including the network status of providers, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient hospital admissions
- Applied behavior analysis
- Skilled nursing care in a skilled nursing facility
- Home health care
- Hospice care
- Home infusion therapy (in a home setting)
- Motorized and customized wheelchairs and certain other durable medical equipment totaling over \$5,000
- Transplants
- Advanced Imaging
- Cardiology
- Joint and spine surgery
- Pain management
- Sleep study
- All inpatient treatment of behavioral health care, substance use disorder and serious mental illness; and
- The following outpatient treatment of behavioral health care, substance use disorder and serious mental illness:
 - Electroconvulsive therapy
 - Repetitive transcranial magnetic stimulation, and
 - Intensive outpatient program.

Other services may require preauthorization. Visit with your provider and/or a health advocate if you have additional questions.

Care should also be preauthorized if you or your doctor wants to:

- Extend your hospital stay beyond the approved days (you or your doctor must call for an extension before your approved stay ends); or
- Transfer you to another facility or to or from a specialty unit within the facility.

Note: You must request preauthorization to use a non-network provider to receive the network level of benefits. Preauthorization for medical necessity of services does not guarantee the network level of benefits. Even if approved by Blue Cross and Blue Shield of Texas, non-network providers paid at the network level may bill for charges exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services. You are responsible for these charges, which can be significant.

What happens if services are not preauthorized?

Blue Cross and Blue Shield of Texas will review the medical necessity of your treatment prior to the final benefit determination. If Blue Cross and Blue Shield of Texas determines the treatment or service is not medically necessary, benefits will be denied.

How to Preauthorize

To satisfy preauthorization requirements, you, your physician or other provider of services, or a family member must call the toll-free number **(1-800-441-9188)** on the back of your Medical ID Card. The call for preauthorization should be made between 6:00 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned no later than 24hrs after the call is received. A benefits management nurse will follow up with your provider's office.

Preauthorization for Inpatient Hospital Admissions

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

When an inpatient hospital admission is preauthorized, a length of stay is assigned. Your UT SELECT plan is required to provide a minimum length of stay in a hospital facility for the following:

- Maternity care
- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Caesarean section
- Treatment of breast cancer
- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

If you require a longer stay than was first preauthorized, your provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Note: Your provider will not be required to obtain preauthorization from Blue Cross and Blue Shield of Texas for prescribing a length of stay less than 48 hours (or 96 hours) for maternity care. If you require a longer stay, your provider must seek an extension for the additional days by obtaining preauthorization from Blue Cross and Blue Shield of Texas.

Preauthorization for Extended Care Expense and Home Infusion Therapy

Preauthorization for extended care expense and home infusion therapy (in a home setting) may be obtained by having the agency or facility providing the services contact Blue Cross and Blue Shield of Texas to request preauthorization. The request should be made:

- Prior to initiating extended care expense or home infusion therapy
- When an extension of the initially preauthorized service is required
- When the treatment plan is altered

Blue Cross and Blue Shield of Texas will review the information submitted prior to the start of extended care expense or home infusion therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If extended care expense or home infusion therapy is to take place in less than one week, the agency or facility should call the preauthorization telephone number shown on your ID card **(1-800-441-9188)**. If Blue Cross and Blue Shield of Texas has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Behavioral Health Care

- All inpatient and certain outpatient treatment of behavioral health care should be preauthorized by calling the toll-free number on your ID card **(1-800-528-7264)**.

Cost Comparison

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 your health advocate will assist. You 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



One call can result in big savings ... to you and to UT SELECT!

Just call 1-866-882-2034 to talk to a Health Advocate.

Note: Cost comparison is only available to members covered by the PPO plan.

Accessing Care Outside Texas



Your benefits travel with you. Your UT SELECT Medical ID Card features the Blue Cross and Blue Shield symbols and the PPO-in-a-suitcase logo telling providers that you are part of the BlueCard® program. This means that you and your covered dependents may use Blue Cross and Blue Shield network providers throughout the United States. Follow these steps to receive the network (highest) level of benefits offered under your plan while traveling or away from home:

- 1) If you are outside of Texas and need health care, refer to your UT SELECT Medical ID Card and call a Health Advocate at **1-866-882-2034** for information on the nearest network doctors and hospitals.
- 2) Although network providers outside of Texas may preauthorize those services that require preauthorization (such as a hospital admission), it is ultimately your responsibility to obtain preauthorization by calling the appropriate number on the back of your UT SELECT Medical ID Card.
- 3) When you arrive at the doctor's office or hospital, present your UT SELECT Medical ID Card, and the doctor or hospital will verify eligibility and coverage information.
- 4) After you receive medical attention, the network provider will file claims for you.
- 5) You will be responsible for paying any applicable copayment, deductible, or coinsurance amounts, as well as any charges for non-covered services. Blue Cross and Blue Shield providers have agreed to accept the Blue Cross and Blue Shield Plan's allowable amount for covered services and will not bill you for any costs exceeding the allowable amount.

For more information, see the notice regarding other Blue Cross and Blue Shield's separate financial arrangements with providers.

Does UT SELECT provide benefits for medical services outside the United States?

Yes. Through the Blue Cross Blue Shield Global Core® program, you have access to hospitals on almost every continent and to a broad range of medical assistance services when you travel or live outside the United States. Blue Cross Blue Shield Global Core provides the following services:

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

If you need to locate a doctor, other provider or hospital, or need medical assistance, call the service center at **1-800-810-BLUE (2583)** or call collect at **1-804-673-1177**, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at Blue Cross Blue Shield Global Core hospitals.

In an emergency, go directly to the nearest hospital.

Call Blue Cross and Blue Shield of Texas for preauthorization, if necessary. (Refer to the phone number on the back of your UT SELECT ID card. The preauthorization phone number is different than the Blue Cross Blue Shield Global Core number.)

In most cases, you will not need to pay for inpatient care at Blue Cross Blue Shield Global Core hospitals in advance. The hospital should submit your claim. You will, however, be responsible for the usual out-of-pocket expenses (non-covered services, copayment, deductible, and coinsurance amounts).

If you do not use a Blue Cross Blue Shield Global Core provider for care, you must pay the provider or hospital at the time of service and obtain proof of payment (itemized receipt). Then, you will need to complete and submit an international claim form, along with your proof of payment and send it to the Blue Cross Blue Shield Global Core Service Center to receive any applicable reimbursement for covered expenses. The claim form is available online at bcbstx.com/ut. Except for emergency care, non-network benefits will apply towards covered expenses if you are eligible to receive in-area benefits. If you are eligible for out-of-area benefits, the out-of-area benefit level will apply. You must submit claim information within 12 months of the date of service.

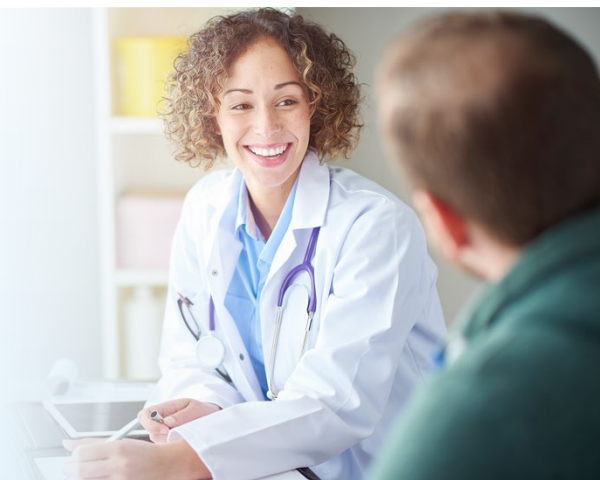
Remember that bills from foreign providers differ from billing in the United States. The bills may be missing the provider's name and address, in addition to other critical information. It is very important that you fill out the Blue Cross Blue Shield Global Core claim form completely and attach your bills from the foreign provider. Missing information will delay claims processing.

The Blue Cross and Blue Shield Global Core program was formerly known as BlueCard WorldWide®.

WHAT THE UT SELECT MEDICAL PLAN COVERS

The following medical expenses are covered by UT SELECT. The descriptions have been alphabetized for quick reference. Covered services may be subject to other plan limitations.

Refer to the Benefits Summaries for UT SELECT for more detailed information, including the applicable copayment, deductible and coinsurance.



Acquired Brain Injury

Benefits for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment, neurofeedback therapy, remediation, post-acute transition services and community reintegration services – including outpatient day treatment services or any other post-acute treatment services, are covered if such services are necessary as a result of and related to an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, UT SELECT includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an acquired brain injury
- Has been unresponsive to treatment
- Becomes responsive to treatment at a later date

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Note: *Service* means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury. *Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury. Treatment for an acquired brain injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Allergy Care

Coverage is provided for testing and treatment for medically necessary allergy care. Allergy injections are not considered immunizations for purposes of the UT SELECT preventive care benefit. The plan will not pay for injections and testing occurring on the same date.

Ambulance Services

UT SELECT covers ambulance services when medically necessary as outlined below:

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

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

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

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

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

Non-emergency transports between medical facilities may be considered medically necessary for a patient who has a medical problem requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. *Disabled* means the patient's physical condition limits his mobility and is unable to stand and sit unassisted or requires continuous life support systems. Non-emergency transport from a patient's home is not a covered benefit.

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

What does medical necessity or medically necessary mean?

Supplies and services are covered only if they are medically necessary. This means that the services and supplies must be:

- Essential to, consistent with, and provided for diagnosis or the direct care or treatment of the condition, sickness, disease, injury, or bodily malfunction
- Within the standards of generally accepted health care practice as determined by Blue Cross and Blue Shield of Texas
- Not primarily for the convenience of the participant, his physician, the hospital or other provider
- The most economical supplies or levels of service appropriate for safe and effective treatment. When applied to hospitalization, this further means that the participant requires acute care as a bed patient due to the nature of the services provided or the participant's condition and the participant cannot receive safe or adequate care as an outpatient.

Medical necessity is determined by Blue Cross and Blue Shield of Texas, considering the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a physician may have prescribed treatment, such treatment may not be medically necessary within this definition. A determination of medical necessity does not guarantee payment unless the service is covered by the UT SELECT plan.

Autism Spectrum Disorder

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

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

Behavioral Health Care (preauthorization required for all inpatient care and certain outpatient care, see Preauthorization section)

UT SELECT covers charges for inpatient and outpatient behavioral health care for:

- Diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used by Blue Cross and Blue Shield of Texas, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin
- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the direction or supervision of a provider, when the eligible expense is:
 - Individual, group, family or conjoint psychotherapy
 - Counseling
 - Psychoanalysis
 - Psychological testing and assessment
 - For administering or monitoring of psychotropic drugs
 - Hospital visits or consultations in a facility providing such care
 - Electroconvulsive treatment
 - Psychotropic drugs

All inpatient and certain outpatient treatment for behavioral health should be preauthorized by calling the toll-free number on your ID card **(1-866-882-2034)**.

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

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

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

Breastfeeding Support, Services and Supplies

To be considered Preventive Care, Covered Health Services, services must be received from Network Provider. Benefits will be provided for breastfeeding counseling and support services by a provider, during pregnancy and/or in the post- partum period. Benefits include the purchase of manual or electric breast pumps, accessories and supplies and the rental of hospital-grade breast pumps. Manual and electric pumps with a valid prescription to rent or purchase through network providers or retail stores are covered at 100% of the allowable amount. Contracted providers will file the claim for you. Breast pumps purchased from retail stores; you must submit a claim form to BCBSTX for reimbursement. Any shipping costs related to purchase of a breast pump are non-Covered Health Services under this Benefit.

Limited benefits are also included for the rental of Hospital grade breast pumps.

If you use a Non-Network Provider, the Benefits may be subject to the out of network benefit. Additionally, you may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the breast pump, accessories, and supplies.

Coverage is provided for one pump per pregnancy. For assistance, please contact BCBSTX Health Advocate at the Customer Service Number on your medical ID card..

Chiropractic Care

UT SELECT pays benefits for services (including occupational therapy and physical therapy) and supplies provided by or under the direction of a licensed Doctor of Chiropractic.

Clinical Trials

Benefits are available for services provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- Centers for Disease Control and Prevention of the United States Department of Health and Human Services
- National Institutes of Health
- United States Food and Drug Administration
- United States Department of Defense
- United States Department of Veterans Affairs
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services

Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Cosmetic, Reconstructive, or Plastic Surgery

Cosmetic, reconstructive and/or plastic surgery is surgery which can be expected or is intended to improve the physical appearance of a participant; or is performed for psychological purposes; or restores form but does not correct or materially restore a bodily function. For cosmetic, reconstructive or plastic surgery, UT SELECT covers only the following services if medically necessary:

- Treatment for correction of defects due to accidental injury while covered under UT SELECT
- Reconstructive surgery following cancer surgery
- Surgery performed for the treatment or correction of a congenital defect
- Reconstruction of the breast on which a mastectomy has been performed while covered under a health care plan offered by UT System; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses (two per plan year) and treatment of physical complications, including lymphedemas, at all stages of the mastectomy

Benefits for eligible expenses will be the same as for the treatment of any other sickness as shown on the Benefits Summary. No other cosmetic, reconstructive or plastic surgery is covered unless particularly specified in this Benefits Booklet.

Dental Services and Covered Oral Surgery

General dental services are not covered by UT SELECT. When medically necessary as determined by Blue Cross and Blue Shield of Texas and prescribed by your doctor, covered oral surgery is limited to:

- Covered oral surgery, including removal of complete/partial bony impacted teeth (soft tissue wisdom tooth removal is not a covered benefit)
- Services provided to a newborn for treatment or correction of a congenital defect
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the participant is covered by UT SELECT
- Orthognathic surgery

Facility and related services, when medically necessary, are covered for participants who are unable to undergo treatment in a dental office or under local anesthesia due to a documented physical, mental, or medical reason. Preauthorization is required. The specific dental procedure is not covered under the UT SELECT plan; only the facility and related services are covered.

What is covered oral surgery?

Covered oral surgery means maxillofacial surgical procedures limited to:

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

Diabetic Management Services

UT SELECT covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Covered items include:

Diabetic Equipment

- Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies)
- Podiatric appliances, including up to two pairs of therapeutic footwear per plan year, for the prevention of complications associated with diabetes

Diabetic Prescriptions

- Insulin and insulin analog preparations
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

Diabetic Supplies

- Test strips for blood glucose monitors
- Lancets and lancet devices
- Visual reading and urine test strips and tablets which test for glucose, ketones and protein
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers

Note: All diabetic supplies listed above, along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind), are covered under the prescription drug program, administered by Express Scripts. The specific diabetic management service (supplies or equipment) is payable by either Blue Cross and Blue Shield of Texas or Express Scripts (the Prescription Drug Program administrator). Please call your Health Advocate for assistance.

Diabetic Management Services/Diabetes Self-Management Training Programs

Includes initial and follow-up instruction concerning:

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

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

Durable Medical Equipment

UT SELECT covers the rental (or purchase at the discretion of Blue Cross and Blue Shield of Texas) of therapeutic supplies and rehabilitative equipment required for therapeutic use, such as a standard wheelchair, crutches, walker, bedside commode, hospital-type bed, suction machine, artificial respirator, or similar equipment.

Note: Continuous Passive Air Pressure (CPAP) equipment is subject to deductible and coinsurance, in addition to any office visit copayment.

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

Emergency Care and Treatment of Accidental Injury

Your UT SELECT plan covers medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In case of emergency, call 911 or go to the nearest emergency room. Whether you require hospitalization or not, you should notify your network physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

For in-area participants, a copayment will be required for facility charges for each outpatient hospital emergency room visit. If admitted for the emergency condition immediately following the visit, the services apply to the inpatient services and preauthorization of the inpatient hospital admission will be required. (For out-of-area participants, benefits for emergency care and treatment of accidental injury are determined on the same basis as for treatment of any other illness.)

All emergency care, whether provided by a network provider or a non-network provider, will be eligible for the network level of benefits. If you continue to be treated by a non-network provider after you receive emergency care and you can safely be transferred to the care of a network provider, only non-network benefits will be available. Non-network providers may bill you for any charges exceeding the non-contracting allowable amount.

What is an emergency?

Emergency care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

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



24/7 Nurseline

1-888-315-9473

Available 24 hours a day, seven days a week; bilingual nurses available. The 24/7 Nurseline can help:

- Decide if a situation is an emergency
- Answer health-related questions
- Understand your condition

Eyeglasses or Lenses

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

For medical emergencies, call 911.

24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

Fertility Benefits

Testing for problems with infertility is covered under this medical plan.

Note: Fertility and family building benefits are available with Progyny. To access the Progyny benefit, the person(s) receiving fertility treatment must be an employee or covered spouse continuously enrolled for 12 months in an employee health plan offered through The University of Texas System. Prior periods of coverage under a UT System medical plan (with a break following coverage) cannot be counted toward the continuous coverage requirement. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Dependent children are not eligible for the Progyny benefit. Your coverage will be subject to out-of-pocket payments. To learn more and activate your benefit, you can reach out to your dedicated Patient Care Advocate at **1-844-535-0711**.

Hearing Aids

For covered adults, age 19 and older, UT SELECT allows a **\$1,000 maximum benefit per ear every three years** for non-disposable hearing aids, fittings, and molds. Blue Cross and Blue Shield of Texas will pay up to a **\$1,000 maximum benefit**, and you will be responsible for the difference between that benefit and the Blue Cross and Blue Shield of Texas allowable amount when using network or ParPlan providers. If you use a non-contracting provider, Blue Cross and Blue Shield of Texas will pay up to a **\$1,000 maximum benefit**, based on the non-contracting allowable amount and you will be responsible for the difference between the benefit and the provider's billed charges. Deductibles do not apply. Hearing aid repair and batteries are not covered.

For covered members through age 18, UT SELECT allows coverage for medically necessary hearing aids and related services and supplies including fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; any treatment related to hearing aids, including coverage for habilitation and rehabilitation as necessary for educational gain. Coverage is limited to one hearing aid in each ear every three years as medically or audiotically necessary.

Savings on Hearing Aids

Blue Cross and Blue Shield of Texas has given its members access to savings on hearing aids through TruHearing*. TruHearing saves members 30% to 60% off the average retail price on over 100 hearing aid models from name brand manufacturers. Included with your TruHearing purchase are 3 follow-up visits with a provider for fitting and programming after the initial exam, a 45-day money-back guarantee, 3-year warranty for repairs and one-time loss and damage replacement, and 48 free batteries per hearing aid. As a UT SELECT member, your children, parents and grandparents can also access this discount hearing program.

To access the program, call TruHearing, toll-free, at **1-866-581-9466**, 8 a.m. to 8 p.m. CT, Monday through Friday to locate a provider near you and schedule a hearing exam. It's that easy! For additional information, visit **TruHearing.com**.

*The relationship between Blue Cross and Blue Shield of Texas and TruHearing is that of independent contractors.

Home Health Care (preauthorization required)

UT SELECT covers medically necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Private Duty Nursing (PDN) or Coordinated Home Care (CHC) provided by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, speech, and respiratory therapy services provided by licensed therapists
- Supplies and equipment routinely provided by the home health agency

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, and services provided primarily for custodial care.

Limits:

- Coordinated Home Care (CHC) – Limit of 30 visits per condition per year
- Private Duty Nursing (PDN) – Limit of 90 days per year
- When physical therapy, speech therapy or occupational therapy are being ordered under CHC, standard plan limits apply

Home Infusion Therapy (preauthorization required for services in a home setting)

UT SELECT covers the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous (IV) or gastrointestinal (enteral) infusion or by intravenous injection. Home infusion therapy includes:

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

Over-the-counter products which do not require a prescription, including standard nutritional formulations used for enteral nutrition therapy, are **not** covered unless it is determined to be the sole source of nutrition.

Hospice Care (preauthorization required)

UT SELECT covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for *home* hospice care:

- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN)
- Part-time or intermittent home health aide services for patient care
- Physical, respiratory, and speech therapy by licensed therapists
- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling.

Covered *facility* hospice care includes:

- All usual nursing care by a registered nurse (RN), advance practice nurse (APN), or licensed vocational nurse (LVN)
- Room and board and all routine services, supplies and equipment provided by the hospice facility
- Physical, speech and respiratory therapy services by licensed therapists
- Counseling services routinely provided by the hospice facility, including bereavement counseling

Hospital Admission (preauthorization required)

UT SELECT covers room and board (up to the hospital's semiprivate room rate; a private-room rate is allowed only when medically necessary), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rental.

Lab and X-Ray Services

Medically necessary laboratory and radiographic procedures, services and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered when ordered by a provider.

Network providers are responsible for referring patients to network labs, imaging centers or an outpatient department of a network hospital for medically necessary lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your plan when using network providers.

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to a non-network provider prior to the visit, network benefits will be paid. If a non-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

In some situations, a provider or facility will refer the results of lab tests and X-rays to a radiologist or pathologist for a professional interpretation of the results. If a non-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

What happens if lab and X-ray work are performed outside the doctor's office, or the lab work and X-rays are sent to another location for interpretation?

Lab and X-ray services, including interpretations, performed outside the doctor's office at a free-standing network facility are paid at 100% of the allowable amount. Lab and X-ray services performed in conjunction with an outpatient procedure or inpatient at an in-network facility will be subject to deductible and coinsurance.

Are non-network specialists such as anesthesiologists, radiologists and pathologists covered at the network level of benefits if the hospital or surgeon is in the network?

These services will be paid at the network benefits level. However, payment for non-network services is limited to the Blue Cross and Blue Shield of Texas allowable amount, and you are responsible for any charges billed by the provider which exceed the allowable amount, except for emergency care services.

Male Sexual Dysfunction

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

- Inflatable or non-inflatable penile implants (prostheses)
- Vacuum erection devices
- Intracavernosal injection therapy
- (Trans)urethral suppository method

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

Maternity Care

UT SELECT covers maternity-related expenses for employees and covered dependents. Maternity care includes diagnosis of pregnancy, pre- and post-natal care and delivery (including delivery by Caesarean section). UT SELECT covers inpatient care for the mother and newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Caesarean section.

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

When using a Network facility: If the mother is a covered participant, she will be responsible for inpatient copayments of \$200 per day, not to exceed \$1,000 per stay, in addition to any applicable deductible and coinsurance. Deductible and inpatient copays for newborn will be waived. Baby has coinsurance only regardless whether or not mother is covered.

How are doctor's charges for maternity care covered?

You pay the office visit copayment for your initial visit. For delivery, you pay your coinsurance after your copayment and deductible.

What are complications of pregnancy?

Complications of pregnancy means:

- Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy
- Non-elective Caesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible

Does UT SELECT provide coverage for using a licensed midwife as a practitioner?

UT SELECT will only allow benefits for midwife services provided by an advanced practice nurse (APN). UT SELECT does not recognize these or other designations/certifications for midwife services: (1) certified midwife, an individual who has obtained a state issued certificate from the State Midwifery Agency; and (2) certified professional midwife, a professional certification that can be obtained from the National Association of Registered Midwives.

Does UT SELECT provide coverage for birth at home using a licensed nurse midwife as a practitioner?

UT SELECT will only allow benefits for birth at home using midwife services provided by an advanced practice nurse (APN). Please see above.

How is a newborn child covered under UT SELECT?

UT SELECT automatically provides coverage for a newborn child of a covered employee (or a covered dependent of an employee) for the first 31 days after the date of birth, but this coverage ends at the end of 31 days unless the newborn is added to the employee's coverage. To add coverage for the newborn beyond the first 31 days, you must make the appropriate changes to your benefit designations within the 31-day period after the date of birth. Application for changes must be made through your institution Benefits Office. If you do not finalize the appropriate changes during the 31-day period following the birth, the changes cannot be honored. You may apply for coverage for your dependent during the next annual enrollment period or when a qualified change of status event occurs. Please contact your institution Benefits Office with questions or changes in status.

For grandchildren to be eligible for newborn coverage, the grandchild must be added to the employee's (or retiree's) coverage for benefits within 31 days of the newborn's birth. An eligible grandchild must be a dependent of the employee for federal income tax purposes. Consult your institution Benefits Office for more information about grandchildren as eligible dependents.

Medical-Surgical Expenses

UT SELECT provides coverage for medical-surgical expenses for you and your covered dependents. These include:

- Services of physicians and other professional providers
- Services of a certified registered nurse-anesthetist (CRNA)
- Diagnostic X-ray and laboratory procedures
- Radiation therapy
- Anesthetics and its administration, when performed by someone other than the operating physician or other professional provider
- Oxygen and its administration provided the oxygen is used
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the participant
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the participant's effective date of coverage under UT SELECT, excluding all replacements of such devices other than those necessitated by growth to maturity of the participant
- Services or supplies used by the participant during an outpatient visit to a hospital, a therapeutic center, or a substance use disorder treatment center, or scheduled services in the outpatient treatment room of a hospital
- Certain diagnostic procedures including, but not limited to, bone scan, cardiac stress test, CT scan, MRI, myelogram, PET Scan
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes
- Injectable drugs, administered by or under the direction or supervision of a physician or other professional provider

Services and supplies for medical-surgical expense must be furnished by or at the direction or prescription of a physician or other professional provider. A service or supply is furnished at the direction of a physician or other professional provider if the listed service or supply is:

- Provided by a person employed by the directing physician or other professional provider
- Provided at the usual place of business of the directing physician or other professional provider
- Billed to the patient by the directing physician or other professional provider

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

Obesity

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

- It is determined to be medically necessary
- It satisfies the criteria established in Blue Cross and Blue Shield of Texas medical policy guidelines

Contact Blue Cross and Blue Shield of Texas customer service for current medical necessity determination criteria. A member must be continuously enrolled in a UT medical plan (UT SELECT or UT CONNECT) for 36 months prior to coverage for bariatric surgery.

Organ and Tissue Transplants (preauthorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if the:

- Transplant is not experimental/investigational in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- Recipient or donor is a participant under UT SELECT (Benefits are also available to the donor who is not a participant under UT SELECT)
- Transplant procedure is preauthorized
- Recipient meets all of the criteria established by Blue Cross and Blue Shield of Texas in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the hospital in which the transplant is performed

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Donor search and acceptability testing of potential live donors
- Removal of organs or tissues from deceased donors
- Transportation and storage of donated organs and tissues

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies not covered by UT SELECT include:

- Living and/or travel expenses of the recipient or live donor
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species

Orthotics

Orthotics are covered when medically necessary and prescribed by a physician, chiropractor or other qualified provider. Covered orthotics include, but are not limited to:

- Braces for leg, arm, neck, back, and shoulder
- Corsets for the back or for use after special surgical procedures
- Splints for extremities
- Trusses (including Sykes hernia control device)
- Orthopedic shoes when either one or both shoes are an integral part of a leg brace [Legislation may apply, check each Plan]
- Functional Foot orthotics (for therapeutic support, protection, restoration, or function of an impaired body part or for the treatment of diabetes)
- Compression stockings with a gradient > 40 mm HG each

Non-covered items include, but are not limited to:

- Oral orthotics (for temporomandibular joint (TMJ) disorders, or sleep related breathing disorders)
- Accommodative Foot Orthotics (that do not address structural or functional abnormalities)
- Stock orthotics (over-the-counter items such as arch supports and other foot support devices and foot orthotics, including transferrable shoe inserts, compression stockings with a gradient < 40 mm HG each, and garter belts)
- Experimental/investigational orthoses and stabilizers

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the participant's responsibility.

Outpatient Facility Services

UT SELECT covers the following services provided through a hospital outpatient department or a free-standing facility when medically necessary:

- Radiation therapy
- Chemotherapy
- Dialysis
- Rehabilitation services
- Outpatient surgery

Preauthorization for outpatient procedures is not required, but calling customer service to confirm benefits before services are performed is recommended.

Prenatal Genetic and Chromosomal Metabolic Testing

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

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

Preventive Care Covered Under Medical

Preventive care services will be provided for the following covered services:

- a. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”)
- b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved
- c. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents
- d. With respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

For purposes of this benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items a. through d. may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at bcbstx.com or contact customer service at the toll-free number on your Identification Card.

Drugs (including both prescription and over-the-counter) that fall within a category of the current “A” or “B” recommendations of the USPSTF and that are listed in the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximum, if applicable.

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the PHARMACY BENEFITS portion of your Plan, when prescribed by a Health Care Practitioner.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services included in items a. through d. above provided by an In-Network Provider will not be subject to Coinsurance, Deductible, Copayment or dollar maximums. Deductibles and coinsurance are not applicable to immunizations covered under Required Benefits for Childhood Immunizations provision.

Preventive care services included in items a. through d. above provided by an Out-of-Network Provider will be subject to Coinsurance and Deductibles.

Covered services not included in items a. through d. above may be subject to Coinsurance, Deductible, Copayment and/or dollar maximums.

If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment or setting in which it must be provided, BCBSTX may use reasonable medical management techniques to apply coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, you may be responsible for Coinsurance, Deductible and/or Copayments for the office visit only. If an office visit and the preventive care service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for Coinsurance, Deductible and/or Copayments.

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

Benefits are available for certain tests for the detection of Human Papillomavirus and Cervical Cancer, for each woman enrolled in the Plan who is 18 years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, except that benefits will not be available for more than one routine mammography screening each Calendar Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a Qualified Individual, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

1. A postmenopausal woman not receiving estrogen replacement therapy
2. An individual with:
 - Vertebral abnormalities
 - Primary hyperparathyroidism
 - A history of bone fractures
3. An individual who is:
 - Receiving long-term glucocorticoid therapy
 - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for participants who are 45 years of age or older and who are at normal risk for developing colon cancer:

- All colorectal cancer examinations, preventive services, and laboratory test assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits provided above by an In-Network Provider will not be subject to a Deductible, Copayment Amounts, or Coinsurance Amounts.

Benefits provided above by an Out-of-Network Provider will be subject to any applicable Deductible, Copayment Amounts, or Coinsurance Amounts.

Benefits for Outpatient Contraceptive Drugs, Devices, and Procedures

Benefits for Outpatient Contraceptive Drugs, Devices, and Procedures Not Subject to Coinsurance, Deductible, Copayment, or Benefit Maximum Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives; vaginal contraceptive devices; spermicide and female condoms. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified.

NOTE: Prescription contraceptive medications are covered under the PHARMACY BENEFITS portion of your Plan.

Contact Customer Service at the toll-free number on your Identification Card to determine what contraceptive drugs and devices are covered under this benefit provision.

Contraceptive drugs and devices not covered under this benefit provision may be covered under other sections of this certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum.

Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient Contraceptive Services benefits. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner. The Participant will be responsible for submitting a claim form with the written prescription and itemized receipt for the female over-the-counter contraceptive. Visit the BCBSTX website at bcbstx.com/ut to obtain a claim form.

You may find more information about covered preventive care services by visiting healthcare.gov or by contacting customer service at the toll-free number on your ID card. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your doctor bills for services that are not preventive.

Professional Services

Covered services must be medically necessary as determined by Blue Cross and Blue Shield of Texas and provided by a licensed doctor or by other covered health providers as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Who are covered health providers?

UT SELECT provides benefits for services provided by professional providers:

- Advanced Practice Nurse (APN)
- Board Certified Behavior Analyst
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage Family Therapist (LMFT)
- Licensed Clinical Social Worker
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Licensed Surgical Assistant
- Nurse First Assistant (NFA)
- Physician Assistant (PA)
- Psychological Associates who work under the supervision of a Doctor in Psychology

Prosthetic Devices

UT SELECT provides coverage for prosthetic appliances, including replacements necessitated by growth to maturity of the participant. Coverage is provided for medically necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of:

- An absent body organ (including contiguous tissue)
- The function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses)

For purposes of this definition, a wig or hairpiece is **not** considered a prosthetic appliance.

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the participant's responsibility.

Rehabilitation Services (Physical, Speech and Occupational Therapies)

UT SELECT covers rehabilitation services and physical, speech and occupational therapies that are medically necessary, meet or exceed treatment goals for a participant, and are provided on an inpatient or outpatient basis or in the provider's office. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration.

Serious Mental Illness (preauthorization required for all inpatient care and certain outpatient care)

Benefits for the treatment of serious mental illness will be provided on the same basis as any other illness. Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*:

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

All inpatient and outpatient treatment for serious mental illness should be preauthorized by calling the toll-free number on your ID card **(1-800-528-7264)**.

Skilled Nursing Facility (preauthorization required)

UT SELECT covers care in a skilled nursing facility and pays benefits for:

- Room and board
- Routine medical services, supplies, and equipment provided by the skilled nursing facility
- General nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist

What is a skilled nursing facility?

A skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services. A skilled nursing facility is licensed in accordance with state law (where the state law provides for licensing of such facility) and is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care. Skilled nursing facilities are not for individuals convalescing.

Substance Use Disorder Treatment (preauthorization required)

Substance Use Disorder Treatments are an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats. Substance use disorder is the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Substance Use Disorder means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. All inpatient and certain outpatient treatment for substance use disorders should be preauthorized by calling the toll-free number on your ID card **(1-866-882-2034)**.

Substance Use Disorder Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

A series of treatments is a planned, structured, and organized program to promote substance-free status. A program may include different facilities or modalities, such as inpatient detoxification, inpatient rehabilitation/ treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a participant is discharged on medical advice or when a participant fails to materially comply with the treatment program.

Inpatient treatment of substance use disorder must be provided in a substance use disorder treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a hospital will be available on the same basis as any other illness.

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
- 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 **1-866-882-2034** or you can chat live either online (**bcbstx.com/ut**) or via the BCBSTX app (**bcbstx.com/mobile**).

Virtual Doctor Visits – \$0 Copayment: Powered by MDLIVE®

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.
- 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
- No out-of-pocket cost

Visit **hingehealth.com/UTS** for more information.

Learn to Live

Learn to Live (L2L) is a behavioral health digital platform available to UT SELECT and UT CONNECT members which offers condition-specific programs, each delivered in a user-paced multimedia experience. Services are also available on demand with the options for one-to-one clinician coaching services. Go to **learntolive.com/welcome/BCBSTX** and Enter Access Code: **BETTERME** to get started.

If you are in crisis, call the national hotline at **1-800-273-TALK (8256)** or call **911** if you feel you are in immediate danger.

* Health advocates do not give medical advice or replace the care of a doctor, and you should talk to your doctor about any medical questions or concerns.

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

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Hinge Health is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide an online musculoskeletal program for members with coverage through BCBSTX.

Learn to Live provides educational behavioral health programs; members considering further medical treatment should consult with a physician. Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through Blue Cross and Blue Shield of Texas.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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
- No out-of-pocket cost

Visit bcbstx.com/ut/healthy-living/livongo to learn more.

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
- Researched curriculum paired with professional health coaches
- No out-of-pocket cost

Visit omadahealth.com/UTS for more information.

Ovia Health: A Digital Support Program

Ovia Health provides maternity and family apps to support you through your entire parenthood journey. These apps are included in your UT SELECT health plan, offered through Blue Cross and Blue Shield of Texas.

With Ovia, you'll have access to enhanced, personalized health and wellness features:

- Health assessment and symptom tracking | Receive alerts and predictive, personal coaching when Ovia detects a potential medical issue
- More than fifty physician-developed clinical programs to help you be as healthy as possible | Engage with personalized health and wellness programs to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding, and more
- Unlimited 1-on-1 coaching | Message with health coaches to ask all your questions
- Career and return-to-work programs | Find coaching and career advice for preparing for maternity leave, returning to work, and being a working parent

Download the app that's right for you:

- Ovia Fertility – Health & Fertility
- Ovia Pregnancy – Pregnancy & Postpartum
- Ovia Parenting – Family & working parents

To create an account, choose "I have Ovia Health as a benefit" before tapping "Sign up" and make sure to select BCBSTX as your health plan and enter your employer name. You can also contact a health advocate at 866-882-2034 for more information or should you have any questions.

Progyny Fertility and Family Building Benefits

The Progyny benefit offers inclusive and comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates (PCAs).

Your Progyny coverage includes:

2 Smart Cycles, Progyny Rx (integrated fertility medication coverage), Fertility preservation (Egg and sperm freezing), and Donor tissue (egg and sperm coverage). Contact your Progyny Patient Care Advocate at **1-844-535-0711** to learn more.

Note: The person(s) receiving fertility treatment must be an employee or covered spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to utilizing the benefit. Prior periods of coverage under a UT System medical plan (with a break following coverage) cannot be counted toward the continuous coverage requirement. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Your coverage may be subject to copayments.

Livongo and Omada are independent companies that have contracted with Blue Cross and Blue Shield of Texas to provide chronic disease prevention and management solutions. Ovia Health, an independent company, has contracted with Blue Cross and Blue Shield of Texas to provide maternity and family benefits solutions. These benefits are for members with coverage through BCBSTX.

Seasons of LifeSM

Seasons of Life is a proactive outreach program offered through your UT SELECT benefits and Blue Cross and Blue Shield of Texas that provides personalized claims resolution assistance to you and your dependents who may be dealing with the death of a loved one.

When BCBSTX learns of a death, a specially trained customer advocate will send a handwritten sympathy card. This advocate will become your single point of contact for the duration of the program. You and/or your family can then contact the customer advocate at a time that is convenient for you to discuss any insurance-related matters.

BCBSTX will conduct a full review of the deceased's reimbursement history, claims status and customer service history before contacting you and/or your family, so the customer advocate can anticipate needs and ensure that compassionate help is available when it's needed most.

While the Seasons of Life program is launched proactively based on information provided to BCBSTX, please know that you and/or your dependents can contact a health advocate for assistance if needed. Simply call **1-866-882-2034**.

Wondr HealthTM

Wondr Health is a weekly, self-paced, online program that teaches you how to lose weight and improve your health without giving up your favorite foods. To find out more and join the waitlist, go to **wondrhealth.com/livingwell**.

Wondr Health is an independent company that provides weight loss programs for members with coverage through Blue Cross and Blue Shield of Texas. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

WHAT THE UT SELECT MEDICAL PLAN DOES NOT COVER



Limitations and Exclusions

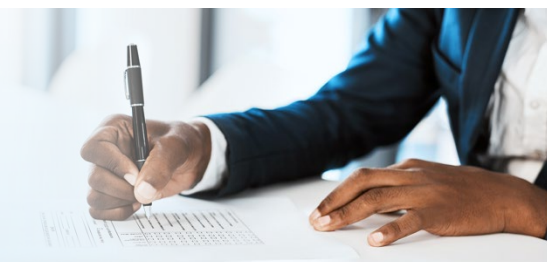
In addition to the limitations and exclusions set out in the description of What the Medical Plan Covers, UT SELECT does not cover medical expenses for the following:

1. Any services or supplies which are not medically necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any experimental/investigational services and supplies.
3. Any services or supplies relating to the treatment of personnel for work-related health requirements, including but not limited to medical services that are required such as testing, vaccination, or treatments. This includes and is not limited to a time period where a public health emergency has been declared. Work-related services are the responsibility of the employer, not the UT SELECT health plan.
4. Any portion of a charge for a service or supply that is in excess of the allowable amount as determined by Blue Cross and Blue Shield of Texas.
5. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
6. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
7. Any services or supplies for which a participant is not required to make payment or for which a participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
8. Any services or supplies provided by a person who is related to the participant by blood or marriage.
9. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war
 - While on active or reserve duty in the armed forces of any country or international authority
10. Any charges resulting from the failure to keep a scheduled visit with a physician or other professional provider; or for completion of any insurance forms; or for acquisition of medical records.
11. Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the participant's physical condition or the quality of medical care provided.
12. Any services or supplies provided before the patient is covered as a participant hereunder or any services or supplies provided after the termination of the participant's coverage.
13. Any services or supplies provided for custodial care, long term care, respite care (except as specifically mentioned under the hospice care program) and maintenance care.
14. Any services or supplies related to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions is subject to medical necessity.
15. Any services or supplies incurred for dental care and treatments, dental surgery, or dental appliances, except as provided under dental services and covered oral surgery in this Benefits Booklet.
16. Any services or supplies provided for cosmetic, reconstructive, or plastic surgery, except as provided for in this Benefits Booklet.
17. Any services or supplies provided for the correction of vision deficiencies, including, but not limited to, radial keratotomy, eye refraction, photo reflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in benefits for eyeglasses and vision services.
18. Any services or supplies provided for treatment of adolescent (up to age 18) behavior disorders, including conduct disorders and opposition disorders.
19. Any services or supplies provided for any medical social services (except as provided as an extended care expense), bereavement counseling (except as provided under hospice care), and vocational counseling.

20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
21. Travel or ambulance services because it is more convenient for the participant than other modes of transportation whether or not recommended by a physician or other professional provider.
22. Any services or supplies provided primarily for environmental sensitivity; clinical ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or inpatient allergy testing or treatment.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Sterilization reversal (male or female).
25. Abortion, unless the participant's life would be endangered by continuing the pregnancy, there is a diagnosed fetal anomaly, or the pregnancy is caused by a criminal act such as rape or incest.
26. Any services or supplies in connection with:
 - Routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease, or
 - Foot care for flat feet, fallen arches, and chronic foot strain
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Any services or supplies provided for the following treatment modalities:
 - Acupuncture
 - Intersegmental traction
 - Surface EMGs
 - Spinal manipulation under anesthesia
 - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron
29. Benefits for any covered services or supplies furnished by a contracting facility for which such facility has not been specifically approved to furnish under a written contract or agreement with Blue Cross and Blue Shield of Texas will be paid at the non-network benefit level.
30. Any services or supplies furnished by a non-contracting facility (except that for accidents, the immediate, initial treatment necessary to stabilize the participant furnished by any hospital, including a governmental facility) shall be subject to benefits as provided in this booklet.
31. Any services or supplies provided for reduction mammoplasty, except when medically necessary.
32. Any items that include, but are not limited to, an orthodontic or other dental appliance; including oral orthotics (for temporomandibular joint (TMJ) disorders, or sleep related breathing disorders), accommodative foot orthotics (that do not address structural or functional abnormalities), stock orthotics (over-the-counter items such as arch supports and other foot support devices and foot orthotics, including transferrable shoe inserts), compression stockings with a gradient < 40 mm HG each, and garter belts, and experimental/investigational orthoses and stabilizers, and any orthotics not considered medically necessary according to Blue Cross medical policy.
33. Any benefits in excess of specified benefits maximums.
34. Any services and supplies provided to a participant incurred outside the United States if the participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
35. Replacement prosthetic appliances except those necessitated by growth due to maturity of the participant.
36. Inpatient private duty nursing services.
37. Outpatient drugs except as provided under the plan by the prescription drug program.
38. Outpatient contraceptive services, drugs and devices, except for contraceptive prescription drugs provided under the Prescription Drug Program portion of this plan.
39. Any drugs and medicines purchased for use outside a hospital which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a physician or other professional provider.
40. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except: when medically necessary for the treatment of morbid obesity; or, when provided under preventive care for healthy diet/intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

41. The use of the procedures, supplies, or medications for treatment of psychological/psychogenic male sexual or erectile dysfunction/impotence.
42. Over-the-counter contraceptives.
43. Non-covered Durable Medical Equipment includes, but is not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
44. Services or supplies used primarily for patient convenience.
45. Most supplies available for purchase over the counter without a doctor's prescription.
46. Any tobacco cessation prescription drug products including, but not limited to, nicotine gum and nicotine patches, except as may be provided under the prescription drug program.
47. Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient.
48. Investigational services and supplies and all related services and supplies, except for routine patient care costs associated with investigational cancer treatment if those services or supplies would otherwise be covered under UT SELECT. Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.
49. Long-term care service, respite care service (except as specifically mentioned under hospice care), and maintenance care.
50. Any services or supplies not specifically defined as eligible expenses in this plan.

UT SELECT MEDICAL PLAN CLAIMS AND APPEALS



How to File a Medical Claim

You or your provider must submit and Blue Cross and Blue Shield of Texas must receive all claims for benefits under UT SELECT within 12 months of the date on which you received the services or supplies. Claims not submitted and received by BCBSTX within this 12-month period will not be considered for payment of benefits.

Who files claims?

When you receive treatment or care from a network provider (or non-network provider who is a ParPlan provider), you will not be required to file claims. The provider will submit the claims directly to BCBSTX for you.

You may be required to file your own claims when you receive treatment or care from a non-network provider who is not a ParPlan provider. At the time services are provided, inquire whether the provider will file claims for you.

Benefit payments will be made directly to network or contracting providers when they bill BCBSTX. Written agreements between BCBSTX of Texas and other providers may require payment directly to them. However, if the benefit payments are for claims from providers with no written agreement with BCBSTX, BCBSTX may choose to pay either you or your provider. If you receive payment from BCBSTX, it will be your responsibility to settle your account with your provider.

If allowed by law, any benefits available to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

To file a medical claim, follow these steps:

1 Get a claim form	Claim forms are available from your institution Benefits Office, or you can download a claim form from the website by logging onto bcbstx.com/ut . Use a separate claim form for each individual; do not combine expenses for family members on one claim form.
2 Complete the claim form	Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim. <ul style="list-style-type: none">• Patient's name• Subscriber number, including the alpha prefix (UTS or UZS)• Correct address• Diagnosis (<i>preferably indicated by your provider on an itemized bill</i>)• Date of injury, illness, or pregnancy• Whether the patient has other group health insurance coverage
3 Attach an itemized bill	Attach an itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim: <ul style="list-style-type: none">• Name and address of the provider providing the services or supplies• Date of service• Type of service• Charges for each service• Patient's name• Diagnosis
4 Mail the claim form and itemized bills <i>Keep a copy of the claim form and itemized bills for your records.</i>	Send the claim form and itemized bills to: BCBSTX, P.O. Box 660044, Dallas, TX 75266-0044. (The address also appears on the form.) Do not send the claim form to UT System. This will only delay processing. Note: Foreign claims must be translated. If no translation is attached, processing may be delayed. <i>You must file and Blue Cross and Blue Shield of Texas must receive claims for expenses within 12 months after the date of service.</i>
5 Review your Explanation of Benefits (EOB) statement after the claim is processed	The EOB will confirm if the expense is covered by UT SELECT and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reasons why. Note: EOBs are available online through Blue Access for Members at bcbstx.com/ut ; you must log in and elect to receive paper copies by mail.

To assist providers in filing your claims, you should always carry your UT SELECT ID card with you.

Receipt of Claims

A claim will not be considered received for processing until Blue Cross and Blue Shield of Texas receives the claim at the proper address and with all of the required information. If the claim is not complete, Blue Cross and Blue Shield of Texas will return it. On claims that need further information for proper processing, Blue Cross and Blue Shield of Texas may contact either you or the provider for the additional information. The claim will be processed when Blue Cross and Blue Shield of Texas receives all the requested information. After processing the claim, BCBSTX will notify the participant by way of an Explanation of Benefits summary.

Review of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion to interpret and determine benefits in accordance with UT SELECT plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and UT System.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your UT SELECT medical plan.

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by BCBSTX; then review this Benefits Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision as described in **Medical Claim Appeal Procedures**.

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

- The reasons for the determination
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used; upon request, diagnosis/treatment codes with their meanings and the standards used are also available
- An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review)
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s)
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request
- In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care/expedited claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification
- Contact information for applicable office of health insurance consumer assistance or ombudsman

Medical Claim Appeal Procedures

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

- 1. Urgent Care Clinical Claim** is any pre-service claim that requires preauthorization for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- 2. Pre-Service Claim** is a non-urgent request for approval that BCBSTX requires you to obtain before you get medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.
- 3. Post-Service Claim** is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

Urgent Care Clinical Claims*

TYPE OF NOTICE OR EXTENSION	TIMING
If your claim is incomplete, BCBSTX must notify you within:	24 hours
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	48 hours after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call BCBSTX at the toll-free number listed on the back of your UT SELECT ID card as soon as possible to appeal an Urgent Care Clinical Claim.

Pre-Service Claims

TYPE OF NOTICE OR EXTENSION	TIMING
If your claim is filed improperly, BCBSTX must notify you within:	5 days
If your claim is incomplete, BCBSTX must notify you within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is incomplete, within:	15 days*
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
If you require post-stabilization care after an emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

*This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.

Post-Service Claims

TYPE OF NOTICE OR EXTENSION	TIMING
If your claim is incomplete, BCBSTX must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
If the initial claim is complete, within:	30 days*
After receiving the completed claim (if the initial claim is incomplete), within:	45 days

*This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, notice of the final determination will be provided no later than 24 hours after receipt of your claim for benefits.

Claim Appeal Procedures – Definitions

- 1. Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces or terminates such treatment (other than by amendment or termination of the UT SELECT medical plan) before the end of the approved treatment period, that is also an adverse benefit determination. A rescission of coverage is also an adverse benefit determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.
- 2. Final Internal Adverse Benefit Determination** means an adverse benefit determination that has been upheld by UT System at the completion of BCBSTX's and UT System's internal review/appeal process.
- 3. Clinical Appeal** means a request to change an adverse determination for care or services that were denied on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic. May be pre- or post-service. Review is conducted by a physician. Members or their authorized representative may file a clinical appeal. Providers may also file a clinical appeal on their own behalf.
- 4. Non-Clinical Appeal** means a request to reconsider a previous inquiry, complaint or action by BCBSTX that has not been resolved to the member's satisfaction. This relates to administrative health care services such as membership, access, claim payment, etc. and may be pre-service or post-service. Review is conducted by a non-medical appeal committee. Only members or their authorized representative may file a non-clinical appeal.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. You or your authorized representative may request an expedited clinical appeal either orally or in writing. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. BCBSTX shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization or any other determination made by BCBSTX regarding your UT SELECT benefits.

An appeal of an adverse benefit determination (clinical or non-clinical) may be filed by you or a person authorized to act on your behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you, except to your authorized representative. To obtain an authorization form, you or your representative may call BCBSTX customer service at the number on the back of your UT SELECT ID card, or download the Standard Authorization Form to use or Disclose Protected Health Information from the bcbstx.com/ut website within the section for Forms and Resources.

For clinical adverse determinations made on the basis of lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic, a health care provider may appeal on his/her own behalf.

If you believe all or part of your benefits were incorrectly denied, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedures:

Within 180 days after you receive notice of a denial or partial denial, you may call or write to BCBSTX to appeal.

- If you appeal in writing, send your written request to appeal along with any additional written comments, documents, records, and any other information you wish BCBSTX to consider as part of your appeal to:

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

If you appeal by phone, you should specifically state that you wish to appeal a claim denial. BCBSTX will assign and provide you with an appeal reference number during the call. You should make a note of the reference number and use it each time you are calling or writing BCBSTX about your appeal. BCBSTX will also mail you an acknowledgement of your appeal within 10 days. An appeal by phone may also be supplemented by written comments, documents, records, and any other information you may wish to submit to support your appeal. If you appeal by phone, you will be responsible for mailing in any additional written comments, documents, records, and any other information you wish BCBSTX to consider as part of your appeal to the address provided above for written appeals.

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. The designation and the appeal along with any other documents should be mailed to the address above.
- In support of your appeal review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your appeal file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an adverse benefit determination. Once you have filed a timely appeal, you may also submit additional information at any time during the claim review process.
- BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse benefit determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal determination will be made by a physician associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by BCBSTX or UT System.
- If you have any questions about the claims procedures or the review procedure, write to BCBSTX or call Customer Service at **1-866-882-2034**.

Timing of Appeal Determinations

- BCBSTX shall render a determination of a non-urgent pre-service appeal as soon as practical, but in no event more than 15 days after the appeal has been received by BCBSTX.
- BCBSTX shall render a determination of a non-urgent post-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by BCBSTX.

Notice of First-Level Internal Appeal Determination

BCBSTX will notify the party filing the appeal, you, and if a clinical appeal, any health care provider who recommended the services involved in the appeal, of its determination, followed by a written notice of the determination. The written notice will include:

- The reason for the determination
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used; upon request, diagnosis/treatment codes with their meanings and the standards used are also available
- An explanation of UT System's second level appeal process
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s)
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request
- A description of the standard that was used in denying the claim and a discussion of the decision
- Contact information for applicable office of health insurance consumer assistance or ombudsman

Appeal of Second-Level Internal Appeal Determination

If BCBSTX's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you have the right to appeal to The University of Texas System. Your written request must be submitted within 60 days after the receipt of the notice of a denial from BCBSTX. Your appeal should include any written comments, documents, records, and any other information you may wish to submit to support your position. Submit your written appeal by U.S. Mail, fax or e-mail to:

Office of Employee Benefits
The University of Texas System
Attn: Appeals
210 West 7th Street
Austin, Texas 78701
Phone: **1-512-499-4616**
Toll Free: **1-800-888-6824**
Fax: **1-512-499-4620**
benefits@utsystem.edu

UT System shall render a determination of a non-urgent pre-service appeal as soon as practical, but in no event more than 15 days after the appeal has been received by UT System.

UT System shall render a determination of a non-urgent post-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by UT System.

UT System will provide you with a written notice of the determination if another party filed the appeal, that party, and in case of a clinical appeal, any health care provider who recommended the services involved in the appeal. The written notice will include:

- The reason for the determination
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used; upon request, diagnosis/treatment codes with their meanings and the standards used are also available
- An explanation of BCBSTX external review process (and how to initiate an external review)
- In certain situations, a statement in non-English language(s) that the written notice of claim denial and certain other benefit information may be available upon request in such non-English language(s)
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request
- A description of the standard that was used in denying the claim and a discussion of the decision
- Contact information for applicable office of health insurance consumer assistance or ombudsman

If UT System's decision is to continue to deny or partially deny your claim, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call BCBSTX at 866-882-2034. BCBSTX customer service is accessible from 8:00A.M. to 6:00 P.M., Monday through Friday.

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

Standard External Review

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination of a clinical appeal by an independent review organization (IRO). To obtain an authorization form, you or your representative may call BCBSTX customer service at the number on the back of your UT SELECT ID card, or download the *HIPAA Authorization Form to Disclose PHI* from the bcbstx.com/ut website within the section for Forms and Resources.

1. Request for external review

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

2. Preliminary review

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

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided
- The adverse benefit determination or the final adverse internal benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination)
- You have exhausted BCBSTX's and UT System's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations; please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review; you will be notified within 1 business day after BCBSTX completes the preliminary review if your request is eligible or if further information or documents are needed; you will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request; if your claim is not eligible for external review, BCBSTX will outline the reasons it is ineligible in the notice

3. Referral to Independent Review Organization

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

3. Referral to Independent Review Organization (*continued*)

The IRO must provide the following:

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

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

4. Reversal of plan's decision

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

Expedited External Review

1. Request for expedited external review

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

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

2. Preliminary review

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

3. Referral to independent review organization

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

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

4. Notice of final external review decision

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

Exhaustion

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

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

Refund of Benefit Payments

If the plan pays benefits for eligible expenses incurred by you or your covered dependents and it is found that the payment was more than it should have been, or was made in error, the plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the plan may deduct any refund due it from any future benefit payment. The Office of Employee Benefits will pursue necessary steps to receive reimbursement for ineligible medical or prescription benefits paid on your behalf, including possible referral for collections.

Subrogation, Reimbursement and Third-Party Recovery Provision

Subrogation

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

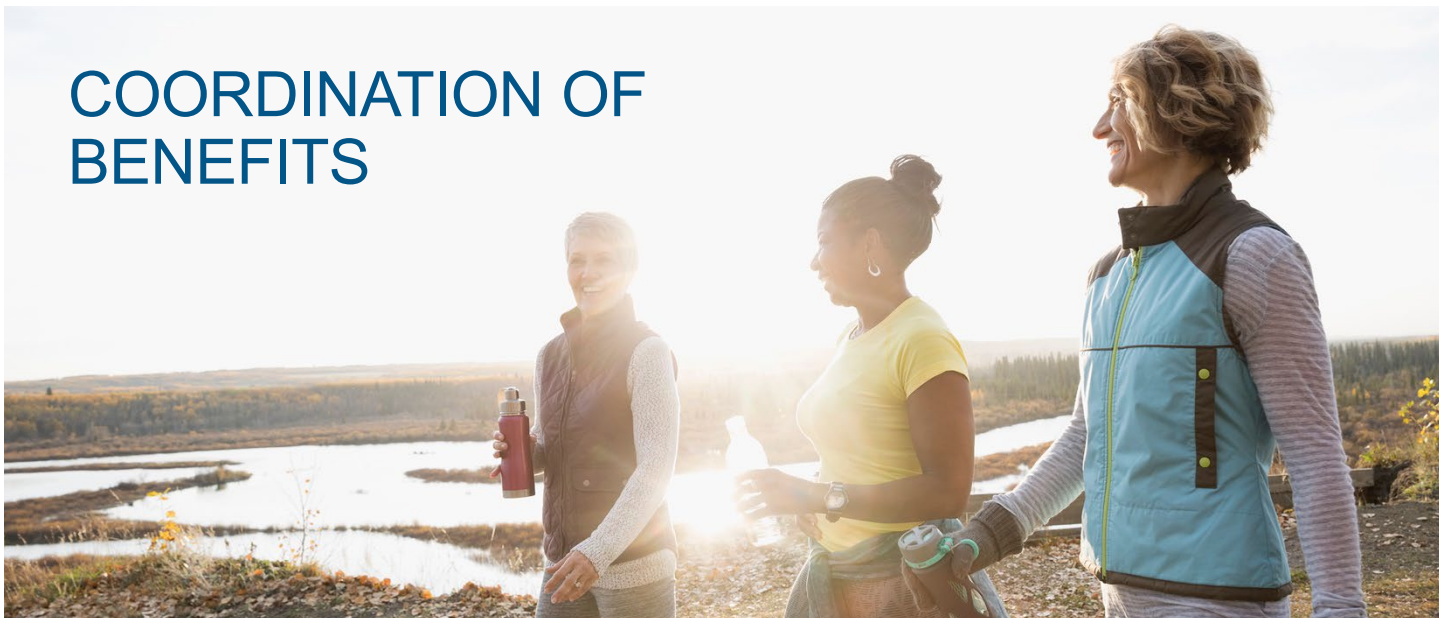
Right of Reimbursement

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

Right to Recovery by Subrogation or Reimbursement

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

COORDINATION OF BENEFITS



UT SELECT includes a Coordination of Benefits (COB) provision that determines how benefits will be paid when you or your dependent is covered by more than one group health plan.

When you have other group medical coverage (through your spouse's employer, for example), your UT SELECT benefits may be combined with others to pay covered charges. The COB provision eliminates duplicate payments for the same medical expenses.

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

Coordination of Benefit Definitions

Plan means any group insurance or group-type coverage, whether insured or uninsured. This includes:

- Group or blanket insurance
- Franchise insurance that terminates upon cessation of employment
- Group hospital or medical service plans and other group prepayment coverage
- Any coverage under labor-management trusted arrangements, union welfare arrangements, or employer organization arrangements;
- Governmental plans
- Coverage required or provided by law

Plan does not include any coverage held by the participant for hospitalization and/or medical-surgical expense which is written as a part of or in conjunction with any automobile casualty insurance policy; a policy of health insurance that is individually underwritten and individually issued; or school accident type coverage. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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

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

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

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

Order of Benefit Determination Rules

1. General Information

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

2. Rules

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

- a. Non-Dependent/Dependent** – The benefits of the plan, which covers the participant as an employee, member or subscriber, are determined before those of the plan which covers the participant as a dependent. However, if the participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (1) secondary to the plan covering the participant as a dependent and (2) primary to the plan covering the participant as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the participant as a dependent are determined before those of the plan covering that participant other than as a dependent.
- b. Dependent Child/Parents Not Separated or Divorced** – Except as stated in paragraph below, when this plan and another plan cover the same child as a dependent of different parents:
 - 1. The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year
 - 2. If both parents have the same birthday, the benefits of the plan, which covered one parent longer, are determined before those of the plan which covered the other parent for a shorter period of time.However, if the other plan does not have the rule described in this paragraph, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- c. Dependent Child/Parents Separated or Divorced** – If two or more plans cover a participant as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1. First, the plan of the parent with custody of the child
 - 2. Then, the plan of the spouse of the parent with custody, if applicable
 - 3. Finally, the plan of the parent not having custody of the childHowever, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph c does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has actual knowledge of the decree.
- d. Joint Custody** – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is primarily responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.
- e. Active/Inactive Employee** – The benefits of a Plan, which covers a participant as an employee who is neither laid off nor retired, are determined before those of a plan which covers that participant as a laid off or retired employee. The same would hold true if a participant is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph c does not apply.
- f. Continuation Coverage** – If a participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:
 - 1. The COBRA continuation coverage plan that covers member as a subscriber/policyholder is the Primary Plan
 - 2. Secondary liability is the plan that covers the UT SELECT subscriber as a dependent
- g. Longer/Shorter Length of Coverage** – If none of the above rules determine the order of benefits, the benefits of the plan, which covered an employee, member or subscriber longer, are determined before those of the plan, which covered that participant for the shorter period of time.

Effect on the Benefits of this Plan

1. When This Section Applies

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

2. Reduction in This Plan's Benefits

The benefits of this plan will be reduced when the sum of:

- a. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision.
- b. The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim is made, exceeds those allowable expenses in a claim determination period.

In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Blue Cross and Blue Shield of Texas may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this plan. Blue Cross and Blue Shield of Texas will not have to pay that amount again.

Right to Recovery

If the payments the plan makes are more than should have been paid under this COB provision, Blue Cross and Blue Shield of Texas may recover the excess from one or more of:

- The persons paid or for whom payment has been made
- Insurance companies
- Hospitals, physicians, or other providers
- Any other person or organization

UT SELECT AND MEDICARE



Different parts of Medicare cover different services. You may hear about four parts of Medicare: Part A, Part B, and Part D.

Original Medicare is administered directly by the federal government. It is the way participants in UT SELECT get their Medicare coverage. It has two parts:

- 1. Part A (Hospital Insurance)** covers most medically necessary hospital, skilled nursing facility, home health, and hospice care. It is free if you have worked and paid Social Security taxes for at least 40 calendar quarters (10 years); you will pay a monthly premium if you have worked and paid taxes for less time.
- 2. Part B (Medical Insurance)** covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, behavioral health care, and some home health and ambulance services. You pay a monthly premium for this coverage.

Medicare Part D (Outpatient Prescription Drug Insurance) is the part of Medicare that provides outpatient prescription drug coverage. Part D is provided to UT SELECT participants by UT SELECT (UT CARE Part D Plan effective 1/1/2023). It is never provided directly by the government (like Original Medicare is).

Active Employees

In most cases, we recommend that any active employee, or spouse of an active employee enrolled in UT SELECT enroll in Medicare Part A once they reach age 65 and decline enrollment in Part B. Failure to enroll in Medicare Part A once you qualify due to age may affect your ability to enroll in Part A later. In most instances, if you are eligible for Medicare and are working in a benefits-eligible position for at least 20 hours per week, UT SELECT will be primary coverage primary for active employees and their covered dependents, regardless of age, and Medicare will be secondary.

Retired Employees

All retired participants in UT SELECT are required to enroll in Medicare Parts A and B when they become eligible, usually at age 65 (or earlier if they are eligible due to a disability.) Retired employees and/or soon-to-be retired employees, or their dependents who are eligible for Medicare must have Medicare Parts A and B to receive the maximum benefits available from the UT SELECT plan. It is your responsibility to inform your institution Benefits Office when you and/or your covered dependents become Medicare-eligible. It is recommended to enroll as early as possible up to 90 days before you turn 65 or you retire. If you are retired and also eligible for Medicare, Medicare Part A or B becomes your primary payer and pays your medical claims first; UT SELECT pays second. If you choose a doctor who accepts Medicare assignment, you will not be responsible for any difference between the billed charge and the Medicare allowed amount.

Through 12/31/2022, these terms are in effect. As of 1/1/2023, the UT CARE Medicare PPO plan will cover medical benefits for Medicare-eligible retired employees. (See more information on the UT CARE plan below). If you decline Part B, you will have to pay a higher premium if you ever re-apply for Medicare coverage. As a retiree, if you or your Medicare-eligible dependent have declined Medicare Part B and fail to re-apply, you will be required to pay the portion that Medicare Part B would have paid as primary insurer for Part B-covered items for yourself and any Medicare-eligible dependents.

To ensure claims are correctly processed, you should inform your providers of all the insurance plans in which you are enrolled. Understanding correct coordination of benefits will help to ensure timely and accurate claims payments.

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

- You may visit a provider in or out of the UT SELECT network
- UT SELECT will pay 100% of benefits approved but not paid by Medicare (subject to UT SELECT plan limitations)
- There are no deductibles, copayments or coinsurance
- When you or your dependents are an inpatient at a facility that accepts Medicare assignment, UT SELECT will pay the Medicare inpatient deductible, and the \$200 per day copay (\$1,000 maximum) will not apply

If your provider does not accept Medicare assignment:

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

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

If you and/or your dependents do not enroll in Medicare Part B when eligible, Blue Cross and Blue Shield of Texas will assume that Medicare paid 80% of the Medicare allowed amount when processing your claim. Blue Cross and Blue Shield of Texas will calculate the benefits payable for the allowable expense under UT SELECT as if Blue Cross and Blue Shield of Texas were the primary payer. UT SELECT will pay up to this amount, but not more than the difference between the Medicare allowable and the Medicare paid amount. You may be responsible for deductibles, copayments or coinsurance amounts in some cases. **Note:** If you and/or your dependents are enrolled in Medicare Part B and go to a provider that accepts Medicare assignment and services are covered by Medicare, you will not be responsible for deductibles, copayments or coinsurance amounts for services otherwise. UT SELECT will reimburse up to 100% of the Medicare allowed amount for approved services normally covered by the Plan. Services not normally covered or outside of normal coverage limits will not be paid. If services are not covered by Medicare, UT SELECT will pay primary according to normal plan provisions. Please review the Medicare Coordination of Benefits table on the next page.

For prescription benefits, UT System automatically enrolls Medicare-eligible retirees and Medicare-eligible dependents of retirees into the UT SELECT Part D plan. The UT SELECT Part D plan maintains the familiar copays and other benefits of the employee prescription plan. Enrollment in a separate Part D plan or Medicare Advantage plan with prescription drug coverage will conflict with UT SELECT Part D coverage because the Centers for Medicare and Medicaid Services (CMS) only allows enrollment in one Medicare plan. For current enrollees in the UT SELECT Part D plan, the annual prescription deductible will reset on January 1. Other deductibles and out-of-pocket maximums for the UT Benefits program will reset on September 1, as usual. The Centers for Medicare and Medicaid Services (CMS) will send you prescription drug plan materials, including detailed benefits information and a new ID card. Non-Medicare-eligible UT SELECT plan participants with retiree coverage will continue to be enrolled in what we call “the commercial plan”—the same plan that insures participants with coverage through active employment.

UT CARE Medicare PPO Plan (Effective 1/1/2023)

Effective January 1, 2023, Medicare-eligible retirees and dependents will begin receiving their medical coverage under a new plan, the UT CARE Medicare PPO plan. The UT CARE Medicare PPO (UT CARE) plan will be provided by BCBSTX. This national PPO plan allows you to see any provider that is willing to see you as a patient, accepts Medicare and will submit claims to BCBSTX. You are not required to get a referral to see a specialist.

Please note: you must be enrolled in Medicare Part A and Part B to be a member of this retiree plan. You must also continue to pay your Part B premium just as you do today. If you are eligible for Medicare Part A and/or Part B but are not enrolled, please contact Social Security right away. If you are currently enrolled in UT SELECT medical, as long as you are enrolled in Medicare Parts A and B you will be automatically enrolled in UT CARE for a January 1, 2023 effective date.

There is no form to complete or active enrollment into the UT CARE plan.

If you prefer to opt out of the UT CARE medical and prescription plan, you must do so **between November 1 and November 15, 2022** by declining the coverage through the *My UT Benefits* online system. To access *My UT Benefits*, please visit the “Manage Your UT Benefits” page at utbenefits.link/manage.

IMPORTANT: If you take action to opt out, you will not have any UT medical, prescription or basic retiree life insurance. If CMS does not accept your enrollment because a federal requirement was not met for enrollment, then you will still have UT SELECT medical coverage. However, the benefit will be limited to what the plan would pay after Medicare pays. Typically, that means the plan will pay about 20%.

Please note: The prescription component of the Medicare-eligible retiree plan will continue to be administered by Express Scripts, but the plan name will change to UT CARE Part D Plan.

UT CARE™ Medicare PPO is an open access Medicare Advantage PPO plan. On occasion, you may receive automated communications that reference plan name ‘Blue Cross Group Medicare Advantage Open Access (PPO)™’. This plan name also refers to UT CARE Medicare PPO.

MEDICARE COORDINATION OF BENEFITS

UT SELECT Members with Medicare Primary

Important: If you are retired and you or your dependents do not enroll in Medicare Part B when eligible, Blue Cross and Blue Shield of Texas will assume that Medicare paid 80% of the Medicare allowed amount when processing your claim. Blue Cross and Blue Shield of Texas will calculate the benefits payable for the allowable expense under UT SELECT as if Blue Cross and Blue Shield of Texas were the primary payer. UT SELECT will pay up to this amount, but not more than the difference between the Medicare allowable and the Medicare paid amount. You may be responsible for deductibles, copayments or coinsurance amounts in some cases. This chart is effective 9/1/2022 – 12/31/2022. New benefits under the UT CARE Medicare PPO plan become effective 1/1/2023.

Provider Accepts Medicare Assignment Y/N	BCBSTX In-Network Provider Y/N	Service Covered by Medicare Y/N	Medicare Pays	UT SELECT Pays ¹	Member Pays
Y	Y	Y	80% MC Allowed	20% MC Allowed	No Charge
Y	N	Y	80% MC Allowed	20% MC Allowed	No Charge
Y	Y	N	0	80% of BCBSTX Allowed After \$600 UT SELECT Deductible or 100% after Copay, whichever is applicable	20% of BCBSTX Allowed After \$600 UT SELECT Deductible or Copay, whichever is applicable
Y	N	N	0	60% of BCBSTX Allowed after \$1,800 UT SELECT Deductible	\$1,800 UT SELECT Deductible + 40% of BCBSTX Allowed + Difference between Billed Charge and BCBSTX Allowed
N	Y	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$600 Deductible or 100% after Copay, whichever is applicable	\$600 UT SELECT Deductible and 20% coinsurance or Copay, whichever is applicable
N	N	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$1,800 UT SELECT Deductible	\$1,800 UT SELECT Deductible and 40% coinsurance
N	Y	N	0	80% of BCBSTX Allowed After \$600 UT SELECT Deductible or 100% after Copay, whichever is applicable	20% of BCBSTX Allowed After \$600 UT SELECT Deductible or Copay, whichever is applicable
N	N	N	0	60% of BCBSTX Allowed after \$1,800 UT SELECT Deductible	\$1,800 Deductible + 40% of BCBSTX Allowed + Difference between Billed Charge and BCBSTX Allowed

¹ If a service is not covered by the UT SELECT plan, no payment will be made.

² Provider who does not participate with Medicare may not bill more than the Medicare Limiting Charge (115% of MC Allowed).

³ Allowed charges are the lesser of the Medicare Limiting Charge (115% of MC Allowed) or the BCBSTX allowed amount. If the BCBSTX allowed amount is less, the member may be billed the difference.

HOW YOUR UT SELECT PRESCRIPTION DRUG PROGRAM WORKS



Prescription Drug Benefits

Your prescription drug benefits under UT SELECT are administered by Express Scripts and require a \$200 annual deductible per plan participant, per plan year.

NOTE for Retired Employees: If you are Medicare-eligible and your UT SELECT insurance is through Retired Employee coverage, your prescription drug plan is the UT SELECT Medicare Part D plan (becoming UT CARE Medicare Part D effective 1/1/2023) which provides prescription drug benefits to UT System retirees and their Medicare-eligible dependents. The Centers for Medicare and Medicaid Services (CMS) will send you prescription drug plan materials, including a new ID card before your original effective date and before the beginning of the new Part D plan year each January 1.

UT SELECT Prescription Drug Benefits

Annual Deductible (does not apply to medical plan annual deductible)	\$200/person/year*		
ACCESS OPTIONS	GENERIC DRUG COPAYMENT	PREFERRED DRUG COPAYMENT	NON-PREFERRED DRUG COPAYMENT
Retail Network Pharmacy: <ul style="list-style-type: none">• Up to a 30-day supply• Refills allowed as prescribed• Good option for new prescriptions	\$10	\$35	\$60
90-Day at Walgreens, UT Pharmacy or Express Scripts Home Delivery: <ul style="list-style-type: none">• Up to a 90-day supply• Refills allowed as prescribed• Best option for maintenance medication	\$20	\$87.50	\$150

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

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

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

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

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

If you purchase a Brand Name Drug when there is a less expensive Generic alternative, you must pay the difference between the cost of the Brand Name drug and the Generic drug **plus the applicable Generic Copayment**. This difference does NOT count toward your \$200 annual deductible per person per plan year. Sometimes the cost difference is quite large. Here is an example of how this type of claim would process if you had already met your \$200 annual deductible:

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

The UT SELECT Prescription Drug Plan allows you to utilize both the retail pharmacies and the mail order pharmacy. Most retail pharmacies participate in the nation-wide 30-day retail pharmacy network. If you fill a prescription at a non-network 30-day retail pharmacy, you will pay the full cost of your prescription and send a claim form and your receipt to Express Scripts. Your reimbursement will be based on your total cost, minus the UT System discount, the applicable annual deductible and copayment. You will be responsible for payment of any amount above the UT System contracted rate.

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

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

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

Smart90 Retail Prescriptions

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

Patient Assurance Program

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

Diabetic Supplies

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

Automatic Fills

The automatic refills program helps address one of patients' main sources of anxiety when using home delivery: fear of running out of medication because they forgot to refill, or the medication was not delivered as expected. With automatic refills, patients no longer need to worry because the Express Scripts Pharmacy automatically delivers refills to the patient. And when the medication is out of refills, Express Scripts contacts the doctor for a new prescription. To enroll a medication into automatic refills, visit express-scripts.com/ut, or call Member Services at 1-888-818-0155.

Note: For safety and other reasons, prescriptions for some medications are not eligible to be automatically filled. These prescriptions include specialty medications and controlled substances. When a prescription expires or the last refill is processed, you will need to coordinate with your provider to send a new prescription to Express Scripts..

Gaps in Care Alerts

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

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

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

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

Manufacturers' Coupons

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

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

Ultimately, you and the UT SELECT medical plan save the most when you fill prescriptions with generic drugs whenever possible. If a generic isn't available, consider using a Preferred brand-name drug that's less expensive. The **Price a Medication** tool within express-scripts.com will provide potential lower-cost alternatives under your plan to help guide future conversations with your doctor. For medications you need to treat an ongoing condition, such as high blood pressure or high cholesterol, you'll typically pay even less by using your mail-order service, the Express Scripts PharmacySM. All alternative options are available through **Price a Medication**..

Prescription Limitations

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

Programs with limitations include:

- **Prior Authorization:** Prior Authorization is a process requiring physician review to obtain additional clinical information for select drugs to determine qualification of coverage under the UT SELECT Plan. To initiate a prior authorization, please contact Express Scripts. Your doctor can also contact Express Scripts directly through the Physician Prior Authorization process.
- **Step Therapy:** Coverage under the Step Therapy Program may require that you try a generic drug or lower-cost brand-name alternative drug before using higher cost non-preferred drugs.
- **Quantity Per Dispensing Event:** A medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period or per prescription.

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

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

What's not covered?

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

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

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

Preventive Medications

In accordance with the Affordable Care Act (ACA), the UT SELECT Prescription Drug plan covers certain preventive items and services at a \$0 cost share. The list of preventive medications under your benefit is based on the recommendations of the U.S. Preventive Services Task Force. To receive these medications at a \$0 copayment, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy.

Drug categories include:

- Aspirin – Generic over-the-counter (OTC) product for adults under 70 years of age for cardiovascular protection
- Statins – Low to moderate dose generic statins for prevention of cardiovascular disease for adults >40 and < 75 years of age.
- Folic Acid – Over-the-Counter doses of 400 to 800 mcg/day for adults under the age of 51 who are pregnant or who are planning to become pregnant
- Fluoride – A prescription product for children age 6 months to 16 years to prevent dental cavities
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be administered at a network retail pharmacy if available. The cost of the vaccine is covered under the UT SELECT pharmacy plan. See the summary of the medical plan for more details on vaccines administered in the doctor's office.

- Prescription and OTC bowel prep generic medications for colonoscopy for men and women age 50-75
- Tobacco cessation products for adults 18 and over
 - Nicotrol NS
 - Nicotrol Inhaler
 - Zyban
 - Chantix
 - Nicorette Gum/Lozenge
 - Nicotine Transdermal System
- Breast cancer prevention therapy with Tamoxifen, Raloxifene, Soltamox, generic anastrozole and generic exemestane for adults 35 and over at high risk with copay review approval.
- HIV pre-exposure prophylaxis will be covered for emtricitabine/tenofovir disoproxil fumarate 200mg/300mg for persons at high risk of HIV acquisition.
- Contraceptives for individuals through the age of 50
 - Prescription FDA-approved contraceptive agents (includes prescription IUDs—Mirena, Depo-Provera, patches, and oral agents)
 - Emergency contraceptives (Plan B and Ella)
 - OTC contraceptive devices and medications

\$0 copay applies for the generic or single source contraceptive options. A cost may be applied for multisource brands unless the covered generic or single source contraceptive option would be medically inappropriate for that individual, and the prescribed multisource contraceptive is medically appropriate as determined through a clinical review. Express Scripts handles all clinical reviews at **1-800-818-0155**.

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

Specialty Pharmacy

Specialty drugs

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

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

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

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

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

Accredo Pharmacy

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

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

SaveOn SP

The UT SELECT Prescription Drug plan has partnered with SaveOn SP to provide a specialty pharmacy co-pay assistance program.

- Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum or deductible. A list of the program drugs can be found at saveonsp.com/uts
- Although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum or deductible, for UT SELECT members who qualify for and enroll in the SaveOnSP program, the cost of the specialty medication will be reimbursed by the manufacturer and result in no financial responsibility for the participant

PRESCRIPTION DRUG CLAIMS AND APPEALS



Initial Review

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

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

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

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

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

Urgent Claims (Expedited Reviews)

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

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

Appeal of Adverse Benefit Determination

Non-Urgent Appeal

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

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

This information should be mailed to: **Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588 Attn: Appeals**. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. Additional assistance and notices are available in Spanish, Tagalog, Chinese, and Navajo by calling 1-800-818-0155.

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

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

This information should be mailed to **Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588 Attn: Appeals**. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

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

Urgent Appeal

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your appeal. Urgent appeal requests may be oral or written. You or your physician may call **1-800-935-6103** or send a written request to: **Express Scripts, Inc., P.O. Box 66588, St. Louis, MO 63166-6588, Attn: Appeals**. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination no later than 72 hours after receipt of your appeal request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your appeal. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Independent External Review

External Appeals Review

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

To file for an independent external review, Express Scripts must receive your external review request within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: **Express Scripts Attn: External Review Requests P.O. Box 66588, St. Louis, MO 63166-65887. Phone: 1-800-753-2851 Fax: 877-852-4070.**

Non-Urgent External Review

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

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

Urgent External Review

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

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

UT SELECT PLAN PROVISIONS



Eligibility for UT SELECT Coverage

Important: This is just a summary of eligibility information. Consult your institution Benefits Office and/or the Office of Employee Benefits Administrative Manual for complete eligibility policies.

The eligibility date is the date a person becomes eligible to be covered under UT SELECT. A person becomes eligible to be covered when he becomes an employee, retiree or a dependent and is in a class eligible to be covered under the plan.

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

Employee Eligibility

If you are eligible to participate in the UT System uniform group insurance program under Chapter 1601 of the Texas Insurance Code, you are eligible for the benefits described in this Benefit Booklet.

For purposes of this plan, the term Eligible Employee will also include those individuals who are no longer an employee of The University of Texas System, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may apply for coverage for yourself (or for yourself and your dependents) on or before your eligibility date, within 31 days of your eligibility date or during the annual enrollment period.

Retired Employee Eligibility

You are eligible to receive the benefits described in this Benefit Booklet if you are a former UT employee who meets all eligibility as determined by UT and has retired under the:

- Teacher Retirement System of Texas
- Employees Retirement System of Texas
- Optional Retirement Program

Dependent Eligibility

If you are eligible for coverage, you may include your dependents. If both you and your spouse are UT employees, then your children may be covered as dependents of either parent, but not both. In addition, a spouse that is a UT Employee may be covered as a dependent only if the spouse's medical coverage as an employee is declined.

The plan defines a dependent as:

- 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
 - Certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support

Surviving Dependent Benefits

Certain individuals who qualify as surviving spouse or other benefits-eligible dependent of an employee or retired employee who meet certain service requirements are eligible for benefits as a surviving dependent if the dependent had been participating in UT SELECT at the time of the employee or retired employee's death. See UT policy on surviving spouses for more information.

Initial Period of Eligibility for Employees

You have 31 days from your 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. 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.

Waiting Period

Newly hired employees and their dependents may be required to satisfy a state-mandated waiting period before enrollment in the UT SELECT Medical plan is allowed and state premium sharing is available. Consult with your institution Benefits Office for additional information regarding the waiting period.

Life Event Changes

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

Examples of qualified life events include:

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

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

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

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

Address Changes

It is your responsibility to keep UT SELECT aware of any address changes for yourself and your covered dependents. Please notify your institution Benefits Office promptly of all address changes for yourself and your dependents. An address change may result in benefit changes for you and your dependents if you move out of your plan service area.

Address changes must be submitted through your institution Benefits Office.

Termination of Coverage

Coverage under UT SELECT for you and/or your dependents will automatically terminate if:

- Your portion of the group contribution is not received timely by the plan
- The last day of the month in which you lose eligibility to participate in the plan occurs
- The plan is amended to terminate the coverage of the class of employees to which you belong
- A dependent ceases to meet the plan's definition of a dependent

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

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

Termination of the Plan

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

GLOSSARY OF TERMS



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

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

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

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

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

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

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

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

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

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

Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lesser of billed charge or the amount prescribed by law.

- For multiple surgeries – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.
- For procedures, services, or supplies provided to Medicare recipients – The Allowable Amount will not exceed Medicare's limiting charge.
- For Covered Drugs as applied to Participating and non-Participating Pharmacies – The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Participating Pharmacy contract rate.

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- For Covered Drugs as applied to Participating and non-Participating Pharmacies – The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Participating Pharmacy contract rate.
- For non-Emergency Care provided by an Out-of-Network Provider when a contracting Provider is not reasonably available as defined by applicable law or when services are preapproved or have received Prior Authorization based upon the unavailability of a Preferred Provider and balance billing is not prohibited by Texas or Federal law – The Allowable Amount will be the Plan's usual and customary rate as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between BCBSTX and the Out-of-Network Provider, not to exceed billed charges.
- For Out-of-Network Emergency Care, care provided by an Out-of-Network facility-based Provider in a Network Hospital, ambulatory surgery center or birthing center, or services provided by an Out-of-Network Laboratory or Diagnostic Imaging Service in connection with care delivered by a Network Provider – The Allowable Amount will be the Plan's usual and customary rate or at a rate agreed to between BCBSTX and the Out-of-Network Provider as prescribed by the Texas Insurance Code, not to exceed billed charges. The Plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less than the non-contracting Allowable Amount as defined in this Plan.

Approved Clinical Trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from obtaining an investigational new drug application; or
3. Approved or funded by:
 - a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
 - b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
 - c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
 - d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to: (1) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (2) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.
4. Conducted and approved by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

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

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency (SUD), only as listed in this Benefit Booklet.

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

Certain Diagnostic Procedures means:

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

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance. Also referred to in this Benefit Booklet as substance use disorder (SUD).

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

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by an agency of the state of Texas having legal authority to so license, certify or approve; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

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

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

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Coinsurance Amount means the dollar amount expressed as a percentage of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Community Reintegration Services means services that facilitate the continuum of care as an affected individual transitions into the community.

Complications of Pregnancy means:

1. Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Contract Anniversary means the corresponding date in each year after the Contract Date for as long as the Contract is in force.

Contract Date means the date on which coverage for the Employer's Contract with BCBSTX commences.

Contract Month means each succeeding monthly period, beginning on the Contract Date.

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

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

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

Covered Oral Surgery means maxillofacial surgical procedures limited to:

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

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

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

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

Dependent means your spouse or any child covered under the Plan.

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent child under the Plan.

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

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

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

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

Eligible Employee means an Employee who works on a full-time basis, who usually works at least 30 hours a week, and who otherwise meets the Participation Criteria established by a Large Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. Participation Criteria means any criteria or rules established by a Large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The Participation Criteria may not be based on Health Status Related Factors.

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

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

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

Employee means an individual employed by a Large Employer.

For purposes of this Plan, the term Employee may also include those individuals who are no longer an Employee of the Large Employer, but who are Participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code.

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

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

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

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSTX in assessing Experimental/Investigational status but will not be determinative.

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

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

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

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

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

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

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

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance
2. Credit-only insurance
3. Disability insurance coverage
4. Coverage for a specified disease or illness
5. Medicare services under a federal contract
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits
8. Coverage that provides limited-scope dental or vision benefits
9. Coverage provided by a single service health maintenance organization
10. Coverage issued as a supplement to liability insurance
11. Workers' compensation or similar insurance
12. Automobile medical payment insurance coverage
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that
 - Contain a plan of benefits for Employees
 - Is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the Employees
 - Is authorized under 29 U.S.C. Section 157

14. Hospital indemnity or other fixed indemnity insurance
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis
16. Short-term major medical contracts
17. Liability insurance, including general liability insurance and automobile liability insurance
18. Other coverage that is:
 - Similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits
 - Specified in federal regulations
19. Coverage for onsite medical clinics
20. Coverage that provides other limited benefits specified by federal regulations

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

Health Status Related Factor means:

1. Health status
2. Medical condition, including both physical and mental illness
3. Claims experience
4. Receipt of health care
5. Medical history
6. Genetic information
7. Evidence of insurability, including conditions arising out of acts of family violence
8. Disability

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

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

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

1. Drugs and IV solutions
2. Pharmacy compounding and dispensing services
3. All equipment and ancillary supplies necessitated by the defined therapy
4. Delivery services
5. Patient and family education
6. Nursing services

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

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

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

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

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

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital Provider under Medicare
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse
5. Has in effect a Hospital Utilization Review Plan

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

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

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed by an agency of the state of Texas having legal authority to so license, certify or approve.

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

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

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

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider
2. Provided by a Hospital or a Chemical Dependency Treatment Center
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

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

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

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

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

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

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - 1) termination of employment;
 - 2) reduction in the number of hours of employment;
 - 3) termination of the other plan's coverage;
 - 4) termination of contributions toward the premium made by the Employer;
 - 5) the death of a spouse;
 - 6) divorce;
 - 7) COBRA coverage or State continuation benefits have been exhausted;
 - 8) cessation of Dependent status;
 - 9) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - 10) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives the court order or notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The Employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP;
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
7. The individual has a change in family composition due to marriage or birth of a newborn child, placement as a foster child, adoption of a child, or because a Participant becomes a party in a suit for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or birth, adoption or date an insured becomes a party in a suit for the adoption.
8. The individual becomes a Dependent due to marriage or birth of a newborn child, placement as a foster child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child provided the request for enrollment is made no later than the 31st day after the date of the marriage or birth, adoption or date an insured becomes a party in a suit for the adoption.

Life-Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

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

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

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

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

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

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

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

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

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

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient. BCBSTX does not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

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

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

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by the Carrier, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy
 - b. Counseling
 - c. Psychoanalysis
 - d. Psychological testing and assessment
 - e. The administration or monitoring of psychotropic drugs
 - f. Hospital visits or consultations in a facility listed in subsection 5, below
3. Electroconvulsive treatment
4. Psychotropic drugs
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility, Other Provider, or other licensed facility or unit providing such care

Network means identified Physicians, Behavioral Health Practitioners, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

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

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological Testing means an evaluation of the functions of the nervous system.

Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

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

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

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

1. Facility Other Provider - an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Residential Treatment Center for Children and Adolescents
 - l. Skilled Nursing Facility
 - m. Therapeutic Center

2. Professional Other Provider - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
- a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry
 - e. Doctor of Podiatry
 - f. Doctor in Psychology
 - g. Licensed Acupuncturist
 - h. Licensed Audiologist
 - i. Licensed Chemical Dependency Counselor
 - j. Licensed Dietitian
 - k. Licensed Hearing Instrument Fitter and Dispenser
 - l. Licensed Marriage and Family Therapist
 - m. Licensed Clinical Social Worker
 - n. Licensed Occupational Therapist
 - o. Licensed Physical Therapist
 - p. Licensed Professional Counselor
 - q. Licensed Speech-Language Pathologist
 - r. Licensed Surgical Assistant
 - s. Nurse First Assistant
 - t. Physician Assistant
 - u. Psychological Associates who work under the supervision of a Doctor in Psychology

The listings shown, above, in 1. and 2., unless otherwise defined in the Plan, shall have the meaning assigned to them by the Texas Insurance Code. In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

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

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

Out-of-Pocket Maximum means, if “Employee only” coverage is elected, the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the Employee during a Calendar Year. If “Family” coverage is elected, Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the family during a Calendar Year.

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

Outpatient Day Treatment Services means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

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

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

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the Texas Insurance Code.

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

Post-Acute Care Treatment Services means services provided after acute care confinement and/or treatment that are based on an assessment of the individual’s physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-Acute Transition Services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines. Can also be referred to as a retrospective review or post-service claims request.

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

Proof of Loss means written evidence of a claim including:

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

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

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

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

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

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified ABA Provider means a Provider operating within the scope of their license or certification that has met the following requirements: For the treatment supervisor / case manager / facilitator:

1. Health Care Practitioner who is licensed, certified, or registered by an appropriate agency in the state where services are being provided; or
2. Health Care Practitioner whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst –Doctoral (BCBA-D)); or
3. Health Care Practitioner who is certified as a Provider under the TRICARE military health system.

For the para-professional / line therapist:

1. Two years of college educated staff person with a Board-Certified Assistant Behavior Analyst (BCaBA) for the para-professional/therapist; or
2. A staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019.

Remediation means the process(es) of restoring or improving a specific function.

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

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

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

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Retail Health Clinic means a Provider that provides treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The investigational item, device, or service, itself
2. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

1. Bipolar disorders (hypomanic, manic, depressive, and mixed)
2. Depression in childhood and adolescence
3. Major depressive disorders (single episode or recurrent)
4. Obsessive-compulsive disorders
5. Paranoid and other psychotic disorders
6. Schizo-affective disorders (bipolar or depressive)
7. Schizophrenia

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

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

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

Subscriber means an employee, retiree or other individual who is eligible to participate in UT SELECT and who is not eligible to participate based on his or her status as a dependent. A subscriber is also the primary policyholder.

Teledentistry Dental Service means a health service delivered by a Dentist, or a health professional acting under the delegation and supervision of a Dentist, acting within the scope of the Dentist's or health professional's license or certification to a patient at a different physical location than the Dentist or health professional using telecommunications or information technology.

Telehealth Service means a health service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner licensed in Texas, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

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

1. An ambulatory (day) surgery facility
2. A freestanding radiation therapy center
3. A freestanding birthing center

The University of Texas System (UT System) means your employer and is also the plan sponsor.

Virtual Provider means a licensed Provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in Benefits for Virtual Visits provision.

NOTICES



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

Group health plans sponsored by State governmental employers, such as UT System must generally comply with certain requirements in title XXVII of the federal Public Health Services Act. However, the Act also permits State governmental employers that sponsor “self-funded” health plans (rather than provide coverage through a health insurance policy) to elect to exempt the self-funded plan from such requirements. UT System has elected to exempt the UT 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 2022-2023 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.

HIPAA Privacy Notice

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

For more information, contact your institution Benefits Office.

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

BlueCard

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

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

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

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

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

Continuation of Group Coverage

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

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

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

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

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

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

1. Death of the employee
2. Divorce or legal separation from the employee
3. Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without group health coverage)
4. Children who lose coverage due to eligibility provisions (for example: reaching age 26)

Who is eligible for the continuation option?

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

How do the participants apply?

1. If a qualifying event is either: (a) the divorce of an employee; or (b) a child becoming ineligible for coverage, the eligible participants notify the employer in writing. Then, the employer will give written notice to the participants of the continuation option. If the qualifying event is the employee’s death, Medicare eligibility, or termination of employment (or reduction of hours), the employer will give written notice to the participants of the continuation option.
2. The eligible participants have 60 days to give written notice to the employer of their desire to continue coverage. The election must specify names of covered individuals and the reason for and date of the qualifying event.
3. If you elect continuation coverage, you do not have to send any payment with the Application Form. However, you must make your first payment for continuation coverage to the plan administrator not later than 45 days after the date of your election. (This is the date the Application is post-marked, if mailed.) Benefits cannot be accessed until the initial payment is received and processed. If you fail to make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plans. You are responsible for making sure that the amount of your first payment is correct. You may contact the appropriate plan administrator using the contact information on the application form to confirm the correct amount of your first payment.

4. After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each level of coverage is shown separately in this notice. If you make a periodic payment by the due date, coverage under the Plans will continue for each coverage period without any break. If payment is not received by the due date, coverage will be temporarily suspended until premium is paid. If payment is received prior to the end of the grace period, coverage will be reinstated once payment has been processed. The Plans will notify you of payments due for each coverage period.
5. Although periodic payments are due on particular dates as billed, you are entitled to a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, until payment for the period is received and processed by the plan administrator, coverage may be temporarily suspended, and benefits may not be accessible during a particular period.
6. If you fail to make the full periodic payment before the end of the grace period for a particular coverage period, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to the appropriate plan administrator as noted on the application form.
7. A participant's coverage shall terminate upon the occurrence of any of the following:
 - The maximum time period expires
 - A continued participant obtains coverage after the date of election under any other group health Plan (as an employee or otherwise) which does not contain an applicable exclusion for any Preexisting Condition of the participant
 - A continued participant becomes covered by any Medicare benefits after the date of election
 - The employer no longer provides group health coverage for employees
 - The required payment to continue coverage is not made on a timely basis

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

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

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

If you have questions, contact your institution Benefits Office or call UT Benefits Billing for COBRA at 1-844-579-8683.

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

Notice Regarding Network Facilities and Non-Network Providers

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

Notice About Nondiscrimination and Accessibility Requirements

The University of Texas SELECT, Dental SELECT, and UT FLEX health plans comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University of Texas SELECT, Dental SELECT, and UT FLEX health plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University of Texas SELECT, Dental SELECT, and UT FLEX health plans:

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

If you need these services, contact the UT Office of Employee Services

If you believe that The University of Texas SELECT Medical, SELECT Dental, and UT FLEX health plans have 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 Talent & Innovation (Human Resources), 210 W. 7th Street, Austin, Texas 78701, **P: 1-512-499-4587, F: 1-512-499-4395, grp-hrsp@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 Talent & Innovation 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 hhs.gov/ocr/office/file/index.html.

Spanish

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

UT SELECT Medical 1-866-882-2034

UT SELECT Prescription Drug 1-800-818-0155

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

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 1-866-882-2034

UT SELECT Prescription Drug 1-800-818-0155

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

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 1-866-882-2034

UT SELECT Prescription Drug 1-800-818-0155

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

Korean

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

UT SELECT Medical 1-866-882-2034

UT SELECT Prescription Drug 1-800-818-0155

UT SELECT Medicare Part D 1-800-860-7849 (TTY: 1-800-716-3231) 번으로 전화해 주십시오.

Arabic :

ةظوحلم .ناجملاب كل رفاوت ةيوغلا ةدعاسملا تامدخ نإف ،ةغللا ركذا ةدحتت تنك اذإ مقرب لصتا

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

Urdu

نیرک لاک - نیہ بایتسد نیم تفم تامدخ یک ددم یک نابز وک پآوت ،نیہ ےتلوب ودر پآرگا :رادرخ

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

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 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

French

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

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

Hindi

ध्यान दः यः द आप हंदः बोलते हः तो आपके हः लए मुफ्त मः भाषा सहायता सेवाएं उपलब्ध हः ।

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

Persian (Farsi)

مهارف امش یارب ناگیار تروصب ینابز تالیهست ،دینک یم وگتفگ یسراف نابز هب رگا :هجوآ اب .دشاب یم

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

دیریگب سامت

German

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

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UT SELECT Prescription Drug 1- 800-818-0155

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

Gujarati:

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

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

પર કોલ કરો

Russian

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

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UT SELECT Prescription Drug 1- 800-818-0155

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

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 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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

まで、お電話にてご連絡ください。

Laotian

ໂປດຊາບ: ັຖາວ່າ ັ່ທ ານເວ ັ່ າພາສາ ລາວ, ກາ ັ່ນບ ັ່ວການຊ່ວຍເຫຼືອ ອ ັດ ານພາສາ, ໂດ ັ່ຍບ ັ່ ັ່ເສ ງ ັ່ຄ າ, ແມ່ ນີມ ັ່ພ ອມໃ ັ່ທທ ານ. ໂທສ

UT SELECT Medical 1- 866-882-2034

UT SELECT Prescription Drug 1- 800-818-0155

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



THE UNIVERSITY of TEXAS SYSTEM
THIRTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

OFFICE OF EMPLOYEE BENEFITS
210 W. 7th STREET
AUSTIN, TX 78701

Claims Address

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

Customer Service

866-882-2034

24 hours/seven days a week*

Online Provider Directory and Website

bcbstx.com/ut

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

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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