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Comptroller of Public Accounts

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RFP 720-1728 FULLY-INSURED EPO FOR THE EMPLOYEES AND CERTAIN RETIRED EMPLOYEES OF THE UT SYSTEM

Open Date: 06/09/17 03:00 PM

Agency Requisition Number: 720-1728

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THE UNIVERSITY OF TEXAS SYSTEM

REQUEST FOR PROPOSALS

FOR

A FULLY-INSURED EPO

FOR THE

EMPLOYEES AND CERTAIN RETIRED EMPLOYEES

OF

THE UNIVERSITY OF TEXAS SYSTEM



TO BE EFFECTIVE SEPTEMBER 1, 2017 AND/OR SEPTEMBER 1, 2018

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1.0 INTRODUCTION AND OVERVIEW

1.1 DESCRIPTION OF THE UNIVERSITY OF TEXAS SYSTEM

The Texas Constitution of 1876 provided that “the Legislature shall, as soon as practical, establish, organize and provide for maintenance, support and direction of a university of the first class, to be located by vote of the people of this State, and styled ‘The University of Texas.’” In 1881, the 17th Texas Legislature passed an act to establish The University of Texas. Later that year, voters determined that the Main System was to be located in Austin and the Medical School was to be located in Galveston.

Today, The University of Texas System (System) includes academic institutions in Arlington, Austin, Dallas, El Paso, Odessa (Permian Basin), Rio Grande Valley (Brownsville and Edinburg), San Antonio, and Tyler, plus health institutions in Austin, Dallas, Galveston, Harlingen, Houston (2), San Antonio, and Tyler. In addition, the main System Administration office is located in Austin; however, many of the operations of System Administration are decentralized and therefore located in numerous areas of Texas as well as in Washington, D.C. Many of the UT institutions have their own payroll systems.

The System has approximately 22,000 benefits-eligible employees working at UT institutions in the Dallas area who will be eligible to participate in the EPO plan. The System has approximately 3,700 benefits-eligible retired employees from UT institutions in the Dallas area, some of whom will be eligible to participate in the EPO plan. A small number of additional employees and retirees from other UT institutions and COBRA participants also live in the Dallas area and would be eligible to participate in the EPO plan.

The table below includes the name, location, and approximate number of benefits-eligible employees and retirees associated with each institution in the System as of April 2017.

The University of Texas System April 2017			
Location	Institutions	Benefits-Eligible Employees	Benefits-Eligible Retired Employees
Austin	The University of Texas at Austin	17,594	5,333
	The University of Texas System Administration	811	299
Dallas	The University of Texas at Arlington	3,531	1,145
	The University of Texas at Dallas	3,786	625
	The University of Texas Southwestern Medical Center at Dallas	14,714	1,948
El Paso	The University of Texas at El Paso	2,638	849

Galveston	The University of Texas Medical Branch at Galveston	12,112	4,740
Houston	The University of Texas Health Science Center at Houston	7,836	1,647
	The University of Texas M.D. Anderson Cancer Center	19,761	4,084
Odessa	The University of Texas of the Permian Basin	487	114
Rio Grande Valley (Brownsville, Edinburg)	The University of Texas Rio Grande Valley	3,171	877
San Antonio	The University of Texas at San Antonio	3,446	911
	The University of Texas Health Science Center at San Antonio	5,282	1,802
Tyler	The University of Texas at Tyler	941	259
	The University of Texas Health Science Center at Tyler	1,383	611
TOTAL		97,493	25,244

1.2 OBJECTIVES OF THIS REQUEST FOR PROPOSALS (RFP)

Section 1601.054 of the Texas Insurance Code requires the System to submit for competitive bidding at least once every six years for each of its group insurance plan arrangements. As described in this Request for Proposals (RFP), the System is soliciting proposals from qualified and appropriately licensed carriers to offer a fully-insured Exclusive Provider Organization (EPO) Medical plan to be made available under the System Group Employee Benefits Program for certain employees and retirees in the Dallas/Ft. Worth area.

The contract for the EPO plan will be for the two-year period beginning September 1, 2017 through August 31, 2019 or September 1, 2018 through August 31, 2020 with the opportunity at System's sole option to renew for up to two additional two-year periods, subject to terms and conditions acceptable to the System. The UT System reserves the right to determine which effective date, September 1, 2017 or September 1, 2018, is best for its members and insures adequate time to implement all aspects of the plan.

All qualified carriers are invited to submit a proposal. It is the System's intention to select one carrier to administer the EPO plan and to have a signed contract in place prior to implementation.

The carrier proposal must demonstrate a commitment to work closely with the System to ensure a seamless transition into the new plan for those employees and retirees who choose to participate.

Responding carriers should confirm their understanding of the described financial terms as described in this RFP, in Section 5.0 of this RFP.

The term “carrier” and “insurer” have the same meaning.

1.3 CURRENT SYSTEM ENROLLMENT

Summaries of current plan enrollment are provided to illustrate the number of potential plan participants eligible for the EPO plan. These plan statistics including enrollment and demographic data are available in Appendix C of this RFP.

The System currently has about 125,000 employees and retired employees plus approximately 115,000 dependents participating in its Uniform Group Insurance Program (known as UT Benefits). In addition, there are approximately 1,200 COBRA participants continuing coverage in various plans within the program. The System offers a self-funded preferred provider (PPO) health plan (UT SELECT) for all eligible program participants. Approximately 120,000 employees, retired employees, and COBRA subscribers along with about 88,600 dependents were covered by UT SELECT during April 2017. UT SELECT medical benefits are currently administered by Blue Cross and Blue Shield of Texas and prescription benefits are currently administered by Express Scripts. The System’s “Living Well” program is a comprehensive health and wellness initiative available to all participants enrolled in a System offered health plan. This program is administered in-house by OEB staff and is integrated with both the medical and prescription plans and some voluntary plans such as the dental plan and vision plan.

The System currently offers the following optional coverages as part of the UT System uniform group employee insurance program: group term life and accidental death and dismemberment insurance currently issued by Dearborn National, two self-funded dental PPO plans (UT SELECT Dental) currently administered by Delta Dental, a dental health maintenance organization currently offered by Delta Dental, two vision care plans currently issued by Superior Vision, medical and dependent care flexible spending accounts currently administered by Maestro, and short and long term disability coverage currently issued by Dearborn National. Participation in all optional coverages is voluntary and generally the premiums are paid solely by the participating employees and retired employees.

The System’s Office of Employee Benefits (OEB), located in Austin, Texas, has oversight over all insurance plans provided by the System through its uniform group insurance program. A primary objective of the UT Benefits Program is to maximize the benefits and services that eligible System employees, retired employees and their covered dependents receive for each dollar spent on insurance benefits. The duties of OEB are described elsewhere in this RFP and dictated by Chapter 1601 of The Texas Insurance Code.

1.4 SUMMARY OF SERVICES TO BE PROVIDED

The System desires that the selected carrier will provide EPO insurance services on a fully-funded basis to System employees and non-Medicare retirees residing in the service area. It is the intent of the System to

select one carrier to offer coverage through a single contract for the two (2) year period beginning September 1, 2017 or September 1, 2018 with an option to renew for two additional two-year periods.

System does not guarantee that any of the submitted proposals will be accepted.

2.0 GENERAL INFORMATION AND REQUIREMENTS

2.1 CONFLICT OF INTEREST

No member of the System Board of Regents or System employees (including the Chancellor, Executive Vice Chancellor for Business Affairs, Assistant Vice Chancellor for Employee Benefits and Services, and Office of Employee Benefits management) may have any direct interest in the awarding of the Contract or any indirect conflict of interest involving the carrier, including but not limited to any financial interest.

2.2 NON-RESPONSIVE PROPOSALS

The System will not accept for consideration any proposal that does not comply with the criteria set forth herein. Failure to address any of the RFP requirements may result in rejection of a proposal.

2.3 REPRESENTATIONS BINDING

Representations made within the proposal will be binding on the carrier. The System will not be bound to act by any other previous communication of any type or non-conforming proposals submitted by a carrier.

2.4 NONDISCRIMINATORY PRACTICE

A carrier shall not discriminate against eligible System employees by excluding, seeking to exclude, or otherwise imposing restrictions on services or benefits on the basis of gender, race, national origin, religion, age, sexual orientation, veteran status, disability, or pregnancy.

2.5 BINDING ARBITRATION CLAUSE EXCLUSION

Each proposal must specify that the carrier will not impose a binding arbitration requirement upon a plan participant. Any proposal containing a requirement that plan participants must agree to engage in binding arbitration will not be accepted by the System.

2.6 MODIFICATION PROHIBITED

No proposal may be changed, amended, or modified after submission to the System except to correct an inadvertent error.

2.7 EXEMPTION FROM STATE TAXES

Coverages provided by the System are exempt from state premium and maintenance taxes.

2.8 CARRIER INITIATED CHANGES

The carrier must notify the System in writing prior to making any significant changes in operating policies or business practices, including material changes to its key personnel on the designated System Account Team,

or in any other aspect of the carrier's operations that could affect the EPO plan. The System reserves the exclusive right to determine if such potential changes may be applied to the System, and if so, when they shall be applied.

2.9 MEMBER IDENTIFICATION AND CONFIDENTIALITY OF SSNS

The primary reference ID used to identify plan subscribers and their dependents (collectively referred to herein as "participants") is a unique 8-character alphanumeric Benefits ID (BID) that is issued by the Office of Employee Benefits. The carrier must be able to identify a participant and/or the participant's coverage using the BID. The BID shall be the preferred identifier for any telephone communication, unencrypted electronic communication, and in printed reports when referencing specific participants.

Carriers must be able to comply with all federal and Texas state legislation, as well as System policy, applicable to the protection and use of Social Security numbers. The carrier must be able to coordinate with the System to fully comply with all applicable laws and System policies relating to the security, protection and use of plan participants' Social Security numbers. All sensitive System data, including Social Security numbers, must be encrypted when transmitted over the internet.

2.10 COMPLIANCE WITH LEGAL REQUIREMENTS AND FUTURE CHANGES

All proposals must comply with all currently applicable laws and regulations including rules promulgated by the Texas Department of Insurance.

The requirements of applicable laws and regulations, as well as future program appropriations made by the Texas Legislature, are subject to change and such changes may affect overall plan design and/or administrative responsibilities. The System requires a good faith effort on the part of the carrier to comply with any additional responsibilities imposed by changes in state or federal laws or regulations, or by future court or administrative rulings, without requiring mid-year premium rate increases.

Carriers must agree to collaborate with the System to effect necessary changes and to execute any agreements that may be required as a result. Should a mandated change materially affect the carrier's obligations under the Contract, the System reserves the right to negotiate with the carrier regarding any premium rate adjustment that may be appropriate under the circumstances, as provided in the Contract.

2.11 SYSTEM'S HISTORICALLY UNDERUTILIZED BUSINESS (HUB) PROGRAM

The System is committed to providing full and equal opportunity for all businesses to provide goods and services needed in support of the System's missions. The System's Historically Underutilized Business (HUB) Program formalizes the System's commitment to carry out this effort. The HUB program ensures compliance with state HUB laws and serves to educate both the university and business communities about the benefits of using HUB vendors. In all contracts entered into for professional services, contracting services, and/or commodities with an expected value of \$100,000 or more, the purchase solicitation must indicate whether the System has determined that subcontracting opportunities are probable in connection with the contract. If so, a HUB Subcontracting Plan is a required element of the vendor response to this RFP.

2.11.1 SUBCONTRACTING OPPORTUNITIES DETERMINATION

System has reviewed this RFP in accordance with Title 34, Texas Administrative Code, Section 20.13 (a), and has determined that subcontracting opportunities are probable under this RFP. As identified by the System Office of HUB Development, the HUB Goal for this RFP is 26 percent.

For specific questions regarding the HSP, please submit questions through the RFP website and questions will be directed to the UT System Office of HUB Development.

2.11.2 HUB SUBCONTRACTING PLAN (HSP) REQUIRED FOR CONSIDERATION

A HUB Subcontracting Plan (“HSP”) is required as part of vendor’s proposal. The HSP will be developed and administered in accordance with System’s Policy on Utilization of Historically Underutilized Businesses attached as Appendix H and incorporated for all purposes. The RFP No. for this HSP is 720-2015-UTGTL.

Each vendor must complete and return an HSP in accordance with the terms and conditions of this RFP for each proposal submitted, including System’s Policy on Utilization of Historically Underutilized Businesses. Vendors that fail to do so will have their proposals considered non-responsive to this RFP in accordance with Section 2161.252, Texas Government Code.

The Contractor will not be permitted to change its HSP unless: (1) the Contractor completes a newly modified version of the HSP in accordance with the terms of System’s Policy on Utilization of Historically Underutilized Businesses that sets forth all changes requested by the Contractor, (2) the Contractor provides System with such a modified version of the HSP, (3) System approves the modified HSP in writing, and (4) all agreements or contractual arrangements resulting from this RFP are amended in writing by System and the Contractor to conform to the modified HSP.

2.11.3 GOOD FAITH EFFORT REQUIRED

All agencies of the State of Texas are required to make a good faith effort to assist historically underutilized businesses (each a “HUB”) in receiving contract awards. The goal of the HUB program is to promote full and equal business opportunity for all businesses in contracting with state agencies. Pursuant to the HUB program, if under the terms of any agreement or contractual arrangement resulting from this RFP the Contractor subcontracts any of the services to be provided, then the Contractor must make a good faith effort to utilize HUBs certified by the Procurement and Support Services Division of the Texas Comptroller of Public Accounts. Proposals that fail to comply with the requirements contained in this section will constitute a material failure to comply with advertised specifications and will be rejected by System as non-responsive.

Additionally, compliance with good faith effort guidelines is a condition precedent to awarding any agreement or contractual arrangement resulting from this RFP. Proposing vendor acknowledges that, if selected by System, its obligation to make a good faith effort to utilize HUBs when subcontracting any of the Program will continue throughout the term of all agreements and contractual arrangements resulting from this RFP. Furthermore, any subcontracting of the Program by the vendor is subject to review by System to ensure compliance with the HUB program.

2.11.4 MANDATORY REQUIREMENTS FOR HSP SUBMISSION

For each proposal, the carrier must submit to the System three (3) original copies of the HSP along with, but packaged separately from, each complete proposal. In addition, a copy of the HSP should be included as an exhibit to the RFP. The three (3) originals of the HSP must be submitted under separate cover in a clearly marked envelope (the “HSP Envelope”) that is attached to the outside of the box containing the other proposal materials submitted by the carrier or must otherwise be provided contemporaneously with the other proposal materials. The top outside surface of the HSP Envelope when attached to the exterior of the packaging for the carrier’s other proposal materials must clearly show:

- 1) the RFP title (as noted on the cover page) and the Submittal Deadline, both marked in the lower left hand corner of the front of the envelope,
- 2) the name and return address of the proposing carrier, and
- 3) the phrase “HUB Subcontracting Plan.”

It is the carrier’s sole responsibility to ensure that the three HSP originals arrive concurrently with the other proposal materials as specified above. System will open a vendor’s HSP Envelope prior to opening the proposal submitted by the carrier, in order to ensure that the HUB Subcontracting Plan (“HSP”) is in compliance and that the carrier has submitted the number of original HUB Subcontracting Plans (“HSP”) that are required.

A carrier’s failure to submit a compliant HSP and the required number of originals requested will result in rejection of the proposal as non-responsive due to material failure to comply with advertised specifications; without exception, any such proposal will be returned to the vendor unopened.

Note: The requirements regarding submission of the HSP outlined above are separate from and do not affect a carrier’s obligation to provide the specified number of copies of the complete proposal as specified elsewhere within this RFP.

2.12 USE OF SUBCONTRACTORS

Any planned or proposed use of subcontractors by the carrier must be clearly disclosed and documented in the submitted proposal and agreed to by the System. The carrier shall be completely responsible for all services performed and for the fulfillment of its obligations under the Contract, even if such services are delegated to a subcontractor. Any proposal to utilize subcontracting must be addressed in the carrier’s Subcontracting HUB Plan, as described in a separate section.

2.13 PRIVACY AND SECURITY COMPLIANCE REQUIREMENTS

The System’s EPO plan must comply with the System’s privacy and applicable information technology security policies. In response to the related interrogatories included in Section 12.0 of this RFP, the carrier must describe in detail its information security program.

2.14 TERM OF ACCEPTANCE

It is the intent of the System, at this time, to enter into a two-year contract for the fully-insured EPO plan. At the System's option, this Contract may be renewed for two additional two-year periods, subject to terms and conditions acceptable to the System.

2.15 RESERVATION OF RIGHTS

2.15.1 ADDITIONAL INFORMATION FROM RESPONDING CARRIERS

System reserves the right to request additional documentation and responding carrier agrees to provide the information requested.

2.15.2 VALIDATION OF PROPOSAL MATERIALS

The System reserves the right to audit/validate all materials and responses submitted with the carrier's proposal.

2.15.3 REJECTION OF PROPOSALS

The System retains the right to reject any and/or all proposals submitted and/or to call for new proposals.

2.15.4 CARRIER NEGOTIATIONS

The System reserves the right to enter into discussions and negotiations with one or more carriers selected at its discretion to determine the best and final terms. The System is not under obligation to hold these discussions or negotiations with each carrier that submits a proposal.

2.15.5 REVISION OF PROVISIONS

The System specifically reserves the right to revise any or all RFP or Contract provisions set forth at any time prior to the System's execution of a Contract.

2.15.6 EXECUTION OF CONTRACT

The System is under no legal obligation to execute a Contract on the basis of this RFP or upon receipt of a proposal.

2.16 DISCLOSURE OF CONTROLLING INTEREST

Proposer must agree to comply with Section 2252.908, Texas Government Code ("Disclosure of Interested Parties Statute") and 1 Texas Administration Code Sections 46.1 through 46.3 ("Disclosure of Interested Parties Regulations") as implemented by the Texas Ethics Commission ("TEC"), including, among other things, providing the TEC and University with the information required by the Disclosure of Interested Parties Statute

and the Disclosure of Interested Parties Regulations on the form promulgated by the TEC and set forth in APPENDIX J. For more complete information, see the TECs webpage at:

https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm.

2.17 REFERENCES

Each carrier must provide a list of current major customers as requested in this RFP. These customers may be contacted by the System to provide information regarding the carrier's overall record of service in providing the program for their employees.

The provision of references by the carrier shall constitute verification that the System has the carrier's permission to contact these organizations and obtain any required information without obtaining further permission from the carrier.

2.18 MATERIALS

A copy of materials to be used by the carrier in administering the EPO plan must be provided as requested in the section of this RFP dealing with communications requirements. The System retains the right to review and approve all such materials prior to distribution. The carrier is required to submit proposed marketing and other informational materials in the specified format and according to deadlines set by the System. The cost for preparation of such materials for the term of the Contract.

2.19 NO COMPENSATION FOR EXPENSES

Carriers shall submit proposals at their own expense. No compensation will be provided to carriers for expenses incurred for proposal preparation or demonstrations, unless otherwise expressly stated in writing by the System.

2.20 RETENTION OF PROPOSALS

Proposals and all materials submitted in response to this RFP become the sole property of the System and will not be returned to the carriers. During the evaluation process, the System shall make reasonable efforts as allowed by law to maintain proposals in confidence, and shall release proposals only to personnel involved with the evaluation of the proposals and implementation of the Contract unless otherwise required by law. Further information dealing with the confidential status and potential disclosure of proposal contents is addressed below in a separate section.

2.21 CONFIDENTIAL STATUS AND DISCLOSURE OF PROPOSAL CONTENTS

As a state institution of higher education, the System is subject to the Texas Public Information Act ("the Act"), Chapter 552 of the Texas Government Code, and has no authority to enter into a confidentiality agreement in contravention of the Act. In response to any public information requests under the Act that are submitted during the RFP process, the System shall deem and argue to the State Attorney General that during the bidding

process all proposals submitted in response to the RFP are confidential under the Act. However, once the RFP process has concluded, this exception will no longer apply.

Carriers should be aware that the Texas Attorney General may determine that full or partial disclosure is required for information deemed to be confidential or proprietary by a carrier. It is the sole obligation of a carrier to advocate for the confidential or proprietary nature of any information provided in or along with its proposal. The System shall not advocate for the confidentiality of the carrier's material to the Texas Attorney General or to any other person or entity. Upon receipt of any public information request involving a submitted proposal after the conclusion of the RFP process, the System shall, pursuant to the Act, make a good faith effort to notify the carrier of the request.

For any such request, the carrier will be responsible for submitting written justification to the State Attorney General detailing why particular information should be withheld, such as the exception applicable to certain commercial information. In order to ensure its ability to claim exemption from the release of information contained in a submitted proposal, a carrier should clearly designate within its proposal and accompanying materials any information that it believes to be exempt from disclosure and provide legal justification for each instance.

Additionally, carriers should be aware that, pursuant to the Act, upon request from a member of the Legislature and where needed for legislative purposes, the System may be required to release a carrier's entire proposal, including information designated by the carrier to be confidential or proprietary. By submitting a proposal, a carrier acknowledges its understanding and agreement that System shall have no liability to the carrier or to any other person or entity for any disclosure of information made in accordance with the Act.

This section applies regardless of whether a contract is awarded as the result of this RFP.

2.22 NEWS RELEASES

Written approval by the System will be required prior to the issuance of any news release or other public communication regarding any Contract awarded to a carrier or the availability of such plan offering to eligible employees and non-Medicare retirees.

2.23 USE OF SYSTEM INFORMATION FOR SOLICITATION IS PROHIBITED

The carrier must explicitly agree never to use any information received from any source about System employees for any marketing purpose or to solicit business of any other type. This agreement extends to all forms of discussions, advertisement, distribution, or other marketing by the carrier (or a parent or subsidiary) for coverage, products, or materials other than those explicitly relating to the carrier's participation in the System EPO plan, including the provision of such items to lists of System employees and retirees obtained from other carriers contracting with System. This prohibition is also applicable to any use of the carrier's System-specific website. This prohibition continues subsequent to termination of the Contract.

2.24 AGENT OF RECORD

The System will not designate an Agent of Record or any other such company employee or commissioned representative to act on behalf of either the System or the carrier. Requests for the System to provide such designation shall be rejected. Carriers are specifically instructed to submit proposals directly to the System as specified herein in separate sections detailing HUB Subcontracting Plan submission requirements and overall proposal submission requirements. Proposals submitted through a third party agent will not be accepted.

2.25 DEFINITIONS

For purposes of this RFP and any responses provided, the terms “employee”, “dependent”, “optional coverage”, “retired employee”, and “The University of Texas System (“System”)), shall have the same meanings as defined by System (definitions available at <https://utsystem.edu/documents/docs/employee-benefits/130-office-employee-benefits-terms-and-definitions>). System reserves the right to define any other terms used in this RFP.

2.26 RESPONSES, ORDERING OF CONTENTS, DEVIATIONS

Proposals must concisely describe the carrier’s ability to meet the requirements of the RFP. Emphasis should be on providing complete, clear responses that demonstrate an understanding of the requirements and of the System’s needs. The content of all responses submitted must be ordered to correspond with the specifications as they appear in this RFP.

Unless a deviation is specifically noted in a response, it will be assumed that the carrier agrees to meet all specifications exactly as set forth in this RFP. Proposals containing deviations, items not called for herein, or irregularities of any kind are subject to disqualification at the System’s option.

Information about proposed unique or value-added benefits and programs that would enhance or supplement the current benefit offering specified within this RFP are welcome when presented in conjunction with confirmation that the carrier agrees to the requirements as presented in this RFP.

Important: Responding carriers must acknowledge and confirm each enumerated section of this RFP and/or clearly state any deviations to the specific section(s). Your RFP responses will be incorporated into the Contract.

2.27 CERTIFICATION

By completing and submitting the signed Signature Page included in Section 14.0 of this RFP with the original copy of carrier’s complete proposal as specified, an authorized carrier officer certifies that the proposal complies with the RFP specifications and that the appropriate carrier staff have reviewed and confirmed their applicable sections based on their expertise.

2.28 SUBMISSION OF PROPOSALS

Only proposals submitted in compliance with the following requirements will be accepted by System:

- 1) This RFP is available on the System's RFP website in both PDF and Word format. Carriers must use the Word version of the RFP to complete and include the following items with your submission:
 - a) Detailed responses to each interrogatory;
 - b) Acknowledgement and agreement to financial terms; and
 - c) The signature page, verifying the carrier's ability to meet all requirements.
- 2) One (1) original proposal signed with blue ink and clearly marked "Original", and seven (7) identical copies of the proposal must be received by the System on or before **3:00 p.m. (Central) on Friday, June 9, 2017**. The original and copies of the proposal should be delivered to:

Darya Vienne
Office of Procurement Services
The University of Texas System
210 West 6th Street, Room B.140E
Austin, Texas 78701

- 3) Carriers must submit three (3) complete electronic versions of the proposal on USB drives, using either Microsoft Office or PDF format for all included documents. The drives must be clearly labeled with the carrier name and the title of this RFP. All materials included in the printed binders *must* be included with the electronic versions, including exhibits and the separate HUB Subcontracting Plan submission.
- 4) All materials, other than the HUB Subcontracting Plan ("HSP"), must be submitted in sealed envelope(s), box(es), or container(s). **The HSP must be affixed to the outside of the main proposal packaging so that it arrives along with the other proposal materials, but is separately accessible.** Proposals without a correctly completed HSP will be returned, unopened. Proposal packaging must clearly indicate the submittal deadline, the carrier's name, and the carrier's return address on the exterior.
- 5) Proposals must be valid for one hundred twenty (120) days following the proposal receipt date.
- 6) The financial arrangement illustrated in this RFP will be adhered to for the term of the contract.
- 7) A Table of Contents with sufficient detail (including page numbers) to facilitate easy reference to all sections of the proposal, as well as to separate attachments, must be included. Any supplemental items not requested in the RFP should be clearly identified as such in the Table of Contents and must be provided in a separate section(s) of the proposal from required items.
- 8) Under no circumstances will proposals received after the submission deadline be considered. Properly marked late proposals will be returned unopened at the carrier's expense. Unmarked late proposals will be held at the System Office of Employee Benefits for 30 days and then discarded.
- 9) Proposals transmitted electronically, or by any means other than as specified in this section, will not be considered.

2.29 ADDENDA TO RFP, INQUIRIES REGARDING SPECIFICATIONS

Any response to an inquiry that alters an interpretation of, or requires a change to, this RFP will be posted as addenda on the [CPA Web Application Portal Website](#). All carriers will be responsible for regularly checking this website for RFP addenda and other announcements. All addenda issued by the System prior to receipt of a proposal shall be considered part of the RFP. All carriers are required to acknowledge all of the addenda issued on the space provided on the Signature Page of this proposal.

To ensure that all replies can be provided to all prospective carriers prior to the deadline for submission of proposals, questions received after **5:00 p.m. Wednesday, May 24, 2017**, will not be considered or responded to by the System.

2.30 TELECONFERENCE FOR INTERESTED CARRIERS

To provide representatives of interested carriers an opportunity to pose questions regarding the specifications and selection process, a teleconference for prospective respondents is scheduled to be held on **Thursday, May 18, 2017, at 11:00 a.m. Central Time. Interested prospective carriers may dial 877-226-9790, participant code 2241454.**

Questions and comments should be submitted to:

Darya Vienne
Office of Procurement Services
dvienne@utsystem.edu

Details regarding the teleconference will be provided in advance to those carriers that register to participate.

2.31 FINALIST INTERVIEW

Following the System's initial review of the RFP Proposals, if a carrier is selected as a finalist in the carrier selection process, the System may, at its sole option, request that personnel from the carrier, at the carrier's expense, attend a meeting at a System-designated location to clarify responses and to answer questions regarding the carrier's Proposal. If the System deems necessary, a site visit to the carrier may be conducted during the RFP review period at the System's expense.

3.0 IMPLEMENTATION TIMELINE

The following describes key milestones during the implementation phase for the fully-insured EPO plan. An altered timeline with appropriate dates will be negotiated with the contract carrier should the effective date be September 1, 2018 rather than September 1, 2017. The carrier will be required to meet all deadlines as shown throughout the implementation process for a September 1, 2017 effective date.

Post RFP Notice on Texas Marketplace Site	05/12/2017
Request for Proposal (RFP) Issued	05/12/2017
Prospective Vendor Teleconference	05/18/2017 11:00 AM CT
Last date to submit written questions to the System	05/24/2017 5:00 PM CT
Vendor Proposals Due to the System	06/09/2017 3:00 PM CT
Office of Employee Benefits and Vendor Implementation Team conference call, planning meeting	06/19/2017
Drafts of Annual Enrollment materials due to the System	06/23/2017
Benefits & Human Resource Conference(BHRC) in Austin, TX	June of each year
Testing of automated transmission of claims data processing system and electronic Fee Billing Invoice	06/23/2017
System-specific Vendor website available for testing	06/23/2017
Setup of eligibility sFTP procedures and authorizations	06/23/2017
Distribution deadline of Annual Enrollment materials to institutions	06/30/2017
System-specific Vendor website ready for use	06/30/2017
Begin testing transmission of test eligibility data	06/30/2017
Drafts of new employee communication materials to the System	07/07/2017
Annual Enrollment Period (employee meetings)	07/15-07/31/2017
Contracts Finalized and Signed	07/19/2017
Begin Testing of Electronic Fee Billing Invoice	08/01/2017
New Employee materials due to the Institution Benefit Offices	08/04/2017
Testing of eligibility error dataset transmission from Vendor	08/08/2017
The first date for enrollment data to be transferred to the Vendor	08/11/2017
Mailing of member ID cards	08/18/2017
Banking arrangements completed	09/01/2017
Plan Year begins (Effective date of coverage)	09/01/2017
ACH transaction of first Vendor payment	October of each year

4.0 THE CONTRACT AND OTHER LEGAL REQUIREMENTS

The Contract shall be in the format specified by the System. The Contract will incorporate this RFP, the carrier's proposal thereto, and any other information the responding carrier may be required to provide. Until a Contract has been executed and signed, the RFP and the carrier proposal will be binding. A Sample Contract is included as Appendix G to this RFP. Carrier responses containing proposed changes to the Sample Contract will not be considered.

Important: The carrier should not attempt to modify or sign the Sample Contract. The actual Contract will be prepared by the System Office of General Counsel and signed by the carrier prior to the first day of the plan year.

4.1 INTRODUCTION

No Contract will be executed until the System has accepted a carrier's proposal and has notified the carrier of its approval. The Contract will be for a two-year term beginning on September 1, 2017 and will extend through the following two-year period, to be renewed at the System's option for up to two additional two-year periods unless terminated as provided herein or in the Contract. If the current carrier submits a proposal and is not selected, the current carrier shall continue to perform in good faith all obligations under its existing contract with the System.

The System and the contracting carrier shall agree and acknowledge, as applicable, that the benefits and coverage to be provided under the Contract will be provided from September 1, 2017 through August 31, 2019. However, the System and the contracting carrier shall also agree and acknowledge that there are duties and obligations specified by the RFP to be performed prior to September 1, 2017 and following August 31, 2019, and the Contract will specify that the parties agree to perform all such duties and obligations, and that all applicable damage provisions shall be in effect as to these duties and obligations.

The Contract shall comprise the complete and exclusive statement of each agreement between the System and the contracting carrier and supersede all prior or contemporaneous agreements, negotiations, course of prior dealings, and oral representations relating to the subject matter hereof.

The System has specific contracting requirements that cannot be waived or altered. All carriers should carefully review the Sample Contract included in Appendix G to this RFP, including but not limited to the provisions on Indemnification, Auditing, and the EIR Warranty. The carrier should include in their written submission all alternate requirements, terms, or conditions they wish to have considered. However, the carrier should not assume that an opportunity exists to add such matters through the contract negotiation as a part of the RFP process. Unacceptable terms and conditions added by the carrier may result in the rejection of the carrier's proposal, despite other factors to be evaluated. In addition, the carrier should not strike-through or otherwise alter anything in the Sample Contract. Submission of an altered Sample Contract as part of a response may result in rejection of the carrier's proposal, despite other factors to be evaluated.

In the event that a contracting carrier fails or refuses to perform any of its duties or obligations as provided by the Contract, the System, without limiting any other rights or remedies it may have by law, equity or under

contract, will have the right to terminate the Contract immediately. Notwithstanding such termination, certain obligations of the carrier shall survive the termination of the Contract.

At any time during the term of a Contract and for a period of four (4) years thereafter, the System or a duly authorized audit representative of the System, or the State of Texas, at its expense and at reasonable times, reserves the right to audit the contracting carrier's records and books relevant to all services provided under the Contract. In the event such an audit reveals any errors/overpayments by the System, the contracting carrier will be required to refund the full amount of such overpayments within thirty (30) days of such audit findings, or the System may, at its option, reserve the right to deduct such amounts from any payments due the carrier.

The contracting carrier must agree not to publicize the Contract or disclose, confirm or deny any details thereof to third parties or use any photographs or video recordings of the System's employees or retirees or use the System's name in connection with any sales promotion or publicity event without the prior express written approval of the System.

Duties assigned to the carrier under the Contract may not be assigned or delegated to a third party.

4.2 FAILURE TO COMPLY

Failure to comply with the procedures required by the RFP or any other applicable guidelines shall be cause for immediate suspension or cancellation of the Contract. A suspended or canceled carrier that provides coverage or services will not be permitted to accept new enrollees, but must continue to provide coverage for those employees whose effective date was prior to the date of suspension or cancellation. Any suspension will remain in effect until System is satisfied that circumstances resulting in suspension have been corrected. Upon the loss of the contracting carrier of any licensure or certification required by Texas law to provide a service required under the Contract, or the filing of a petition for bankruptcy, or upon judgment of bankruptcy or insolvency by or against the contracting carrier, the System may terminate the Contract for cause without notice.

4.3 NOT AN ERISA PLAN

As a governmental entity, the System is not subject to the provisions of the Employee Retirement and Income Security Act (ERISA).

4.4 COMPLIANCE WITH TEXAS DEPARTMENT OF INSURANCE RULES

Pursuant to Chapter 1601 of the Texas Insurance Code (Code), System is exempt from some of the provisions of the Code and regulations promulgated by the Texas Department of Insurance (TDI). However, nothing in any agreement between the System and a contracting carrier shall be construed to require or permit any action that is prohibited by, or in conflict with, an applicable provision of the Code or an applicable TDI rule or regulation.

4.5 CARRIER ID NUMBERS

A carrier must obtain a Carrier Identification Number issued by the Comptroller of Public Accounts of the State of Texas. The carrier will be required to complete and submit a Payee Identification Form in order to receive payment.

4.6 AUTHORIZED SIGNATURES

The Chief Executive Officer, General Counsel, or an authorized officer of the responding carrier must sign the Contract. The proposal must state the name and office of the individual who will sign the Contract on behalf of the carrier and include documentation verifying that the individual has the authority to do so.

4.7 RELATIONSHIP OF PROPOSAL TO CONTRACT

Any contract resulting from the selection of a carrier by the System shall incorporate by reference the applicable portions of the Policy to be issued by the carrier to System, the RFP including Appendices, the carrier's response thereto, and any other information the carrier may be required to provide.

5.0 FINANCIAL ARRANGEMENTS

5.1 BACKGROUND

The University of Texas System (System) Office of Employee Benefits (OEB) is seeking a licensed insurance company (the Insurer) to arrange for and provide a fully insured Exclusive Provider Organization (EPO) under the System's Health Benefits Plan (the Plan) for FY18.

System leadership has instructed OEB to operate the EPO on a breakeven basis; i.e., the Plan cannot pay more for medical benefits provided through the EPO than would have been paid through the UT SELECT Medical plan. This requirement will be met through the process described below.

5.2 TERMINOLOGY

For purposes of this discussion the following terminology is used.

- 1) Active employees and non-Medicare-primary retirees are referred to as Subscribers.
- 2) Subscribers and dependents are referred to collectively as Participants.

5.3 DESCRIPTION OF THE EPO

The EPO will be offered as an alternative to the medical benefits provided under Systems' self-funded PPO, UT SELECT, effective September 1, 2017; i.e., for FY18.

- 1) The EPO will provide medical benefits only; i.e., prescription drug benefits for EPO Participants will continue to be provided through the current arrangement.
- 2) The EPO will be responsible for all medical benefits provided to its Participants, including out-of-area benefits for those temporarily outside the EPO service area.
- 3) The EPO will be available to eligible active employees and non-Medicare eligible retirees and their dependents who live or work in the EPO service area.
- 4) The covered population will be largely comprised of employees and retirees of UT Arlington (UTA), UT Dallas (UTD) and UT Southwestern (UTSW).

Participants for whom Medicare is primary are not eligible to participate in the EPO.

5.4 EPO ELIGIBILITY

- 1) All Subscribers that live or work in the EPO service area will be eligible to elect to participate in the EPO in lieu of UT SELECT.
- 2) During 2017 Summer Enrollment, current Subscribers will be eligible to elect to participate in the EPO rather than UT SELECT for FY18.

- 3) During their initial enrollment period, Subscribers beginning employment on or after September 1, 2017, will be eligible to elect to participate in the EPO rather than UT SELECT for FY18.
- 4) A Subscriber who elects to participate in the EPO for FY18 may also elect to cover his/her eligible dependents under the EPO. An EPO Subscriber may not elect UT SELECT coverage for his/her dependents.
- 5) An election to participate in the EPO for FY18 will remain in effect until the end of FY18 except in the event of a Qualified Life Event.

5.5 EMPLOYER AND SUBSCRIBER CONTRIBUTION RATES

The monthly Employer and Subscriber contribution rates for EPO Subscribers will be the same as the UT SELECT contribution rates for FY18. Note: The contribution rates are used solely for funding purposes and will not be used to determine EPO Premium.

5.6 EPO PREMIUMS

Due to the difficulty of establishing appropriate prospective EPO Premium Rates for a new plan with an uncertain enrollment, OEB will pay EPO Premiums based on the following:

1) Claims Premium

The Claims premium is intended to provide for EPO claims beneath a specific stop loss threshold of \$300,000 per Participant per year.

- September, 2017 – February, 2018

Each month during the period September, 2017 – February, 2018 (the Preliminary Period), OEB will pay a Preliminary Claims Premium determined by multiplying (i) the actual enrollment for the month by (ii) the Preliminary Claims Rate: \$403.00 per Participant per month, which is intended to provide for EPO claims beneath a specific stop loss threshold of \$300,000 per Participant per year. (Note: The Preliminary Claims Rate is the average monthly UT SELECT medical claims cost for all UTA, UTD and UTSW Participants for FY16 trended for two years at the current UT SELECT medical trend (3% per year), discounted 5.6% in recognition of the stop loss threshold.)

The Preliminary Claims Premium will be reconciled through the Preliminary Period Settlement Process described below.

- March, 2018 – August, 2018

Each month during the period March, 2018 – September, 2019, OEB will pay Claims Premium determined by multiplying (i) actual enrollment for each Participant Category for each month by (ii) the Final Claims Rates (determined as specified below) for the applicable category.

2) Administrative Premium

OEB will pay a monthly Administrative Premium of \$25.00 per enrolled Subscriber.

3) Reimbursement for Stop Loss Claims

In addition to the Claims Premium and the Administrative Premium, the Insurer will be reimbursed for actual claims paid in excess of the specific stop loss threshold through submission of invoices to OEB.

4) Payment Schedule

a) The Claims Premium and the Administrative Premium will be paid monthly in arrears on a schedule TBD.

b) Reimbursement for stop loss claims will occur in accordance with the following process:

- The Insurer will process and pay all stop loss claims incurred by EPO participants as described herein. The Insurer will pay such claims through the issuance of drafts or through Electronic Funds Transfer (EFT) from the Insurer's account prior to seeking reimbursement from System. On at least a weekly basis, the Insurer will present an invoice to System for stop loss claim payments made during the previous invoice period. The Insurer will be responsible for maintaining its own funds which are sufficient to provide for the stop loss claims incurred under the EPO. The Insurer will be responsible for the escheatment process in accordance with Texas law for any payments disbursed on behalf of the EPO.
- Due to the timing of the reimbursements, the Insurer could potentially be required to advance up to two weeks of stop loss claim payments before being reimbursed by System.
- The Insurer will be reimbursed only for actual stop loss claim payments (i.e., it is not acceptable for the Insurer to seek reimbursement from System in an amount that is different than the amount the Insurer paid to the provider, facility, or participant). The Insurer will be reimbursed only for paid stop loss claims, and will not be reimbursed for such claims that have been processed but not yet paid.

5.7 FINAL CLAIMS RATES

Final Claims Rates (FCRs) will be established using the following methodology. On or before March 1, 2018, OEB's actuary will develop FY18 FCRs using the following methodology.

- 1) Actual FY17 enrollment data and medical claims experience for Participants enrolled in the EPO on September 1, 2017 will be tabulated by Participant Category.
- 2) Medical claims experience will be based on claims incurred during the period September 1, 2016 – August 31, 2017 and paid through November, 2017. For this purpose, incurred claims in excess of \$300,000 per Participant per year will be excluded.
- 3) The claims experience tabulated in (b) will be completed to provide for remaining runoff claims after November 30, 2017, based on factors developed by the OEB actuary using historical experience.
- 4) Data will be tabulated for the following four Participant Categories: active employees, non-Medicare-primary retirees, spouses and children.

- 5) The FY17 claims and enrollment data will be used to develop the FY17 monthly per capita claims cost for each Participant Category.

The FY17 monthly per capita claims cost for each Participant Category will be (a) trended to FY18 using annual trend rates derived based on actual UT SELECT experience through November, 2017 and (b) discounted 5.6% in recognition of the stop loss threshold to produce the FY18 FCRs.

5.8 PRELIMINARY PERIOD SETTLEMENT PROCESS

The Preliminary Period Settlement Process will proceed as follows:

- 1) Total Preliminary Claims Premium

The Total Preliminary Claims Premium for the Preliminary Period will be determined by summing the Preliminary Claims Premium for each month of the Preliminary Period.

- 2) Total Claims Premium

The Total Claims Premium for the Preliminary Period will be developed by multiplying (a) the FCR for each Participant Category by (b) the applicable enrollment in each category for each month of the Preliminary Period and summing the results for all months.

- 3) The Insurer will pay OEB the excess, if any, of (a) over (b).
- 4) Conversely, OEB will pay the Insurer the excess, if any, of (b) over (a).
- 5) Any payment required hereunder will be made no later than April 15, 2018.
- 6) The Settlement Process does not apply to the following:
 - Stop-Loss Claims
 - Administrative Premium
 - Claims Premium paid for the period March, 2018 – August, 2018.

5.9 STIPULATIONS

- 1) The terms of this section are null and void in the event that EPO enrollment is less than 1,000 Participants on September 1, 2017. In such event, the Insurer will be reimbursed for actual claims based on the payment schedule specified above.
- 2) The terms specified herein are applicable to FY18 only. A successor document for FY19 and subsequent years will be negotiated by the Insurer and System during FY18.
- 3) OEB's actuary will work collaboratively with the Insurer's actuary to the extent possible without violating confidentiality agreements with other parties.

- 4) OEB will provide no reimbursement to the Insurer other than the EPO Premiums as specified herein.
- 5) All aspects of this agreement will be subject to audit at such time and in such manner as determined by OEB.

6.0 BENEFITS AND PROGRAM REQUIREMENTS

6.1 INTRODUCTION

The System currently offers the self-funded UT SELECT PPO plan. The System is conducting this EPO RFP process to obtain a carrier who can accept risk, manage and administer an EPO plan for the Dallas/Ft. Worth area. The System requires that the carrier be able to effectively administer a provider network, benefit design, and overall program which meets or exceeds the requirements presented in this RFP. Administration of the EPO plan should have significant emphasis placed in the area of medical management and care coordination. The System desires to compare utilization, network and plan performance of a tightly managed EPO vs the UT SELECT PPO in an effort to deliver care in a manner which produces cost savings to the system.

6.2 THE BENEFIT (OR PLAN) YEAR

The System's benefits are administered using a Plan Year that begins on September 1st and ends the following August 31st. This time period corresponds with the fiscal year of the System and the State of Texas.

6.3 SUMMARY OF CURRENT MEDICAL PLAN BENEFITS

A complete Benefits Guide for the UT SELECT Medical Plan is included as Appendix B to this RFP.

6.4 BASIC AND OPTIONAL COVERAGE

As required by Chapter 1601 of the Texas Insurance Code, employees and retired employees are automatically eligible for coverage in the UT SELECT PPO. For full-time employees, coverage in the UT SELECT plan is automatic once a person's employment appointment or retiree record is processed by the institutions Office of Human Resources. The EPO plan will be an optional benefit which may be elected during the July Annual Enrollment period which occurs each year between July 15 and July 31, during a new employee's initial period of eligibility (first 30 days of employment) or during a qualified status change if the change in medical plans is consistent with the qualified change in status. Employee's will maintain enrollment in the basic life, AD&D, wellness and EAP programs through the premiums set for the EPO plan.

6.5 CONTINUITY OF COVERAGE

Insured persons must not lose coverage solely by reason of a change in carriers. Employees who are not actively at work on the effective date must be assured continuity of coverage if their insurance would otherwise have been continuous except for the change in carriers. All provisions and exclusions met under the current plan must be credited under any new plan and a transition of care program developed during the implementation phase of the contract.

6.6 ENROLLMENT

Chapter 1601 of the Texas Insurance Code (see Appendix G) establishes the enrollment requirements for System's plans. The enrollment process is governed by System policies. The EPO plan shall be offered to all UT System employees and non-Medicare retirees and dependents residing in the defined Dallas service area.

6.7 ELIGIBILITY

6.7.1 EMPLOYEES

Section 1601.101 of the Texas Insurance Code (Appendix G) states that an employee who is expected to work at least 20 hours per week and to continue in the employment (is expected to work) for a term of at least four and one-half months, or is appointed for at least 50% of a standard full-time appointment, is eligible for benefits.

6.7.2 RETIRED EMPLOYEES

In accordance with Section 1601.102 of the Texas Insurance Code, certain retired employees of the System are eligible for benefits. For the EPO plan, only non-Medicare eligible retirees will be eligible.

6.7.3 DEPENDENTS

Benefits-eligible dependents are defined in Section 1601.004 of the Texas Insurance Code. Eligible dependents of the employee or non-Medicare retiree are eligible to enroll in the EPO plan. Dependent children remain eligible to age 26. Only non-Medicare enrollees are eligible for the EPO plan; therefore, only employees and non-Medicare retirees with non-Medicare eligible dependents may elect the EPO plan.

An individual may not be enrolled in any of the System plans as both an employee and a dependent.

6.8 USE OF PREMIUM SHARING FUNDS

On a biennial basis, the Texas Legislature determines the amount of premium sharing available for employees, retired employees and any eligible dependents. For the current biennium, premium sharing is funded to cover the total cost of the basic package for full-time employees, half the cost for part-time employees and the total cost of the basic package for retired employees. A percentage of the medical plan cost for covered dependents of participating active and retired employees is also paid through premium sharing.

Currently, for newly benefits-eligible employees, state premium sharing is not available for payment of the basic package until the first of the calendar month that begins after the 90th day after the employee begins employment. The maximum waiting period will be 90 days. Each institution has the option to supplement premium sharing for all employees during this waiting period. However, if an institution does not supplement premium sharing, that institution's employees will not be eligible for the UT SELECT Medical plan or the EPO plan, including prescription benefits, until the end of the waiting period.

For newly retired benefits-eligible employees, state premium sharing is available to pay the retired employee's premium for the basic package if there is no break in coverage between the period of active employment and the effective date of retirement. If there is a break in coverage between active employment and retirement, premium sharing is not available for payment of the retired employee's basic package until the first day of the calendar month that begins after the 90th day after the effective date of retirement or after 90 days. System institutions do not have the option to supplement premium sharing for retired employees during this waiting period.

At this time, full-time employees and retirees with comparable coverage from another source may waive the basic coverage package and receive up to 50% of the state premium sharing amount to pay premiums for certain optional coverages offered by UT. Additionally at this time, part-time employees with comparable coverage from another source may waive the basic coverage package and receive up to 25% of the state premium sharing amount to pay premiums for certain optional coverages.

6.9 OTHER FACTORS

There are a number of factors that should be taken into consideration when preparing a response to this RFP, including:

- 1) Some System employees have nine-month appointments of employment. The covered monthly earnings for an employee on a nine-month contract are determined by dividing the total salary to be paid under the contract by nine and then by multiplying the answer by 12. This annualizes the monthly earnings of the nine month employees. This is necessary because it is sometimes not possible to determine if an employee will be teaching summer school and to include the additional earnings in the calculations of the covered monthly earnings.
- 2) Some System employees, such as faculty members, may take extended leaves of absence at which time they may have full benefits from another source. In such cases, employees may put their System coverage in abeyance (i.e. freeze benefit elections). During the abeyance period, the employee is not eligible for medical coverage and will not pay premium. Upon return to the System, such employees are immediately eligible to resume coverage. If an employee chooses to pay for premiums while on leave of absence, they may do so and retain their medical coverage.
- 3) The System does not have a single payroll system. There are currently nine different payroll systems. Premiums are sent by the institutions based upon the deductions taken from the subscribers on those payroll systems. The System routinely will provide eligibility data which will coincide with the same data used to calculate the payment of premium. The carrier may need to interface with the institutions regarding eligibility or coordination for the payment of a claim.
- 4) Salary: Employees of the System are paid in arrears; therefore, premiums for September coverage will not be collected and remitted until October. October premiums are collected and remitted to the selected carrier in November, etc.

6.10 EPO BENEFIT STRUCTURE

UT SELECT is the sole health plan offered to System employees and retired employees and is structured with two levels of benefits for participants residing in the service area: network and out-of-network. In addition, the current plan provides an out-of-area level of benefits for those residing outside of the service area. System seeks to offer an EPO plan with a carrier who contracts with the physicians and facilities of UT Southwestern Medical Center in Dallas (UTSW). This plan will be an additional offering to employees and non-Medicare retirees and dependents residing in the Dallas area. The EPO effective date will be September 1, 2017.

The carrier may choose to augment their provider network with physicians and facilities in the North Texas area to fulfill the access needs of the Dallas service area. The EPO plan may structure a concentric network offering with no out-of-network benefits or may offer a tiered benefit level for participants seeking care outside the concentric network. The carrier may or may not also offer a wrap network for any claims outside a concentric network component and/or for out of network emergency claims.

The highest level of benefits is paid when services are received from a network provider. If a plan participant resides in an area where a satisfactory level of network services is available, he or she will be required to use network providers. Plan participants who reside in an area with an inadequate EPO network, are not eligible to enroll in the EPO plan unless they seek and receive a zip code exception for enrollment. Members who seek and are granted a zip code exceptions acknowledge they are aware they do not reside in an area with an appropriate number of contracted EPO physicians and facilities but have elected the exception to participate in the plan due to working at a location that is in the service area.

System requires that EPO participants have in-network access to System medical providers and to System medical facilities of UT Southwestern Medical Center. In addition, carriers must submit an electronic data file of contracting providers in the format described in Appendix E to this RFP.

When describing the proposed service area, carriers should list all zip codes included. Carriers are required to confirm their provider networks adequately serve the entire Dallas service area prior to the start of the enrollment period in July.

6.11 PLAN DESIGN

A summary description of the current UT SELECT plan design is included as Appendix A to this RFP. The carrier may propose a plan design option which will attract members to enroll in the EPO. The plan design should be at a minimum equal to the design of UT SELECT, but may include lower member out-of-pocket costs for certain benefits. The EPO plan will be made available to employees, non-Medicare retirees, and dependents from all UT System institutions residing in the Dallas service area. The EPO plan may require a primary care physician (PCP) to be selected. The EPO carrier should be able to accept PCP elections, if required, no later than August 21, 2017.

Participants of the EPO plan will continue participation in the Living Well Make it a Priority Wellness Program offered to all members enrolled in a medical plan offered under the Uniform Group Insurance Program (UGIP). The program includes various wellness initiatives, walks, etc. The System may add new wellness initiatives on

an ongoing basis or may elect to make changes to the wellness initiatives based on plan experience or other factors during the contract period. The carrier should be prepared to make adjustments as needed. Enrollees of the EPO plan will NOT be eligible for the flu shot program and the on-site biometric screenings made available to the members of the UT SELECT plan. If the EPO prefers to organize onsite flu shots or onsite biometric screenings at the three Dallas institutions, it may do so with a carrier of their choice.

6.11.1 PRESCRIPTION DRUG BENEFITS

Prescription drug benefits will be provided to EPO participants through a separate pharmacy benefit. Currently, that plan is administered by Express Scripts. However, the EPO carrier shall administer benefits for drug therapies received other than retail and mail service prescriptions. These therapies include home infusion therapy, chemotherapy administered at a physician's office or a facility, and drugs dispensed at a facility or physician's office, including fertility drugs. The selected EPO must be willing to work closely with the prescription benefit manager to appropriately manage a patient's care. The selected EPO carrier must have in place the appropriate data sharing agreements such as a BAA prior to September 1, 2017.

6.11.2 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The EPO shall offer mental health and substance abuse service applicable to both state and federal law. The EPO shall provide for mental illness and/or substance abuse issues (MH/SA) based on an individual plan participant's clinical need. System's intention is that the features listed below be available as part of the MH/SA benefits structure.

- A triage mechanism, performed by appropriately licensed professionals and available for participants accessing care to any point along the continuum of the delivery system, directs patients to the proper level of care. Access methods include direct access for participants to mental health or substance abuse treatment professionals, as well as referral by a participant's family care physician. The triage function includes a formal clinical assessment scale to measure functional status and well-being and coordinates with the family care physician.
- A dedicated, toll-free MH/SA phone number allows participants or emergency care providers to obtain assistance in accessing care and benefits information 24 hours a day, 7 days a week. Emergency calls receive a telephone response within 15 minutes. The plan provides benefits for an inpatient facility within a 45-minute drive for the participant and an outpatient facility within a 30-minute drive. Requests for urgent care have the first appointment within 24 hours. Requests for routine evaluation and assessment are accommodated within 5 days.
- Locations of facilities and practitioners providing MH/SA services to EPO participants are guaranteed to be sufficient in terms of geographic convenience, accessibility for individuals with disabilities, and proximity to public transportation routes.
- Benefits for a variety of psychotherapeutic services are available, as appropriate to the presenting problems of an individual participant. Care is delivered based upon an assessment of individual needs. Coverage decisions are based on determinations of medical necessity and are assisted by measurement of functional status and well-being.
- An MH/SA case manager is assigned at the point of the intervention for all participants being admitted to inpatient or alternative treatment facilities or receiving detoxification. Case management continues

proactively until the patient is determined to be capable of sustaining long-term stability. As appropriate, the case manager ensures that a post-discharge treatment plan is in place, monitors the patient's progress, and coordinates with the applicable institution Employee Assistance Program.

- Providers and facilities offering varying levels of care are available to the extent that such resources exist in the community, including: residential treatment, partial hospitalization programs, day treatment, halfway houses, intensive outpatient care, and home therapy.

6.11.3 COVERAGES, LIMITATIONS, AND EXCLUSIONS

EPO coverages, limitations, and exclusions shall continue to be administered in substantially the same manner as the UT SELECT plan are currently administered.

6.12 COORDINATION OF BENEFITS

The carrier must be capable of processing coordination of benefit claims for participants who have other coverage to which the EPO is secondary. The cost of processing these claims should be included in the proposed administrative fee. All savings attributable to such programs shall accrue solely to the EPO plan.

6.13 EVIDENCE OF INSURABILITY

Consistent with federal regulations, evidence of insurability (EOI) is not currently required in order for eligible participants to enroll in EPO coverage, regardless of circumstances. Should the regulatory environment change, EOI requirements could be put in place for eligible individuals who declined coverage upon initial eligibility. In that event, the carrier shall provide the underwriting support and appropriate staff, including qualified and duly licensed medical doctors in good standing with the state of Texas, to service the EOI function.

6.14 PROVIDER NETWORK

The carrier will ensure that the EPO network complies with the following requirements regarding provider accessibility, credentialing and contracting, local medical management, utilization management, care management and quality assurance.

6.14.1 NETWORK MANAGEMENT

The carrier must provide all network management services specified in this RFP, including but not limited to the following:

- Initial and ongoing recruitment, credentialing, and contracting with a sufficient number of qualified and duly licensed Health Care Providers, as defined herein, in good standing with the state of Texas, to provide the full range of covered benefits and services in the network service areas;
- Ongoing management of network providers in accordance with applicable laws, regulations, credentialing criteria, and provider contracting provisions;

- Initial and ongoing provider education to ensure that network providers are familiar with and knowledgeable about the EPO benefits (including any benefit design changes) and other plan provisions;
- Ongoing review of fees paid to network providers, recommending adjustments as appropriate;
- Ongoing review, with reports as requested, regarding network provider accessibility with respect to driving time and appointment waiting time;
- Ongoing provider quality assurance review, to include periodic participant surveys and other reporting mechanisms;
- Ongoing utilization management, including preauthorization of services, monitoring and enforcement of compliance with medical protocol, and reporting of utilization management information to System as requested;
- Monitoring of denials made under the utilization management program to ensure the ongoing appropriateness of the medical protocol;
- Recruiting of additional network providers on a general, regional, or specific basis when requested by System;
- Notifying System and making reasonable efforts to notify affected current participants in writing at least forty-five (45) days prior to the effective date of the carrier's termination of any provider's contract without cause unless prohibited or limited by applicable law;
- Notifying System as soon as possible upon determining the need to terminate the provider's contract with cause, but no later than the next business day following termination, and using reasonable effort to notify affected participants in writing of such termination;
- Immediately notifying System and making reasonable efforts to notify affected current participants in writing if a provider initiates termination of its contract with the carrier; and
- Including the name of the terminated provider, the names of other providers available to participants, and the effective dates of the changes in all written notices of provider termination being sent to affected participants.

6.14.2 CREDENTIALING AND RE-CREDENTIALING

The carrier is solely responsible for credentialing, re-credentialing, and contracting with all network providers and will contract only with licensed healthcare providers in good standing in their profession and with the appropriate state and/or federal licensing and regulatory agencies. All healthcare providers participating in the network throughout the entire term of the Contract must be screened and investigated through a rigorous credentialing process prior to being contracted. A detailed description of the carrier's credentialing process must be included with the response as requested in the interrogatory section.

6.14.3 CONTRACTS

The carrier must have a valid contract with each provider that is submitted with the response as part of its network. The contract must include, but not be limited to, agreements regarding accessibility, adherence to medical protocols, care management, utilization management and quality assurance standards, reporting requirements, claims processing procedures, and fee arrangements.

6.14.4 ACCESSIBILITY AND AVAILABILITY

The carrier must provide complete details about its existing provider network in the required format as described in Appendix and E to this RFP. Separate documentation must be provided for primary care physicians (PCPs), specialty care physicians, behavioral health providers and hospitals. Please note that the required documentation is more detailed than what is generally listed in the carrier's provider directory. Failure to properly meet the data requirements as specified in Appendix E may result in a delay in the review of the carrier's response.

System also requires the carrier to provide a GeoAccess report for the proposed provider network. GeoAccess can be analyzed in relation to: 1) driving distance, 2) shortest distance but not necessarily driving distance, or 3) in minutes. System believes that driving distance is the most accurate method for GeoAccess reporting. The applicable access standard to be used for general practitioners (PCPs) is two (2) medical providers within fifteen (15) miles of an employee's residence (or ZIP code). The analysis for PCPs should include providers designated as family practice, general practice, internal medicine, pediatrician and OB/GYN, if used as a PCP. Hospital information should be provided on the basis of one (1) facility within fifteen (15) miles of an employee's residence. In addition, a listing of ZIP codes where the desired access is not met must be submitted for each of the outlined provider types.

Based on the provider network information submitted, System will also conduct a disruption analysis to determine the number of participants that would potentially have to change physicians due to differences between the current network and the carrier's proposed network.

6.14.5 LOCAL MEDICAL MANAGEMENT

The carrier shall have a Medical Director on staff who is a licensed physician in good standing with the State of Texas and who has final authority on medical necessity decisions. The response must include a description of routine interactions between the medical director and network providers via such arrangements as medical protocol committees and utilization review groups.

6.14.6 UTILIZATION MANAGEMENT

The carrier is responsible for providing ongoing utilization management, if desired, including, but not limited to preauthorization of services, monitoring and enforcement of compliance with medical policies, and other programs described herein. It is the responding carrier's decision if they wish to require the election of the PCP. Network providers will be responsible for meeting all preauthorization requirements as established by the EPO, such as:

- Inpatient hospital admission;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Hospice care;
- Home infusion therapy;

- Motorized and customized wheelchairs and certain other durable medical equipment totaling over \$5,000;
- Transplants;
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
 - (i) Psychological testing,
 - (ii) Neuropsychological testing,
 - (iii) Electroconvulsive therapy, and
 - (iv) Intensive outpatient programs.

6.14.7 QUALITY ASSURANCE

The carrier shall have in place processes to monitor the provider network, the quality of patient care and participant satisfaction.

6.15 CARE AND DISEASE MANAGEMENT

The carrier must make available, implement, and administer a comprehensive program to deliver support and educational information intended to assist participants with care and disease management. This may be accomplished through the carrier or through Care Coordinators assigned to physician practices. The carrier may recommend modifications to materials used in this educational program when the carrier determines such adjustments to be in the best interests of participants who would potentially benefit from the proposed changes. The carrier must notify the System and obtain consent as to any modification of the educational program prior to implementing a change or making revised information available to EPO participants.

The carrier may use program information to profile patients only for the purposes of offering, implementing, and administering its support and educational program providing information for disease management purposes; for assessing patterns of care and measuring outcomes; and for providing opportunity analysis related to potential interventions as well as adherence analysis. Only non-personally identifiable participant information may be used by the carrier to administer, evaluate, and improve its support and educational program for disease management and other care management programs. The carrier must be willing to coordinate with the System’s pharmacy benefit manager, currently Express Scripts, to offer comprehensive and seamless education and support to the UT SELECT participant.

The carrier must have the capability to provide quarterly and ad hoc reports for disease management and other care management programs.

The carrier enters into an arrangement with a physician who utilizes Care Coordinators, it is between the carrier and that physician to determine and fund cost associated with the Care Coordinator.

6.16 PROCESS FOR GRIEVANCE AND APPEALS

The carrier must have in place a claims review and appeals process that complies with applicable requirements specified in the Affordable Care Act (ACA; Public Law 111-148). The carrier is responsible for all appeals submitted for claims incurred in connection with services rendered. De-identified ad hoc reports describing the type of appeal shall be made available to System on a quarterly basis if requested.

6.17 TRANSITION OF CARE

The carrier must have in place an appropriate transition of care strategy and must fully describe that strategy in response to this RFP.

7.0 OPERATIONAL REQUIREMENTS

The carrier shall administer the EPO plan in a manner consistent with all applicable laws and regulations, as well as with the requirements set forth in this RFP by the System. The carrier shall provide all services associated with the administration of the plan, including, but not limited to the items specified in the following sections. The cost to the carrier of meeting the following requirements are included in the administration fee as described in the Financial Arrangements section.

7.1 GENERAL REQUIREMENTS

- 1) The carrier shall provide general administrative support as required in the operation of the EPO plan.
- 2) The carrier shall provide legal and technical assistance as it relates to the operation and administration of the EPO plan.
- 3) The carrier shall provide appropriate materials and staffing for Annual Enrollment meetings and fairs.
- 4) Customer Service Center and staff trained and prepared to answer customer questions no later than July 15, 2017.
- 5) Produce and mail member ID cards no later than August 25, 2017.

7.2 IMPLEMENTATION AND ACCOUNT TEAMS

If selected, the carrier must notify the System in writing of the names and roles of all members of its complete Implementation Team by no later than **June 19, 2017**. In addition, the carrier will be required to establish an Account Management Team that is acceptable to System and agree to make staffing adjustments to this team as required by System throughout the contract period. The carrier must ensure that the Account Management Team is established by the same date, **June 19, 2017**, and that this team will be available to assist System as required every Monday through Friday from 8:00 a.m. until 5:00 p.m. Central Time (excluding national holidays).

The carrier's Implementation and Account Management Teams must each include a designated information technology contact with the technical knowledge and expertise to efficiently and effectively collaborate with System's information technology team regarding data transmission, data integrity, and timely processing of data. The designated information technology contact should be appropriately positioned within the carrier's organization to allow for direct management of and possible changes to all technical issues related to the contract.

7.3 CUSTOMER AND ACCOUNT SERVICE

- 1) The System strongly believes that the account service relationship is the critical link in developing and maintaining a strong partnership dedicated to the achievement of plan objectives. As such, the carrier must be committed to provide the System with service attention that is at the highest levels in the industry, and fully consistent with expectations.

- 2) The carrier's Account Management Team must provide a minimum of one face-to-face meeting with the System per year to review the utilization and performance of the EPO plan, including recommendations and updates regarding ongoing operational activities. The System may also require quarterly operational meetings (in-person or via telephone conference), as needed.
- 3) The carrier is required to notify the Director of the Office of Employee Benefits in writing prior to any anticipated major change to the organization that may likely impact the EPO plan.
- 4) The carrier's customer service unit should be staffed and trained adequately to handle the plan's specific benefit questions, claims administration, resolution of complaints, and program clarification. The carrier's customer service hours must include, at a minimum, Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time.
- 5) The carrier shall designate carrier customer service representatives as contacts for System staff. The carrier warrants and represents that it will adequately train additional team members as needed to support the System's requirements. The carrier must accept verbal verification of a System participant's coverage by an authorized representative of the System or verify the participant's coverage through an online system and subsequently update coverage in the carrier's system prior to receipt of the System's weekly/monthly enrollment information.
- 6) The carrier shall dedicate additional staff members, as needed, to update System related records and accounts and to provide additional help for the carrier client service team during and following the System Annual Enrollment period including the 2016 Annual Enrollment period, which is prior to the September 1, 2016 contract effective date.
- 7) Customer Service call centers must be located within the United States, preferably within the state of Texas. The establishment of toll free lines (telephone and facsimile) is required and customer service staffing levels must be adequate at a minimum to maintain the following performance standards:
 - a) Average abandonment rate of 5% or less; and,
 - b) Average time to answer of 30 seconds or less.
- 8) The carrier must make available to System staff the ability to listen to and monitor calls to and from the carrier call center(s).
- 9) The Customer Service Center is not permitted to be located off-shore or in another country.

7.4 CLAIMS PROCESSING AND ADMINISTRATION

- 1) The carrier shall process and administer all required EPO plan claims incurred on or after September 1, 2017 and throughout the term of the Contract. General requirements for claims processing include the following:
 - a) Using System enrollment records, the carrier shall create and maintain participation records to be used for the processing of claims and other administrative functions for the fully insured EPO plan. System enrollment records, however, shall control in the event of a conflict.
 - b) The carrier shall review claims for eligibility based on the coverage in effect on the date of service. Any ineligible claims inadvertently paid by the carrier shall be the sole responsibility of the carrier to recapture.

- c) The carrier shall process claims submitted by EPO plan participants. Each claim payment must include an Explanation of Benefits (EOB) for all applicable claims, if appropriate. The carrier must submit all claim forms and sample EOBs as an attachment to the Proposal for the System's review and approval.
 - d) All System EPO plan claims must be processed within an average of thirty (30) calendar days of submission to the carrier unless additional information and/or investigation is required or unless otherwise required by law.
- 2) In the event the carrier issues excess payments or payments for ineligible claims or participants, it will:
- a) Take all steps necessary to recover the overpayment, including in rare situations, the recoupment (offset) from participants' subsequent claim payments;
 - b) Assume 100% liability for incorrect payments which result from policy or System errors attributable to the carrier in whole or in part, including payments made for any covered services to a former EPO plan participant reported by the System as no longer a plan participant, if the carrier receives such notification at least two (2) full business days prior to the date of such claim payment; and
 - c) Notify System of and seek System Office of General Counsel's input on any proposed litigation to recover such overpayment.
- 3) The carrier shall maintain a complete and accurate claims reporting system and provide for the retention, maintenance, and storage of all payment records with provision for appropriate reporting to the System. The carrier shall maintain all such records throughout the term of the Contract and for at least three (3) years following the end of the Contract, and shall make such records accessible and available to the System for inspection and audit upon the System's request. In the event the carrier is scheduled to destroy payment records, the carrier must contact the System for approval prior to the destruction of the payment records. If the System approves destruction, verification of the destroyed records shall be required at the System's direction.

7.5 COST CONTAINMENT INITIATIVES

The carrier shall maintain effective automated systems to detect fraud and misuse of the program, overpayments, wrongful or incorrect payments and verification of enrollment. The carrier shall also conduct thorough, diligent, and timely investigations with regard to fraudulent or suspicious claims and report quarterly all such claims to the System. The carrier must include a written description of its comprehensive fraud detection plan with its response.

The carrier understands that System may develop further policies in connection with the detection and prevention of fraud or abuse of the EPO plan. The carrier shall comply with all applicable laws and regulations and shall also comply with all System policies, and the carrier is encouraged to develop additional safeguards as allowed by law.

7.6 REPORTING AND INFORMATION SHARING

Routine carrier reporting, including utilization and cost data, is required to support the System's ability to proactively monitor trends and to identify/address variances on targeted carrier performance guarantees and customer service standards. The timelines and formats for required reports shall be specified by the System. Additionally, the System may request customized reports on an ad hoc basis. Such reports must be provided in a timely manner at no additional cost to the System.

7.6.1 PERFORMANCE MONITORING

Some report formats shall include a column indicating a performance standard for the item being reported, which shall be utilized by the System as a benchmark to monitor compliance and to analyze the reported statistics. See the Administrative Performance Report template included in Appendix F of this RFP for examples of this type of reporting.

7.6.2 EPO PLAN STATISTICS

The carrier shall accumulate operations statistics and develop reports for the System EPO plan, as is typically done in the normal course of business, on a semi-annual basis. The carrier shall provide copies of such reports upon request by the System along with results of any audits conducted in connection with the reports.

7.6.3 CONSULTING ACTUARY

The System retains an independent consulting actuary on insurance matters. The consulting actuary assists and advises System staff on benefit plan design, proposal review, premium rate analysis and administrative cost analysis. System staff or the consulting actuary may, from time to time, request that the carrier provide additional information specific to the EPO plan. The carrier must cooperate with and act in good faith in working with the consulting actuary and must be prepared to respond to these requests promptly.

8.0 TECHNICAL, DATA EXCHANGE, AND SECURITY REQUIREMENTS

Each System institution self-administers its eligibility. For payroll purposes, the System's fourteen (14) institutions utilize approximately nine (9) different payroll systems. System institutions transmit eligibility data to System, and System in turn transmits the appropriate data to the plan carrier.

Datasets are transmitted by institutions directly to the System as often as desired. Institutions can also make real-time updates to the System eligibility database and can transmit either a full replacement file or a partial replacement file as needed. Some institutions update their payroll files only shortly before payroll is processed; therefore, they transmit eligibility data to System only twice per month. However, other institutions update their data more often.

Due to the nature of the processes involved, there can often be a delay between the effective date of coverage and notification of eligibility to the carrier. To accommodate the variation in institutional eligibility administration and payroll systems and to minimize delays and errors, the System has developed standardized methods for receiving and transmitting information between System, institutions, and carriers.

8.1 SECURE FILE TRANSFER PROTOCOL (SFTP) OVER THE INTERNET

System's security requirements mandate that SFTP be used to access all System servers. Eligibility data will be sent to the selected carrier at least two times each week and will be available to the carrier by 6:00 a.m. Central Time. A carrier's ability to use SFTP over the Internet and to work with ANSI X12 transaction sets will be important considerations in the System's evaluation of the proposals.

8.2 WEB AUTHENTICATION VIA SECURITY ASSERTION MARKUP LANGUAGE (SAML)

Security Assertion Markup Language (SAML) is an XML-based framework that forms the basis for the method of single sign-on user authentication that System strongly prefers for a carrier's System-specific website. An alternative method of user authentication must also be provided for those participants, including many retired employees, who cannot or who choose not to authenticate via single sign-on. Responses that indicate a carrier's willingness and ability to implement SAML-based authentication (v2.0) will be strongly preferred over those that do not.

When implementing SAML-based authentication for a carrier's System-specific website, each of the 14 System institutions plus System Administration will act as an Identity Provider (IdP) and determine whether the user has authenticated properly using local credentials. If the user authenticates correctly, System will redirect the user's browser and pass a SAML assertion to the carrier site in question. The carrier site will accept the SAML assertion in order to grant access.

The carrier must either agree to use System's SAML Discovery Service or to host an alternative solution for IDP discovery on the carrier's System-specific website and subsequently accept the IDP's assertion that

identifies the individual using the Benefits Identification (BID) number, which is included as an attribute in the SAML assertion. Each participant has a unique BID, and BIDs will be regularly communicated to the carrier via eligibility dataset.

Only user authentication will be handled via SAML. Authorization to access specific information, such as limiting the ability to view member-specific data to only the authenticated member, will still need to be handled by the carrier website.

It is System's strong preference that the carrier be capable of immediate implementation of SAML-based authentication (v2.0) at the start of the Contract period or that the carrier anticipates implementation within six months of the start of the Contract period. A carrier who is currently unable to implement SAML-based authentication (v2.0) should provide a statement of its ability to support authentication via proxy and should note in its response when it anticipates implementation of SAML-based authentication (v2.0).

8.3 ELIGIBILITY DATA

8.3.1 SYSTEM'S ELIGIBILITY DATABASE

Each institution's eligibility data is transmitted to the System and stored in an eligibility database maintained by the System. This database is the source used to generate eligibility (enrollment) datasets specific to the EPO plan. The database maintained by the System is directly updated by enrollees during the Annual Enrollment period using the System's *My UT Benefits* online enrollment application. During the July 2015 Annual Enrollment, approximately 48% of all employees made election changes, and approximately 99% of those were made using the *My UT Benefits* online system on the Web. This enrollment process provides the advantage of making most of the new enrollment data available three weeks prior to the September 1 beginning of each new plan year.

8.3.2 ELIGIBILITY DATASET EXCHANGE

A partial replacement eligibility file will be transmitted by the System to the EPO carrier two (2) times per week. Each month the System sends the carrier a full eligibility file. The files are available to the carrier by 6:00 a.m. Central Time on the designated transmission days.

The carrier will be required to receive and process at least two eligibility (enrollment) datasets per week. The carrier may receive either full or partial eligibility datasets each week. A partial replacement dataset includes only records for individuals who are new employees or who have had changes in coverage since the last dataset was generated. If the carrier elects to receive partial datasets weekly, then once per month a full replacement dataset that includes all current participants will be sent to the carrier. Each year during the second half of August and the majority of September, larger than normal datasets can be expected due to updates related to Annual Enrollment and the start of the new plan year.

It is System's expectation that the carrier immediately process eligibility datasets and that updated information will be loaded into the carrier's information system within 24 hours of receipt under normal circumstances. Within twenty-four hours, the carrier must positively confirm via email the receipt, processing, and successful load (or failure to load) of each eligibility dataset. Further, in the event that an

eligibility dataset fails to load, the carrier should provide an explanation for the failure to load either within or as immediate follow-up to the initial notification. The carrier must work directly with System as needed to ensure that dataset load issues are resolved as quickly as possible and updates are applied to the carrier's information system.

The required format for eligibility data being transferred to and from the System is the "Benefit Enrollment and Maintenance Transaction Set (ASC X12N 834)" format. Responses must confirm that the carrier agrees to use the ASC X12N 834 format, or, if unable to comply with the requirement, the response should include rationale for an alternate, applicable, dataset layout.

8.3.3 RETIRED EMPLOYEES

Each System institution keeps records on its retired employees' coverage. Currently, each institution (with OEB's UT Benefits Billing department handling the 6 UT Share institutions) collects premiums, if any are due, from the retired employees and their benefits-eligible dependents. The retired employees will be identifiable on eligibility transmissions.

8.3.4 RETROACTIVE ELIGIBILITY ADJUSTMENTS

The System requires contracting carriers to allow a retroactive window for eligibility changes to be made up to 90 days after the end of the coverage period affected. The adjustments that must be allowed include activation of eligibility, termination of eligibility, and other variations that may occur as a result of participant status changes. The System retroactively adjusts the payment of premium to ensure agreement with updated eligibility information.

8.4 REQUIREMENTS TO FACILITATE EMERGENCY UPDATES

On occasion, System institutions may need to make emergency updates to the coverage of their plan participants. Emergency updates are updates to eligibility coverages on the carrier's eligibility system made through a means other than the eligibility dataset. The System has implemented a "controlled emergency update email process" through which an institution Benefits or Human Resources representative can submit an emergency update request when needed.

The institutions are required to update the System eligibility database prior to sending an emergency update request to the plan carrier. The eligibility system verifies the coverage prior to sending an emergency update email which is always sent from a single, controlled email account.

Social Security numbers will never be transmitted on emergency update email messages. The carrier will either need to be able to add a new member to its eligibility system prior to receiving the Social Security number or be able to connect to a secured System website to retrieve complete update information. The link to the secure website will be included in all emergency update email messages.

The emergency update system can be configured to send the email update request to designated carrier staff members for handling. The email can be formatted to include the carrier's preferences for coding, and its structure does include some free-form text. The carrier may choose up to five (5) email addresses to receive

emergency update emails. Confirmation of a completed update to the carrier's database is required within four (4) business hours of receipt of an emergency update email.

Preference will be given to responses indicating the willingness and ability to accept and process emergency updates via email as specified above. However, if a carrier is unable to receive and process emergency update emails, the carrier may, as a less preferred option, provide an SSO-access-controlled, software interface through which the System can directly update the carrier's eligibility database. The preferred method for this option is an Internet interface accessible via Web browser such as Firefox, Microsoft Internet Explorer, Google Chrome, or Apple Safari.

8.5 DATA FORMAT FOR PREMIUM PAYMENTS

The System will produce a "self-bill" by the fourteenth (14th) day of the month for the premium due for the prior month (billing month). Self-bills currently are created in a System-specific premium billing dataset format; however, for the purpose of this contract, self-bills may be generated in either an administrative fee billing format or the "Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction Set (ASC X12N 820)" format.

The dataset will be transmitted via SFTP over the Internet to a secure FTP server. Upon placement of the dataset on the server, an automated email will be sent to the appropriate carrier contacts with notification of the dataset transmission and self-billing total. Each self-bill will reflect remittance detail for the current month along with any necessary adjustments for the prior three months.

Based on an eligibility snapshot taken from the System eligibility database on the first Sunday of each month, the System will prepare a report detailing the premium remittance as support for the monthly payment of the premium. The report will reference specific plan participants, their BIDs, affected coverage periods, and the amounts being remitted for each.

8.6 AD HOC REQUESTS AND ISSUE RESOLUTION

The carrier shall assign high priority to System ad hoc service requests and issues. Through the designation of an appropriate technical contact as required for the Implementation and Account Management Teams, the carrier shall ensure that all System information systems requests and issues are given priority positioning and are thoroughly analyzed to ensure speedy resolution. The carrier shall provide competent, focused attention to each request or issue presented by System.

It is the expectation that the carrier will make every effort to deliver a resolution within 30 days of receipt of the System's written notification of a request or issue related to the carrier's information systems. The System will be responsible for supplying detailed information reasonably necessary for the carrier to complete the requested services. If a 30-day resolution is not reasonable for a particular issue, the carrier must provide System with an implementation plan and timeline for resolution within five (5) days from receipt of notification.

An example of a requirement falling under this provision would include, but would not be limited to:

Modifications to benefits or eligibility processing -- requirements must be reviewed, responded to, and approved by the carrier within fifteen (15) days of such request by System. If the carrier requires adjustments prior to granting approval, the carrier shall immediately notify the System and set up weekly update meetings to be held until the System agrees that the modifications will meet the System's operating requirements. Once requested modifications have been agreed upon, the carrier shall complete the eligibility or benefits project, including required testing within forty-five (45) days of Systems' approval.

8.7 SYSTEM DATA SECURITY REQUIREMENTS

For the purpose of this RFP, System data is defined as any and all information maintained, created, or received by or on behalf of System.

Responding carriers must maintain a robust security program capable of protecting the integrity, confidentiality, appropriate accessibility, and security of System data. Questions included in Section 12 of this RFP are designed to elicit specific information about the carrier's security program and must be thoroughly and accurately completed.

9.0 COMMUNICATION REQUIREMENTS

The carrier will be required to communicate information regarding the EPO plan design approved by System. All plan communications should be designed to educate both potential enrollees and current participants and must be approved by System prior to dissemination. Communications regarding the EPO plan must be clear and concise, using terminology familiar to participants as specified by System.

The carrier will be required to develop EPO plan communications for written, electronic, and verbal dissemination to accommodate the varying needs of potential participants. However, System prefers that electronic communication be used whenever reasonably possible. Printed materials must always be made available electronically. Communication materials must meet ADA requirements for accessibility.

The costs of the services described in this section are part of the administration fee described in the Financial Requirements Section.

9.1 GENERAL INFORMATION

Communication materials to be developed by the carrier may include, but are not limited to:

- 1) Participant brochures and information for inclusion in benefits books and newsletters;
- 2) A customized, System-specific EPO plan website;
- 3) Presentations to UT institution Benefits Staff and participants;
- 4) Scripted responses to be used by customer service representatives;
- 5) Advertising materials in association with plan enrollment;
- 6) Claim forms;
- 7) ID Cards;
- 8) News releases, including contract signing announcement;
- 9) Participant welcome letter; and
- 10) Token giveaways for enrollment fairs and events.

Communication materials designed for System EPO plan participants cannot, and the carrier represents and warrants that it shall not, advertise or promote coverage, products, or materials, other than those relating to the carrier's administration of the System's plans.

9.2 SAMPLE COMMUNICATION MATERIALS REQUIRED

Electronic draft copies of proposed Plan Year 2017-2018 printed materials, plan participants' handbook, and advertising (newspaper ads, radio scripts, television ads, etc.) must be submitted as part of the proposal. Respondents to this RFP should also submit samples of other communication materials with their proposal, including consumer targeted educational materials (in both print and electronic format) and the format of the customized System-specific website.

Important: All materials relating to the plan must be approved by the System prior to distribution to institution employees and retirees.

9.3 ANNUAL ENROLLMENT

Annual Enrollment information must be promptly provided to all benefits-eligible employees and retirees. The requirements listed below apply to all Annual Enrollment materials, including information for benefits guides.

9.3.1 CUSTOMER SERVICE INFORMATION

All items must include the customer service phone number, hours of operation, and the carrier's website address.

9.3.2 DESCRIPTION OF BENEFITS

The carrier must provide a Schedule of Benefits that contains the benefits that are at least as good as those set forth in Appendix B to this RFP. The summary shall include any additions, limitations and exclusions approved by the System.

9.3.3 DUE DATES FOR ENROLLMENT MATERIALS

All educational and enrollment materials used for both Annual Enrollment and new employees must be distributed to all System institution benefit offices no later than June 30, 2017 and June 1 of each subsequent plan year. **All materials must be approved by the System before distribution to System institutions and employees.**

9.3.4 CARRIER ATTENDANCE AT ANNUAL ENROLLMENT MEETINGS

The contracting carrier is required to attend key scheduled Annual Enrollment meetings at each System institution when requested by the institution Benefits Office at the carrier's own expense. Carrier participation at Annual Enrollment meetings will help educate employees about the EPO plan. If the contracting carrier is unable to attend all Annual Enrollment meetings being offered at a particular System institution, the institution will have the discretion to designate a particular meeting or meetings as high-priority and request carrier attendance specifically for the designated priority meeting(s).

Note: Based on prior Annual Enrollment experience, the carrier is generally requested to attend approximately 10 Annual Enrollment events in the Dallas area each year. Additional Annual Enrollment meetings are held at non-Dallas area institutions.

9.3.5 CUSTOMER SERVICE DURING ANNUAL ENROLLMENT

The carrier's dedicated Customer Service Team will be required to assist in answering questions regarding the EPO plan each year during the System Annual Enrollment period, including during the July 2017 Annual Enrollment period. Education by the carrier Customer Service Team must be provided to all current and potential EPO plan participants. Customer service should be made available via phone, email, in writing, or in person.

9.4 UT SYSTEM-SPECIFIC WEB SITE

The carrier must establish a customized, System-specific website with the primary goal of allowing participants to easily access plan information regarding customer service toll-free numbers, documentation and contacts for the EPO plan. The website must meet all requirements as detailed in this section.

The carrier's System-specific website must be available to the System for testing no later than **June 23, 2017**. The final System-approved website for plan year 2017-2018 must be made available by **June 30, 2017**, and must include the System-approved enrollment materials. In subsequent years, the System-approved website must be made available for testing no later than June 1 of each year. The System must approve new website additions or redesigns at least two weeks prior to any scheduled launch date. The carrier must update the website as often as needed with System-specific content (e.g., news) when requested by the System. The System's requests should be implemented within two weeks from the request date, or within a reasonable time as agreed by the System, depending on the complexity of the update requested.

9.4.1 CONTENT SPECIFICATIONS

The System-specific website should be kept regularly updated with timely, relevant information for the EPO plan. All content for the System-specific website must be approved by the System before it is released. The site must include:

- 1) A link to the EPO plan brochures and summaries, as approved by the System;
- 2) Customer service information, including phone numbers, mail and claim addresses, hours of operation, and guidelines for the complaint and appeals process;
- 3) Electronic forms or email addresses for customer complaints and questions. Responses to email complaints should have no more than a 48-hour turnaround time. A tracking system for complaints submitted online, similar to the tracking of telephone complaints, must be in place with the ability to provide data and details to the System upon request;
- 4) All necessary carrier forms (e.g. claims forms) for participants. If forms are made available in PDF format, an easily identifiable link must be provided to download Adobe Acrobat Reader to enable participant viewing and printing;
- 5) System's branding and a System-specific welcome message must be included to clearly indicate the site is specific to UT System and the EPO plan;
- 6) A link to the System's UT Benefits website; and
- 7) If the carrier provides a Web page on which a participant may view specific individual information, the site must utilize secured protocol (<https://>) and require authentication. The site may not use the participant's social security number, in whole or part, as either the user identification or the password. The Benefits ID may be used as the user identification. Authentication via Single Sign-On is strongly preferred over requiring a unique user identification and password specific to the site. See the section of this RFP entitled "Technical and Data Requirements" for additional details.

9.4.2 TECHNICAL SPECIFICATIONS

The System-specific website must be accessible to as many participants as possible. Therefore, the following specifications must be met:

- 1) All website content must be clearly visible and functional in Internet Explorer, Safari, Google Chrome and Firefox browsers, and compatible with PCs, Apple Mac and mobile devices (smartphones and tablets);
- 2) Entering a Social Security number should not be required at any time to access information on the website;
- 3) The log-on page must not allow the browser to store the information entered in the cache. The auto-complete feature must be turned off for every form;
- 4) The font and text must be legible and easy to read; Refer to the Web Content Accessibility Guidelines (WCAG), including text size and color contrast to comply with a minimum of WCAG AA level: <http://www.w3.org/TR/WCAG20/>; and
- 5) All forms and Adobe Portable Document Format (PDF) files must be accessible. Refer to the W3C accessibility standards for PDFs: <http://www.w3.org/TR/WCAG20-TECHS/pdf.html>.

9.5 ELECTRONIC AND INFORMATION RESOURCES (EIR) WARRANTY

System is required to acquire all EIRs in compliance with the legal requirements governing access to such EIRs by individuals with disabilities (“EIR Accessibility Requirements”). The EIR Accessibility Requirements applicable to the University are set forth in Chapter 2054, Subchapter M of the *Texas Government Code*, Title 1, Section 206.70 of the *Texas Administrative Code*, and Title 1, Chapter 213, Subchapter C of the *Texas Administrative Code*. In order for System to ensure that the EIRs offered by each Proposer responding to this RFP are in compliance with the EIR Accessibility Requirements, Proposer must include all of the following in its proposal:

COMPLIANCE WITH THIS STATUTE AND THESE RULES IS NOT OPTIONAL AND THEIR APPLICABILITY CANNOT BE WAIVED.

- 1) The carrier must warrant that the website complies with the requirements set forth in Title 1, Rules §§ 206, 213.30 and 213.36 of the *Texas Administrative Code* (as authorized by Chapter 2054, Subchapter M of the *Texas Government Code*). The proposal must provide that to the extent carrier becomes aware that the website does not satisfy the EIR Category Warranty, carrier will, at no cost to System, perform all necessary remediation to make the website satisfy the EIR Category Warranty.
- 2) Carrier is required to submit a completed Electronic and Information Technology (EIR) Accessibility Checklist (included as Appendix I to this RFP) along with proposals. Proposals or bids without a completed checklist will be disqualified.

- 3) Carrier must provide a written explanation for each of its responses to the requirements in the Checklist with respect to the website:
 - a) If Proposer determines that the website **complies** with an applicable accessibility requirement in the Checklist, Proposer’s written response to that requirement must identify how Proposer made such a determination (merely responding with “Complies” or similar non-explanatory language is **not acceptable**).
 - b) If the carrier determines that the website **does not or will not comply** with an applicable accessibility requirement in the Checklist, Proposer’s written response to that requirement must identify the cause of such non-compliance and the **specific** efforts and costs that Proposer would need to assume in order to remedy such non-compliance (merely stating “Does not comply” or similar non-explanatory language is **not acceptable**).
 - c) If Proposer determines that an accessibility requirement in the Checklist **is not applicable** to the website, then Proposer’s written response to that requirement must identify the reason for such inapplicability (merely stating “N/A” or similar non-explanatory language is **not acceptable**).
- 4) All carrier Proposals must:
 - a) Agree to authorize UT System to engage in product accessibility conformance testing prior to and after completion of purchase.
 - b) Provide the name and contact information of the individual responsible for addressing accessibility questions and issues about the product.
 - c) Describe the carrier’s capacity to respond to and resolve any complaint regarding accessibility of products or services provided pursuant to this RFP.

9.6 PROHIBITIONS; NOTICE OF INQUIRIES FROM THIRD PARTIES

As the insurer for the EPO plan, the carrier may receive numerous inquiries from interested third parties relating to the EPO plan and their program administration. The carrier is strictly prohibited from disseminating any information about coverage, products, or materials on the carrier’s website other than those explicitly relating to the carrier’s plan offered or service provided to System participants, including the System-specific website.

The carrier must forward all inquiries from interested third parties relating to the EPO plan and program administration to the System Office of Employee Benefits.

9.7 DISSEMINATION OF COMMUNICATION MATERIALS

Communication materials may be considered “published” when a final electronic copy is delivered to the System or is accessible on the carrier’s website. Materials that contain protected health information or other confidential information such as a participant’s Benefits ID number must be mailed in an envelope or packaging designed to secure confidential information from casual viewers.

9.8 PLAN BOOKLETS

Plan booklets (certificates/Summary Plan Descriptions), approved by the Texas Department of Insurance, must be provided each plan year. If corrections or amendments are made to a certificate during a plan year, the revisions will be announced via e-mail and by Web announcement. The updated certificate(s) will also be posted on the website. Each certificate must include the Summary of Benefits as approved by the System and shall include any additions, limitations and exclusions, and a description of the appeals process. The plan booklets should include a description of current eligibility requirements, as set forth in Chapter 1601 of the Texas Insurance Code.

The carrier is responsible for providing a draft of the certificate to the System each year. Final drafts of any required certificate must be submitted by the carrier to the System for review by **June 28, 2017**. The carrier must follow any Texas Department of Insurance requirements for the issuance and distribution of plan booklets.

9.9 TRAINING OF SYSTEM AND INSTITUTION STAFF

The carrier must provide training to System staff and institution HR and Benefits staff regarding the EPO plan. Centralized training for institution HR and Benefits staff occurs on an annual basis during the Benefits and Human Resources Conference (BHRC) hosted in Austin by OEB; however, due to the timing of this RFP, training must occur for the three Dallas institutions prior to June 28, 2017. Training in subsequent years may occur during the June Benefits and Human Resource Conference. In addition, specific training for institution HR and Benefits staff may be required at other times during the year based on changes to operations and the needs of the System.

10.0 PERFORMANCE STANDARDS AND PENALTIES

The carrier must comply with the System requirements listed below and report the specified information to the System on a quarterly basis in an Administrative Performance Report. Refer to the template for the required reporting format for the EPO plan Administrative Performance Report (Appendix F to this RFP).

The carrier selected to administer the System EPO plan must agree to pay the financial penalties as shown in this section if the associated performance standards are not met. Additionally, the carrier should be aware that compliance with these requirements will be a key consideration during any future contract renegotiations.

10.1 ANNUAL ENROLLMENT MATERIALS

System Requirement: The carrier must meet all due date requirements as specified in this RFP for materials related to Annual Enrollment.

Financial Penalty: A penalty of \$15,000 may be assessed for each violation of the due date requirements for: (1) preparation of the System-specific website; (2) distribution of plan materials and (3) having customer service trained and ready for Annual Enrollment.

10.2 ADMINISTRATIVE REPORT TIMELINESS

System Requirement: Each Administrative Performance Report is due no later than the last day of the month that immediately follows the end of the System plan year quarter or by the first business day following the last day of the month.

Financial Penalty: A penalty of \$10,000 may be assessed for each quarter in which the carrier fails to submit the Administrative Performance Report by the required due date.

10.3 COMPLAINTS

System Requirement: The average time to resolve System participants' complaints should not exceed 30 calendar days, with at least 90% resolved in 15 days. The carrier must report the total number of complaints received from System participants (via mail or email), the average length of time to resolve complaints, and the percentage resolved within 15 days of receipt. System-specific data is required.

Financial Penalty: A penalty of \$10,000 may be assessed for each quarter in which the average time to resolve complaints received from System participants exceeds 30 days or when fewer than 90% are resolved within 15 days.

10.4 CUSTOMER SERVICE CALL HANDLING

System Requirement: When contacting the toll-free EPO plan customer service number, the average time a caller waits before speaking to a carrier customer service representative should be 30 seconds or less. The average abandonment rate should not exceed 5%. System-specific data is strongly preferred; however, if

System-specific data is not available due to technical limitations, these two customer service statistics for the complete book of business may be reported instead.

Financial Penalty: A penalty of \$10,000 may be assessed for each quarter in which the ASA exceeds 30 seconds and \$10,000 for each quarter in which the ABR exceeds 5%.

10.5 CALL CENTER AND WEBSITE OUTAGES

System Requirement: Outages of customer service access points, including telephone and IVR services at the Customer Service call center as well as with the System-specific website, should be kept to a minimum. If an outage does occur (or is expected to occur), the carrier must report the outage to System as soon as possible and service should generally be restored within one (1) hour of the outage, dependent upon specific circumstances.

Financial Penalty: A penalty of \$3,000 may be assessed for each outage longer than one (1) hour but less than eight (8) hours. If an outage is greater than 8 hours but less than 24 hours, a penalty of \$7,000 may be assessed. If an outage lasts longer than 24 hours, a penalty of \$10,000 per 24-hour period may be assessed for each occurrence, up to a maximum penalty of \$15,000 for each quarter. OEB may waive this penalty based on extenuating circumstances, including down time due to unusually severe weather, a natural disaster, or an act of terrorism.

10.6 CLAIMS PROCESSING

System Requirement: Once complete information is received, the carrier should average processing System participants' claims as follows:

- 1) 85% of claims to be processed within fifteen (15) calendar days following date of receipt, and
- 2) 98% of claims to be processed within thirty (30) days of receipt.

The carrier must report its total number of System claims received from System participants, the total dollar amounts paid and denied, the average processing time (in days) for these claims, and the percentage processed within 15 days and 30 days, respectively, from date of receipt.

Financial Penalty: A penalty of \$10,000 may be assessed for each quarter and for each timeliness standard regarding claims processing that the carrier fails to meet.

10.7 APPEALS

System Requirement: The carrier's appeals procedure must be in compliance with all applicable statutes and regulations including, but not limited to, the rules and regulations of the Texas Department of Insurance. The carrier must have all levels of appeals required by law. The carrier must provide performance in total number of appeals received, upheld and denied plus the average time (in days) to reach a decision, as well as the percentage processed within 30 days of receipt.

Financial Penalty: A penalty of \$5,000 may be assessed for each quarter in which the average time to resolve complaints received from System participants exceeds 30 days.

10.8 ELIGIBILITY DATASET PROCESSING

System Requirement: Maintenance eligibility datasets received from the System by 11:00 a.m. (central) on any business day will be processed within 24 hours of receipt and System notified of the status once processed. If problems with a dataset or with the carrier's information system prevent processing of any file within 24 hours of receipt, the carrier shall immediately notify System of the issue and begin resolving the issue(s).

Financial Penalty: A penalty of \$7,000 may be assessed for each successfully transmitted dataset not processed by the carrier within the specified time frame or failure to notify System of a transmitted dataset's status within the specified time frame, up to a maximum penalty of \$28,000 per Contract Year.

10.9 EMERGENCY UPDATE PROCESSING

System Requirement: Valid emergency update requests from System institution staff must be processed and confirmation sent to the submitter within four (4) hours of receipt when received by 1:00 p.m. (central) on a business day. Requests received after 1:00 p.m. (central) on a business day or anytime on a non-business day must be processed no later than noon (central) on the following business day.

Financial Penalty: A penalty of \$2,000 may be assessed for each occurrence in which a valid update request was not processed and confirmation sent within the required time frame.

11.0 PROPOSAL EVALUATION

Proposals submitted in response to this RFP will be evaluated on the basis of criteria described below. The criteria, which should not be assumed to be listed in order of importance, are intended to provide the basis for an objective evaluation of each proposal.

The evaluation process will focus on the selection of a carrier who, in the judgment of the System, demonstrates the ability to consistently and effectively partner with System to provide the best administration of the fully insured EPO plan during the contract period for the amount of premium paid.

11.1 CARRIER LICENSURE

To be considered for selection, carriers must have a certificate of authority in good standing from the Texas Department of Insurance to provide the proposed plan that has been filed and approved by TDI.

11.2 COMPLIANCE WITH AND ADHERENCE TO THE RFP

Proposals containing deviations are strongly discouraged. If included, deviations must be specifically identified and described in detail to be considered. While a proposal with minor deviations from the RFP specifications will not be disqualified, preference will be given to prospective carriers whose proposals contain the fewest and least significant deviations from the requirements presented herein. Information about proposed unique or value-added benefits and programs that would enhance or supplement the current benefit offering specified within this RFP are welcome when presented in conjunction with confirmation that the carrier agrees to the requirements as presented in this RFP.

The System will interpret all responses to be indicating agreement with the specifications contained herein except in cases where deviations are specifically noted and described as required. Deviations will not be included in the final contract unless expressly accepted and agreed to by the System in writing and accepted by the System. In all cases, this RFP, the carrier's RFP response, and the contract terms shall be binding.

11.3 IMPLEMENTATION TIMELINE AND CRITICAL DEADLINES

The carrier's ability to meet the required dates for critical implementation tasks as specified in the section of this RFP entitled "Implementation Timeline," will be an important consideration in the evaluation of carrier proposals.

11.4 THE CONTRACT

All proposals must include an affirmation of the carrier's willingness to accept the provisions set forth in the System's Sample Contract, included as Appendix H to this RFP. Proposals indicating that a carrier is unwilling to sign a contract in the format prescribed by System and containing the essential terms set forth in the Sample Contract, without deviations, will not be considered.

11.5 FINANCIAL STRENGTH

The System has specified a minimum net worth of \$100 million that is applicable for consideration as a prospective carrier under this RFP. A net worth substantially in excess of the minimum will not be considered to indicate a superior proposal. However, a net worth below the specified minimum will result in disqualification of the proposal.

11.6 ADMINISTRATIVE CAPABILITY

Carriers will be evaluated on the basis of their demonstrated ability to provide high-quality services to the System in the management and administration of the EPO plan. All aspects of the services described herein are considered important to this evaluation, including customer service, claims processing, data processing and reporting capabilities.

11.7 OPERATIONAL EXPERIENCE

Demonstrated experience with administering and managing EPO plan and on behalf of large employers (with more than 10,000 members), and particularly experience with large public employer plans, will be an important consideration in the overall proposal evaluation process.

11.8 ACCOUNT MANAGEMENT TEAM

A carrier's commitment to a strong and consistent Account Management Team will be an important consideration in the evaluation process.

The System considers the account service relationship to be a critical link in developing and maintaining a strong partnership dedicated towards the achievement of plan objectives. Carriers must be prepared to provide the System with account service that is at the highest levels in the industry and that is fully consistent with the System's expectations. The carrier and the System will mutually define the criteria to be used for measurement and evaluation of account service performance.

11.9 DATA MANAGEMENT

The carrier's ability to consistently and accurately provide data transmission and processing, as specified in this RFP, will be an important consideration in the selection process. Some of the key factors to be evaluated include:

- 1) A management information system that will support the database maintenance and management reporting requirements specified herein;
- 2) The carrier's ability to accept eligibility datasets as specified herein, to update eligibility records in a timely manner, and to promptly notify System upon the success or failure of the attempt to load each eligibility dataset received;

- 3) The carrier's ability to accept emergency eligibility updates via email and confirm processing of requested changes within the timeframes specified herein; and
- 4) The availability of a secure website through which System staff can view enrollment status for participants and make updates if necessary.

11.10 CUSTOMER SERVICE

Evaluation of the carrier's ability and willingness to provide customer service according to the standards specified in this RFP will include consideration of the carrier's:

- 1) Customer service and data reporting capabilities;
- 2) Ability to provide general administrative services;
- 3) Willingness to commit to specified service and quality performance levels;
- 4) Willingness to provide communications materials and personnel for attendance at the annual Benefits and Human Resources Conference for HR and Benefits Office staff from all System institutions (usually held in Austin for 2-3 days during each year) and for attendance at Annual Enrollment meetings for employees and retirees (generally approximately 10 meetings beginning in early July and continuing through the entire month of July) held at locations throughout the Dallas area;
- 5) Ability to meet the Electronic Information and Resources (EIR) Warranty requirements described in the "Communications Requirements" section of this RFP;
- 6) Ability to develop and maintain a System-specific website; and
- 7) Provision of a dedicated toll-free phone number.

11.11 FINANCIAL REQUIREMENTS

The System expects to receive proposals from several qualified carriers, all of which can provide high-quality, cost-effective service. All proposals must include an affirmation of the carrier's/insurer's willingness to accept the provisions set forth in the Financial Arrangements Section of this RFP.

11.12 SECURITY OF SYSTEM DATA

System will require the selected carrier to demonstrate its ability to safeguard the privacy and security of System data collected and/or maintained by the carrier on behalf of System in compliance with System's own privacy and security requirements.

11.13 EIR ACCESSIBILITY RULES

The System is required to ensure that the carrier is able to comply with the EIR Accessibility Rules and provide the required EIR Accessibility Warranty as described in Appendix I of this RFP.

11.14 DISCLOSURE OF CONTROLLING INTEREST

System is required to ensure that the carrier will comply with Section 2252.908, Texas Government Code (“Disclosure of Interested Parties Statute”) and 1 Texas Administration Code Sections 46.1 through 46.3 (“Disclosure of Interested Parties Regulations”) as implemented by the Texas Ethics Commission (“TEC”), including, among other things, providing the TEC and University with the information required by the Disclosure of Interested Parties Statute and the Disclosure of Interested Parties Regulations on the form promulgated by the TEC.

11.15 OTHER FACTORS

- 1) Based on responses provided, other factors will be considered during the evaluation process, including the following:
 - a) The carrier’s overall financial stability;
 - b) An organizational structure and a delivery mechanism that have demonstrated the ability to deliver high-quality, cost-effective management and administration of the Disability plans; and
 - c) Information obtained from the carrier’s list of references.
- 2) System reserves the right to request that representatives from carriers determined to be finalists meet with System representatives (at a location to be determined by System) to clarify responses and answer questions related to this RFP. System may also choose to conduct site visits with selected finalists. System will utilize information gained during any such meetings and site visits with selected finalists during the evaluation process.
- 3) The System reserves the right to reject any and/or all proposals and/or call for new proposals if the System deems it to be in the best interests of the EPO plan and its participants. The System also reserves the right to reject any proposal submitted that does not fully comply with the RFP’s instructions and criteria. The System is under no legal requirement to execute a Contract on the basis of this notice or upon issuance of the RFP or receipt of a Proposal.

11.16 PROPOSAL SCORING

Proposals will be scored based on the following matrix:

- 1) Agreement to financial arrangement set forth in Section 5.0 (60%);
- 2) Carrier’s ability to fulfill administrative/delivery requirements as specified in the RFP (25%)
- 3) Carrier’s Experience and Qualifications (10%); and
- 4) Carrier’s ability to accept the terms of the contract as set forth in this RFP without exception (5%).

No points will be assigned or responses considered for any submissions not found to be in full compliance with applicable state and federal law.

12.0 INTERROGATORIES

The carrier must provide responses to all of the items in this section. Responses must be detailed enough to satisfactorily explain the carrier's position on each particular issue. It is the carrier's responsibility to respond to each item in such a way that the System has a full and complete understanding of the carrier's intent. It is important that the carrier carefully defines any key words or phrases used in this section. Each response must be preceded by the question to which the response pertains.

12.1 DEVIATIONS FROM THE RFP

- 1) Identify any provision in your response that does not conform to the standards described in the RFP and the provisions of the sample contract. For each deviation, provide the specific location in the response and a detailed explanation as to how the provision differs from the RFP standards and why.

12.2 ORGANIZATIONAL INFORMATION

Please provide the following details:

- 2) The carrier's full legal name, address, telephone number, and the URL for the corporate website.
- 3) The name, title, mailing address, telephone number, fax number, and email address for:
 - a) The carrier's contact person for this RFP;
 - b) The person authorized to execute any contract(s) that may be awarded (include documentation verifying that this individual has the authority to do so);
 - c) The person who will serve as the carrier's legal counsel;
 - d) The actuarial/financial expert(s) responsible for preparation of items in this response, who must be available to respond to inquiries made by System or its consulting actuary and provide any requested information concerning such items.
- 4) Names of all officers and directors and percentage of ownership in the company, if applicable. Are any of these individuals contracting providers in the proposed network?
- 5) If applicable, a description of the parent company of the carrier as well as any subsidiaries and/or affiliates, including whether each is publicly or privately owned.
- 6) Type of incorporation (for-profit, not-for-profit, or nonprofit); publicly or privately owned.
- 7) State of incorporation.
- 8) A copy of the carrier's current certificate of authority, issued by the Texas Department of Insurance, to provide the type of GTL and AD&D services described in the proposal in the state of Texas.
- 9) The carrier's 14-digit State of Texas Carrier ID number.

- 10) Is the carrier required to maintain any other license(s)? If so, please describe and confirm the validity of any required license(s).
- 11) Copies of recent ratings and reports issued by independent rating organizations or similar entities (e.g., Best's, Moody's, Standard & Poor's, etc.) regarding the carrier.
- 12) A copy of the carrier's most recent audited financial statement.
- 13) A copy of the carrier's current SSAE No. 16 report.

12.3 FINANCIAL INTERESTS

- 14) Provide the names and addresses of all parties who would receive compensation as a result of the carrier's selection under this RFP, including, but not limited to, consulting fees, finder's fees, and service fees.
- 15) State the name and address of any sponsoring, parent, or other entity that provides financial support to the carrier. Include an indication of the type of support (i.e., guarantees, letters of credit, etc.) provided as well as the maximum limits of additional financial support from other entities. If applicable, provide a copy of the sponsoring organization's most current audited financial statement.
- 16) Is the carrier presently actively considering or subject to any mergers with and/or acquisitions of or by other organizations? If so, provide specifics. Affirm that the carrier agrees to notify the System immediately upon reaching any form of binding agreement in connection with any merger, acquisition or reorganization of the carrier's management.
- 17) Please disclose any contractual relationships with affiliates that could present a conflict of interest with the carrier's role as administrator of the EPO plan.
- 18) Disclose any network medical facility in which your organization, or any subsidiary or sister organization, maintains a majority ownership or controlling interest.
- 19) Is the carrier owned by or are there any understandings or financial agreements in place with health professionals? Describe the steps the organization has taken to ensure that such relationships do not create actual or potential conflicts of interest as well as the action plan in place for addressing unforeseen conflicts as they arise.
- 20) Identify by name and address all persons or entities that hold a 20% or greater ownership interest in the carrier.

12.4 REFERENCES

- 21) List as references five major employers for whom you provide EPO services. System is particularly interested in employers located in Texas and in public entities. For each employer, include:
 - a) The name and telephone number of a representative of the employer who is familiar with the services you provide;
 - b) The nature of your relationship with the employer, i.e., insurer, administrator, reinsurer, manager of provider network; and,
 - c) The number of employees and dependents for whom EPO benefits are administered and the total amount of claims paid annually.

Note: Your response to this request officially authorizes System to discuss services provided for these employers and authorizes the employers to provide such information to System.

12.5 LEGAL AND REGULATORY HISTORY

- 22) Describe any litigation, regulatory proceedings, and/or investigations completed, pending or threatened against the carrier and/or any of its related affiliates, officers, directors, and any person or subcontractor performing any part of the services being requested in connection with the Contract during the past five (5) years. Identify the full style of each suit, proceeding or investigation, including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any.
- 23) Describe any investigations, proceedings, or disciplinary actions by any state regulatory agency against the carrier and/or any of its related affiliates, officers, directors and any person or subcontractor performing any part of the services being requested in connection with the Contract during the past five (5) years. Identify the full style of each suit, proceeding or investigation including county and state, regulatory body and/or federal district, and provide a brief summary of the matters in dispute, current status and resolution, if any.

12.6 PRIVACY PRACTICES AND HIPAA COMPLIANCE

- 24) Please provide a detailed description of the carrier's HIPAA Privacy and Security Compliance programs as these would apply to System data. Include information on workforce training and monitoring. Describe all policies and practices implemented to ensure the privacy of all confidential information as defined in the Contract, including but not limited to protected health information as defined by the HIPAA privacy rule, employee/participant information, or other confidential information about the System and its participants. Include a link to the carrier's HIPAA policies and Notice of Privacy Practices as well as a brief description of any HIPAA violations alleged against the carrier by consumers or the Department of Health and Human Services, including the outcomes. (See section 12.23 for additional questions regarding Information Security.)
- 25) Confirm that the carrier is currently in compliance with all HIPAA requirements, in particular, confirm compliance with the rules and regulations applicable to data transmission and privacy, and the organization's willingness to comply with future changes.
- 26) Provide the name of carrier's HIPAA privacy officer and a description of his or her qualifications.

12.7 HUB POLICY COMPLIANCE

- 27) Confirm that three original versions of the HUB Subcontracting Plan (HSP), based on details included within this RFP and requirements included in Appendix H to this RFP, have been completed and submitted with this proposal. Provide the name, mailing address, telephone number, fax number, and email address of the person who can answer questions from System regarding the submitted HUB documents.
- 28) Indicate whether the Texas Comptroller of Public Accounts certifies the organization as a Historically Underutilized Business (HUB) and provide any information about past participation in a HUB program. See Appendix H of this RFP.
- 29) Indicate whether any of the services to be provided to the System will be subcontracted by the carrier.

12.8 CONFIRMATION AND ACKNOWLEDGEMENTS

- 30) Confirm that the carrier understands, has the ability to, and will comply with all of the requirements included within each of the following sections of this RFP:
- a) General Requirements (Section 2.0);
 - b) Substantive Terms of the Sample Contract and Legal Requirements (Section 4.0);
 - c) Financial Arrangements (Section 5.0);
 - d) Benefits and Program Requirements (Section 6.0);
 - e) Operational Requirements (Section 7.0);
 - f) Technical, Data Exchange, and Security Requirements (Section 8.0);
 - g) Communication Requirements (Section 9.0); and,
 - h) Performance Standards and Penalties (Section 10.0)

12.9 FINANCIAL REQUIREMENTS

- 31) Does the carrier confirm they will adhere to the EPO financial arrangement set forth in this RFP?
- 32) Does the carrier agree to assume responsibility for the escheatment process in accordance with Texas law for any payments disbursed on behalf of the EPO?

12.10 GENERAL ADMINISTRATION

- 33) Are all administrative services performed internally? If the carrier contracts with a management company for some or all of its administrative services, please specify the name of the company, the services provided and the method of reimbursement.
- 34) Where is the primary administrative facility located?
- 35) Provide the names and titles of the carrier's administrative support staff that will administer the EPO plan, including the total number of full-time equivalent employees and which employees are located in Texas. What is the turnover rate among this staff for the past two (2) years?
- 36) What are the carrier's contingency plans and procedures for providing back-up service in the event of strike, natural disaster, backlog, or other event that might interrupt, delay, or disrupt service? Provide a copy of the carrier's disaster recovery plan and/or business resumption plan, including results of the carrier's most recent test of the plan.

12.11 BENEFITS ADMINISTRATION

- 37) How long has the carrier been providing managed health care services such as an EPO?
- 38) Provide the carrier's total commercial enrollment as of September 1, 2016. Provide a statement of the carrier's capacity to enroll new participants and the likelihood of any future limitations on enrollment.
- 39) Describe the carrier's transition plan for EPO participants currently under case management with acute care needs whose provider is not in the carrier's network. Include a copy of any forms applicable to transitional benefits and address each of the following conditions in the response:

- a) Pregnancy in the third trimester;
 - b) Terminal illness;
 - c) Pre-scheduled, pre-certified surgery to be done on or after September 1, 2017;
 - d) Psychiatric treatment (for a limited period of time of not more than 60 calendar days);
 - e) Acute care following trauma or recent surgery; and
 - f) Chemotherapy.
- 40) Describe the carrier's process for implementing plan design or benefit changes. How much advance notice is required for a change to be programmed into the carrier's information systems? What quality assurance measures are in place to ensure the accuracy of such programming?
- 41) Describe in detail the facilities, personnel, and procedures the carrier intends to use to service those functions required for the EPO plan other than the processing of claims. This response should include a description of:
- a) Personnel that will be available to confer with the System's consulting actuaries concerning financial issues,
 - b) Legal and other expertise available to represent the carrier in administrative hearings and litigation, including subrogation, and to assist the System in the execution of its duties under the Contract, and
 - c) The carrier's internal processes to deal with participant grievances.

12.12 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

- 42) Describe the carrier's mental health and substance abuse program, including the following aspects:
- a) The methods by which participants access care for mental health and substance abuse issues, including a description of the carrier's triage process;
 - b) A description of the structural and functional aspects of the carrier's mental health and substance abuse case management services, including how such services lend to long-term stability of a patient.
 - c) The utilization management activities conducted in connection with the program;
 - d) The network development and management services applicable to mental health and substance abuse providers;
 - e) The cost management techniques applied to mental health and substance abuse services;
 - f) The reimbursement arrangements in place with mental health and substance abuse facilities; and
 - g) The quality assurance techniques used to ensure that participants receive cost effective, high quality care.
- 43) Do you subcontract any services associated with mental health or substance abuse care? If so, identify the subcontractor and provide a detailed description of their program.

12.13 HEALTH CARE MANAGEMENT

- 44) Describe the manner in which you conduct the following activities and how the results of such activities are used in the health care management process:

- a) Development of profiles of primary care physicians' practice and referral patterns;
 - b) Monitoring of frequently used services;
 - c) Review of physician coding patterns;
 - d) Identification of procedure codes requiring 100% review, including a current list of codes subject to such review; and
 - e) Review of certain types of claims on a standard basis.
- 45) How does the carrier measure quality of care and how is that communicated to participants?
- 46) Describe how data gathered by tracking various elements of patient care is used in the overall measurement of provider efficiency and patient outcomes.
- 47) What strategies does the carrier currently use and what new innovative strategies does the carrier plan to use to improve quality of care and control costs?
- 48) Describe the carrier's process for determining Experimental and Investigational procedures and the sources used to develop support or denial of services.
- 49) How does the carrier determine when a procedure is no longer Experimental and Investigational? How often is this process reviewed?
- 50) Does the carrier have the ability to make online consultations available for use in non-emergency situations? If so, what is the fee structure associated with such consultations?
- 51) Describe the methodology for establishing medical protocols for your managed care network and the extent to which protocols are used in the management of health care. Include a description of how a health care provider obtains approval to deviate from the protocols when treating a patient with complications. Your response should include how you communicate the results of such activities to health care providers and how the results may be used to modify practice patterns.
- 52) Describe the organizational relationship between corporate, regional, and local medical management, including any distinct responsibilities that pertain to each and a summary of the functions handled at each level.
- 53) Describe the responsibilities and expertise of each member of the medical management staff assigned to each network location, including an indication of whether each member is an employee versus independent contractor and full-time versus part-time.
- 54) Describe the interaction of the carrier's Medical Director and staff with the provider network, including any arrangements involving medical protocol committees, utilization review groups, etc.
- 55) Provide a detailed description of the carrier's experience with the following:
- a) Integrated delivery systems such as Patient-Centered Medical Homes, Accountable Care Organizations and affiliated provider groups.
 - b) Alternative reimbursement arrangements.

12.14 NETWORK ADMINISTRATION

12.14.1 GENERAL ISSUES

- 56) Describe your network management operations. If your organization contracts with a network management company or leases the network from another entity, provide details of that arrangement.
- 57) Describe the professional, general liability, malpractice, etc., insurance requirements for each type of provider in the carrier's network.
- 58) Have your provider network discounts been evaluated and compared against those of other carriers by an independent third party? If so, provide a copy of the applicable documentation. A summary prepared by the carrier will not be considered adequate.
- 59) Does the carrier currently have contractual arrangements with non-network providers? If so, provide the following information concerning those contracts:
 - a) Summarize the key provisions of those contracts related to participant access.
 - b) Describe the reimbursement arrangements applicable to contracted non-network providers. Quantify the difference in reimbursement between (i) the level provided under these arrangements and (ii) network reimbursement for similar specialties in the same geographic region.
 - c) Provide a file in the format described in Appendix E for contracted non-network providers.
- 60) Does the carrier maintain contractual relationships of any kind with health care providers other than those in the EPO? If so, describe these relationships fully. Are these networks considered wrap networks and do you share in a percent of any savings associated with these networks? If applicable, do the wrap networks balance bill patients?
- 61) When using GeoAccess, do you use third-party networks such as subcontracted, rental or wrap networks. Are these types of networks included in your disruption analysis?
- 62) Do you have high performing providers in your network and if so, how do you promote these high performing doctors to your participants? Are there indicators in the provider directory showing these providers are considered high performing? How do you define "high performing?"
- 63) What is your average utilization of your high performing providers? Do you have specific strategies for directing care to these providers?

12.14.2 PROVIDER CREDENTIALING

- 64) Describe the general credentialing and re-credentialing process and minimum criteria for all health care providers, including whether independent verification of hospital staff privileges, licenses, board certification, etc., is included and whether peer evaluation and on-site inspections are part of the process.
- 65) Provide copies of sample contracts used for each type of health care provider and each network location.
- 66) Describe the professional liability insurance requirements for each type of health care provider in your network. What professional liability and general liability insurance coverages are required of your hospitals and ambulatory surgery centers?
- 67) What is the average annual turnover rate for participating health care providers?

12.14.3 PROVIDER CONTRACTING

- 68) Provide information concerning the most common out-of-network reimbursement bases used by the carrier in Texas?
- a) The information should be provided separately for facilities and professional providers.
 - b) Among professional providers, the information should be provided separately for hospital-based and non-hospital based providers.
 - c) Reimbursement should be expressed relative to Medicare reimbursement levels
 - d) Reimbursement should be compared to that of similar network providers.
- 69) Discuss the carrier's ability to administer unique financial reimbursement arrangements with providers, including, but not limited to, hospitals and physician hospital organizations, that have different discounts from the carriers' current agreement.
- 70) Describe the utilization review and cost containment procedures conducted by network providers. Confirm that these are the responsibility of the providers and not the participants when care is rendered in-network.
- 71) What are the minimum time periods included in your health care provider contracts concerning:
- a) Provider's notice to not accept new patients?
 - b) Provider's intent to terminate?
 - c) Carrier's intent to terminate?
 - d) Provider's required continuation of care to existing network participants following provider's termination from the network?
- 72) Furnish your established standards for access to appointments for 1) routine physicals, 2) office visits for illness, 3) urgent care, and 4) emergency care. For each of the above categories, in what percentage of cases does your organization satisfy the established access standard?
- 73) Describe your processes for monitoring:
- a) Adequacy of patient care;
 - b) Appropriateness of utilization of health care services, including under-utilization as well as over-utilization;
 - c) Adequacy of health care providers, participant access to health care providers, including your access standards for routine, urgent, and emergency;
 - d) Health care provider satisfaction; and
 - e) Adequacy of claims service.

12.14.4 PROVIDER ACCESSIBILITY

- 74) Confirm that electronic documentation has been included with the carrier's response demonstrating that the proposed provider network contains a sufficient number of health care providers to serve EPO participants and has been provided as requested in Section 6.8.4 of this RFP and further detailed in Appendix E to this RFP, including separate documentation for each of the following, with indication of any

providers not currently accepting new patients: 1) primary care providers, 2) specialty care providers, 3) behavioral health providers and 4) hospitals.

- 75) If the carrier's network is not currently adequate to provide the access and services described herein, discuss the process for expanding the network, including how much expansion the carrier anticipates, and provide a timeframe for completing the expansion process.
- 76) Is the carrier approved by TDI for reciprocity arrangements? If yes, identify the locations approved and describe any such arrangements the carrier has in place.
- 77) Describe the methodology used to evaluate patient access to healthcare providers for each network.
- 78) How many family care physicians and specialty care physicians participate in the carrier's organization?
- 79) What percentage of each network's physicians are Board certified? Board eligible?
- 80) Confirm the carrier's ability to comply with System's requirement that in-network access be available for EPO participants seeking treatment.
- 81) Confirm the physicians and facilities of UT Southwestern Medical Center are in your network.
- 82) Confirm your ability to provide additional providers in the network to ensure the service area meets the needs of the eligible members?
- 83) Describe how the carrier ensures that participants can get assistance with selecting a provider as needed.

12.15 UTILIZATION REVIEW

- 84) Provide a detailed description of the utilization review program to be used in connection with the EPO, including but not limited to the following details:
 - a) If applicable, the name, address, and telephone number for any contracted third party providing utilization review services;
 - b) The location and hours of operation of the carrier's utilization review facility or facilities;
 - c) Confirmation as to whether licensed personnel are on duty at all utilization review facilities during all hours of operation;
 - d) The types and numbers of licensed professionals and the number of support staff involved with the utilization review program;
 - e) The credentials and qualifications required for utilization review nurses;
 - f) The number of telephone lines associated with the utilization review program;
 - g) A description of how the carrier ensures compliance with the statutory requirements concerning utilization review;
 - h) The percentage of utilization review referral and authorization requests that are referred to the carrier's Medical Director;
 - i) The methods used to establish utilization review protocols and the frequency of review for these protocols;
 - j) The utilization review procedures utilized by network health care providers; and
 - k) The process available to health care providers for the appeal of denied claims.

12.16 DISEASE AND CARE MANAGEMENT

- 85) Describe the carrier's current disease and care management programs. Do you subcontract any services associated with disease management? If so, identify the subcontractor and provide a detailed description of their program.
- 86) How are participants identified as candidates for the carrier's disease and care management programs? Include a description of how your disease management, health and wellness programs, and internal medical management functions interact to facilitate early identification and intervention. Additionally, please address specifically the resources and information utilized in the identification of possible concerns involving mental health or situations that may involve substance abuse.
- 87) Once identified as potential candidates for disease and care management, what factors would trigger efforts by the carrier to connect participants with Case Management, System's Living Well resources, and/or Disease Management resources?
- 88) Describe the process by which the carrier would work to ensure that participants are connected with the appropriate program based on their specific circumstances, including those situations where potential issues with mental health or substance abuse have been identified.
- 89) Please provide a brief description (no more than 500 words) of the processes in place at the carrier that integrate data from multiple sources (e.g., medical and pharmacy claims, completed health risk assessments, diagnostic test results, etc.) in support of disease management and overall wellness efforts.
- 90) Describe key changes made to any aspect of the carrier's disease and care management programs during the past year as well as any changes planned over the next year or two.
- 91) Please provide sample quarterly and ad hoc reports that demonstrate the carrier's reporting capabilities in relation to disease management and other care management programs.

12.17 WELLNESS CARE BENEFITS AND VALUE-BASED BENEFITS DESIGN (VBBD)

- 92) Please provide details regarding any consumer support programs the carrier currently has available to provide coaching and educational support to individuals with specific chronic conditions. Indicate whether these programs are managed directly by the carrier or provided by a subcontractor.
- 93) What specific attributes of the carrier's coordinated care programs are designed to attract and engage those participants whose health habits or status place them at risk (as opposed to those without known risk factors, i.e. the "worried well"), even though they are not presently experiencing adverse health effects?
- 94) Does the carrier track and refer participants to specific care programs on an individual level? For example, for a participant identified as having type-2 diabetes, high cholesterol, and high blood pressure, would the carrier make specific recommendations to the participant regarding available programs such as System's Living Well program?
- 95) Please describe the specific steps that the carrier would take and the criteria that would be used to support participants during their pregnancy.
- 96) Describe any processes the carrier has in place with contracted physicians to help the physician engage the participant in pre-natal programs.
- 97) Please describe examples of specific projects and initiatives that demonstrate the carrier's ability to collaborate with clients and other carriers around improving the health and well-being of plan participants.

- 98) Please describe the carrier's view of the role of the employer and the investment necessary in partnering with a TPA to maximize participation in wellness initiatives and beneficial outcomes.
- 99) Please describe your organizations view of the effectiveness of Value-Based Benefits Design (VBBD) to improve the health status of covered lives and reduce the plans costs.
- 100) Please describe the specific steps that the carrier would take and the criteria that would be used to help an employer determine whether VBBD would be a beneficial strategy to pursue with regard to their PDP.
- 101) Describe in detail the carrier's capabilities to assist with evaluating VBBD as a plan design option by:
- a) Including additional data in the overall analysis, such as long-term and short-term disability claims, and personal health assessment survey results; and,
 - b) Providing a comprehensive assessment of the results of the data analysis described above and assisting with interpreting those results.
- 102) Detail any specific mechanisms used to assure that different units of the carrier, the plan sponsor, and other carriers all coordinate to offer a smooth-running VBBD plan.
- 103) How many accounts does the carrier currently support that have implemented some aspect of VBBD?
- 104) If applicable, please provide the names of three accounts that have implemented a VBBD plan with the carrier, with at least one being available to enrollees for more than 12 months.
- 105) If applicable, please describe any issues that have arisen with the implementation of VBBD concepts and how the carrier addressed those issues.
- 106) Please provide sample quarterly and ad hoc reports that demonstrate the carrier's reporting capabilities in relation to wellness and VBBD programs.

12.18 IMPLEMENTATION AND ACCOUNT TEAMS

- 107) Provide a list of individuals who will comprise the carrier's implementation team along with a résumé and complete contact information for each team member. Identify the individuals who will be primarily responsible for handling details related to each of the following categories:
- a) Information systems and technology, including specifically benefits programming, claims processing, and eligibility data processing;
 - b) Customer service;
 - c) Communication materials;
 - d) Appeals process;
 - e) Transitional benefits; and,
 - f) Financial functions, including payments and reconciliation.
- 108) If applicable, describe in detail any previous significant issues with contract implementation the carrier has experienced and all measures the carrier took to remedy the situation.
- 109) Provide a list, beginning with the most recent, of any performance assessments incurred by the carrier during the last ten (10) years, or the life of the company if less than ten (10) years. Separate by governmental and nongovernmental clients indicating the reason for the assessment and the amount paid.

- 110) Briefly outline the carrier's account management philosophy. Please include information about how the team members are compensated by the carrier.
- 111) Where would the primary person responsible for account and client management associated with System's contract be located? Will any Account Management Team members be located in Austin?
- 112) How many other contracting customer organizations is the assigned account manager currently servicing and how many total participants are represented by those organizations?
- 113) What is the carrier's account manager/executive turnover rate for the last twelve (12) months?
- 114) Describe the overall organization, location, and structure of the Account Management Team that will provide ongoing program support for the EPO plan. Please provide a résumé for each team member, including current professional responsibilities and length of employment with the carrier.
- 115) Confirm that the System will be notified of any change in the dedicated Account Management Team. Describe the efforts the carrier makes to discourage turnover of Account Management Team personnel responsible for oversight of major group accounts.

12.19 CUSTOMER SERVICE

- 116) Describe the carrier's customer service unit, including the manner in which it is accessed, days and hours of call center operation, and the location of the customer service call center(s) that will provide service to EPO participants.
- 117) Are any major changes currently planned or anticipated for the customer service organization or facilities (e.g., moving to a different location, reorganizing or merging units)? If so, please describe.
- 118) Will the carrier provide a separate toll-free telephone number for System participants?
- 119) Provide sample(s) of proposed ID cards which include, at a minimum, the participant's name and Benefits ID, the customer service phone number, the UT specific website and pertinent benefits copayment information. The sample(s) should feature a font which clearly differentiates between the letters and numbers L, I, 1, O and 0.
- 120) How many telephone lines and support staff will be dedicated to customer service and claims processing for the EPO plan?
- 121) Describe the carrier's ability to track and monitor customer service metrics on an account-specific basis.
- 122) How are after-hours calls to customer service handled?
- 123) Does the carrier's customer service system support TTY, also known as TDD (Telecommunications Device for the Deaf) technologies?
- 124) How does the carrier's customer service system support Spanish-speaking participants? What other languages can the carrier's customer service system support?
- 125) Does the carrier's customer service unit include nurses or physicians who will be performing services in connection with the Contract?
- 126) How will the customer service unit be staffed? What is the turnover rate for carrier's non-management call center staff?

- 127) Briefly describe the training that each employee or representative receives to provide customer service. Include the length of time it takes to advance from training to a qualified Customer Service Representative (CSR).
- 128) How does the carrier ensure that its CSRs are providing timely and accurate information?
- 129) How does the carrier monitor first-call resolution and participant inquiries that do not get resolved?
- 130) Does the carrier's customer service inquiry system allow CSRs to enter information and provide the ability for CSRs to review previous notes to better assist participants?
- 131) Can CSRs view historical claims information online to assist participants? Will participants be able to view their claims information online via the carrier's website?
- 132) Does the carrier record all phone calls and notify all parties that their conversations are being electronically recorded and stored? If not, how many calls are recorded, and what criteria are used in their selection?
- 133) Will System have the ability to listen to customer service calls in Austin?
- 134) Describe how the carrier handles written inquiries. Are they always responded to in writing?
- 135) What is the carrier's current standard for response time with respect to questions requiring written communication?
- 136) Describe the carrier's problem resolution policies.
- 137) Describe the carrier's procedures for handling and escalation of customer service complaints.
- 138) Confirm that the carrier's proposal contains no provision for "binding arbitration" in a complaint procedure and that no such provision shall be utilized with regard to System participants.
- 139) Describe the customer complaint tracking system that the carrier utilizes. How long has this system been in place?
- 140) Describe any changes that are planned or scheduled within the next 36 months for the carrier's computer systems, including Customer Support changes, and provide timelines for when the changes will be implemented to the existing computer system.

12.20 CLAIMS ADMINISTRATION

- 141) Confirm that, as described in Section 13.0 of this RFP and further detailed in Appendix C, the carrier has provided the requested electronic documentation of the allowable amount and network status information in response to the detail claim files included as Appendix D-3.
- 142) Please provide a sample claim form.
- 143) Confirm that System will have a specific high-level contact for issues regarding EPO claims administration and indicate where this contact will be located.
- 144) Please provide a detailed description of the carrier's facilities and procedures for processing claims, including the following:
 - a) The location where will claims be processed and hours of operation;
 - b) The size and composition of the staff that will be assigned to process EPO claims;
 - c) Your hiring and training practices for claims examiners, processors, and data entry operators;
 - d) The claims processing system to be utilized and how long the system has been in operation;

- e) Any procedures used to expedite claims processing, such as electronic claims submission;
- f) Any arrangements designed to reduce or eliminate participant responsibility for filing claims;
- g) Procedures for processing claims incurred outside of Texas, including international claims;
- h) The steps performed to coordinate processing of claims using both network and non-contracting providers; and,
- i) How network and out-of-network claims are integrated for data accumulation purposes.

145) How does the carrier’s claim processing system interact with enrollment and utilization review information?

146) Can the carrier match System enrollment against other client enrollment to identify dual coverage? If so, explain the verification process and identify other clients that currently access this process.

147) Describe any other review procedures in place to identify dual coverage.

148) What dollar threshold triggers a requirement that an individual claim payment be approved by a claims supervisor? Describe how the EPO will share claims information for high cost claims exceeding \$300,000.

149) What parameters are used to determine when detailed audit of a claim is required?

150) What processes are used to identify potential subrogation claims? Please explain your subrogation process in detail. Do you guarantee a percent of recoveries through claim audits or subrogation?

151) How long will claims records specific to the EPO be maintained?

152) For the claims office that would be processing claims for System participants, please provide the following statistics for all claims paid by the carrier for 2016:

	Company Standard	Actual
Claims payment accuracy rate		
Claims processing accuracy rate		
Financial accuracy rate		
Processing time (COB claims)		
Processing time (non-COB claims)		
Average turnaround time (all claims)		

153) Confirm that the carrier’s proposal contains a description of claims appeal procedures as well as where that procedure is described in the proposal.

154) Does the carrier administer episode-based bundled payments? If so, please respond to the following items:

- a) Discuss the disadvantages and advantages of the carrier’s bundled payment approach;
- b) Discuss how the carrier mitigates the risks associated with the difficulties of a bundled payment approach;
- c) Discuss the method used to distribute payments to providers.

155) What is bundled in the global payment for an episode of care?

156) Does the carrier administer a medical home program? If so, please respond to the following items:

- a) Discuss the disadvantages and advantages of the carrier’s medical home program;

- b) Discuss how the carrier mitigates the risks associated with the difficulties of a medical home program;
- c) Discuss the method used to distribute payments to providers.

12.21 COST CONTAINMENT

- 157) Describe the preauthorization process that will be applicable for EPO participants. What services do you suggest be preauthorized?
- 158) Explain in detail how your organization detects overcharges, unnecessary or extensive hospitalization, unnecessary medical treatment, excessive drug use received in physician's office or facilities and other forms of misuse or abuse of medical services.
- 159) Provide a detailed description of the procedures and systems that the carrier uses to prevent, deter, detect and investigate fraud or related issues, and explain how such processes will be applied in connection with the EPO.
- 160) Confirm that the carrier agrees to comply with any additional policies System may develop in connection with the detection and prevention of fraud or abuse.
- 161) Discuss how the carrier would communicate with the participant, provider, or carrier once a fraud or abuse issue has been identified. How will such information be reported to the System?
- 162) Discuss the carrier's policies and procedures for addressing situations in which benefits have been utilized after a participant's benefits have ended (e.g., due to a delay with updating participant data or similar issue). Provided that the carrier receives adequate notice of termination from System, will the carrier guarantee that the participant will not be billed for claims that processed after a participant's coverage has terminated?
- 163) Describe the carrier's experience in providing cost-containment enhancements to current and former clients.

12.22 QUALITY ASSURANCE

- 164) Describe the carrier's quality assurance (QA) program. Include or address the following as part of the description:
 - a) The name of the designated senior executive responsible for the program;
 - b) The carrier's current QA policies and procedures;
 - c) The extent of the Medical Director's involvement in the program;
 - d) The extent of participating health care providers' involvement in the program;
 - e) Quality of clinical care and quality of service issues;
 - f) The composition and activities of the quality assurance committee;
 - g) The number and expertise of staff dedicated to quality assurance;
 - h) The methodology utilized by each network to evaluate quality;
 - i) Procedures used to address providers who do not meet the standards of quality, including for the removal of such providers from the network; and
 - j) A description of how quality assurance requirements are incorporated into provider contracts.

- 165) Describe the carrier's processes for monitoring the adequacy of customer service and claims service. How often are surveys specific to these functions conducted? Please provide a copy of the most recent results.
- 166) Does the carrier currently perform overall participant satisfaction surveys? If so, does an outside organization perform the surveys? Are health care providers notified of the results? Please provide a copy of the latest survey and its results, if applicable, including the percentage of participants who indicated that they were "satisfied" or "very satisfied" with the overall program.

12.23 INFORMATION SECURITY

- 167) Please provide a detailed description of the carrier's information technology security program that would be applicable to System data collected and/or maintained by the carrier. Include, at a minimum, the following details:
- a) Does the carrier have an information security plan in place, supported by security policies and procedures, to ensure the protection of information and information resources? If so, provide an outline of the plan and note how often it is updated. If not, describe what alternative methodology the carrier uses to ensure the protection of information and information resources.
 - b) Describe the procedures and tools used for monitoring the integrity and availability of the information systems interacting with the service proposed, detecting security incidents, and ensuring timely remediation.
 - c) Describe the physical access controls used to limit access to the carrier's data center and network components.
 - d) What procedures and best practices does the carrier follow to harden all information systems that would interact with the service proposed, including any systems that would hold, process, or from which System data might be accessed?
 - e) If the carrier were selected, would the carrier agree to a vulnerability scan by System of all information systems that would interact with the service proposed including any systems that would hold, process, or from which System data might be accessed? If the carrier objects to a vulnerability scan, describe in detail the reasons for objection.
 - f) Does the carrier have a data backup and recovery plan, supported by policies and procedures, in place for the hosted environment? If so, provide an outline of the plan and note how often it is updated. If not, describe what alternative methodology the carrier uses to ensure the restoration and availability of System data.
 - g) Does the carrier encrypt data backups? If so, describe the methods used to encrypt backup data. If not, what alternative safeguards will the carrier use to protect System data backups against unauthorized access?
 - h) Does the carrier encrypt data in transit and at rest? If so, describe how that security is provided. If not, what alternative methods are used to safeguard data in transit and at rest?
 - i) What technical security measures does the carrier propose to take to detect and prevent unintentional (accidental) and intentional corruption or loss of System data?
 - j) What safeguards does the carrier have in place to segregate System and other customers' data to prevent accidental or unauthorized access to System data?

- k) What safeguards does the carrier have in place to prevent the unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access, or disclosure of System data?
- l) What administrative safeguards and best practices does the carrier employ with respect to staff members (carrier and third-party) who would have access to the environment hosting all information systems that would interact with the service proposed, including any information systems that would hold, process, or from which System data may be accessed, to ensure that System data and resources will not be accessed or used in an unauthorized manner.
- m) Describe the procedures and methodology in place to detect information security breaches and notify customers in a manner that meets the requirements of HIPAA and Texas breach notification laws.
- n) Describe the procedures the carrier has in place to isolate or disable all information systems that would interact with the service proposed, including systems that would hold, process, or from which Institution data might be accessed, when a security breach is identified?
- o) Describe the safeguards in place to ensure that all information systems that would interact with the service proposed, including any systems that would hold, process, or from which System data might be accessed, reside within the United States.
- p) What additional administrative, technical, and physical security controls does the carrier have in place or plan to put in place?

12.24 DATA EXCHANGE AND PROCESSING

- 168) Confirm that the carrier can accept and properly manage eligibility and other key System data using the dataset layouts as described in this RFP, including the Benefit Enrollment and Maintenance Transaction Set (ASC X12N 834) as well as administrative fee billing datasets.
- 169) Confirm that the carrier has the capability to accept data via SFTP on a real-time basis.
- 170) Confirm that the carrier has the ability to comply with the user-authentication requirements for the System-specific EPO website as described in this RFP, including the use of SAML-based authentication (v2.0).
- 171) Describe the carrier's ability to provide automated notification upon receipt of eligibility data as well as automated, timely notifications confirming either successful load or failure to load for each eligibility dataset received from System.
- 172) Explain how the carrier plans to ensure that it meets all requirements regarding protecting the confidentiality of Social Security numbers as outlined in this RFP, including the requirements of Section 35.58 of the Texas Business and Commerce Code, CONFIDENTIALITY OF SOCIAL SECURITY NUMBER.
- 173) Describe the carrier's experience with automated enrollment systems, including any specific automated systems that the organization has worked with.
- 174) Explain how data is entered into the carrier's eligibility system. Provide a data flow diagram of the process to receive, audit, and load eligibility datasets, including an indication of whether the diagram refers to a current or proposed system. If documenting a proposed system, the anticipated implementation date should be included.
- 175) What is the location of the computer system that maintains and hosts the carrier's eligibility system and data? Is a third-party application used for entering data into the carrier's eligibility system or was proprietary software developed in-house?

- 176) Upon receipt of eligibility datasets from System, can the carrier's eligibility system produce a detailed error report indicating which records have been accepted for loading and which have been rejected? Will such reports be provided following each eligibility transmission?
- 177) Discuss the staffing and capabilities of the carrier's team that would be responsible for managing information systems and data.
- 178) How soon after receiving eligibility data from the System would any updates be reflected in the carrier's eligibility system?
- 179) Describe the carrier's process for implementing changes to the benefit plan design. How much advance notice is required for a change to be made in the carrier's information system?
- 180) What quality assurance processes are integrated into the carrier's information systems to ensure accurate programming of the initial benefit plan design and to improve the accuracy of programming related to plan design changes during the contract period?
- 181) Confirm the carrier's ability to accept emergency updates to eligibility, as specified in this RFP. Additionally, please describe the carrier's ability to provide a website allowing designated System staff to view eligibility and make emergency eligibility updates directly in the carrier's database when necessary.
- 182) Confirm that the carrier will comply with the requirement to provide a monthly dataset to System including details as specified for all ID cards issued during the prior month.

12.25 COMMUNICATIONS

- 183) Provide samples of proposed communication materials to be used in administering the EPO plan for plan year 2017-2018 as required by Section 9.2 of this RFP along with additional sample communication materials as described.
- 184) Explain in detail the resources and procedures to be applied in connection with communications and the services that will be available at no additional cost to System regarding development and dissemination of communications materials.
- 185) Discuss the carrier's experience with the innovative use of communication tools and techniques to improve participant engagement and increase participation in disease management programs, opt-in case management programs, and wellness offerings. Include examples of unique approaches to participant communications and a discussion of how results from specific communication campaigns aimed at increasing engagement are measured.
- 186) Describe any enhanced tools and programs currently offered by the carrier in support of participant communication efforts, such as mobile integration features offered through the carrier's website (e.g. option to send provider information direct to mobile device), smart phone applications, etc.
- 187) Will the carrier provide personnel who will attend employee/retiree meetings during Annual Enrollment? Would the carrier be willing to provide personnel for meetings held outside of regular business hours in order to accommodate 24-hour facilities? How many meetings will carrier personnel be available to attend?
- 188) Confirm that the carrier will develop and provide necessary materials for disseminating benefits plan information to EPO eligible employees and retirees during the System Annual Enrollment period.
- 189) Confirm that the carrier will provide the System with a preview of all communications designed to notify participants of features or issues regarding the EPO plan prior to disseminating any communications directly to participants.

190) Describe how System EPO participants will be notified about changes in network providers. How much notice is provided to participants when a provider's contract is terminated by the carrier?

12.26 ELECTRONIC AND INFORMATION RESOURCES (EIR) WARRANTY

191) Confirm that the carrier understands and will comply with the required technical specifications for the System-specific website as specified in this RFP and that the Electronic and Information Resources (EIR) Accessibility Checklist, included as Appendix J to this RFP, has been completed and included with this response.

12.27 PERFORMANCE STANDARDS AND REPORTING

192) Describe the carrier's current reporting capability. Provide samples of utilization and administrative performance reports currently available to contracting plans. How often are reports prepared? Describe the method that the carrier would use to produce any special reports that might be requested by System.

193) Confirm that the carrier is able to provide detailed information required in the quarterly Administrative Performance Report template, included as an appendix to this RFP. Please provide copies of sample administrative performance reports meeting the requirements.

194) If the carrier is unable to provide any of the information requested in the Administrative Performance Requirements Report template included as an appendix to this RFP, please describe in detail any information that cannot be provided and explain why it cannot be provided.

195) Describe any unique reporting capabilities that differentiate the carrier from its competitors.

196) Confirm that the carrier can provide normative data against which System can benchmark the EPO plan.

13.0 PROPOSAL RESPONSE

13.1 GENERAL INFORMATION

13.1.1 PREMIUM TAXES

In accordance with the Texas Insurance Code, no premium, maintenance, or administrative service taxes will be levied on the carrier selected to underwrite and administer the coverages described herein.

13.1.2 RESPONSES REQUIRED FOR REQUESTED PLAN

To be eligible for consideration, a carrier must submit a proposal for the EPO plan. A response that includes a different plan or funding arrangement will not be considered.

13.1.3 NO LOSS / NO GAIN

The carrier must certify that no person currently covered by the System plan will experience a loss of benefits or a loss of coverage as a result of a change of carrier. An employee or retired employee must be able to maintain all benefits in effect as of August 31, 2017 during the 2017-2018 plan year without being required to fulfill any evidence of insurability, active service, or preexisting condition requirements.

13.1.4 LEGISLATIVE MANDATE

If, subsequent to the submission of a response prepared in accordance with these specifications, Federal or State legislation or regulation is enacted or interpreted in a manner which materially impacts the coverages which are the subject of this RFP, the System shall enter into good faith negotiations with the carrier selected to underwrite and administer the program to arrive at mutually agreeable adjustments to the rates submitted in response to these specifications so as to appropriately reflect the anticipated impact of such legislation.

14.0 SIGNATURE PAGE

In accordance with the attached proposal(s), _____
(Print Name of Organization)

hereby agrees, if selected by The University of Texas System, to enter into negotiations for a Contract to provide a fully-insured EPO for at least one two-year period beginning September 1, 2017. I have read the RFP from which this page is taken and verify that the above named organization can meet the requirements outlined. I also agree the above named organization agrees to the financial requirements as defined in Section 5.0.

The Number of Addenda to this RFP reviewed is _____

.....
The Primary Contact Person regarding this proposal is:

Name _____

Title _____

Mailing Address _____

Telephone # _____ Fax # _____

Email Address _____

.....
Printed Name of Individual Signing this Form _____

Title _____

Mailing Address _____

City _____ State _____ Zip _____

I hereby certify that I have the authority to bind the above named organization.

Signature of Individual Signing this Form

Date

15.0 APPENDICES

Appendix A	Summary of Benefits (UT SELECT PPO)
Appendix B	Current Schedule of Benefits (UT SELECT PPO Full Benefits Guide)
Appendix C	Dataset Requirements
Appendix D	Enrollment Data (UT SELECT PPO)
Appendix E	Provider Accessibility and Availability Reporting Instructions
Appendix F	Administrative Performance Report Template
Appendix G	Chapter 1601, Texas Insurance Code
Appendix H	Sample Contract (with HIPAA Business Associate Agreement)
Appendix I	Historically Underutilized Business (HUB) Program
Appendix J	Electronic and Information Resources (EIR) Accessibility Requirements
Appendix K	Required Texas Ethics Commission Controlling Interest Disclosure Form

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*.

In-Area		
Coverage	BCBS In-Network	BCBS Out-of-Network*
Annual <i>Deductible</i> (applicable when <i>coinsurance</i> is required)	\$350/person \$1,050/family	\$750/person \$2,250/family
Coinsurance Maximum	\$2,150/person \$6,450/family	Unlimited
Annual <i>Out-of-Pocket Maximum</i>	\$6,850/person \$13,700/family (includes medical and prescription drug deductibles, copayments, and coinsurance)	Unlimited
Pre-existing Condition Limitation	None	
Lifetime Maximum Benefit	No Limit	
OFFICE SERVICES		
Preventive Care	Plan pays 100% (no copayment required)	60% Plan/40% Member
Diagnostic Office Visit	FCP \$30 Copay; Specialist \$35 Copay; 100% covered after 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 \$35 Copay	60% Plan /40% Member
Allergy Testing	FCP \$30 Copay; Specialist \$35 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		
Coverage	BCBS In-Network	BCBS Out-of-Network*
EMERGENCY CARE		
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member
Hospital Emergency Room	\$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services	\$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services
Emergency Physician Services	Plan Pays 100% (No copayment required – Member may not be balance billed)	Plan Pays 100% (No copayment required – Member may be balance billed)
OUTPATIENT CARE		
Observation	80% Plan/20% Member	60% Plan/40% Member
Surgery – Facility	\$100 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	\$100 Copay/Service (copay waived if member calls <u>Benefits Value Advisor/BVA</u> prior to service) Note: For related services, such as contrast materials or injections, 80% Plan/20% Member	\$100 Copay/Service, then 40% Member (copay waived if member calls <u>Benefits Value Advisor/BVA</u> prior to service)
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member
INPATIENT CARE		
Hospital - Semi private Room and Board**	\$100 Copay/Day (\$500 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 \$35 Copay (initial visit only)	60% Plan/40% Member
Delivery – Facility/Inpatient Care**	\$100 Copay (\$500 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. 20 visits/year/condition)	\$35 Copay/Visit	60% Plan/40% Member
Occupational Therapy (max. 20 visits/year/condition)	\$35 Copay/Visit	60% Plan/40% Member
Speech and Hearing Therapy (max. 60 visits/year/condition)	\$35 Copay/Visit	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		
Coverage	BCBS In-Network	BCBS Out-of-Network*
BEHAVIORAL HEALTH		
Serious Mental Illness – Office Visit	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member
Serious Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member
Serious Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Office	FCP \$30 Copay; Specialist \$35	60% Plan/40% Member
Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Chemical Dependency – Office	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member
Chemical Dependency – Outpatient Treatment**	80% Plan/20% Member	60% Plan/40% Member
Chemical Dependency – Inpatient Treatment**	\$100 Copay/Day (\$500 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 (\$500 per ear; once every 4 years)	80% Plan/20% Member	
Bariatric Surgery (pre-determination recommended)	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. (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 plan for 36 continuous months prior to the date of the surgery to receive benefits.	

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

**These services require preauthorization to establish medical necessity; see page 13 for preauthorization requirements.

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 BCBS 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.***

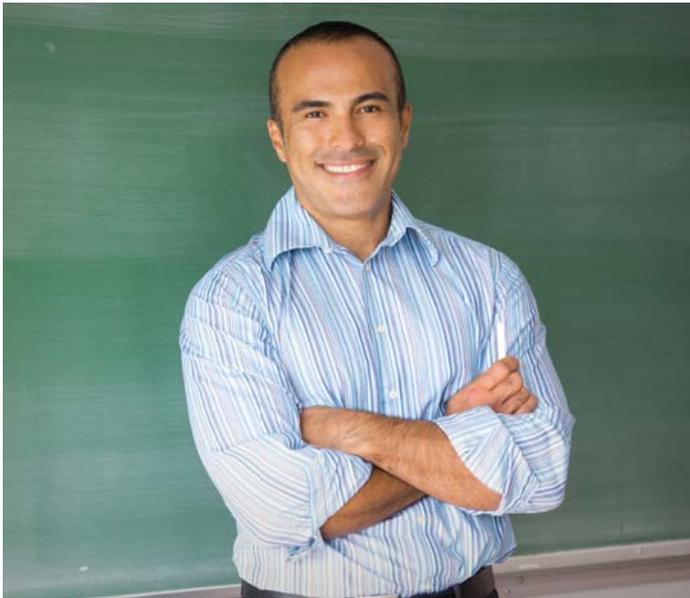
Coverage	Out of Area*
Annual <i>Deductible</i>	\$350/person \$1,050/family (applicable when <i>coinsurance</i> is required)
Annual Coinsurance Maximum	\$2,150/person; \$6,450 family
Annual <i>Out-of-Pocket Maximum</i>	\$6,850/person \$13,700/family (includes medical and prescription drug deductibles, copayments, and coinsurance)
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No Limit
OFFICE SERVICES	
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/Injections (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 – Semi private 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
THERAPY	
Physical Therapy/Chiropractic Care (max. 20 visits/yr/condition)	75% Plan/25% Member
Occupational Therapy (max. 20 visits/yr/condition)	75% Plan/25% Member
Speech and Hearing Therapy (max. 60 visits/yr/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

Coverage	Out of Area*
BEHAVIORAL HEALTH	
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
Chemical Dependency – Office	75% Plan/25% Member
Chemical Dependency – Outpatient Treatment**	75% Plan/25% Member
Chemical Dependency – Inpatient Treatment**	75% Plan/25% Member
OTHER SERVICES	
Durable Medical Equipment**	75% Plan/25% Member
Prosthetic Devices	75% Plan/25% Member
Hearing Aids (\$500 per ear; once every 4 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 plan for 36 continuous months prior to date of the surgery to receive benefits.)

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

**These services require preauthorization to establish medical necessity; see page 13 for preauthorization requirements.

Your UT SELECT Health Benefits



Effective September 1, 2016



**BlueCross BlueShield
of Texas**



THE UNIVERSITY of TEXAS SYSTEM
FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

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Welcome

Meeting Your Health Care Needs

This booklet is a guide to your UT SELECT medical (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 (www.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.

Important Phone Numbers

Customer Service (*Benefits Value Advisor/BVA*)

1-866-882-2034

8 a.m. - 6 p.m. (Central Time)

Monday through Friday

Preauthorization

1-800-441-9188

7:30 a.m. - 6 p.m. (Central Time)

Monday through Friday

Behavioral Health

1-800-528-7264

8 a.m. - 5 p.m. (Central Time)

Monday through Friday

BlueCard PPO Access

1-800-810-BLUE (2583)

24 hours, seven days a week

Blue Care Connection® Condition Management

1-866-412-8795

Special Beginnings® Prenatal Program

1-888-421-7781

24/7 Nurseline

1-888-315-9473

Websites

UT SELECT and Online Provider Directory

www.bcbstx.com/ut

Office of Employee Benefits

<https://www.utsystem.edu/offices/employee-benefits>

Wellness Resources

www.livingwell.utsystem.edu

Express Scripts, Inc.

Prescription Drug Program – Customer Service

1-800-818-0155

www.express-scripts.com/ut

Express Scripts Medicare (PDP) for UT SELECT member with Medicare Primary

800-860-7849



**BlueCross BlueShield
of Texas**



THE UNIVERSITY OF TEXAS SYSTEM

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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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 www.bcbstx.com/ut to order Medical ID cards online or print a temporary ID card.
- **Prescription Drug:** Call Express Scripts Customer Service at 1-800-818-0155 or you can print one through the Express Scripts website, www.express-scripts.com. A virtual card is also available through the new Express Scripts app (application) via your mobile phone.

Website Features

You can access helpful information and administrative forms through the UT SELECT website. Go to www.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.

Blue Access for Members (requires registration)

With Blue Access for Members you can:

- Check the status of a claim.
- Confirm who is covered under your *plan*.
- View and print detailed claim history and information (Explanation of Benefits/EOBs). **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.

How to Find Blue Access for Members

Go to www.bcbstx.com/ut

Select the link for “Blue Access for Members”

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 user name and password that you'll use for all future visits to Blue Access for Members.

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*.

In-Area		
Coverage	BCBS In-Network	BCBS Out-of-Network*
Annual Deductible (applicable when coinsurance is required)	\$350/person \$1,050/family	\$750/person \$2,250/family
Coinsurance Maximum	\$2,150/person \$6,450/family	Unlimited
Annual Out-of-Pocket Maximum	\$6,850/person \$13,700/family (includes medical and prescription drug deductibles, copayments, and coinsurance)	Unlimited
Pre-existing Condition Limitation	None	
Lifetime Maximum Benefit	No Limit	
OFFICE SERVICES		
Preventive Care	Plan pays 100% (no copayment required)	60% Plan/40% Member
Diagnostic Office Visit	FCP \$30 Copay; Specialist \$35 Copay; 100% covered after 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 \$35 Copay	60% Plan /40% Member
Allergy Testing	FCP \$30 Copay; Specialist \$35 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		
Coverage	BCBS In-Network	BCBS Out-of-Network*
EMERGENCY CARE		
Ambulance Service (if transported)	80% Plan/20% Member	80% Plan/20% Member
Hospital Emergency Room	\$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services	\$150 Copay/Visit, then 20% Member (no deductible; copay waived if admitted) If admitted, ER services are added to claims for inpatient services
Emergency Physician Services	Plan Pays 100% (No copayment required – Member may not be balance billed)	Plan Pays 100% (No copayment required – Member may be balance billed)
OUTPATIENT CARE		
Observation	80% Plan/20% Member	60% Plan/40% Member
Surgery – Facility	\$100 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	\$100 Copay/Service (copay waived if member calls Benefits Value Advisor/BVA prior to service) Note: For related services, such as contrast materials or injections, 80% Plan/20% Member	\$100 Copay/Service, then 40% Member (copay waived if member calls Benefits Value Advisor/BVA prior to service)
Other Diagnostic Tests	80% Plan/20% Member	60% Plan/40% Member
Outpatient Procedures	80% Plan/20% Member	60% Plan/40% Member
INPATIENT CARE		
Hospital - Semi private Room and Board**	\$100 Copay/Day (\$500 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 \$35 Copay (initial visit only)	60% Plan/40% Member
Delivery – Facility/Inpatient Care**	\$100 Copay (\$500 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. 20 visits/year/condition)	\$35 Copay/Visit	60% Plan/40% Member
Occupational Therapy (max. 20 visits/year/condition)	\$35 Copay/Visit	60% Plan/40% Member
Speech and Hearing Therapy (max. 60 visits/year/condition)	\$35 Copay/Visit	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		
Coverage	BCBS In-Network	BCBS Out-of-Network*
BEHAVIORAL HEALTH		
Serious Mental Illness – Office Visit	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member
Serious Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member
Serious Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Office	FCP \$30 Copay; Specialist \$35	60% Plan/40% Member
Mental Illness – Outpatient**	80% Plan/20% Member	60% Plan/40% Member
Mental Illness – Inpatient**	\$100 Copay/Day (\$500 max/admission) then 80% Plan/20% Member	60% Plan/40% Member
Chemical Dependency – Office	FCP \$30 Copay; Specialist \$35 Copay	60% Plan/40% Member
Chemical Dependency – Outpatient Treatment**	80% Plan/20% Member	60% Plan/40% Member
Chemical Dependency – Inpatient Treatment**	\$100 Copay/Day (\$500 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 (\$500 per ear; once every 4 years)	80% Plan/20% Member	
Bariatric Surgery (pre-determination recommended)	\$3,000 deductible (does not apply to plan year deductible or out-of-pocket maximum) After \$3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. (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 plan for 36 continuous months prior to the date of the surgery to receive benefits.	

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

**These services require preauthorization to establish medical necessity; see page 13 for preauthorization requirements.

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 BCBS 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 <i>Deductible</i>	\$350/person \$1,050/family (applicable when <i>coinsurance</i> is required)
Annual Coinsurance Maximum	\$2,150/person; \$6,450 family
Annual <i>Out-of-Pocket Maximum</i>	\$6,850/person \$13,700/family (includes medical and prescription drug deductibles, copayments, and coinsurance)
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No Limit
OFFICE SERVICES	
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/Injections (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 – Semi private 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
THERAPY	
Physical Therapy/Chiropractic Care (max. 20 visits/yr/condition)	75% Plan/25% Member
Occupational Therapy (max. 20 visits/yr/condition)	75% Plan/25% Member
Speech and Hearing Therapy (max. 60 visits/yr/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

Coverage	Out of Area*
BEHAVIORAL HEALTH	
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
Chemical Dependency – Office	75% Plan/25% Member
Chemical Dependency – Outpatient Treatment**	75% Plan/25% Member
Chemical Dependency – Inpatient Treatment**	75% Plan/25% Member
OTHER SERVICES	
Durable Medical Equipment**	75% Plan/25% Member
Prosthetic Devices	75% Plan/25% Member
Hearing Aids (\$500 per ear; once every 4 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 plan for 36 continuous months prior to date of the surgery to receive benefits.)

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

**These services require preauthorization to establish medical necessity; see page 13 for preauthorization requirements.

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 <i>ParPlan</i> Provider	See a Non-Network 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 <u>allowable amount</u> 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; <i>ParPlan</i> providers will usually file claims for you You are not balance billed; <i>ParPlan</i> providers will not bill for costs exceeding the BCBSTX <u>allowable amount</u> for covered services In most cases, <i>ParPlan</i> 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 <u>allowable amount</u> for covered services You must preauthorize necessary services

Network vs. Non-Network Providers

Network	Non-Network (Including <i>ParPlan</i>)
<p>You pay lower out-of-pocket costs if you choose network care</p> <p>If you need to...</p>	<p>Payment for non-network services is limited to the <u>allowable amount</u> as determined by BCBSTX. <i>ParPlan</i> providers accept the <u>allowable amount</u>. You are responsible for all charges billed by non-<i>ParPlan</i> providers which exceed the <u>allowable amount</u>.</p>
<p>Visit a doctor or specialist <i>A "specialist" is any physician other than a family practitioner, internist, OB/GYN or pediatrician</i></p>	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the office visit <u>copayment</u> Pay any <u>deductible</u> and <u>coinsurance</u> Your doctor or other provider cannot charge more than the <u>allowable amounts</u> for covered services
<p>Receive preventive care</p>	<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 <u>deductible</u> and <u>coinsurance</u> Your costs will be based on <u>allowable amounts</u>; the non-network doctor from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX
<p>Visit any network doctor or specialist</p> <p>Plan pays 100% for certain age-specific and gender-specific preventive care services; see page 28</p> <p>Your doctor or other provider cannot charge more than the <u>allowable amounts</u> for covered services</p>	<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 <u>deductible</u> and <u>coinsurance</u> Your costs will be based on <u>allowable amounts</u>; the non-network doctor from whom you receive services may require you to pay any charges over the <u>allowable amounts</u> determined by BCBSTX

	Network	Non-Network (Including <i>ParPlan</i>)
	You pay lower out-of-pocket costs if you choose network care	Payment for non-network services is limited to the <i>allowable amount</i> as determined by BCBSTX. <i>ParPlan</i> providers accept the <i>allowable amount</i> . You are responsible for all charges billed by non- <i>ParPlan</i> providers which exceed the <i>allowable amount</i> .
If you need to...		
Receive <i>emergency</i> care	<ul style="list-style-type: none"> • Call 911 or go to any <i>hospital</i> or doctor immediately; you will receive network benefits for <i>emergency</i> care • Pay the <i>copayment</i> (waived if admitted) and <i>coinsurance</i> • Pay any <i>deductible</i> and <i>coinsurance</i> (if admitted) (see <i>Emergency Care</i> on page 22) 	
Be admitted to the <i>hospital</i>	<ul style="list-style-type: none"> • Your network doctor will preauthorize your admission • Go to the network <i>hospital</i> • Pay any applicable <i>copayment</i>, <i>deductible</i> and <i>coinsurance</i> 	<ul style="list-style-type: none"> • You, a family member, your doctor or the <i>hospital</i> must preauthorize your admission • Go to any licensed <i>hospital</i> • Pay any <i>deductible</i> and <i>coinsurance</i> each time you are admitted • Your costs will be based on <i>allowable amounts</i>; the non-network doctor/facility from whom you receive services may require you to pay any charges over the <i>allowable amounts</i> determined by BCBSTX
Receive behavioral health or chemical dependency 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 page 13) • See any licensed doctor or other provider, or go to any network <i>hospital</i> or facility • Pay any applicable <i>copayment</i>, <i>deductible</i> and <i>coinsurance</i> 	<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 page 13) • See any licensed doctor or other provider, or go to any licensed <i>hospital</i> or facility • Pay any <i>deductible</i> and <i>coinsurance</i> • Your costs will be based on <i>allowable amounts</i>; the non-network doctor or other provider from whom you receive services may require you to pay any charges over the <i>allowable amounts</i> 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 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 <http://www.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, such as 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*
- 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
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
 - Electroconvulsive therapy
 - Repetitive transcranial magnetic stimulation, and
 - Intensive outpatient program.

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 that are unlikely to benefit from treatment programs that focus solely on mental illness conditions.

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 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. 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; and
- 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 Chemical Dependency, Serious Mental Illness, Mental Health Care

- All inpatient and certain outpatient treatment of chemical dependency, serious mental illness and mental health care should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Benefits Value Advisor (BVA)

You have a choice when selecting where to go for health care. Many times you can choose between different providers or facilities and receive the same procedure at a lower cost. This is where Benefits Value Advisor (BVA) comes in. You can call a BVA and get cost comparison information from providers in your area for:

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

A BVA can also help you:

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

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

Just call 1-866-882-2034 to talk to a Benefits Value Advisor.

The \$100 copay per MRI and CT scan will be waived if you call customer service and speak to a Benefits Value Advisor **prior** to service.

Note: BVA is only available to members covered by the PPO plan. The \$100 copay per MRI and CT does not apply to out-of-area members or to members with Medicare-primary coverage.

Accessing the BlueCard Program for Health 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 BlueCard Access at 1-800-810-BLUE (2583) 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. BlueCard 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 on page 68 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 BlueCard Worldwide 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. BlueCard Worldwide 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 BlueCard Access at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at BlueCard Worldwide *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 BlueCard Access number.)

In most cases, you will not need to pay for inpatient care at BlueCard Worldwide *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 BlueCard Worldwide 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 BlueCard Worldwide Service Center to receive any applicable reimbursement for covered expenses. The claim form is available online at www.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.

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 BlueCard Worldwide claim form completely and attach your bills from the foreign provider. Missing information will delay claims processing.

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 on pages 4-8 of this booklet 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; and
- 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.

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; or
 - 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 (for children up to age 19; \$36,000 maximum benefit per year);
- behavior training and behavior management;
- speech therapy;
- occupational therapy; or
- physical therapy.

Breastfeeding Support, Services and Supplies

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. Standard manual and electric pumps purchased at a retail store, through network providers or contracted durable medical equipment suppliers (DME) are covered up to \$500. If purchased from a contracted provider, they will file the claim for you. If not, you will need to submit a manual claim for reimbursement.

Hospital grade pumps are only available for monthly DME rental with coverage up to the purchase price of \$1,000 or 12 months, whichever comes first. Upon end of coverage, the unit must be returned to the DME provider. Claims from non-network DME providers (other than retail) are covered at the non-network benefit level and reimbursed at the allowable amount.

Coverage is provided for one pump per pregnancy. For assistance, please contact BCBSTX Benefits Value Advisor (BVA) at the Customer Service Number on your medical ID card.

Chemical Dependency Treatment (preauthorization required)

Chemical dependency is the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance. All inpatient and certain outpatient treatment (see page 13) for chemical dependency should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

A series of treatments is a planned, structured, and organized program to promote chemical-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 chemical dependency must be provided in a chemical dependency 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.

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; or
- 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.

Condition Management

UT SELECT provides voluntary condition management (also known as disease management) programs designed specifically for *participants* who have been diagnosed with asthma, diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, metabolic syndrome (high blood pressure, high cholesterol), low back pain, cancer, end stage renal disease or any other chronic condition. Lifestyle management programs are also available to address weight management and Tobacco cessation. When you enroll in one of the programs, you'll receive helpful information about your condition, at no cost to you.

The programs work collaboratively with your health *plan*, doctor and you to identify the best way to manage your condition more effectively. Enrolling in a program can help:

- Decrease the intensity and frequency of your symptoms
- Enhance your self-management skills
- Reduce (or decrease) missed days at work
- Enrich your quality of life

Claims, lab results, pharmacy data, preauthorization prior to hospitalization, predictive modeling, health risk assessments, self referrals and/or a physician referral are some of the sources used to determine if you may be a candidate for enrollment in a condition management program. As you know, your physician plays an important role in treating your condition and Blue Cross and Blue Shield of Texas will notify your physician by letter and/or contact you directly to invite you to enroll in one of the programs. Program participation is voluntary.

Each program addresses your specific needs, based on the severity of your condition, complications and risk factors. If the severity of your condition is mild, you will receive:

- Coverage for targeted preventive screenings
- Seasonal mailings with educational materials related to your condition
- Annual contact calls to encourage medication compliance
- Tools to help you better self-manage your condition

If the symptoms of your chronic condition are moderate to severe, your program will be tailored to provide you with:

- Personalized self-management planning
- Regularly scheduled monitoring by a registered nurse
- 24-hour-a-day telephone access to a specialty nurse
- An audio library of topics related to your condition, available by telephone around-the-clock
- Assistance in getting selected condition-specific durable medical equipment for monitoring your chronic condition covered under your health plan
- Home health visits and social service consultation, if needed

Please be assured your health care information is kept confidential and will not be released to your employer. Blue Cross and Blue Shield of Texas condition management programs are fully compliant with federal and state privacy regulations. Such regulations do permit a health insurer and its contracted business associates (such as a pharmacy benefits manager and a disease management program) to use and disclose individuals' health information for purposes of *health care operations* without a patient authorization, as long as the business associates also agree to keep the information protected and to use it only for the specified purposes. *Health care operations* includes population-based activities relating to improving health or reducing health care costs, plus contacting patients with information about treatment alternatives. Regulators have determined that disease management activities are part of *health care operations*.

To enroll or ask questions about Blue Cross and Blue Shield of Texas condition management programs, call **1-866-412-8795**.

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 on a newborn child 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. Services must be received within 24 months of the date of the accident or to the termination date of the UT SELECT *plan*, whichever occurs first. (An injury sustained as a result of biting or chewing is not considered to be an accidental injury); and
- 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) and
- 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 and
- 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; see pages 52 to 57).

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; and
- 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, or

In the case of a pregnant woman, serious jeopardy to the health of the fetus.

24/7 Nurseline

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.

Hearing Aids

UT SELECT allows a \$500 maximum benefit per ear every four years for non-disposable hearing aids, fittings, and molds. Blue Cross and Blue Shield of Texas will pay up to a \$500 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 \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider's billed charges. *Deductibles* do not apply. Hearing aid repair and batteries are not covered.

Savings on Hearing Aids

Blue Cross and Blue Shield of Texas has 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. CST, Monday through Friday to locate a provider near you and schedule a hearing exam. It's that easy! For additional information, visit www.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:

- 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, occupational, speech, and respiratory therapy services provided by licensed therapists, and
- 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, or services provided primarily for *custodial care*.

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, and
- 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, and
- 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, and
- 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.

Infertility Services

Testing for problems of infertility is covered.

Note: Services or supplies, including testing such as HSG, provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are **not** covered. See pages 32-34 for additional exclusions.

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 (see page 22.)

Does the \$100 copay apply to all imaging services?

The \$100 copay applies to MRIs and CTs only for members covered by the PPO plan. The copay will be waived if you call customer service and speak to a **Benefits Value Advisor (BVA)** prior to service and utilize a network provider.

Note: The copay does not apply to out-of-area members or to members with Medicare-primary coverage.

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 (protheses)
- 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 \$100 per day, not to exceed \$500 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.

Note: UT SELECT includes a free voluntary comprehensive prenatal program – Special Beginnings – that helps mothers take better care of themselves and their babies. The program assesses pregnancy risk level and provides close monitoring through a series of calls from an experienced obstetrical nurse from pregnancy through six weeks after delivery. To enroll or ask questions about the program, call the toll-free number: **1-888-421-7781**.

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, and
- 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 nurse midwife as a practitioner?

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

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 actually used
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the *participant*
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the *participant's effective date* of coverage under 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 chemical dependency 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; and
- 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.

Mental Health Care (preauthorization required for all inpatient care and certain outpatient care, see page 13)

UT SELECT covers charges for inpatient and outpatient mental 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 outpatient treatment for mental health should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Medically necessary mental health care in a *psychiatric day treatment facility*, a *crisis stabilization unit* or facility, or a *residential treatment center*, in lieu of hospitalization, will be considered inpatient *hospital* expense at a mental health facility. Each full day of mental health care in a *psychiatric day treatment facility*, *crisis stabilization unit* or facility, or *residential treatment center* will count as a half day of inpatient care when calculating *plan year* limitations.

Obesity

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

- It is determined to be medically necessary; and
- It satisfies the criteria established in 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.

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

UT SELECT covers orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom-designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, asplints or bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings and garter belts.

Note: Foot orthotics are covered for the treatment of diabetes.

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

UT SELECT encourages preventive care and maintenance of good health. Covered services under this benefit must be billed by the provider as "preventive care." Preventive care benefits will be provided for the following covered services and when using network providers, the services will not be subject to ***copayment, deductible, coinsurance*** or ***dollar maximums***:

- 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");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- 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; and
- Additional preventive care and screenings for women, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, 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 above may change as USPSTF, CDC and HRSA guidelines are modified. For the most recent list of recommended services, check with your doctor or visit www.healthcare.gov.

Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); tobacco cessation counseling services; healthy diet counseling; and obesity screening/counseling. Examples of covered services for women with reproductive capacity are female sterilization procedures and specified FDA-approved contraception methods with a written prescription by a ***health care practitioner***, including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Express Scripts. To determine if a specific contraceptive drug or device is included in this benefit, contact customer service at the toll-free number on your identification card. The list of contraceptive drugs and devices covered under this benefit may change as FDA guidelines, medical management and medical policies are modified.

Covered preventive care services not included in the description above may be subject to applicable ***copayment, deductible, and coinsurance***. Examples include hearing screenings and early detection tests for cardiovascular disease.

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.

More about Your Preventive Care Benefits

Benefits for the Prevention and Detection of Osteoporosis

If a **participant** is a *qualified individual*, as defined below, benefits will be determined on the same basis as for any other illness as shown on the *Benefits Summary*. Benefits are provided for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the **participant's** risk of osteoporosis and fractures associated with osteoporosis.

Qualified individual means a **participant** who is:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

Benefits for Certain Tests for Detection of Prostate Cancer

If a male **participant** incurs medical-surgical expenses for diagnostic medical procedures incurred in conducting a medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided for:

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

Benefits for Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are provided as a surgical benefit as referenced in the *Benefits Summary*.

Benefits for Speech and Hearing Services

Benefits as shown on the *Benefits Summary* are available for the services of a physician or other professional provider to restore loss of or correct an impaired speech or hearing function. Any benefit payments made by Blue Cross and Blue Shield of Texas for hearing aids will apply toward the benefit maximum amount indicated on the *Benefits Summary*.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

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

Benefits will be determined on the same basis as for other preventive care services as shown on the *Benefits Summary*, for each woman enrolled in UT SELECT for eligible expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. **Note:** UT SELECT provides coverage for the HPV vaccine.

Childhood Immunizations

Benefits for childhood immunizations will be determined at 100% of the **allowable amount**. Any **copayment, deductible,** and **coinsurance** and amounts will not be applicable. Benefits are available for:

- Diphtheria
- Hemophilus influenzae type B
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella
- Any other immunization that is required by law for the child

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

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. Covered services not included in the description above may be subject to applicable *copayment*, *deductible*, and *coinsurance*.

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), or
- 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, see page 13)

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.

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

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

dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

41. The use of the procedures, supplies, or medications for treatment of psychological/psychogenic male sexual or erectile dysfunction/impotence.
42. Over-the-counter contraceptives.
43. Non-covered Durable Medical Equipment includes, but is not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
44. Services or supplies used primarily for patient convenience.
45. Most supplies available for purchase over-the-counter without a doctor's prescription.
46. Any tobacco cessation prescription drug products including, but not limited to, nicotine gum and nicotine patches, except as may be provided under the prescription drug program.
47. Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient.
48. Investigational services and supplies and all related services and supplies, except for routine patient care costs associated with investigational cancer treatment if those services or supplies would otherwise be covered under UT 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 (BCBSTX) 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 www.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 (<i>UTS or UZS</i>)• 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 www.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 actually 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; and
- 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 (see page 13) 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.

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 may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own 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 www.bcbstx.com/ut website within the section for Forms and Resources.

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 BCBS 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 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; and
- 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 6th Street, Room B.140E
Austin, Texas 78701
Phone: (512) 499-4616
Fax: (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; 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, with 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 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; and
- 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 www.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.

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; and
 - (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:
 - 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);
 - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - 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;
 - 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;
 - A statement that judicial review may be available to you or your authorized representative; and
 - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by BCBSTX, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4 Reversal of plan's decision.

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

Expedited External Review

1 Request for expedited external review.

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

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

2 Preliminary review.

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

3 Referral to independent review organization.

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

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

4 Notice of final external review decision.

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

Exhaustion

For standard internal review of a clinical appeal, you have the right to request external review once the internal review process has been completed and you have received the final internal adverse benefit determination from 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, or
- 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

General Information

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

Rules

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

- **Non-Dependent/Dependent** – The benefits of the plan, which covers the *participant* as an employee, member or *subscriber*, are determined before those of the plan which covers the *participant* as a dependent. However, if the *participant* is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (a) secondary to the plan covering the *participant* as a dependent and (b) primary to the plan covering the *participant* as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the *participant* as a dependent are determined before those of the plan covering that *participant* other than as a dependent.

- **Dependent Child/Parents Not Separated or Divorced** – Except as stated in paragraph c below, when this *plan* and another plan cover the same child as a dependent of different parents:
 1. The benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
 2. If both parents have the same birthday, the benefits of the plan, which covered one parent longer, are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- **Dependent Child/Parents Separated or Divorced** – If two or more plans cover a *participant* as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 1. First, the plan of the parent with custody of the child
 2. Then, the plan of the spouse of the parent with custody, if applicable
 3. Finally, the plan of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph c does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has actual knowledge of the decree.

- **Joint Custody** – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is primarily responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.
- **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.
- **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.
- **Longer/Shorter Length of Coverage** – If none of the above rules determine the order of benefits, the benefits of the plan, which covered an employee, member or *subscriber* longer, are determined before those of the plan, which covered that *participant* for the shorter period of time.

Effect on the Benefits of this Plan

When This Section Applies

This section applies when this *plan* is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of this plan may be reduced under this section.

Reduction in This Plan's Benefits

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

- The benefits that would be payable for the allowable expense under this *plan* in the absence of this COB provision; and
- The benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim 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, Part C, 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, mental 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. 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 and Part D. 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. However, Medicare may be primary for some Medicare-eligible active employees with certain medical conditions, such as End Stage Renal Disease. Consult with your local Social Security Administration office to learn what illnesses qualify for Medicare coverage prior to turning age 65.

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, 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.

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

If you decline Part B, you will have to pay a higher premium if you ever re-apply for Medicare coverage. As a 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 contact Blue Cross and Blue Shield of Texas and report you or your dependent's Medicare Health Insurance Claim (HIC) number and the effective dates of Medicare Parts A and B immediately upon enrollment. It is important to 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:

- The provider may be 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; and
- 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 \$100 per day copay (\$500 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; and
- 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.

UT SELECT
Medicare Coordination of Benefits
UT SELECT MEMBERS WITH MEDICARE PRIMARY
(typically members 65+ with retiree coverage; see page 49 for details)

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.

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 BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	20% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or <i>Copay</i> , whichever is applicable
Y	N	N	0	60% of BCBS <i>Allowed</i> after \$750 UT SELECT <i>Deductible</i>	\$750 UT SELECT <i>Deductible</i> + 40% of BCBS <i>Allowed</i> + Difference between Billed Charge and BCBS <i>Allowed</i>
N	Y	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$350 <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	\$350 UT SELECT <i>Deductible</i> and 20% <i>coinsurance</i> or <i>Copay</i> , whichever is applicable
N	N	Y	After MC Deductible is satisfied, 80% MC Limiting Charge ²	20% of allowed charges ³ after \$750 UT SELECT <i>Deductible</i>	\$750 UT SELECT <i>Deductible</i> and 40% <i>coinsurance</i>
N	Y	N	0	80% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or 100% after <i>Copay</i> , whichever is applicable	20% of BCBS <i>Allowed</i> After \$350 UT SELECT <i>Deductible</i> or <i>Copay</i> , whichever is applicable
N	N	N	0	60% of BCBS <i>Allowed</i> after \$750 UT SELECT <i>Deductible</i>	\$750 <i>Deductible</i> + 40% of BCBS <i>Allowed</i> + Difference between Billed Charge and BCBS <i>Allowed</i>

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 Blue Cross and Blue Shield allowed amount. If the Blue Cross and Blue Shield allowed amount is less, the member may be billed the difference.

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 \$100 annual deductible per plan participant, per plan year.

NOTE for Retired Employees: Effective 1/1/2017, if you are Medicare-eligible and your UT SELECT insurance is through Retired Employee coverage, your prescription drug plan is the Express Scripts Medicare (PDP) or prescription drug plan (which provides Medicare Part D benefits to UT System retirees and their eligible dependent. The Centers for Medicare and Medicaid Services (CMS) will send you prescription drug plan materials, including a new ID card.

UT SELECT PRESCRIPTION DRUG BENEFITS			
Annual Deductible (does not apply to medical plan annual deductible)	\$100/person/year		
Access Options	Generic Drug Copayment	Preferred Drug Copayment	Non-Preferred Drug Copayment
Retail Network Pharmacy: <ul style="list-style-type: none"> Up to a 31-day supply Refills allowed as prescribed Good option for new prescriptions 	\$10	\$35	\$50
Home Delivery Pharmacy: <ul style="list-style-type: none"> Up to a 90-day supply Refills allowed as prescribed Best option for maintenance medication 	\$20	\$87.50	\$125

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

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

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

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

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

Cost of Brand Name Drug	\$150
Less cost of Generic Equivalent	- \$55
Plus Cost of Generic Copayment	+ \$10
Your Payment	\$105

The 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 retail pharmacy network. If you fill a prescription at a non-network pharmacy, you will pay the full cost of your prescription and send a claim form and your receipt to Express Scripts. Your reimbursement will be based on your total cost, minus the UT System discount, the applicable annual deductible and copayment. You will be responsible for payment of any amount above the UT System contracted rate.

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

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

The best thing you can do is research your options. Prices vary by retail store. *My Rx Choices* (available at www.express-scripts.com) 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.

Diabetic Supplies

If you have a claim for insulin, syringes and diabetic supplies (except for insulin pumps) are dispensed on the same day that the insulin is processed, the copayment is waived on the syringes and diabetic supplies. If no claim for insulin is found on the same day, a separate copayment is taken for each item.

My Rx Choices

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

- View a single presentation of medications with potential savings;
- Comparison-shop for available lower-cost alternatives;
- Use the “Continue” option to have Express Scripts contact physicians on members’ behalf to request approval for equivalent conversions received through mail; and
- Review options with your doctor and request prescriptions for lower-cost alternatives.

Accessed via the web (www.express-scripts.com/ut), via the new Express Scripts app or through the toll-free service line (1-800-818-0155), *My Rx Choices* features include

- Personal assessment of cost-saving opportunities;
- Best-value alternatives based upon greatest cost savings to you presented in order from highest value to you;
- The most accurate, actionable drug pricing information available in the industry today;
- Brand-to-generic and retail-to-mail comparison options;
- Refill or renew prescriptions filled at the mail order pharmacy;
- Get the order status of your prescription filled at the mail order pharmacy;
- Locate a pharmacy that is in your retail pharmacy network;
- Easily transfer your retail prescriptions to the mail order pharmacy;
- See your full prescription history (going back up to 36 months) and
- Drug information.

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. Visit **My Rx Choices**[®] to find potential lower-cost alternatives under your plan, and ask your doctor which alternative would be right for you. For medications you need to treat an ongoing condition, such as high blood pressure or high cholesterol, you'll typically pay even less by using your mail-order service, the **Express Scripts Pharmacy**SM. All alternative options are available through **My Rx Choices**[®].

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.
- **Therapy:** Coverage under the Step Therapy Program may require that you try a generic drug or lower-cost brand-name alternative drug before using higher cost non-preferred drugs.
- **Quantity Per Dispensing Event:** A medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period or per prescription.

Consult the Express Scripts website (www.express-scripts.com/ut) 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 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

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

- Aspirin – an Over-the-Counter (OTC) product for men ages 45-79 and women age 55-79 for cardiovascular protection
- Folic Acid – Over-the-Counter doses of 400 to 800 mcg/day for women who are pregnant or who are planning to become pregnant
- Vitamin D for men and women 65 years of age and older
- Fluoride – a prescription product for children to prevent dental cavities
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Any charge related to the administration of a vaccine in a doctor's office is covered under the UT SELECT medical plan. See the summary of the medical plan for more details.
- Prescription and OTC Bowel Prep medications for colonoscopy for men and women age 49-76
- Iron Supplements – an OTC product to treat/prevent anemia
- Tobacco Cessation Products

- Nicotrol NS
- Nicotrol Inhaler
- Zyban
- Chantix
- Nicorette Gum/Lozenge
- Nicotine Transdermal System
- Female contraceptives for women up to age 50
 - Prescription FDA-approved contraceptive agents (includes prescription IUDs—Mirena, Depo-Provera, patches, and oral agents)
 - Emergency contraceptives (Plan B and Ella)
 - OTC contraceptive devices and medications

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

For more specific information regarding coverage options and limitations, please contact Express Scripts customer service.

Personalized Medicine Program

Your prescription drug coverage includes the Personalized Medicine Program, which is a program that incorporates genetic testing to optimize prescription drug therapies for certain conditions. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available and are included in the program. The most up-to-date information on the conditions and drugs covered by the program can be accessed online at www.express-scripts.com/ut or by calling an Express Scripts customer service representative at **1-800-818-0155**. If you are a qualified participant, additional services are available to you through the Personalized Medicine Program at no additional cost.

Process description: Upon receipt of a prescription that has an associated genetic test, Express Scripts will contact your physician to request a prescription for that test. If your physician prescribes the test, the clinical laboratory will facilitate sending you the test. You mail back the test to the laboratory for processing. The laboratory shares the results of the test with your physician and Express Scripts. The results of the genetic test are for informational purposes only; any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and if you decide to participate, Express Scripts will facilitate your coverage under the Program.

Specialty Pharmacy (Accredo)

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

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

Accredo focuses on infused, injectable, and oral specialty drugs that are used to treat complex conditions. They are typically very expensive and often have restrictions as determined by the FDA. These specialty drugs may be difficult to self-administer, have a potential for adverse reactions, and require temperature control or other specialized handling.

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.

You can obtain most drugs designated by Express Scripts as specialty drugs using either your retail or mail order benefit. The following drugs are only available via the Express Scripts specialty pharmacy or UT campus pharmacies: Specialty Oral Cancer Medications and Medications used to treat Hepatitis C. You will be responsible for paying the corresponding mail order or retail pharmacy copayment. If you choose to receive specialty drugs from a mail order pharmacy, you must use Accredo as your pharmacy. The exception to this would be for certain products that are available through only one or two U.S. pharmacies. For those products, you will be directed to a pharmacy that can fill your prescription.

Worry-free Fills

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

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

Gaps in Care Alerts

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

After your one-time registration, any alerts will automatically be waiting for you whenever you log in to [Express Scripts.com/ut](https://www.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.

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

You can take advantage of this new online safety feature today by registering at [Express Scripts.com/ut](https://www.express-scripts.com/ut). You will need your prescription drug ID card and a recent prescription number. If you are already registered on [Express Scripts.com/ut](https://www.express-scripts.com/ut), your new online safety feature is already activated and your protection is working.

Prescription Drug Claims and Appeals

(For Medical Claims and Appeals Procedures, see page 37.)

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 (Expedited Review)

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

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 666588, St. Louis, MO 63166-65887. Phone: 800-753-2851 Fax: 888-235-8551**

Non-Urgent External Review

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

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

Urgent External Review

Once you have submitted your urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the 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; or
- 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 waived.

The *plan* defines a dependent as:

- Your spouse;
- Your children, including stepchildren and adopted children, who are under age 26 regardless of marital status for the UT SELECT Medical plan,
- Your unmarried grandchild(ren) under age 25, provided the child meets the requirements which includes proof that you claim the child as your dependent for federal tax purposes;
- Certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and
- Children for whom you are named a legal guardian by a court or who are the subject of a medical support order requiring such coverage.

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 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.

Changes in Your Status

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

Examples of qualified change of status events include:

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

Your benefit selection changes must be consistent with your change in status.

An employee or retired employee...

- Whose dependent loses insurance coverage under the Medicaid or CHIP program as a result of loss of eligibility of either the employee or the dependent; or
- Whose dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll this dependent in UT 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 coverage 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

These definitions apply to all UT SELECT benefits unless specifically limited.

Allowable Amount: The allowable amount is the maximum amount that will be paid by UT SELECT for a medical service or supply. The allowable amount is determined by Blue Cross and Blue Shield of Texas and is based on either charges made for the same service by providers in the same geographic area with similar training, experience and facilities, or negotiated rates with providers who have contracted with Blue Cross and Blue Shield of Texas. See page 11 for additional information.

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

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or

Sublingual provocative testing (droplets of allergenic extracts are placed in mouth). **UT SELECT does not provide coverage for clinical ecology; the definition is included for clarification purposes only.**

Coinsurance: A participant's share of covered services and supplies, not counting the deductible or copays. It is usually a percentage of the allowable amount. For example, if the coinsurance amount is "80/20" that means that UT SELECT pays 80% and you pay 20% of the allowable amount for the eligible charges.

Copayment (Copay): The set amount you pay for certain medical services and prescription drugs at the time of service. The \$30 amount a participant must pay for an FCP office visit when using network physicians is an example of a copay amount.

Creditable Coverage: Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid.

Crisis Stabilization Unit: An institution which is appropriately licensed and accredited as a crisis stabilization unit or facility for the provision of mental health care services to persons who are demonstrating an acute, demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care: Services and supplies, including room and board and other institutional services, provided primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. Custodial care is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a person walk, bathe, dress, eat, prepare special diets, and take medication. **UT SELECT does not provide coverage for custodial care; the definition is included for clarification purposes only.**

Deductible: The amount of out-of-pocket expense that must be paid for health care services by the covered individual before becoming payable by UT SELECT. The family deductible means three individuals in the family must each meet a plan year deductible under one UT SELECT subscriber identification number.

Dental Care Services: The professionally recognized dental services, supplies, or appliances which are provided to a participant by a physician or provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental care services include, but are not limited to, cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium process of the maxilla and the mandible. **UT SELECT does not provide coverage for dental services; the definition is included for clarification purposes only.**

Effective Date: The date the participant's coverage begins under UT SELECT or any portion for which the participant has enrolled.

Eligibility Date: The date the participant satisfies the definition of a(n) employee, retiree, or dependent and is in a class eligible for coverage under UT SELECT.

Emergency: An emergency is the sudden 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, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

UT SELECT covers medical emergencies wherever they occur. In case of emergency, call 911 or go to the nearest emergency room.

Environmental Sensitivity: The inpatient or outpatient treatment of allergic symptoms by controlled environment; or sanitizing the surroundings, removal of toxic materials; or use of special non-organic, non-repetitive diet techniques. **UT SELECT does not provide coverage for environmental sensitivity; the definition is included for clarification purposes only.**

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

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

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or facility in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of Blue Cross and Blue Shield of Texas shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is experimental/investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a physician or other professional provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, Blue Cross and Blue Shield of Texas 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, except as referenced in the clinical trial section of this Benefits Booklet.

Extended Care Expense: Means the services and supplies provided by a skilled nursing facility, a home health agency or a hospice.

Facility Other Provider: Is licensed to provide services and supplies that are covered by UT SELECT and is approved by Blue Cross and Blue Shield of Texas, including:

- Birthing Center
- Chemical Dependency Treatment Center
- Crisis Stabilization Unit or Facility
- Durable Medical Equipment Provider
- Home Health Agency
- Home Infusion Therapy Provider
- Hospice
- Imaging Center
- Independent Laboratory
- Prosthetics/Orthotics Provider
- Psychiatric Day Treatment Facility
- Radiation Therapy Center
- Renal Dialysis Center
- Residential Treatment Center for Children and Adolescents
- Rural Health Clinic
- Skilled Nursing Facility
- Therapeutic Center

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.

Hospital: A short-term acute care facility which:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from its patients
- Has organized departments of medicine and major surgery and maintains clinical records on all patients
- Provides 24-hour nursing services by or under the supervision of a registered nurse
- Has a hospital utilization review plan, and
- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

Hospital Admission: The period between entry into a hospital as a bed patient and the time of discharge. If a patient is admitted to and discharged from a hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time confined in the hospital, the admission shall be considered a hospital admission. *Bed patient* means confinement 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 designed, staffed and operated to provide long-term institutional care on a residential basis.

Marriage and Family Therapy: Includes 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.

Medicare Limiting Charge: This is the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Out-of-Pocket Maximum: Your share of eligible expenses incurred during a plan year. After you reach the out-of-pocket maximum, UT SELECT pays 100% of the allowable amount for covered charges for the rest of the plan year.

Preauthorization penalties and billed charges exceeding the Blue Cross and Blue Shield of Texas allowable amount do not apply to the out-of-pocket maximum.

Participant: An employee, or retiree or a dependent whose coverage has become effective according to the requirements of UT SELECT.

Plan: UT SELECT

Plan Service Area: Means the geographical area designated by UT System that is used to determine eligibility for UT SELECT benefits.

Plan Year: The plan year for UT SELECT begins September 1 and ends August 31.

Psychiatric Day Treatment Facility: An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to participants for time periods not to exceed eight hours in any 24-hour period. Treatment must be in lieu of hospitalization and certified in writing by the attending physician.

Residential Treatment Center for Children and Adolescents: An institution appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children and/or is approved by Blue Cross and Blue Shield of Texas as a residential treatment center for certain mental health care and serious mental illness services for emotionally disturbed children and adolescents.

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.

Telemedicine: The use of interactive audio, video or other electronic media (excluding telephone or fax machines) to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Therapeutic Center: Means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is an ambulatory (day) surgery facility; a freestanding radiation therapy center; or a freestanding birthing center.

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

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

The exemption from these federal requirements will be in effect for the 2012-2013 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 Policies and Forms*](#) page on the Office of Employee Benefits’ website, <http://www.utsystem.edu/offices/employee-benefits/hipaa-and-privacy>. A paper copy of the privacy notice is available to anyone upon request from OEB.

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

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

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

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

Continuation of Group Coverage

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

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

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

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

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

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

1. Death of the employee;
2. Divorce or legal separation from the employee;
3. Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without group health coverage);
or
4. Children who lose coverage due to eligibility provisions (for example: reaching age 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:
 - a. The maximum time period expires;
 - b. A continued participant obtains coverage after the date of election under any other group health Plan (as an employee or otherwise) which does not contain an applicable exclusion for any Preexisting Condition of the participant;
 - c. A continued participant becomes covered by any Medicare benefits after the date of election;
 - d. The employer no longer provides group health coverage for employees; or
 - e. The required payment to continue coverage is not made on a timely basis.

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

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

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

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

Discrimination is Against the Law

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 Office of Employee Services, 210 W. 6th Street, Suite B.140E, Austin, Texas 78701, (512) 499-4587, (512) 499-4395, esa@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 Employee Services 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 <http://www.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)
UT SELECT Dental 1-800-893-3582
UT FLEX 1-844-887-3539

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
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)
UT SELECT Dental 1-800-893-3582
UT FLEX 1-844-887-3539

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
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)
UT SELECT Dental 1-800-893-3582
UT FLEX 1-844-887-3539

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)
UT SELECT Dental 1-800-893-3582
UT FLEX 1-844-887-3539 번으로 전화해 주십시오.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Tagalog

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

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

French

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

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

पर कॉल करें।

Persian (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

تماس بگیرید.

German

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

Rufnummer: 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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Gujarati

Gujarati: ધ્યાન આપો: જો તમે ગજરાતી ુબોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નનિ: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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

પર કોલ કરો

Russian

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

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Japanese

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

まで、お電話にてご連絡ください。

Laotian

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສີຍຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທຮ

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)

UT SELECT Dental 1-800-893-3582

UT FLEX 1-844-887-3539

Claims Address

Blue Cross and Blue Shield of Texas

P.O. Box 660044

Dallas, TX 75266-0044

Customer Service

866-882-2034

8 a.m. to 6 p.m. (CT)

Monday–Friday

Online Provider Directory and Website

bcbstx.com/ut



APPENDIX C

Dataset Layouts

Benefit Enrollment and Maintenance Transaction Set (ASC X12N 834) can be found at:

<https://www.utsystem.edu/sites/utsfiles/offices/employee-benefits/docs/X095.pdf>,

with addenda at:

<https://www.utsystem.edu/sites/utsfiles/offices/employee-benefits/docs/X095A1.pdf>.

Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction Set (ASC X12N 820) can be found at:

<https://www.utsystem.edu/sites/utsfiles/offices/employee-benefits/docs/X061.pdf>,

with addenda at:

<https://www.utsystem.edu/sites/utsfiles/offices/employee-benefits/docs/X061A1.pdf>.

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE H. HEALTH BENEFITS AND OTHER COVERAGES FOR GOVERNMENTAL
EMPLOYEES

CHAPTER 1601. UNIFORM INSURANCE BENEFITS ACT FOR EMPLOYEES OF THE
UNIVERSITY OF TEXAS SYSTEM AND THE TEXAS A&M UNIVERSITY SYSTEM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1601.001. SHORT TITLE. This chapter may be cited as the State University Employees Uniform Insurance Benefits Act. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.002. PURPOSES. The purposes of this chapter are to:

(1) provide uniformity in the basic group life, accident, and health benefit coverages for all system employees;

(2) enable the systems to attract and retain competent and able employees by providing employees with basic life, accident, and health benefit coverages comparable to those commonly provided in private industry and to employees of a state agency other than a system, including a public college or university whose employees are covered under Chapter 1551;

(3) foster, promote, and encourage employment by and service to the systems as a career profession for individuals of high standards of competence and ability;

(4) recognize and protect the investment of the systems in each employee by promoting and preserving economic security and good health among employees;

(5) foster and develop high standards of employer-employee relationships between the systems and their employees; and

(6) recognize the long and faithful service and dedication of employees and encourage them to remain in service until eligible for retirement by providing health benefits and other group benefits for them.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.003. GENERAL DEFINITIONS. In this chapter:

(1) "Administering carrier" means a carrier or organization that is:

(A) qualified to engage in business in this state; and

(B) designated by a system to administer services, benefits, insurance coverages, or requirements in accordance with this chapter.

(2) "Basic coverage" means coverage, including health benefit coverage, that meets the basic coverage standards required under Section 1601.053(a)(1).

(3) "Cafeteria plan" means a plan defined and authorized by Section 125, Internal Revenue Code of 1986.

(4) "Group life, accident, or health benefit plan" means a group agreement, policy, contract, or arrangement provided by an administering carrier, including:

(A) a group insurance policy or contract;

(B) a life, accident, medical, dental, or hospital service agreement;

(C) a membership or subscription contract; or

(D) any other similar group arrangement.

(5) "Optional coverage" means group coverage other than the basic coverage.

(6) "Service" means personal service to a system for which an employee is credited in accordance with rules adopted by the system.

(7) "System" means The University of Texas System or The Texas A&M University System.

(8) "The Texas A&M University System" means the entities governed under Chapters 85 through 88, Education Code, including the Texas Veterinary Diagnostic Laboratory.

(9) "The University of Texas System" means the entities listed or described by Section 65.02, Education Code.

(10) "Uniform program" means an employees uniform insurance benefits program provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.004. DEFINITION OF DEPENDENT. (a) In this chapter, "dependent," with respect to an individual eligible to participate in the uniform program under Section 1601.101 or 1601.102, means the individual's:

- (1) spouse;
- (2) unmarried child younger than 25 years of age; and
- (3) child of any age who lives with or has the child's care provided by the individual on a regular basis if the child is mentally retarded or physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the system.

(b) In this section:

- (1) "Child" includes:
 - (A) an adopted child; and
 - (B) a stepchild, foster child, or other child who is in a parent-child relationship with an individual who is eligible to participate in the uniform program under Section 1601.101 or 1601.102.

(2) "Spouse" has the meaning assigned by the Family Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.005. DEFINITION OF CARRIER. In this chapter, "carrier" means:

(1) an insurance company that is authorized by the department to provide under this code any of the types of insurance coverages, benefits, or services provided for in this chapter, and that:

- (A) has an adequate surplus;
- (B) has a successful operating history; and
- (C) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter;

(2) a corporation operating under Chapter 842 that provides any of the types of coverage, benefits, or services provided for in this chapter and that:

(A) has a successful operating history; and

(B) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter; or

(3) any combination of carriers described by Subdivisions (1) and (2) on terms the system prescribes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.006. APPLICABILITY OF DEFINITIONS. The definition of a term defined by this subchapter and the use of the terms "employee" and "retired employee" as described by Sections 1601.101 and 1601.102 apply to this chapter unless a different meaning is plainly required by the context in which the term appears.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.007. SYSTEM MAY DEFINE OTHER WORDS. A system may define by rule a word or term necessary in the administration of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.008. EXEMPTION FROM EXECUTION. All insurance benefits and other payments and transactions made under this chapter to a participant under this chapter are exempt from execution, attachment, garnishment, or any other process.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.009. EXEMPTION FROM TAXATION AND FEES. Premiums on a policy, an insurance contract, or an agreement established under this chapter with a health maintenance organization are not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.010. CERTAIN COMBINING OF CARRIERS NOT RESTRAINT OF TRADE. Carriers combining to bid, underwrite, or both bid and underwrite, a group life, accident, or health benefit plan for the

uniform program are not in violation of Chapter 15, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.011. PARTICIPATION OF THE TEXAS A&M UNIVERSITY SYSTEM. Notwithstanding any other provision of this chapter, if The Texas A&M University System elects to participate in the group benefits program under Section 1551.006(c), that system, including the Texas Veterinary Medical Diagnostic Laboratory, does not participate in a uniform program established under this chapter, effective on the date participation in the group benefits program under Chapter 1551 begins.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.01, eff. Sept. 1, 2003.

SUBCHAPTER B. ADMINISTRATION AND IMPLEMENTATION

Sec. 1601.051. ADMINISTRATION AND IMPLEMENTATION. A system shall:

- (1) implement a uniform program for the benefit of its employees and retired employees; and
- (2) determine basic procedural and administrative practices for insurance coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.052. RULEMAKING AUTHORITY. A system shall adopt rules consistent with this chapter as it considers necessary to implement this chapter and its purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.053. GENERAL DUTIES RELATING TO COVERAGE. (a) A system shall:

- (1) determine basic coverage standards that must be comparable to those commonly provided:
 - (A) in private industry; and
 - (B) to employees of another agency or an institution of higher education in this state under Chapter 1551;

and

(2) establish procedures to allow each covered employee and retired employee to obtain prompt action regarding claims pertaining to coverages provided under this chapter.

(b) In designing a coverage plan, a system may consider existing local conditions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.054. COMPETITIVE BIDDING REQUIRED. A system shall submit the uniform program, including any agreement under which a carrier is engaged to administer a self-insured program, for competitive bidding at least every six years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.055. IDENTIFICATION OF ADMINISTRATIVE COSTS IN BIDS. A system shall include in its respective bid documents for the various coverages a provision calling for each bidder to identify the system's administrative costs as a distinguishable figure and to enumerate the services the bidder will render in exchange for the administrative costs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.056. INFORMATION ON BIDDERS AND BIDDING CONTRACTS. (a) The department shall, on request by a system, provide a list of all carriers:

(1) authorized to engage in business in this state;
and

(2) eligible to bid on insurance coverage provided under this chapter.

(b) The department shall, on request by a system, examine and evaluate a bidding contract and certify the contract's actuarial soundness to the system not later than the 15th day after the date of the request.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.057. SELECTION OF BIDS. (a) A system is not required to select the lowest bid under Section [1601.054](#) but shall

take into consideration other relevant criteria, such as ability to service contracts, past experience, and financial stability.

(b) If a system selects a carrier whose bid differs from that advertised, the governing board of the system shall fully justify and record the reasons for the deviation in the minutes of the next meeting of the governing board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.058. SELECTION OF HEALTH MAINTENANCE ORGANIZATIONS. A system shall select and contract for services performed by health maintenance organizations that are approved by this state to offer health care services in specific areas of the state to eligible employees and retired employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.059. CERTIFICATE OF COVERAGE. A system shall ensure that each employee and retired employee participating under this chapter is issued a certificate of coverage that states:

- (1) the benefits to which the participant is entitled;
- (2) to whom the benefits are payable;
- (3) to whom a claim must be submitted; and
- (4) the provisions of the plan document, in summary form, that principally affect the participant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.060. ACCOUNTING BY CARRIER PROVIDING PURCHASED COVERAGE. (a) A carrier providing coverage purchased under this chapter to a system shall provide an accounting for each line of coverage to the system not later than the 120th day after the end of each plan year.

(b) The accounting must be in a form acceptable to the system.

(c) The accounting for each line of coverage must state:

(1) the cumulative amount of contributions remitted to the carrier under the coverage;

(2) the total of all mortality and other claims, charges, losses, costs, contingency reserve for pending and

unreported claims, and expenses incurred; and

(3) the amounts of the allowance for a reasonable profit, contingency reserve, and all other administrative charges.

(d) Information provided under Subsection (c) must be provided:

(1) for the period from the coverage's date of issue to the end of the plan year; and

(2) for the plan year covered by the report.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.061. SPECIAL RESERVE. (a) A carrier issuing a group coverage plan under this chapter may hold as a special reserve for a system an amount that equals the amount by which the total amount described by Section 1601.060(c)(1) exceeds the sum of the corresponding amounts described by Sections 1601.060(c)(2) and (3).

(b) The system may use money in the special reserve at its discretion, including for:

(1) providing additional coverage for participating employees or retired employees;

(2) offsetting necessary rate increases; or

(3) reducing contributions to the coverage by participating employees or retired employees.

(c) A special reserve held by a carrier for a system earns interest at a rate determined each plan year by the carrier and approved by the system as consistent with the rate generally used by the carrier for similar funds held under other group coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.062. REPORTS AND RECORDS BY ADMINISTERING CARRIER. Each contract entered into under this chapter between a system and an administering carrier must:

(1) require the administering carrier to provide reasonable reports that the system determines are necessary for the system to perform its functions under this chapter; and

(2) permit the system and representatives of the state auditor to examine records of the administering carrier as

necessary to accomplish the purposes of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.063. ASSISTANCE IN REQUESTING MONEY. The Legislative Budget Board and the Governor's Budget and Planning Office shall:

- (1) establish procedures to ensure that each system requests appropriate money to support its uniform program; and
- (2) present appropriate budget recommendations to the legislature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.064. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, a system is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the system is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the system and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the system concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the system, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to

return recovered overpayments to the system.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the system in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 8, eff. September 1, 2009.

SUBCHAPTER C. COVERAGE AND PARTICIPATION

Sec. 1601.101. PARTICIPATION ELIGIBILITY: EMPLOYEES. (a) An individual who is employed by the governing board of a system, who performs service, other than as an independent contractor, for the system, and who is described by this section is eligible to participate as an employee in the uniform program on the date specified by Section 1601.1045.

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual receives compensation for services performed for the system, is eligible to be a member of the Teacher Retirement System of Texas, and either:

(1) is expected to work at least 20 hours per week and to continue in the employment for a term of at least 4-1/2 months; or

(2) is appointed for at least 50 percent of a standard full-time appointment.

(c) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual:

(1) receives compensation for services performed for the system;

(2) is employed at least 20 hours a week; and

(3) is not permitted to be a member of the Teacher Retirement System of Texas because the individual is solely employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate-level courses.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1198, Sec. 5, eff. January 1, 2012.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.
Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.02, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1266, Sec. 2.11, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 14.002, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 5, eff. January 1, 2012.

Sec. 1601.102. PARTICIPATION ELIGIBILITY: RETIREES. (a) An individual who retires in a manner described by this section and who meets the requirements of Subsection (f) is eligible to participate, subject to Section 1601.1045, as a retired employee in the uniform program.

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least 10 years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(c) An individual retiring in the manner described by Subsection (b)(3)(C) is a retired employee only if the individual meets all applicable requirements for retirement, including service and age requirements, adopted by the system comparable to the requirements for retirement under the Teachers Retirement

System of Texas.

(d) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual:

(1) meets the minimum requirements under Subsection (b) except that the last state employment before retirement is not at the employing system; and

(2) does not meet the requirements for an annuitant under Section [1551.102](#).

(e) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual retired under Subtitle C, Title 8, Government Code, before September 1, 1991, with at least five and less than 10 years of service.

Text of subsec. (f) as added by Acts 2003, 78th Leg., ch. 366, Sec.

4.03

(f) Notwithstanding Subsections (b)-(d), an individual is eligible to participate in the uniform program only if the individual:

(1) has at least 10 years of service credit and the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(2) is at least 65 years old and has at least 10 years of service credit.

Text of subsec. (f) as added by Acts 2003, 78th Leg., ch. 1266, Sec.

2.08

(f) Notwithstanding Subsection (b), an individual to whom this subsection applies is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section [1601.101](#);

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

Text of subsec. (g) as added by Acts 2003, 78th Leg., ch. 366, Sec.

4.03

(g) A person eligible to participate and participating in the uniform program as an annuitant on September 1, 2003, may continue to participate in the program as an annuitant if a lapse in coverage has not occurred.

Text of subsec. (g) as added by Acts 2003, 78th Leg., ch. 1266, Sec.

2.08

(g) Subsection (f) applies only to a person who, on August 31, 2003:

(1) was eligible to participate in the uniform program as an employee under Section 1601.101; or

(2) was eligible to participate in the uniform program as a retired employee under this section as this section existed on January 1, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.03, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1266, Sec. 2.08, eff. June 20, 2003.

Sec. 1601.1021. PARTICIPATION ELIGIBILITY: CERTAIN POSTDOCTORAL FELLOWS AND GRADUATE STUDENTS. (a) An individual who is not eligible to participate in the uniform program under Section 1601.101 is eligible to participate in the uniform program under

this section if the individual, at an institution in a system:

(1) holds:

(A) a postdoctoral fellowship; or

(B) one or more graduate student fellowships awarded to the individual on a competitive basis that, either singly or in combination, are valued at not less than \$10,000 per year; and

(2) is currently receiving a stipend from an applicable fellowship.

(b) An individual who is eligible to participate in the uniform program under this section shall pay all contributions required under this chapter for the coverage selected by the individual, except that an institution of higher education may make contributions for the individual from available funds other than money appropriated to the institution from the general revenue fund.

(c) An institution of higher education shall determine which individuals are eligible to participate in the uniform program under this section and, at the time of initial eligibility, shall notify each individual of the individual's eligibility to participate in the program.

(d) An individual who participates in the uniform program under this section is not considered an employee of an institution of higher education solely as a result of the individual's participation in the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 3, eff. September 1, 2011.

Sec. 1601.103. RIGHT TO COVERAGE. An individual eligible to participate in the uniform program under Section 1601.101 or 1601.102 may not be denied enrollment in any coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.104. AUTOMATIC COVERAGE. (a) A system shall automatically provide the basic coverage to each full-time employee unless the employee has:

- (1) waived participation in the basic coverage; or
- (2) selected an optional coverage plan.

(b) An employee or retired employee who is automatically covered under this section may subsequently:

(1) retain the basic coverage or waive participation in the basic coverage; and

(2) apply for any other coverage provided under this chapter within applicable standards.

(c) Automatic coverage as described under this section begins on the first date of employment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.1045. DATE ELIGIBILITY BEGINS; WAITING PERIOD.

(a) Except as provided by Subsection (c), (d), or (e), eligibility under Section 1601.101 begins on the first day of the calendar month that begins after the 90th day after the date the employee performs services for a system.

(b) Except as provided by Subsection (c), eligibility under Section 1601.102, for an individual who does not retire at the end of the last month for which the individual is on the payroll of a system before retirement, begins on the first day of the calendar month that begins after the 90th day after the date the individual retires.

(c) The waiting period established by Subsections (a) and (b) applies only to the determination of initial eligibility to participate in the group health benefits program and does not apply to the determination of initial eligibility to participate in optional coverages under the uniform program.

(d) Notwithstanding Subsection (a), eligibility under Section 1601.101 may not begin earlier than the first day that an employee performs services for a system if any amount paid for premium incurred before the date specified under Subsection (a) for the employee and any dependents of the employee is paid from money not appropriated from the general revenue fund, in accordance with policies and procedures established by the system.

(e) Eligibility under Section 1601.101 for an employee reemployed under Chapter 613, Government Code, begins on the first

day of reemployment on which the employee performs services for a system.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.05, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 150 (H.B. 437), Sec. 2, eff. September 1, 2015.

Sec. 1601.105. WAIVER. An employee or retired employee may waive in writing any coverage provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.106. OPTIONAL COVERAGE. A system shall provide optional coverage in accordance with Section 1601.201.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.107. COVERAGE FOR DEPENDENTS. An individual who is eligible to participate in the uniform program under Section 1601.101, 1601.102, or 1601.1021 is entitled to secure for a dependent of the individual any group coverages provided under this chapter for dependents under rules adopted by the applicable system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 4, eff. September 1, 2011.

Sec. 1601.108. COVERAGE OPTIONS FOR CERTAIN SURVIVING SPOUSES. (a) This section applies only to the surviving spouse of:

(1) an individual eligible to participate in the uniform program under Section 1601.101 who had at least five years of service on the date of the individual's death, including at least three years of service as an eligible employee with the employing system; or

(2) an individual eligible to participate in the uniform program under Section 1601.102.

(b) A surviving spouse to whom this section applies may

elect to retain any of the following coverages in effect on the date of the participant's death:

- (1) the surviving spouse's authorized coverages; and
- (2) authorized coverages for any eligible dependent of the deceased participant.

(c) The coverage is at the group rate for other participants.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.109. COVERAGE FOR AIDS, HIV, OR SERIOUS MENTAL ILLNESS. (a) In this section, "serious mental illness" has the meaning assigned by Section [1355.001](#).

(b) A system may not contract for or provide for group insurance or HMO coverage or provide self-insured coverage, that:

(1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service, or human immunodeficiency virus infection; or

(2) provides coverage for serious mental illness that is less extensive than the coverage provided for any other physical illness.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.020, eff. April 1, 2009.

Sec. 1601.110. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the governing board of a system identifies populations requiring disease management.

(b) A health benefit plan provided under this chapter must provide disease management services or coverage for disease management services in the manner required by the governing board of a system, including:

- (1) patient self-management education;
 - (2) provider education;
 - (3) evidence-based models and minimum standards of care;
 - (4) standardized protocols and participation criteria; and
 - (5) physician-directed or physician-supervised care.
- Added by Acts 2003, 78th Leg., ch. 589, Sec. 5, eff. June 20, 2003.

Sec. 1601.111. PROGRAMS PROMOTING DISEASE PREVENTION, WELLNESS, AND HEALTH. A system may establish premium discounts, surcharges, rebates, or a revision in otherwise applicable copayments, coinsurance, or deductibles, or any combination of those incentives, for an individual who participates in system-approved programs promoting disease prevention, wellness, and health.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.02, eff. June 17, 2011.

SUBCHAPTER D. GROUP COVERAGES

Sec. 1601.151. AUTHORITY TO SELF-INSURE; EXEMPTION FROM OTHER INSURANCE LAWS. (a) Notwithstanding any other provisions of this chapter, the governing board of a system may:

- (1) self-insure a plan provided under this chapter; and
- (2) hire a carrier to administer the system's uniform program.

(b) A plan for which a system provides coverage on a self-insured basis is exempt from any other insurance law of this state that does not expressly apply to that plan or this chapter.

(c) Expenses for the administration of a self-insured plan may come from the contributions of employees and the state after payments for any coverage provided under this chapter have been made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.152. CAFETERIA PLAN. (a) The governing board of a system may develop, implement, and administer a cafeteria plan.

(b) The governing board may include in the cafeteria plan any benefit that may be included in a cafeteria plan under federal law.

(c) The governing board may cooperate and work with and enter into a necessary contract or agreement with an independent and qualified agency, person, or entity to:

(1) develop, implement, or administer a cafeteria plan; or

(2) assist in those activities.

(d) The governing board may adopt an order terminating the cafeteria plan and providing a procedure for the orderly withdrawal of the system and its employees from the cafeteria plan if the governing board determines that a cafeteria plan adopted under this section is no longer advantageous to the system and its employees. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.153. SYSTEMS MAY JOIN IN PROCURING INSURANCE. The systems may join together to procure one or more group contracts with an insurance company authorized to engage in business in this state to insure the employees and retired employees of each participating system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.154. LONG-TERM CARE COVERAGE. (a) A system may join with a board of trustees that administers the uniform program established under Chapter 1551 or the group program established under Chapter 1575 to provide long-term care insurance coverage.

(b) Each participating board of trustees and the governing board of the system must mutually agree to join together for this purpose, subject to terms that are beneficial to all participants.

(c) A system may not participate in an agreement under this section unless any cost or administrative burden associated with the development or implementation of or communications about the long-term care coverage plan is incidental.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.155. REINSURANCE. A system may arrange with an administering carrier issuing a policy under this chapter for the reinsurance of portions of the total amount of insurance under the policy with other carriers that elect to participate in the reinsurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER E. PAYMENTS, CONTRIBUTIONS, AND COSTS

Sec. 1601.201. PAYMENT FOR COVERAGE. (a) A system may not contribute more than the amounts specified by this section for coverages provided under the uniform program.

(b) For an employee designated by the system as working 40 or more hours a week, the system may contribute:

- (1) the full cost of basic coverage for the employee; and
- (2) not more than 50 percent of the cost of dependent coverage.

(c) For an employee designated by the system as working less than 40 hours a week, including an individual employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate-level courses, the system, from money appropriated from the general revenue fund, may contribute:

- (1) not more than 50 percent of the cost of basic coverage for the employee; and
- (2) not more than 25 percent of the cost of dependent coverage.

(d) Subsection (c) does not prohibit a system from contributing, from money not appropriated from the general revenue fund, amounts in excess of the amount specified by that subsection for:

- (1) an individual employed by the system in a position that as a condition of employment requires the individual to be enrolled as a student in the system in graduate level courses; or
- (2) an individual who is a tenured faculty member with

whom the system has entered into a phased retirement agreement under which the individual will work less than 40 hours a week for a specified period of time at the end of which the individual will retire.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 366, Sec. 4.06, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.03, eff. June 17, 2011.

Sec. 1601.202. FEES FOR CAFETERIA PLAN. (a) The governing board of a system may establish a monthly fee in an amount set by the board to be paid by each employee who elects to participate in a cafeteria plan for the purpose of paying the expenses of administering the cafeteria plan.

(b) If the governing board establishes a monthly fee, each employee who participates in the cafeteria plan must authorize payment of the fee by executing a separate payroll deduction agreement or as part of a salary reduction agreement, as determined by the governing board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.203. PAYMENT FOR COVERAGE FOR DEPENDENTS. Contributions for coverages for a dependent of an individual eligible to participate in the uniform program under Section 1601.101 or 1601.102 required of the participant that exceed the amount of system contributions shall be paid:

(1) by a deduction from the monthly compensation of the participant;

(2) by a reduction of the monthly compensation of the participant in the appropriate amount; or

(3) in the form and manner the system determines.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.204. AUTHORIZATION OF EMPLOYEE DEDUCTION. (a) Except for a participant who participates in a cafeteria plan, each

individual eligible to participate in the uniform program under Section 1601.101 must authorize a deduction from the participant's monthly compensation in an amount equal to the difference between:

(1) the total cost for coverages for which the participant applies; and

(2) the amount contributed by the system.

(b) The authorization must be:

(1) in writing or performed electronically; and

(2) in a form satisfactory to the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.2041. EMPLOYEE DEDUCTION FOR AUTOMATIC COVERAGE. Each individual automatically enrolled in a uniform program under Section 1601.104 is considered to have authorized a deduction from the participant's monthly compensation in an amount equal to the difference between:

(1) the total cost of the employee's basic coverage; and

(2) the amount contributed by the system for the employee's basic coverage.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1049 (S.B. 5), Sec. 3.04, eff. June 17, 2011.

Sec. 1601.205. EMPLOYEE PAYMENTS FOR PARTICIPATION IN CAFETERIA PLAN. (a) If an employee elects to participate in a cafeteria plan, the employee must execute a salary reduction agreement under which the employee's monthly compensation will be reduced in an amount equal to the difference between:

(1) the amount appropriated for that purpose in the General Appropriations Act or the system's budget; and

(2) the cost of the employee's selected coverages for which the employee is eligible to pay under the cafeteria plan.

(b) The employee must execute a salary reduction agreement for any portion of the cost that is not covered by state or system appropriations and cafeteria plan contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.206. PAYMENT BY RETIRED EMPLOYEE. An individual eligible to participate in the uniform program under Section 1601.102 must execute an agreement and make appropriate contributions in a manner analogous to the requirements adopted under Sections 1601.204 and 1601.205 for an individual eligible to participate in the uniform program under Section 1601.101.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.207. SYSTEM CONTRIBUTIONS. A system shall contribute monthly to the cost of each participant's coverage provided under this chapter an amount:

(1) if the participants are compensated from amounts appropriated in the General Appropriations Act, equal to or greater than the amount appropriated for that purpose in the Act; or

(2) if the participants are compensated from amounts appropriated by the governing board of the system in its official operating budget, an amount equal to the amount appropriated for a participant under the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.208. AMOUNT OF SYSTEM CONTRIBUTION. Not later than November 1 preceding each regular session of the legislature, each system shall certify to the Legislative Budget Board and the budget division of the Governor's Budget and Planning Office the amount necessary to pay the contributions of the system for the coverages provided under this chapter to each employee and retired employee of the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.209. ORDER OF PRECEDENCE OF PAYMENT TO SURVIVORS.

(a) The amount of group life coverages and group accidental death and dismemberment coverages in force for a participant on the date the participant dies shall be paid, on the establishment of a valid claim, to a person surviving the death in the following order of precedence:

(1) to the beneficiary designated by the participant in a signed and witnessed writing received before death by the

appropriate office of the applicable system; or

(2) if a beneficiary is not designated under Subdivision (1), in accordance with the death benefit provisions of Subtitle C, Title 8, Government Code.

(b) For purposes of Subsection (a)(1), a designation, change, or cancellation of a beneficiary in a document, including a will, that is not executed and filed in the manner described by that subsection is not valid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.210. PROVISION OF NECESSARY INFORMATION. The Teacher Retirement System of Texas, Optional Retirement Program carriers, and Employees Retirement System of Texas shall provide to each system information the system considers necessary to provide retired employees with the coverages and system contributions provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER F. CAFETERIA PLAN FUND

Sec. 1601.251. SYSTEM CAFETERIA PLAN FUND. (a) The governing board of each system may establish and administer a cafeteria plan fund.

(b) The following shall be credited to the cafeteria plan fund of a system:

(1) salary reduction payments for benefits included in a cafeteria plan adopted under this chapter, other than group coverage plans under the uniform program;

(2) appropriations by the state for the administration of a cafeteria plan; and

(3) a monthly fee established under Section [1601.202](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.252. USE OF FUND. The cafeteria plan fund of a system is available without fiscal year limitation:

(1) for all payments for any benefits included in a cafeteria plan adopted by the system under this chapter other than

group coverage plans under the uniform program; and

(2) for payment of expenses of administering the cafeteria plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.253. INVESTMENT OF MONEY IN FUND. (a) The governing board of a system may invest the money in the system's cafeteria plan fund.

(b) The earnings, including interest, and the proceeds from the sale of the investments become a part of the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER G. ADVISORY COMMITTEE

Sec. 1601.301. ADVISORY COMMITTEE. An advisory committee for each system shall be selected, serve, and perform duties as provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.302. ELECTION OF MEMBERS. One member of the advisory committee shall be elected from each of the components, units, or agencies of the system:

(1) at times designated by the system; and

(2) in accordance with general guidelines for the election provided by the system.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.303. QUALIFICATIONS OF MEMBERS. (a) A member of a system's advisory committee must be an employee of the system.

(b) A member must:

(1) demonstrate mature judgment, special abilities, and sincere interest in employee coverage plans; and

(2) be able to represent the needs of all employees of the component, unit, or agency the member represents with respect to an action of the advisory committee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.304. TERMS. A member of the advisory committee is elected for a two-year term, subject to reelection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.305. OFFICERS. Annually, the members of a system's advisory committee shall elect a presiding officer and other necessary officers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.306. VACANCY. The chief executive officer of a component, unit, or agency of a system shall appoint to the system's advisory committee an employee of the component, unit, or agency to fill the remainder of a vacated term of a member who is an employee of the component, unit, or agency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.307. DUTIES OF COMMITTEE. (a) The advisory committee of a system shall cooperate and work with the governing board of the system in coordinating and correlating the administration of the uniform program among the various components, units, and agencies of the system.

(b) Members of the advisory committee shall cooperate and work with the governing board of the system as advisors in the development, implementation, coordination, and administration of the uniform program among the various components, units, and agencies of the system.

(c) The advisory committee shall provide a channel for open communication of ideas and suggestions regarding coverages, eligibility, claims, procedures, bidding, administration, and any other aspect of employee plan benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1601.308. EXPENSES. (a) A member's service on the advisory committee of a system is in addition to the duties of the member's state office or employment.

(b) An expense incurred by an advisory committee member in performing a duty as a member of the committee shall be paid from

money made available for that purpose to the system of which the member is an employee or officer.

(c) Employees may not be required to pay from the amount of employer contributions due the employees or from the amount of additional contributions due for selected coverages under this chapter the expenses of an advisory committee established under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. [1969](#)), Sec. 14.017(a), eff. September 1, 2009.

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

OFFICE USE ONLY

Complete Nos. 1 - 4 and 6 if there are interested parties.
 Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the goods or services to be provided under the contract.

4 Name of Interested Party	City, State, Country (place of business)	Nature of Interest (check applicable)	
		Controlling	Intermediary

5 Check only if there is NO Interested Party.

6 AFFIDAVIT I swear, or affirm, under penalty of perjury, that the above disclosure is true and correct.

 Signature of authorized agent of contracting business entity

AFFIX NOTARY STAMP / SEAL ABOVE

Sworn to and subscribed before me, by the said _____, this the _____ day of _____, 20 _____, to certify which, witness my hand and seal of office.

 Signature of officer administering oath Printed name of officer administering oath Title of officer administering oath

ADD ADDITIONAL PAGES AS NECESSARY

**The University of Texas System
Office of Employee Benefits
RFP for Fully-Insured Dallas Area Medical EPO Plan
beginning September 1, 2017**

Appendix J1 – EIR Accessibility Warranty

ACCESS BY INDIVIDUALS WITH DISABILITIES

Access by Individuals with Disabilities. Contractor represents and warrants (“EIR Accessibility Warranty”) that the electronic and information resources and all associated information, documentation, and support that it provides to University under this Agreement (collectively, the “EIRs”) comply with the applicable requirements set forth in Title 1, Chapter 213, *Texas Administrative Code*, and Title 1, Chapter 206, Rule §206.70 of the *Texas Administrative Code* (as authorized by Chapter 2054, Subchapter M, *Government Code*.) To the extent Contractor becomes aware that the EIRs, or any portion thereof, do not comply with the EIR Accessibility Warranty, then Contractor represents and warrants that it will, at no cost to University, either (1) perform all necessary remediation to make the EIRs satisfy the EIR Accessibility Warranty or (2) replace the EIRs with new EIRs that satisfy the EIR Accessibility Warranty. In the event that Contractor fails or is unable to do so, then University may terminate this Agreement and Contractor will refund to University all amounts University has paid under this Agreement within thirty (30) days after the termination date.

**UT SELECT PPO Subscriber Enrollment by Institution (DFW Area)
by Subscriber Status and Level of Coverage**

UT Southwestern Medical Center Dallas

	Active Employees					Retired Employees					Total Enrollment				
	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
Sep-16	8024	1465	1964	2632	14085	227	96	23	24	370	8251	1561	1987	2656	14455
Oct-16	8041	1474	1978	2636	14129	227	96	23	24	370	8268	1570	2001	2660	14499
Nov-16	8075	1474	1996	2642	14187	225	95	23	24	367	8300	1569	2019	2666	14554

UT Arlington

	Active Employees					Retired Employees					Total Enrollment				
	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
Sep-16	1757	414	355	506	3032	90	52	7	9	158	1847	466	362	515	3190
Oct-16	1757	419	356	517	3049	94	50	7	9	160	1851	469	363	526	3209
Nov-16	1765	419	355	526	3065	94	50	7	9	160	1859	469	362	535	3225

UT Dallas

	Active Employees					Retired Employees					Total Enrollment				
	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
Sep-16	1729	414	328	576	3047	47	25	1	2	75	1776	439	329	578	3122
Oct-16	1747	419	325	574	3065	48	25	1	2	76	1795	444	326	576	3141
Nov-16	1764	418	329	576	3087	48	25	1	2	76	1812	443	330	578	3163

**UT SELECT PPO Subscriber Enrollment by Institution (DFW Area)
by Status, Gender, Level of Coverage, and Age
November 2016**

UT Southwestern Medical Center Dallas

AGE	Active Employee									Retired Employee										
	SUB	SSP	Male			Female			Total	SUB	SSP	Male			Female			Total		
			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
<20	2	0	0	0	2	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0
20-24	160	1	2	0	163	326	7	20	1	354	0	0	0	0	0	0	0	0	0	0
25-29	367	36	12	19	434	942	55	97	39	1133	0	0	0	0	0	0	0	0	0	0
30-34	461	106	47	129	743	988	106	258	143	1495	0	0	0	0	0	0	0	0	0	0
35-39	315	58	106	246	725	693	47	279	296	1315	0	0	0	0	0	0	0	0	0	0
40-44	245	32	89	236	602	515	47	274	292	1128	0	0	0	0	0	0	0	0	0	0
45-49	239	30	98	219	586	549	61	250	236	1096	1	0	1	0	2	2	0	0	0	2
50-54	198	45	76	216	535	531	102	195	180	1008	4	1	1	2	8	7	0	2	0	9
55-59	209	88	38	144	479	521	162	90	124	897	14	3	2	2	21	43	15	6	5	69
60-64	158	109	22	57	346	414	179	33	41	667	42	25	2	8	77	112	51	9	7	179
65-69	46	63	4	15	128	142	65	3	7	217	0	0	0	0	0	0	0	0	0	0
70-74	13	33	1	1	48	27	15	2	0	44	0	0	0	0	0	0	0	0	0	0
75+	8	25	0	1	34	3	2	0	0	5	0	0	0	0	0	0	0	0	0	0
Total	2421	626	495	1283	4825	5654	848	1501	1359	9362	61	29	6	12	108	164	66	17	12	259

UT Arlington

AGE	Active Employee									Retired Employee										
	SUB	SSP	Male			Female			Total	SUB	SSP	Male			Female			Total		
			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
<20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	17	1	0	0	18	33	0	1	0	34	0	0	0	0	0	0	0	0	0	0
25-29	89	2	1	7	99	136	8	3	3	150	0	0	0	0	0	0	0	0	0	0
30-34	111	18	12	30	171	121	9	24	12	166	0	0	0	0	0	0	0	0	0	0
35-39	90	19	17	54	180	143	6	34	31	214	0	0	0	0	0	0	0	0	0	0
40-44	79	8	24	56	167	103	7	39	23	172	0	0	0	0	0	1	0	1	0	2
45-49	71	10	26	69	176	92	15	47	39	193	0	0	0	0	0	0	0	0	0	0
50-54	80	20	17	54	171	101	9	39	32	181	2	1	1	1	5	2	0	0	1	3
55-59	65	25	20	46	156	123	49	30	28	230	11	3	2	3	19	8	6	1	0	15
60-64	68	53	11	21	153	97	46	4	11	158	19	16	1	1	37	51	24	1	3	79
65-69	43	53	4	8	108	58	21	2	0	81	0	0	0	0	0	0	0	0	0	0
70-74	20	24	0	2	46	14	5	0	0	19	0	0	0	0	0	0	0	0	0	0
75+	8	10	0	0	18	3	1	0	0	4	0	0	0	0	0	0	0	0	0	0
Total	741	243	132	347	1463	1024	176	223	179	1602	32	20	4	5	61	62	30	3	4	99

UT Dallas

AGE	Active Employee									Retired Employee										
	SUB	SSP	Male			Female			Total	SUB	SSP	Male			Female			Total		
			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total			SCH	SFM	Total	SUB	SSP	SCH	SFM	Total
<20	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	25	2	0	0	27	46	0	0	0	46	0	0	0	0	0	0	0	0	0	0
25-29	124	13	2	4	143	177	9	12	6	204	0	0	0	0	0	0	0	0	0	0
30-34	130	30	12	44	216	179	21	25	27	252	0	0	0	0	0	0	0	0	0	0
35-39	99	10	16	57	182	104	11	47	33	195	0	0	0	0	0	0	0	0	0	0
40-44	99	11	23	65	198	95	5	40	47	187	0	0	0	0	0	0	0	0	0	0
45-49	53	15	24	62	154	89	14	38	27	168	0	0	0	0	0	1	0	0	0	1
50-54	66	11	21	58	156	75	13	20	22	130	1	0	0	0	1	1	1	0	0	2
55-59	41	33	12	54	140	91	25	14	21	151	3	3	0	1	7	8	3	0	0	11
60-64	66	41	10	25	142	83	33	9	8	133	11	5	0	1	17	23	13	1	0	37
65-69	37	51	2	11	101	37	21	1	1	60	0	0	0	0	0	0	0	0	0	0
70-74	20	28	0	3	51	11	6	0	0	17	0	0	0	0	0	0	0	0	0	0
75+	8	15	1	1	25	8	0	0	0	8	0	0	0	0	0	0	0	0	0	0
Total	769	260	123	384	1536	995	158	206	192	1551	15	8	0	2	25	33	17	1	0	51

**UT SELECT Subscribers by County
in the DFW Area**

County	Number of Subscribers
COLLIN	2818
DALLAS	13237
DENTON	1486
ELLIS	450
HUNT	39
JOHNSON	146
KAUFMAN	286
PARKER	59
ROCKWALL	372
TARRANT	4912
WISE	27



**The University of Texas System Office of Employee Benefits
Uniform Group Insurance Program
RFP for a Fully Insured EPO Plan
Serving the Dallas Metro Area**

Appendix E – Provider Accessibility and Availability

As described in Section 6.8.4 of this RFP, the vendor must provide one (1) file for each of the following proposed provider networks: hospitals, primary care providers, specialty care providers, and behavioral health providers.

Failure to provide complete data or to properly identify the data may result in a delay in the review of the TPA’s response. Please note that the documentation required is more detailed than what is generally listed in the TPA’s provider directory.

Section 1 – Formatting and Data Requirements

The required format may not be altered. No other format will be accepted. The data for each provider network must be provided separately in Excel format. Files should be submitted on a CD-ROM included with the vendor’s proposal.

All required data fields must be included for all records or the vendor’s Proposal will be considered incomplete. Blank records, abbreviated names, and extra fields are not acceptable.

Only those specialty codes provided by System, as listed in Section 3 of this Appendix, are valid.

Section 2 – Reporting of Providers

Hospital

The following fields must be included for each record in the hospital network file.

ITEM NO.	FIELD NAME	FORMAT	FIELD DESCRIPTION
1	NPI	Numeric	National Provider Identifier
2	NAME	Character	Hospital Name
3	ADDRESS1	Character	Hospital Street Name
4	ADDRESS2	Character	Additional Street Information
5	CITY	Character	Hospital City Location
6	ZIP	Numeric	Hospital STREET Address ZIP Code

Primary Care Providers

The following fields must be included for each record in the primary care provider network file.

ITEM NO.	FIELD NAME	FORMAT	FIELD DESCRIPTION
1	NPI	Numeric	National Provider Identifier
2	LAST NAME	Character	Physician's Last Name
3	FIRST NAME	Character	Physician's First Name
4	MI	Character	Physician's Middle Initial
5	ADDRESS1	Character	Primary Street Address of Physician's Office (NO P. O. Boxes)
6	ADDRESS2	Character	Additional Address Information (Suite #, Floor, etc.)
7	CITY	Character	Physician's City Location
8	ZIP	Numeric	Physician's STREET Address ZIP code
9	SPEC	Character	Use the values for Specialty type: FP =Family Practice GP =General Practice IM =Internal Medicine PD =Pediatrician OBG =OB/GYN if used as a PCP
10	STATUS	Character	O =Open Practice C =Closed Practice
11	AFF	Character	Affiliated with a group: Y =Yes or N =No
12	GROUP	Character	Name of group practice

Specialty Care Providers (including Ancillary Providers)

The following fields must be included for each record in the specialty care provider network file.

ITEM NO.	FIELD NAME	FORMAT	FIELD DESCRIPTION
1	NPI	Character	National Provider Identifier
2	LAST NAME	Character	Physician's Last Name
3	FIRST NAME	Character	Physician's First Name
4	MI	Character	Physician's Middle Initial
5	ADDRESS1	Character	Primary Street Address of Physician's Office (NO P. O. Boxes)
6	ADDRESS2	Character	Additional Address Information (Suite #, Floor, etc.)
7	CITY	Character	Physician's City Location
8	ZIP	Numeric	Physician's STREET Address ZIP code
9	SPEC	Character	See Specialty Values Table in Section 3 of this Appendix.
10	AFF	Character	Affiliated with a group: Y =Yes or N =No
11	GROUP	Character	Name of group practice

Behavioral Health Providers

The following fields must be included for each record in the behavioral health provider network file.

ITEM NO.	FIELD NAME	FORMAT	FIELD DESCRIPTION
1	NPI	Character	National Provider Identifier
2	LAST NAME	Character	Physician's Last Name
3	FIRST NAME	Character	Physician's First Name
4	MI	Character	Physician's Middle Initial
5	ADDRESS1	Character	Primary Street Address of Physician's Office (NO P. O. Boxes)
6	ADDRESS2	Character	Additional Address Information (Suite #, Floor, etc.)
7	CITY	Character	Physician's City Location
8	ZIP	Numeric	Physician's STREET Address ZIP code
9	SPEC	Character	Use the values for Specialty type: LCSW = Licensed Clinical Social Worker LCDC = Licensed Chemical Dependency Counselor LPA = Licensed Psychological Associate LPC = Licensed Professional Counselor LMFT = Licensed Marriage & Family Therapist PSY = Psychiatry PSYD = Doctor of Psychology (certified as a health service provider) SLP = Licensed Speech Language Pathologist
10	AFF	Character	Affiliated with a group: Y=Yes or N=No
11	GROUP	Character	Name of group practice

Section 3 – Specialty Values

Only the following values are valid to identify specialties for the specialty care provider network file.

Two-Digit Code	Specialty
AI	Allergy and Immunology
AN	Anesthesiology
CD	Cardiovascular Disease
D	Dermatology
EM	Emergency Medicine
GE	Gastroenterology
GS	General Surgery
GYN	Gynecology
N	Neurology
NEP	Nephrology
NP	Neuropathology
NPM	Neonatal-Perinatal Medicine
NTR	Nutrition
OBG	Obstetrics & Gynecology (Not a PCP)
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
ENT	Otolaryngology
PSY	Psychiatry
PM	Physical Medicine & Rehab
PUD	Pulmonary Diseases
RHU	Rheumatology Urology
OTH	All Other Specialties
ANCIL	Ancillary Provider

The University of Texas System
DALLAS AREA EPO ADMINISTRATIVE PERFORMANCE REPORT
PLAN YEAR 2018
September 1, 2017 - August 31, 2018

(EPO Administrator)

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
ADMIN REPORT TIMELINE						
Date Report Due	20 days after qtr	12/20/2017	3/20/2018	6/20/2018	9/20/2018	
Date Submitted by Vendor	--					
Date Received by OEB	--					

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
CUSTOMER SERVICE CALLS						
Total telephone calls received*	--					
Average Abandonment Rate (%)	5%					
Average Waiting Time (seconds)	<30 sec					
% of calls waiting > 30 seconds	N/A					

* Statistics specific to UT SELECT participant calls preferred, but System will accept statistics for total book of business if UT specific call data is not available.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
ID CARDS						
Total ID Cards Mailed*	--					
Average Time to Mail**	<5 days					
% mailed within 5 work days	95%					

* Includes ID Cards mailed to both current and newly enrolled UT SELECT participants.

** Measured from date of request from member or receipt of complete enrollment data from UT System.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
EMERGENCY UPDATE PROCESSING						
Total Update Requests Received*	--					
Avg Time to Process	< 4 hrs					
% of Updates Processed w/ 4 hrs.	100%					

* Includes emergency update requests received from UT Institutions and OEB.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
CLAIMS PROCESSING						
Total Claims Processed	--					
Amount Paid	--					
Amount Denied	--					
Avg Time to Process Claim*	--					
% Processed within 15 days	85%					
% Processed within 30 days	98%					

** Measured from date received to date processed.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
WRITTEN INQUIRIES						
Total Written Inquiries Received*	--					
% response within 5 business days	95%					

* Written inquiries received from UT members that require a response from TPA.

	Standard	9/17-11/17	12/17-2/18	3/18-5/18	6/18-8/18	9/17-8/18
COMPLAINTS*						
Claims Appeals	--					
Customer Service	--					
Plan Design/Benefits	--					
Other	--					
Total Complaints Received	--					
Average Time to Resolve**	<30 days					
% resolved within 15 days	90%					
% resolved within 30 days	--					

* Total number of written and emailed complaints received from UT SELECT participants.

** Measured from date complete information relating to complaint was received by TPA to date resolved.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
FRAUD DETECTION*						
Total amount recovered**	--					

* By no later than Oct. 31, 2017, submit a written description of the TPA's comprehensive fraud detection plan (or amendments to any previously submitted plan), including how the TPA will be using its automated systems to detect and prevent participant and provider fraud, abuse, and other improprieties.

** Report the total number of dollars recovered during the past quarter through the TPA's fraud investigation activity.

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
PROVIDER ADDITIONS/TERMINATIONS						
Additions:						
Primary Care						
Specialty Care						
Facilities						
Other						
Total Provider Additions						
Terminations:						
Primary Care						
Specialty Care						
Facilities						
Other						
Total Provider Terminations						
Net Gain (Loss) in Providers						

* Significant provider changes in a specific area (e.g., city or county) should be reported separately

	Performance Standard	First Quarter 9/17-11/17	Second Quarter 12/17-2/18	Third Quarter 3/18-5/18	Fourth Quarter 6/18-8/18	Total 9/17-8/18
APPOINTMENTS						
Routine Physicals	90% in 30 days					
Illness	90% in 5 days					
Urgent Care	90% in 24 hours					
Emergency Care	Immediate					

*Actual contract will have updated and appropriate references to applicable Exhibits.

APPENDIX H

AGREEMENT BETWEEN SYSTEM AND CONTRACTOR FOR **A FULLY-INSURED EPO PLAN**

This Agreement between System and Contractor ("**Agreement**") is made and entered into effective as of **September 1, 2017** (the "**Effective Date**"), by and between The System of Texas System Administration an agency established under the laws of the State of Texas ("**System**"), and [("**Contractor**")], TX Comptroller Vendor Identification Number []. System and Contractor hereby agree as follows:

1. **Incorporation of the Request for Proposal and Contractor's Response into the Agreement; Interpretation**

1.1 System issued a Request for Proposals for **a fully-insured EPO** for the Employees and Retired Employees of The University of Texas System ("the RFP") to which Contractor submitted a response ("the Response"). The RFP, which shall remain on file as **Exhibit A**, and the Response, which shall remain on file as **Exhibit B**, are both incorporated herein by reference for all purposes as if both are restated in full.

1.2 Pursuant to the RFP and Response, Contractor will issue policies of insurance to System to provide the coverage to be provided as requested in the RFP, **the terms of which policies are attached as Exhibit C and incorporated herein for all purposes.**

1.3 To the extent that the terms of this Agreement or **Exhibit A** or the relevant portions of **Exhibit B** conflict **with Exhibit C, Exhibit C** shall prevail. To the extent that this Agreement conflicts with **Exhibit A** or **Exhibit B**, the terms of this Agreement shall prevail. To the extent that the terms of **Exhibit A** conflicts with **Exhibit B, Exhibit A** shall prevail.

2. **Scope of Work.**

The Coverages and Services to be provided by Contractor shall be the coverages described in **Exhibit C**, and all other related, necessary and appropriate services ("the Services") described in **Exhibits A and B.**

3. **Time for Commencement and Completion.**

The term of this Agreement will begin on the Effective Date and expire on August 31, 2019. System will have the option to renew this Agreement, at its sole discretion, for one (1) additional three (3) year term.

4. **Contractor's Obligations, Performance Guarantees.**

- 4.1 Contractor will provide the Coverages and Services in compliance with all applicable federal, state and local, laws, regulations, and ordinances. Contractor represents and warrants that neither Contractor nor any firm, corporation or institution represented by Contractor, or anyone acting for the firm, corporation or institution, (1) has violated the antitrust laws of the State of Texas, Chapter 15, *Texas Business and Commerce Code*, or federal antitrust laws, or (2) has communicated directly or indirectly the content of Contractor's response to System's procurement solicitation to any competitor or any other person engaged in a similar line of business during the procurement process for this Agreement.
- 4.2 Contractor will maintain a staff of properly trained and experienced personnel to ensure satisfactory performance under this Agreement. Contractor will cause all persons connected with Contractor who are providing the Coverages and/or Services to be duly registered and/or licensed under all applicable federal, state and local, laws, regulations, and ordinances.
- 4.3 Contractor represents that it is a corporation duly organized, validly existing and in good standing under the laws of the State of Texas, or a foreign corporation or limited liability company duly authorized and in good standing to conduct business in the State of Texas, that it has all necessary corporate power and has received all necessary corporate approvals to execute and deliver this Agreement, and the individual executing this Agreement on behalf of Contractor has been duly authorized to act for and bind Contractor.
- 4.4 Contractor will comply with the Performance Guarantees under the terms described in **Exhibit D**, Performance Guarantees, which is attached and incorporated for all purposes.

5. Premium and Contract Costs

- 5.1 Contractor's premium rates for the Coverages to be provided are set forth in **EXHIBIT E** which is attached hereto and incorporated herein for all purposes.
- 5.2 System will pay no additional fees or costs for out of pocket cost to Contractor incurred in the performance of services under this contract not reflected within this agreement.
- 5.3 The Contract Amount includes all applicable federal, state or local sales or use taxes payable as a result of the execution or performance of this Agreement.

6. Payment Terms.

The Payment Methodology is described in **Exhibit A**.

7. Default and Termination.

- 7.1 In the event of a material failure by a party to this Agreement to perform in accordance with the terms of this Agreement (“**default**”), the other party may terminate this Agreement upon fifteen (15) days’ written notice of termination setting forth the nature of the material failure; provided, that, the material failure is through no fault of the terminating party. The termination will not be effective if the material failure is fully cured prior to the end of the fifteen-day period.
- 7.2 System may, without cause, terminate this Agreement at any time upon giving sixty (60) days’ advance written notice to Contractor. Upon termination pursuant to this Section, Contractor will be entitled to payment of an amount that will compensate Contractor for the Work satisfactorily performed from the time of the last payment date to the termination date in accordance with this Agreement. Notwithstanding any provision in this Agreement to the contrary, System will not be required to pay or reimburse Contractor for any services performed or for expenses incurred by Contractor after the date of the termination notice that could have been avoided or mitigated by Contractor.
- 7.3 Termination under **Sections 7.1** or **7.2** will not relieve Contractor from liability for any default or breach under this Agreement or any other act or omission of Contractor.
- 7.4 If Contractor fails to cure any default within fifteen (15) days after receiving written notice of the default, System will be entitled (but will not be obligated) to cure the default and will have the right to offset against all amounts due to Contractor under this Agreement, any and all reasonable expenses incurred in connection with System’s curative actions.

8. Indemnification

8.1 TO THE FULLEST EXTENT PERMITTED BY LAW, CONTRACTOR WILL AND DOES HEREBY AGREE TO INDEMNIFY, PROTECT, DEFEND WITH COUNSEL APPROVED BY SYSTEM, AND HOLD HARMLESS SYSTEM AND THE SYSTEM OF TEXAS SYSTEM, AND THEIR RESPECTIVE AFFILIATED ENTERPRISES, REGENTS, OFFICERS, DIRECTORS, ATTORNEYS, EMPLOYEES, REPRESENTATIVES AND AGENTS (COLLECTIVELY "INDEMNITEES") FROM AND AGAINST ALL DAMAGES, LOSSES, LIENS, CAUSES OF ACTION, SUITS, JUDGMENTS, EXPENSES, AND OTHER CLAIMS OF ANY NATURE, KIND, OR DESCRIPTION, INCLUDING REASONABLE ATTORNEYS' FEES INCURRED IN INVESTIGATING, DEFENDING OR SETTLING ANY OF THE FOREGOING (COLLECTIVELY "CLAIMS") BY ANY PERSON OR ENTITY, ARISING OUT OF, CAUSED BY, OR RESULTING FROM CONTRACTOR'S PERFORMANCE UNDER OR BREACH OF THIS AGREEMENT AND THAT ARE CAUSED IN WHOLE OR IN PART BY ANY NEGLIGENT ACT, NEGLIGENT OMISSION OR WILLFUL MISCONDUCT OF CONTRACTOR, ANYONE DIRECTLY EMPLOYED BY CONTRACTOR OR ANYONE FOR WHOSE ACTS CONTRACTOR MAY BE LIABLE. THE PROVISIONS OF THIS SECTION WILL NOT BE CONSTRUED TO ELIMINATE OR REDUCE ANY OTHER INDEMNIFICATION OR RIGHT WHICH ANY INDEMNITEE HAS BY LAW OR EQUITY. ALL PARTIES WILL BE ENTITLED TO BE REPRESENTED BY COUNSEL AT THEIR OWN EXPENSE.

8.2 IN ADDITION, CONTRACTOR WILL AND DOES HEREBY AGREE TO INDEMNIFY, PROTECT, DEFEND WITH COUNSEL APPROVED BY SYSTEM, AND HOLD HARMLESS INDEMNITEES FROM AND AGAINST ALL CLAIMS ARISING FROM INFRINGEMENT OR ALLEGED INFRINGEMENT OF ANY PATENT, COPYRIGHT, TRADEMARK OR OTHER PROPRIETARY INTEREST ARISING BY OR OUT OF THE PERFORMANCE OF SERVICES BY CONTRACTOR, OR THE USE BY INDEMNITEES, AT THE DIRECTION OF CONTRACTOR, OF ANY ARTICLE OR MATERIAL; PROVIDED, THAT, UPON BECOMING AWARE OF A SUIT OR THREAT OF SUIT FOR INFRINGEMENT, SYSTEM WILL PROMPTLY NOTIFY CONTRACTOR AND CONTRACTOR WILL BE GIVEN THE OPPORTUNITY TO NEGOTIATE A SETTLEMENT. IN THE EVENT OF LITIGATION, SYSTEM AGREES TO REASONABLY COOPERATE WITH CONTRACTOR. ALL PARTIES WILL BE ENTITLED TO BE REPRESENTED BY COUNSEL AT THEIR OWN EXPENSE.

9. Relationship of the Parties.

For all purposes of this Agreement and notwithstanding any provision of this Agreement to the contrary, Contractor is an independent contractor and is not a state employee, partner, joint venturer, or agent of System. Contractor will not bind nor attempt to bind System to any agreement or contract. As an independent contractor, Contractor is solely responsible for all taxes, withholdings, and other statutory or contractual obligations of any sort, including workers' compensation insurance.

10. Miscellaneous.

10.1 **Assignment and Subcontracting.** Drafting Note If vendor will not be subcontracting, the following clause will be included: The parties understand and

agree in good faith that none of the services to be provided by Carrier to System under this Agreement shall be subcontracted by Carrier to any other entity or person, assigned, delegated, or otherwise transferred to a third party, in whole or in part, and any attempt to do so will (a) not be binding on System; and (b) be a breach of this Agreement for which Contractor will be subject to all remedial actions provided by Texas law, including Chapter 2161, Texas Government Code, and 34 TAC Chapter 20, §§20.101 – 20.108.

Drafting Note: If vendor will be subcontracting, the following clause will be included: Except as specifically provided in **Exhibit F**, Historically Underutilized Business Subcontracting Plan, attached and incorporated for all purposes, Contractor's interest in this Agreement (including Contractor's duties and obligations under this Agreement, and the fees due to Contractor under this Agreement) may not be subcontracted, assigned, delegated, or otherwise transferred to a third party, in whole or in part, and any attempt to do so will (a) not be binding on System; and (b) be a breach of this Agreement for which Contractor will be subject to all remedial actions provided by Texas law, including Chapter 2161, *Texas Government Code*, and 34 TAC Chapter 20, §§20.101 – 20.108.

- 10.2 **Texas Family Code Child Support Certification.** Pursuant to Section 231.006, *Texas Family Code*, Contractor certifies that it is not ineligible to receive the award of or payments under this Agreement and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate.
- 10.3 **Tax Certification.** If Contractor is a taxable entity as defined by Chapter 171, Texas Tax Code ("**Chapter 171**"), then Contractor certifies that it is not currently delinquent in the payment of any taxes due under Chapter 171, or that Contractor is exempt from the payment of those taxes, or that Contractor is an out-of-state taxable entity that is not subject to those taxes, whichever is applicable.
- 10.4 **Payment of Debt or Delinquency to the State.** Pursuant to Sections 2107.008 and 2252.903, *Texas Government Code*, Contractor agrees that any payments owing to Contractor under this Agreement may be applied directly toward any debt or delinquency that Contractor owes the State of Texas or any agency of the State of Texas regardless of when it arises, until the debt or delinquency is paid in full.
- 10.5 **Loss of Funding.** System performance of its duties and obligations under this Agreement may be dependent upon the appropriation and allotment of funds by the Texas State Legislature (the "**Legislature**") and/or allocation of funds by the Board of Regents of The University of Texas System (the "**Board**"). If the Legislature fails to appropriate or allot the necessary funds, or the Board fails to allocate the necessary funds, then System will issue written notice to Contractor and System may terminate this Agreement without further duty or obligation hereunder. Contractor acknowledges that appropriation, allotment, and allocation of funds are beyond the control of System.

- 10.6 **Entire Agreement; Modifications.** This Agreement supersedes all prior agreements, written or oral, between Contractor and System and will constitute the entire agreement and understanding between the parties with respect to the subject matter of this Agreement. This Agreement and each of its provisions will be binding upon the parties and may not be waived, modified, amended or altered except by a writing signed by both System and Contractor.
- 10.7 **Force Majeure.** Neither party hereto will be liable or responsible to the other for any loss or damage or for any delays or failure to perform due to causes beyond its reasonable control including acts of God, strikes, epidemics, war, riots, flood, fire, sabotage, or any other circumstances of like character (“**force majeure occurrence**”).
- 10.8 **Captions.** The captions of sections and subsections in this Agreement are for convenience only and will not be considered or referred to in resolving questions of interpretation or construction.
- 10.9 **Governing Law.** Travis County, Texas, will be the proper place of venue for suit on or in respect of this Agreement. This Agreement and all of the rights and obligations of the parties to this Agreement and all of the terms and conditions of this Agreement will be construed, interpreted and applied in accordance with and governed by and enforced under the laws of the State of Texas.
- 10.10 **Waivers.** No delay or omission in exercising any right accruing upon a default in performance of this Agreement will impair any right or be construed to be a waiver of any right. A waiver of any default under this Agreement will not be construed to be a waiver of any subsequent default under this Agreement.
- 10.11 **Confidentiality and Safeguarding of System Records; Public Information.** Under this Agreement, Contractor may (1) create, (2) receive from or on behalf of System, or (3) have access to, records or record systems (collectively, “**System Records**”). Among other things, System Records may contain “Sensitive Personal Information” as that term is defined by the Business & Commerce Code § 512.002, which applies to confidential medical records and, social security numbers. It may also contain other data protected or made confidential or sensitive by applicable federal, state and local, laws, regulations, and ordinances. Contractor represents, warrants, and agrees that it will: (1) hold System Records in strict confidence and will not use or disclose System Records except as (a) permitted or required by this Agreement, (b) required by law, or (c) otherwise authorized by System in writing; (2) safeguard System Records according to reasonable administrative, physical and technical standards as described in its Proposal and that at no time shall be less rigorous than the standards by which Contractor protects its own confidential information; (3) continually monitor its operations and take any action necessary to assure that System Records are safeguarded and the confidentiality of System Records is maintained in accordance with all applicable federal, state and local, laws, regulations, and ordinances, and the terms of this Agreement; and (4) comply with the System’s

rules, policies, and procedures regarding access to and use of System's computer systems.

- 10.10.1 **Notice of Impermissible Use.** If an impermissible use or disclosure of any System Records occurs, Contractor will provide written notice to System within one (1) business day after Contractor's discovery of that use or disclosure. Contractor will promptly provide System with all information requested by System regarding the impermissible use or disclosure to ensure compliance with applicable law, including the breach reporting responsibilities imposed by Business & Commerce Code Chapter 512.002,
- 10.10.2 **Return of System Records.** Contractor agrees that within thirty (30) days after the expiration or termination of this Agreement, for any reason, all System Records created or received from or on behalf of System will be (1) returned to System, with no copies retained by Contractor; or (2) if return is not feasible, destroyed. Twenty (20) days before destruction of any System Records, Contractor will provide System with written notice of Contractor's intent to destroy System Records. Within five (5) days after destruction, Contractor will confirm to System in writing the destruction of System Records.
- 10.10.3 **Disclosure.** If Contractor discloses any System Records to a subcontractor or agent, Contractor will require the subcontractor or agent to comply with the same restrictions and obligations as are imposed on Contractor by this Section.
- 10.10.4 **Public Information.** System strictly adheres to all statutes, court decisions and the opinions of the Texas Attorney General with respect to disclosure of public information under the *Texas Public Information Act*, Chapter 552, *Texas Government Code*. Any disclosures of information maintained, collected, or assembled by Contractor in connection with the transaction of official business of System must be authorized by System. Contractor will instruct its employees that any release of records may be authorized only by System, and will be in accordance with the laws of the State of Texas. If Contractor receives such a request for information, Contractor shall send a copy of same to System by facsimile no later than one business day after receipt of the request, so that System can determine if a disclosure is required under the Act. Contractor shall maintain all information and materials submitted to it by virtue of the Contract, except as is necessary to perform its duties under this Contract. Contractor shall not use or permit to be used or transmitted to others any information obtained as a result of its duties under this Contract without the written consent of System, except as is necessary for Contractor to perform its duties under this Contract.

- 10.10.5 **Termination.** In addition to any other termination rights set forth in this Agreement and any other rights at law or equity, if System reasonably determines that Contractor has breached any of the restrictions or obligations set forth in this Section, System may immediately terminate this Agreement without notice or opportunity to cure.
- 10.10.6 **Duration.** The restrictions and obligations under this Section will survive expiration or termination of this Agreement for any reason.
- 10.12 **Binding Effect.** This Agreement will be binding upon and inure to the benefit of the parties hereto and their respective permitted assigns and successors.
- 10.13 **Records.** Records of Contractor's costs, reimbursable expenses pertaining to the Project and payments will be available to System or its authorized representative during business hours and will be retained for four (4) years after final Payment or abandonment of the Project, unless System otherwise instructs Contractor in writing.
- 10.14 **Notices.** Except as otherwise provided by this Section, all notices, consents, approvals, demands, requests or other communications provided for or permitted to be given under any of the provisions of this Agreement will be in writing and will be sent via certified mail, hand delivery, overnight courier, facsimile transmission, or email, as provided below, and notice will be deemed given (i) if delivered by certified mail, when deposited, postage prepaid, in the United States mail, or (ii) if delivered by hand, overnight courier, facsimile, or email when received:

Scott C. Kelley, Executive Vice Chancellor
for Business Affairs
The University of Texas System
210 West 6th Street, Room B.140E
Austin, Texas 78701-3043
Fax: 512/499-4289

with copy to:

Laura C. Chambers, Executive Director
Office of Employee Benefits
The University of Texas System
210 West 6th Street, Room B.140E
Austin, Texas 78701
Fax: 512/499-4620

If to Contractor: []

or other person or address as may be given in writing by either party to the other in accordance with this Section.

Notwithstanding any other requirements for notices given by a party under this Agreement, if Contractor intends to deliver written notice to System pursuant to Section 2251.054, *Texas Government Code*, then Contractor will send that notice to System as follows:

Scott C. Kelley, Executive Vice Chancellor
for Business Affairs
The University of Texas System
210 West 6th Street, Room B.140E
Austin, Texas 78701-3043
Email: LegalNotices@utsystem.edu

or other person or address as may be given in writing by System to Contractor in accordance with this Section.

- 10.15 **Severability.** In case any provision of this Agreement will, for any reason, be held invalid or unenforceable in any respect, the invalidity or unenforceability will not affect any other provision of this Agreement, and this Agreement will be construed as if the invalid or unenforceable provision had not been included.
- 10.16 **State Auditor's Office.** Contractor understands that acceptance of funds under this Agreement constitutes acceptance of the authority of the Texas State Auditor's Office, or any successor agency (collectively, "**Auditor**"), to conduct an audit or investigation in connection with those funds pursuant to Sections 51.9335(c), 73.115(c) and 74.008(c), *Texas Education Code*. Contractor agrees to cooperate with the Auditor in the conduct of the audit or investigation, including providing all records requested. Contractor will include this provision in all contracts with subcontractors.
- 10.17 **Limitation of Liability.** EXCEPT FOR SYSTEM'S OBLIGATION (IF ANY) TO PAY CONTRACTOR CERTAIN FEES AND EXPENSES SYSTEM WILL HAVE NO LIABILITY TO CONTRACTOR OR TO ANYONE CLAIMING THROUGH OR UNDER CONTRACTOR BY REASON OF THE EXECUTION OR PERFORMANCE OF THIS AGREEMENT. NOTWITHSTANDING ANY DUTY OR OBLIGATION OF SYSTEM TO CONTRACTOR OR TO ANYONE CLAIMING THROUGH OR UNDER CONTRACTOR, NO PRESENT OR FUTURE AFFILIATED ENTERPRISE, SUBCONTRACTOR, AGENT, OFFICER, DIRECTOR, EMPLOYEE, REPRESENTATIVE, ATTORNEY OR REGENT OF THE UNIVERSITY OF TEXAS SYSTEM, OR ANYONE CLAIMING UNDER SYSTEM HAS OR WILL HAVE ANY PERSONAL LIABILITY TO CONTRACTOR OR TO ANYONE CLAIMING THROUGH OR UNDER CONTRACTOR BY REASON OF THE EXECUTION OR PERFORMANCE OF THIS AGREEMENT.
- 10.18 **Survival of Provisions.** No expiration or termination of this Agreement will relieve either party of any obligations under this Agreement that by their nature survive expiration or termination, including **Sections 6.7, 9, 11.5, 11.9, 11.10, 11.11, 11.13, 11.16, 11.17, 11.19 and 11.21.**

10.19 Breach of Contract Claims.

10.19.1 To the extent that Chapter 2260, *Texas Government Code*, as it may be amended from time to time ("**Chapter 2260**"), is applicable to this Agreement and is not preempted by other applicable law, the dispute resolution process provided for in Chapter 2260 will be used, as further described herein, by System and Contractor to attempt to resolve any claim for breach of contract made by Contractor:

10.19.1.1 Contractor's claims for breach of this Agreement that the parties cannot resolve pursuant to other provisions of this Agreement or in the ordinary course of business will be submitted to the negotiation process provided in subchapter B of Chapter 2260. To initiate the process, Contractor will submit written notice, as required by subchapter B of Chapter 2260, to System in accordance with the notice provisions in this Agreement. Contractor's notice will specifically state that the provisions of subchapter B of Chapter 2260 are being invoked, the date and nature of the event giving rise to the claim, the specific contract provision that System allegedly breached, the amount of damages Contractor seeks, and the method used to calculate the damages. Compliance by Contractor with subchapter B of Chapter 2260 is a required prerequisite to Contractor's filing of a contested case proceeding under subchapter C of Chapter 2260. The chief business officer of System, or another officer of System as may be designated from time to time by System by written notice to Contractor in accordance with the notice provisions in this Agreement, will examine Contractor's claim and any counterclaim and negotiate with Contractor in an effort to resolve the claims.

10.19.1.2 If the parties are unable to resolve their disputes under **Section 10.19.1.1**, the contested case process provided in subchapter C of Chapter 2260 is Contractor's sole and exclusive process for seeking a remedy for any and all of Contractor's claims for breach of this Agreement by System.

10.19.1.3 Compliance with the contested case process provided in subchapter C of Chapter 2260 is a required prerequisite to seeking consent to sue from the Legislature under Chapter 107, *Texas Civil Practices and Remedies Code*. The parties hereto specifically agree that (i) neither the execution of this Agreement by System nor any other conduct, action or inaction of any representative of System

relating to this Agreement constitutes or is intended to constitute a waiver of System's or the state's sovereign immunity to suit and (ii) System has not waived its right to seek redress in the courts.

10.19.2 The submission, processing and resolution of Contractor's claim is governed by the published rules adopted by the Texas Attorney General pursuant to Chapter 2260, as currently effective, thereafter enacted or subsequently amended.

10.19.3 System and Contractor agree that any periods set forth in this Agreement for notice and cure of defaults are not waived.

10.20 **Undocumented Workers.** The *Immigration and Nationality Act* (8 *United States Code* 1324a) ("**Immigration Act**") makes it unlawful for an employer to hire or continue employment of undocumented workers. The United States Immigration and Customs Enforcement Service has established the Form I-9 Employment Eligibility Verification Form ("**I-9 Form**") as the document to be used for employment eligibility verification (8 *Code of Federal Regulations* 274a). Among other things, Contractor is required to: (1) have all employees complete and sign the I-9 Form certifying that they are eligible for employment; (2) examine verification documents required by the I-9 Form to be presented by the employee and ensure the documents appear to be genuine and related to the individual; (3) record information about the documents on the I-9 Form, and complete the certification portion of the I-9 Form; and (4) retain the I-9 Form as required by law. It is illegal to discriminate against any individual (other than a citizen of another country who is not authorized to work in the United States) in hiring, discharging, or recruiting because of that individual's national origin or citizenship status. If Contractor employs unauthorized workers during performance of this Agreement in violation of the Immigration Act then, in addition to other remedies or penalties prescribed by law, System may terminate this Agreement in accordance with **Section 7**. Contractor represents and warrants that it is in compliance with and agrees that it will remain in compliance with the provisions of the Immigration Act.

10.21 **Limitations.** THE PARTIES ARE AWARE THAT THERE ARE CONSTITUTIONAL AND STATUTORY LIMITATIONS ON THE AUTHORITY OF SYSTEM (A STATE AGENCY) TO ENTER INTO CERTAIN TERMS AND CONDITIONS THAT MAY BE A PART OF THIS AGREEMENT, INCLUDING THOSE TERMS AND CONDITIONS RELATING TO LIENS ON SYSTEM'S PROPERTY; DISCLAIMERS AND LIMITATIONS OF WARRANTIES; DISCLAIMERS AND LIMITATIONS OF LIABILITY FOR DAMAGES; WAIVERS, DISCLAIMERS AND LIMITATIONS OF LEGAL RIGHTS, REMEDIES, REQUIREMENTS AND PROCESSES; LIMITATIONS OF PERIODS TO BRING LEGAL ACTION; GRANTING CONTROL OF LITIGATION OR SETTLEMENT TO ANOTHER PARTY; LIABILITY FOR ACTS OR OMISSIONS OF THIRD PARTIES; PAYMENT OF ATTORNEYS' FEES; DISPUTE RESOLUTION; INDEMNITIES; AND CONFIDENTIALITY (COLLECTIVELY, THE "**LIMITATIONS**"), AND TERMS AND CONDITIONS RELATED TO THE LIMITATIONS WILL NOT BE BINDING ON SYSTEM

EXCEPT TO THE EXTENT AUTHORIZED BY THE LAWS AND CONSTITUTION OF THE STATE OF TEXAS.

10.22 **Ethics Matters; No Financial Interest.** Contractor and its employees, agents, representatives and subcontractors have read and understand System's Conflicts of Interest Policy available at <http://www.utsystem.edu/policy/policies/int160.html> System's Standards of Conduct Guide available at <http://www.utsystem.edu/systemcompliance/SOCcombined.pdf>, and applicable state ethics laws and rules available at www.utsystem.edu/ogc/ethics. Neither Contractor nor its employees, agents, representatives or subcontractors will assist or cause System employees to violate System's Conflicts of Interest Policy, provisions described by System's Standards of Conduct Guide, or applicable state ethics laws or rules. Contractor represents and warrants that no member of the Board has a direct or indirect financial interest in the transaction that is the subject of this Agreement.

10.23 **Historically Underutilized Business Subcontracting Plan. Drafting Note: If vendor will be subcontracting, the following clause will be included:** Carrier agrees to use good faith efforts to subcontract the Work in accordance with the Historically Underutilized Business Subcontracting Plan ("HSP") submitted by Contractor and attached as **Exhibit F**, which is incorporated into this Agreement for all purposes. Carrier agrees to maintain business records documenting its compliance with the HSP and to submit a monthly compliance report to System in the format required by Texas Procurement and Support Services Division of the Texas Comptroller of Public Accounts or any successor agency (collectively, "TPSS"). Submission of compliance reports will be required as a condition for payment under this Agreement. If System determines that Carrier has failed to subcontract as set out in the HSP, System will notify Carrier of any deficiencies and give Carrier an opportunity to submit documentation and explain why the failure to comply with the HSP should not be attributed to a lack of good faith effort by Carrier. If System determines that Carrier failed to implement the HSP in good faith, System, in addition to any other remedies, may report nonperformance to the TPSS in accordance with 34 TAC Chapter 20, §§20.101 – 20.108. System may also revoke this Agreement for breach and make a claim against the Carrier.

10.23.1. Changes to the HSP. If at any time during the term of this Agreement, Carrier desires to change the HSP, before the proposed changes become effective (a) Carrier must comply with 34 TAC Section 20.14; (b) the changes must be reviewed and approved by System; and (c) if System approves changes to the HSP, this Agreement must be amended in accordance with Section 12.8 to replace the HSP with the revised subcontracting plan.

10.23.2. Expansion of the Work. If System expands the scope of the Work through a change order or any other amendment, System will determine if the additional Work contains probable subcontracting opportunities *not*

identified in the initial solicitation for the Work. If System determines additional probable subcontracting opportunities exist, Carrier will submit an amended subcontracting plan covering those opportunities. The amended subcontracting plan must comply with the provisions of 34 TAC Section 20.14 before (a) this Agreement may be amended to include the additional Work; or (b) Carrier may perform the additional Work. If Carrier subcontracts any of the additional subcontracting opportunities identified by System without prior authorization and without complying with 34 TAC Section 20.14, Carrier will be deemed to be in breach of this Agreement under Section 8 and will be subject to any remedial actions provided by Texas law including Chapter 2161, *Texas Government Code* and 34 TAC Section 20.14. System may report nonperformance under this Agreement to the TPSS in accordance with 34 TAC Chapter 20, §§20.101 – 20.108.]

If vendor will not be subcontracting the following clause will be included: The parties understand and agree in good faith that none of the services to be provided by Carrier to System under this Agreement shall be subcontracted by Carrier to any other entity or person. If, despite this agreement, it should become necessary to subcontract any part of the contract, Carrier agrees to seek authorization from System and comply with all applicable provisions of System's HUB requirements and 1 TAC, Section 111.14, prior to any modifications or performance in the awarded contract involving subcontracting.]

10.24 Access by Individuals with Disabilities. Contractor represents and warrants ("EIR Accessibility Warranty") that the electronic and information resources and all associated information, documentation, and support that it provides to System under this Agreement (collectively, the "EIRs") comply with the applicable requirements set forth in Title 1 TAC Chapter 213 and Title 1 TAC Section 206.70 (as authorized by Chapter 2054, Subchapter M, Texas Government Code). To the extent Contractor becomes aware that the EIRs, or any portion of the EIRs, do not comply with the EIR Accessibility Warranty, then Contractor represents and warrants that it will, at no cost to System, either (1) perform all necessary remediation to make the EIRs satisfy the EIR Accessibility Warranty or (2) replace the EIRs with new EIRs that satisfy the EIR Accessibility Warranty. In the event that Contractor is unable to do so, then System may terminate this Agreement and Contractor will refund to System all amounts System has paid under this Agreement within thirty (30) days after the termination date.

System and Contractor have executed and delivered this Agreement to be effective as of the Effective Date.

SYSTEM:

CONTRACTOR:

By: _____

By: _____

Name: Scott C. Kelley
Title: Executive Vice Chancellor
For Business Affairs

Name:
Title:

Date: _____

Date: _____

Exhibits:

**EXHIBIT A
EXHIBIT B
EXHIBIT C
EXHIBIT D
EXHIBIT E
EXHIBIT F**

**RFP (On File with System)
Response (On File with System)
[Policies]
Performance Guarantees
[Financial Arrangement]
[HUB Subcontracting Plan]**

THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION

OCTOBER 2015

APPENDIX III

POLICY ON UTILIZATION

HISTORICALLY UNDERUTILIZED BUSINESSES

VENDOR/COMMODITIES



**The University of Texas System
Office of HUB Development
Policy on Utilization of Historically Underutilized Businesses (HUBs)**

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**The University of Texas System
Office of HUB Development**

POLICY ON UTILIZATION OF HISTORICALLY UNDERUTILIZED BUSINESSES (HUBS)

Introduction

In accordance with the Texas Government Code, Sections 2161.181-182 and Title 34, Section 20.13 of the Texas Administrative Code (TAC), the Board of Regents of The University of Texas System, acting through the Office of HUB Development shall make a good faith effort to utilize Historically Underutilized Businesses (HUBs) in contracts for construction services, including professional and consulting services; and commodities contracts. The HUB Rules promulgated by the Texas Comptroller of Public Accounts (the "Texas Comptroller"), set forth in 34 TAC Sections 20.10-20.28, encourage the use of HUBs by implementing these policies through race, ethnic and gender-neutral means.

The purpose of the HUB Program is to promote full and equal business opportunities for all business in State contracting in accordance with the following goals as specified in the State of Texas Disparity Study:

- 11.2% for heavy construction other than building contracts;
- 21.1% for all building construction, including general contractors and operative builders contracts;
- 32.9% for all special trade construction contracts;
- 23.7% for professional services contracts;
- 26% for all other services contracts, and
- 21.1% for commodities contracts.

The University of Texas System shall make a good faith effort to meet or exceed the above stated goals to assist HUBs in receiving a portion of the total contract value of all contracts that UT System expects to award in a fiscal year. The University of Texas System may achieve the annual program goals by contracting directly with HUBs or indirectly through subcontracting opportunities in accordance with the Texas Government Code, chapter 2161, Subchapter F.

NOTE: The goals above are the State of Texas HUB goals. For purposes of this procurement, The University of Texas System goals listed in the Special Instructions on page 11 will apply.

SUMMARY OF REQUIREMENTS
Historically Underutilized Business (HUBs) Subcontracting Plan (HSP)

It is the policy of The University of Texas System and each of its component institutions, to promote and encourage contracting and subcontracting opportunities for Historically Underutilized Businesses (HUBs) in all contracts. Accordingly, UT System has adopted “**EXHIBIT H, Policy on Utilization of Historically Underutilized Businesses**”. The policy applies to all contracts with an expected value of \$100,000 or more. The Board of Regents of The University of Texas System is the contracting authority.

1. In all contracts for professional services, contracting services, and/or commodities with an expected value of \$100,000 or more, The University of Texas System, “UT System” or the “University” will indicate in the purchase solicitation (e.g. RFQ, RFP, or CSP) whether or not subcontracting opportunities are probable in connection with the contract. A HUB Subcontracting Plan is a required element of the architect, contractor or vendor Response to the purchase solicitation. The HUB Subcontracting Plan shall be developed and administered in accordance with the Policy. **Failure to submit a required HUB Subcontracting Plan (HSP) will result in rejection of the Response.**
2. If subcontracting opportunities are probable UT System will declare such probability in its invitations for bids, requests for proposals, or other purchase solicitation documents, and shall require submission of the appropriate HUB Subcontracting Plan with the Response.
 - a. When subcontracting opportunities are probable, and the Respondent proposes to subcontract any part of the work, the Respondent shall submit a **HUB Subcontracting Plan as prescribed by the Texas Comptroller** identifying subcontractors **[34 TAC §20.14 (d) (1)(A)(B)(C)(D) (2) (3)(A)(B)(C)(D)(E)(F) (4)(A)(B)]**.
 - b. When subcontracting opportunities are probable, but the Respondent can perform such opportunities with its employees and resources, the Respondent’s HUB Subcontracting Plan shall include **Section 3 –Self Performance [34 TAC §20.14 (d) (5) (A) (B) (C) (D)]**.
3. If subcontracting opportunities are not probable UT System will declare such probability in its invitations or bids, requests for proposals, or other purchase solicitation documents and shall require submission of the appropriate HUB Subcontracting Plan with the Response.
 - a. When subcontracting opportunities are not probable, and the Respondent proposes to perform all the work with its employees and resources, the Respondent shall submit a HUB Subcontracting Plan that includes **Section 3 – Self Performance Justification**.
 - b. When subcontracting opportunities are not probable, but the Respondent proposes to subcontract any part of the work, the Respondent shall submit a **HUB Subcontracting Plan as prescribed by the Texas Comptroller** identifying subcontractors.
4. Respondents shall follow, but are not limited to, procedures listed in the Policy when developing a HUB Subcontracting Plan.
5. **Competitive Sealed Proposals (CSP):** Respondents shall submit a HUB Subcontracting Plan (packaged separately) twenty-four (24) hours following the Response submission date and time or as prescribed by the project manager.
6. In making a determination whether a good faith effort has been made in the development of the required HUB Subcontracting Plan, UT System shall follow the procedures listed in the Policy. If accepted by the

University, the HUB Subcontracting Plan shall become a provision of the Respondent's contract with UT System. **Revisions necessary to clarify and enhance information submitted in the original HUB subcontracting plan may be made in an effort to determine good faith effort.** Any revisions after the submission of the HSP shall be approved by the HUB Coordinator.

7. **Design Build (DB) and Construction Manager @ Risk (CM@R) responses:** Respondents to a "design build" or "construction manager-at-risk" purchase solicitation shall include the Letter of HUB Commitment in their Response attesting that the Respondent has read and understands the Policy on Historically Underutilized Businesses (HUBs), and a HUB Subcontracting Plan for all preconstruction and construction services including a HUB Subcontracting Plan as prescribed by the Texas Comptroller specific to construction services identifying first, second and third tier subcontractors. Respondents proposing to perform Part 1 preconstruction services with their own resources and employees shall submit, as part of their HSP, the Self Performance Justification.
8. **DB and CM@R HUB Contract Requirements:** Contractors engaged under design-build and construction manager-at-risk contracts shall submit a HUB Subcontracting Plan for all preconstruction and construction Phase Services, and, must further comply with the requirements of this Policy by developing and submitting a HUB Subcontracting Plan for each bid package issued in buying out the guaranteed maximum or lump sum price of the project. The HSP shall identify first, second and third tier subcontractors.
9. The University of Texas System shall reject any Response that does not include a fully completed HSP as required. **An incomplete HUB Subcontracting Plan is considered a material failure to comply with the solicitation for proposals.**
10. **Changes to the HUB Subcontracting Plan:** Once a Respondent's HSP is accepted by UT System and becomes a provision of the contract between Respondent and UT System, the Respondent can only change that HSP if (a) the Respondent complies with 34 TAC Section 20.14; (b) the Respondent provides its proposed changes to UT System for review; (c) UT System (including UT System's HUB Coordinator) approves Respondent's proposed changes to its HSP; and (d) UT System and the Respondent amend their contract (in writing signed by authorized officials of both parties) in order to replace the contract's existing HSP with a revised HSP containing the changes approved by UT System.
11. **Expansion of Work:** If, after entering into a contract with a Respondent as a result of a purchase solicitation subject to the Policy, UT System wishes to expand the scope of work that the Respondent will perform under that contract through a change order or any other contract amendment (the "additional work"), UT System will determine if the additional work contains probable subcontracting opportunities not identified in the initial purchase solicitation for that contract. If UT System determines that probable subcontracting opportunities exist for the additional work, then the Respondent must submit to UT System an amended HUB Subcontracting Plan covering those opportunities that complies with the provisions of 34 TAC Section 20.14. Such an amended HSP must be approved by UT System and the Respondent (including UT System's HUB Coordinator) before (a) the contract may be amended by UT System and the Respondent to include the additional work and the amended HSP and (b) the Respondent performs the additional work. If a Respondent subcontracts any of the additional subcontracting opportunities identified by UT System for any additional work (i) without complying with 34 TAC Section 20.14 or (ii) before UT System and that Respondent amend their contract to include a revised HSP that authorizes such subcontracting, then the Respondent will be deemed to be in breach of its contract with UT System. As a result of such breach, UT System will be entitled to terminate its contract with the Respondent, and the Respondent will be subject to any remedial actions provided by Texas law, including those set forth in Chapter 2161, Texas Government Code, and 34 TAC Section 20.14. The University may report a Respondent's nonperformance under a

contract between that Respondent and UT System to the Texas Comptroller in accordance with 34 TAC Sections 20.10 through 20.18.

12. A Response may state that the Respondent intends to perform all the subcontracting opportunities with its own employees and resources in accordance with the Policy. However, if such a Respondent enters into a contract with UT System as a result of such a Response but later desires to subcontract any part of the work set forth in that contract, before the Respondent subcontracts such work it must first change its HUB Subcontracting Plan in accordance with the provisions of Section 10 above.
13. The University of Texas System shall require a professional services firm, contractor or vendor to whom a contract has been awarded to report the identity and the amount paid to its subcontractors on a monthly basis using a **HUB Subcontracting Plan (HSP) Prime Contractor Progress Assessment Report (PAR)** as a condition for payment.
14. If the University of Texas System determines that the successful Respondent failed to implement an approved HUB Subcontracting Plan in good faith, UT System, in addition to any other remedies, may report nonperformance to the Texas Comptroller in accordance with 34 TAC Section 20.14, (g) (1) related remedies of nonperformance to professional services firms, contractor and vendor implementation of the HSP.
15. In the event of any conflict between this "Summary of Requirements" and the remainder of the HUB Policy, the remainder of the HUB Policy will control.
16. These requirements, including the attachments referred to above, may be downloaded over the Internet from <http://utsystem.edu/offices/historically-underutilized-business/hub-forms>. For additional information contact:

The Office of HUB Programs
The University of Texas System
210 West 6th Street
Suite B.140E
Austin, Texas 78701
512/499/4530

**Other Services/Vendor/Commodities HSP
Summary of Attachments Required from Respondents**

	Letter of Transmittal Page 8	Letter of HUB Commitment Page 9	HUB Subcontracting Plan (HSP) Pages 11-18	Progress Assessment Report (PAR) Page 19
1. UT SYSTEM DETERMINES THAT SUBCONTRACTING OPPORTUNITIES ARE PROBABLE.				
1. A. Respondent Proposes Subcontractors: Attachments required from the Respondent for the HUB Subcontracting Plan if the solicitation states that <u>subcontracting opportunities are probable</u> .	X		X	
1.B. Respondent Proposes Self-Performance: Attachments required from the Respondent for the HUB Subcontracting Plan if the solicitation states that <u>subcontracting opportunities are probable</u> , but the Respondent can perform such opportunities with its employees and resources.	X		X	
2. UT SYSTEM DETERMINES THAT SUBCONTRACTING OPPORTUNITIES ARE NOT PROBABLE.				
2.A. Respondent Proposes Self-Performance: Attachments required from the Respondent for the HUB Subcontracting Plan if the solicitation states that <u>subcontracting opportunities are not probable</u> , but the Respondent can perform such opportunities with its employees and resources.	X		X	
2. B. Respondent Proposes Subcontractors: Attachments required from the Respondent for the HUB Subcontracting Plan if the solicitation states that <u>subcontracting opportunities are not probable</u> , but the Respondent proposes to subcontract any part of the work.	X		X	
3. INDEFINITE DURATION/INDEFINITE QUANTITY CONTRACTS: Submit with initial qualifications. Attachments required from the Respondent prior to contract execution for each contract associated with a solicitation for miscellaneous services.		X	X	
4. CHANGES IN THE HUB SUBCONTRACTING PLAN AFTER AWARD: Attachments required from the Respondent to whom a contract has been awarded if it desires to make changes to the approved HUB Subcontracting Plan.			X	
5. REPORTING: Progress Assessment Report (PAR) required with all payment requests. The submittal of this attachment is a condition of payment.				X

(RESPONDENT'S BUSINESS LETTERHEAD)

Date

Regional HUB Coordinator
The Office of HUB Programs
The University of Texas System
201 W. 6th St., Room B.140E
Austin, Texas 78701

RE: Historically Underutilized Business Plan for (Project Title): _____
Project Number: _____ - _____

Dear ,

In accordance with the requirements outlined in the specification section "HUB Participation Program," I am pleased to forward this HUB Subcontracting Plan as an integral part of our response in connection with your invitation for Request for Proposals referencing the above project.

I have read and understand The University of Texas System Policy on Utilization of Historically Underutilized Businesses (HUBs). I also understand the State of Texas Annual Procurement Goal according to 34 Texas Administrative Code Section §20.13, and the goal as stated in the Agency Special Instructions section of the HUB Subcontracting Plan, page 11.

Select one of the following:

- _____ 32.9% for all special trade construction contracts
- _____ 26% for all other services contracts
- _____ 31.04% for commodities contracts

Subcontractors	No. of Subcontractors	Total Subcontract \$ Value	Total Estimated HUB %	% Minority Owned	% Woman Owned	% Service Disabled Veteran
HUB						
NON-HUB						
TOTAL						

I understand the above HUB percentages must represent Texas Comptroller HUB certification standards. For each of the listed HUB firms, I have attached a Texas Comptroller HUB Certification document.

Should we discover additional subcontractors claiming Historically Underutilized Business status during the course of this contract we will notify you of the same. In addition, if for some reason a HUB is unable to fulfill its contract with us, we will notify you immediately in order to take the appropriate steps to amend this contractual obligation.

Sincerely,

(Project Executive)

cc: Contract Administrator

(RESPONDENT'S BUSINESS LETTERHEAD)

Date

Regional HUB Coordinator
The Office of HUB Programs
The University of Texas System
201 W. 6th St., Room B.140E
Austin, TX 78701

RE: Historically Underutilized Business Plan for (Project Title): _____
Project Number: _____ - _____

Dear ,

In accordance with the requirements outlined in the specification section "HUB Participation Program", I am pleased to forward this HUB Subcontracting Plan as an integral part of our proposal in connection with your invitation for request for proposals, referencing Project Number _____.

I have read and understand The University of Texas System Policy on Utilization of Historically Underutilized Businesses (HUBs). I also understand the State of Texas Annual Procurement Goal according to 34 Texas Administrative Code Section § 20.13, and the goal as stated in the Agency Special Instructions section of the HUB Subcontracting Plan, page 11.

Good Faith Effort will be documented by a two part HUB Subcontracting Plan (HSP) process. Part one (1) of the HSP submission will reflect self-performance with the appropriate sections completed per the instructions in Option One of the HSP Quick Checklist located on page 10 of The University of Texas Exhibit H Policy on Utilization of Historically Underutilized Businesses (HUBs).

As the scope of work/project is defined under this ID/IQ contract, part two (2) of the process will require a revised HUB Subcontracting Plan (HSP) and the Good Faith Effort will be documented per instructions in Attachment B (page 16-17) and Option Three of the HSP Quick Check List. The revised HUB Subcontracting Plan will be submitted to the HUB Coordinator prior to execution of each contract process. Documentation of subcontracted work will be provided with each pay request.

Sincerely,

(Project Executive)

cc: Contract Administrator



HUB Subcontracting Plan (HSP)

QUICK CHECKLIST

While this HSP Quick Checklist is being provided to merely assist you in readily identifying the sections of the HSP form that you will need to complete, it is very important that you adhere to the instructions in the HSP form and instructions provided by the contracting agency.

Option One -If you will be awarding all of the subcontracting work you have to offer under the contract to only Texas certified HUB vendors, complete:

- Section 1 - Respondent and Requisition Information
- Section 2a. - Yes, I will be subcontracting portions of the contract
- Section 2b. - List all the portions of work you will subcontract, and indicate the percentage of the contract you expect to award to Texas certified HUB vendors
- Section 2c. - Yes
- Section 4 - Affirmation
- GFE Method A (Attachment A) - Complete an Attachment A for each of the subcontracting opportunities you listed in Section 2b.
- Letter of Transmittal

Option Two - If you will be subcontracting any portion of the contract to Texas certified HUB vendors and Non-HUB vendors, and the aggregate percentage of all the subcontracting work you will be awarding to the Texas certified HUB vendors with which you have a continuous contract in place for five (5) years or less meets or exceeds the HUB Goal the contracting agency identified in the "Agency Special Instructions/Additional Requirements", complete:

- Section 1 - Respondent and Requisition Information
- Section 2a. - Yes, I will be subcontracting portions of the contract
- Section 2b. - List all the portions of work you will subcontract, and indicate the percentage of the contract you expect to award to Texas certified HUB vendors and Non-HUB vendors
- Section 2c. - No
- Section 2d. - Yes
- Section 4 - Affirmation
- GFE Method A (Attachment A) - Complete an Attachment A for each of the subcontracting opportunities you listed in Section 2b.
- Letter of Transmittal

Option Three - If you will be subcontracting any portion of the contract to Texas certified HUB vendors and Non-HUB vendors or only to Non-HUB vendors, and the aggregate percentage of all the subcontracting work you will be awarding to the Texas certified HUB vendors with which you have a continuous contract in place for five (5) years or less does not meet or exceed the HUB Goal the contracting agency identified in the "Agency Special Instructions/Additional Requirements", complete:

- Section 1 - Respondent and Requisition Information
- Section 2a. - Yes, I will be subcontracting portions of the contract
- Section 2b. - List all the portions of work you will subcontract, and indicated the percentage of the contract you expect to award to Texas certified HUB vendors and Non-HUB vendors
- Section 2c. - No
- Section 2d. - No
- Section 4 - Affirmation
- GFE Method B (Attachment B) - Complete an Attachment B for each of the subcontracting opportunities you listed in Section 2b.
- Letter of Transmittal

Option Four - If you will not be subcontracting any portion of the contract and will be fulfilling the entire contract with your own resources, complete:

- Section 1 - Respondent and Requisition Information
- Section 2a. - No, I will not be subcontracting any portion of the contract, and I will be fulfilling the entire contract with my own resources
- Section 3 - Self Performing Justification
- Section 4 - Affirmation
- Letter of HUB Commitment

***Continuous Contract:** Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.



HUB Subcontracting Plan (HSP)

In accordance with Texas Gov't Code §2161.252, the contracting agency has determined that subcontracting opportunities are probable under this contract. Therefore, all respondents, including State of Texas certified Historically Underutilized Businesses (HUBs) must complete and submit this State of Texas HUB Subcontracting Plan (HSP) with their response to the bid requisition (solicitation).

NOTE: Responses that do not include a completed HSP shall be rejected pursuant to Texas Gov't Code §2161.252(b).

The HUB Program promotes equal business opportunities for economically disadvantaged persons to contract with the State of Texas in accordance with the goals specified in the 2009 State of Texas Disparity Study. The statewide HUB goals defined in 34 Texas Administrative Code (TAC) §20.13 are:

- **11.2 percent for heavy construction other than building contracts,**
- **21.1 percent for all building construction, including general contractors and operative builders' contracts,**
- **32.9 percent for all special trade construction contracts,**
- **23.7 percent for professional services contracts,**
- **26.0 percent for all other services contracts, and**
- **21.1 percent for commodities contracts.**

- - Agency Special Instructions/Additional Requirements - -

In accordance with 34 TAC §20.14(d)(1)(D)(iii), a respondent (prime contractor) may demonstrate good faith effort to utilize Texas certified HUBs for its subcontracting opportunities if the total value of the respondent's subcontracts with Texas certified HUBs meets or exceeds the statewide HUB goal or the agency specific HUB goal, whichever is higher. When a respondent uses this method to demonstrate good faith effort, the respondent must identify the HUBs with which it will subcontract. If using existing contracts with Texas certified HUBs to satisfy this requirement, only aggregate percentage of the contract expected to be subcontracted to HUBs with which the respondent does not have a continuous contract* in place for more than five (5) years shall qualify for meeting the HUB goal. This limitation is designed to encourage vendor rotation as recommended by the 2009 Texas Disparity Study.

In accordance with 34 TAC §20.13 (d)(1)9D)(iii), the goals stated below are the applicable goals for The University of Texas System Administration only.

- Commodities HUB Goal – 31.04%**
- Other Services HUB Goal – 26%**
- Special Trades HUB Goal – 32.9%**

- Responses shall submit a completed HUB Subcontracting Plan (HSP) to be considered responsive. Failure to submit a completed HSP shall result in the bid, proposal or other expression of interest to be considered NON-responsive.
- Respondents who intend to Self-Perform all of their work shall submit an HSP for Self-Performance (pages 11-14).
- HUB Subcontracting Plan (HSP) Prime Contractor Assessment Report (PAR) shall be submitted with each request for payment and is a condition of payment.
- Only fax, email and certified letter are acceptable documentation of the Good Faith Effort.

SECTION-1: RESPONDENT AND REQUISITION INFORM

a. Respondent (Company) Name: _____ State of Texas VID #: _____
 Point of Contact: _____ Phone #: _____
 E-mail Address: _____ Fax #: _____

b. Is your company a State of Texas certified HUB? - Yes - No

c. Requisition #: _____ Bid Open Date: _____

Enter your company's name here: _____ Requisition #: _____

SECTION 2: SUBCONTRACTING INTENTIONS RESPONDENT

After dividing the contract work into reasonable lots or portions to the extent consistent with prudent industry practices, and taking into consideration the scope of work to be performed under the proposed contract, including all potential subcontracting opportunities, the respondent must determine what portions of work, including goods and services, will be subcontracted. Note: In accordance with 34 TAC §20.11., an "Subcontractor" means a person who contracts with a prime contractor to work, to supply commodities, or to contribute toward completing work for a governmental entity.

a. Check the appropriate box (Yes or No) that identifies your subcontracting intentions:

- Yes, I will be subcontracting portions of the contract. (If Yes, complete Item b, of this SECTION and continue to Item c of this SECTION.)
- No, I will not be subcontracting any portion of the contract, and I will be fulfilling the entire contract with my own resources. (If No, continue to SECTION 3 and SECTION 4.)

b. List all the portions of work (subcontracting opportunities) you will subcontract. Also, based on the total value of the contract, identify the percentages of the contract you expect to award to Texas certified HUBs, and the percentage of the contract you expect to award to vendors that are not a Texas certified HUB (i.e., Non-HUB).

	Subcontracting Opportunity Description	HUBs		Non-HUBs
		Percentage of the contract expected to be subcontracted to HUBs with which you have a <u>continuous contract*</u> in place for five (5) years or less.	Percentage of the contract expected to be subcontracted to HUBs with which you have a <u>continuous contract*</u> in place for <u>more than five (5) years.</u>	Percentage of the contract expected to be subcontracted to non-HUBs.
1		%	%	%
2		%	%	%
3		%	%	%
4		%	%	%
5		%	%	%
6		%	%	%
7		%	%	%
8		%	%	%
9		%	%	%
10		%	%	%
11		%	%	%
12		%	%	%
13		%	%	%
14		%	%	%

(Note: If you have more than fifteen subcontracting opportunities, a continuation sheet is available online at <http://window.state.tx.us/procurement/prog/hub/hub-subcontracting-plan/>.)

c. Check the appropriate box (Yes or No) that indicates whether you will be using only Texas certified HUBs to perform all of the subcontracting opportunities you listed in SECTION 2, Item b.

- Yes (If Yes, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method A (Attachment A)" for each of the subcontracting opportunities you listed.)
- No (If No, continue to Item d, of this SECTION.)

d. Check the appropriate box (Yes or No) that indicates whether the aggregate expected percentage of the contract you will subcontract with Texas certified HUBs with which you have a continuous contract* in place with for five (5) years or less meets or exceeds the HUB goal the contracting agency identified on page 1 in the "Agency Special Instructions/Additional Requirements".

- Yes (If Yes, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method A (Attachment A)" for each of the subcontracting opportunities you listed.)
- No (If No, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method B (Attachment B)" for each of the subcontracting opportunities you listed.)

**Continuous Contract: Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.*

Enter your company's name here: _____ Requisition #: _____

SECTION-2: SUBCONTRACTING INTENTIONS RESPONDENT (CONTINUATION SHEET)

a. This page can be used as a continuation sheet to the HSP Form's page 2, Section 2, Item b. Continue listing the portions of work (subcontracting opportunities) you will subcontract. Also, based on the total value of the contract, identify the percentages of the contract you expect to award to Texas certified HUBs, and the percentage of the contract you expect to award to vendors that are not a Texas certified HUB (i.e., Non-HUB).

	Subcontracting Opportunity Description	HUBs		Non-HUBs
		Percentage of the contract expected to be subcontracted to HUBs with which you have a <u>continuous contract*</u> in place for five (5) years or less.	Percentage of the contract expected to be subcontracted to HUBs with which you have a <u>continuous contract*</u> in place for <u>more than five (5) years.</u>	Percentage of the contract expected to be subcontracted to non-HUBs.
16		%	%	%
17		%	%	%
18		%	%	%
19		%	%	%
20		%	%	%
21		%	%	%
22		%	%	%
23		%	%	%
24		%	%	%
25		%	%	%
26		%	%	%
27		%	%	%
28		%	%	%
29		%	%	%
30		%	%	%
31		%	%	%
32		%	%	%
33		%	%	%
34		%	%	%
35		%	%	%
36		%	%	%
37		%	%	%
38		%	%	%
39		%	%	%
40		%	%	%
41		%	%	%
42		%	%	%

**Continuous Contract: Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.*

Enter your company's name here: _____ Requisition #: _____

SECTION-3: SELF PERFORMING JUSTIFICATION (If you responded "No" to SECTION 2, Item a, you must complete this SECTION and continue to SECTION 4)

Check the appropriate box (Yes or No) that indicates whether your response/proposal contains an explanation demonstrating how your company will fulfill the entire contract with its own resources.

- Yes (If Yes, in the space provided below list the specific page(s)/section(s) of your proposal which explains how your company will perform the entire contract with its own equipment, supplies, materials and/or employees.)
- No (If No, in the space provided below explain how your company will perform the entire contract with its own equipment, supplies, materials and/or employees.)

SECTION-4: AFFIRMATION

As evidenced by my signature below, I affirm that I am an authorized representative of the respondent listed in SECTION 1, and that the information and supporting documentation submitted with the HSP is true and correct. Respondent understands and agrees that, if awarded any portion of the requisition:

- The respondent will provide notice as soon as practical to all the subcontractors (HUBs and Non-HUBs) of their selection as a subcontractor for the awarded contract. The notice must specify at a minimum the contracting agency's name and its point of contact for the contract, the contract award number, the subcontracting opportunity they (the subcontractor) will perform, the approximate dollar value of the subcontracting opportunity and the expected percentage of the total contract that the subcontracting opportunity represents. A copy of the notice required by this section must also be provided to the contracting agency's point of contact for the contract no later than ten (10) working days after the contract is awarded.
- The respondent must submit monthly compliance reports (Prime Contractor Progress Assessment Report – PAR) to the contracting agency, verifying its compliance with the HSP, including the use of and expenditures made to its subcontractors (HUBs and Non-HUBs). (The PAR is available at <http://www.window.state.tx.us/procurement/prog/hub/hub-forms/progressassessmentrpt.xls>).
- The respondent must seek approval from the contracting agency prior to making any modifications to its HSP, including the hiring of additional or different subcontractors and the termination of a subcontractor the respondent identified in its HSP. If the HSP is modified without the contracting agency's prior approval, respondent may be subject to any and all enforcement remedies available under the contract or otherwise available by law, up to and including debarment from all state contracting.
- The respondent must, upon request, allow the contracting agency to perform on-site reviews of the company's headquarters and/or work-site where services are being performed and must provide documentation regarding staffing and other resources.

Signature	Printed Name	Title	Date <small>(mm/dd/yyyy)</small>
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Reminder:

- If you responded "Yes" to SECTION 2, Items c or d, you must complete an "HSP Good Faith Effort - Method A (Attachment A)" for each of the subcontracting opportunities you listed in SECTION 2, Item b.
- If you responded "No" SECTION 2, Items c and d, you must complete an "HSP Good Faith Effort - Method B (Attachment B)" for each of the subcontracting opportunities you listed in SECTION 2, Item b.

HSP Good Faith Effort - Method B (Attachment B)

Enter your company's name here: _____ Requisition #: _____

IMPORTANT: If you responded "Yes" to SECTION 2, Items c or d of the completed HSP form, you must submit a completed "HSP Good Faith Effort - Method B (Attachment B)" for **each** of the subcontracting opportunities you listed in SECTION 2, Item b of the completed HSP form. You may photo-copy this page or download the form at <http://window.state.tx.us/procurement/prog/hub/hub-forms/hub-sbcont-plan-gfe-achm-b.pdf>.

SECTION B-1: SUBCONTRACTING OPPORTUNITY

Enter the item number and description of the subcontracting opportunity you listed in SECTION 2, Item b, of the completed HSP form for which you are completing the attachment.

Item Number: _____ Description: _____

SECTION B-2: MENTOR PROTÉGÉ PROGRAM

If respondent is participating as a Mentor in a State of Texas Mentor Protégé Program, submitting its Protégé (Protégé must be a State of Texas certified HUB) as a subcontractor to perform the subcontracting opportunity listed in SECTION B-1, constitutes a good faith effort to subcontract with a Texas certified HUB towards that specific portion of work.

Check the appropriate box (Yes or No) that indicates whether you will be subcontracting the portion of work you listed in SECTION B-1 to your Protégé.

- Yes (If Yes, to continue to SECTION B-4.)
- No / Not Applicable (If No or Not Applicable, continue to SECTION B-3 and SECTION B-4.)

SECTION B-3: NOTIFICATION OF SUBCONTRACTING OPPORTUNITY

When completing this section you **MUST** comply with items **a, b, c and d**, thereby demonstrating your Good Faith Effort of having notified Texas certified HUBs and trade organizations or development centers about the subcontracting opportunity you listed in SECTION B-1. Your notice should include the scope of work, information regarding the location to review plans and specifications, bonding and insurance requirements, required qualifications, and identify a contact person. When sending notice of your subcontracting opportunity, you are encouraged to use the attached HUB Subcontracting Opportunity Notice form, which is also available online at <http://www.window.state.tx.us/procurement/prog/hub/hub-subcontracting-plan>.

Retain supporting documentation (i.e., certified letter, fax, e-mail) demonstrating evidence of your good faith effort to notify the Texas certified HUBs and trade organizations or development centers. Also, be mindful that a working day is considered a normal business day of a state agency, not including weekends, federal or state holidays, or days the agency is declared closed by its executive officer. The initial day the subcontracting opportunity notice is sent/provided to the HUBs and to the trade organizations or development centers is considered to be "day zero" and does not count as one of the seven (7) working days.

- a. Provide written notification of the subcontracting opportunity you listed in SECTION B-1, to three (3) or more Texas certified HUBs. Unless the contracting agency specified a different time period, you must allow the HUBs at least seven (7) working days to respond to the notice prior to your submitting your bid response to the contracting agency. When searching for Texas certified HUBs, ensure that you use the State of Texas' Centralized Master Bidders List (CMBL) and Historically Underutilized Business (HUB) Search directory located at <http://mycpa.state.tx.us/tpasscmbsearch/index.jsp>. HUB Status code "A" signifies that the company is a Texas certified HUB.
- b. List the three (3) Texas certified HUBs you notified regarding the subcontracting opportunity you listed in SECTION B-1. Include the company's Vendor ID (VID) number, the date you sent notice to that company, and indicate whether it was responsive or non-responsive to your subcontracting opportunity notice.

CompanyName	VIDNumber	Date Notice Sent (mm/dd/yyyy)	Did the HUB Respond?
			<input type="checkbox"/> - Yes <input type="checkbox"/> - No
			<input type="checkbox"/> - Yes <input type="checkbox"/> - No
			<input type="checkbox"/> - Yes <input type="checkbox"/> - No

- c. Provide written notification of the subcontracting opportunity you listed in SECTION B-1 to two (2) or more trade organizations or development centers in Texas to assist in identifying potential HUBs by disseminating the subcontracting opportunity to their members/participants. Unless the contracting agency specified a different time period, you must provide your subcontracting opportunity notice to trade organizations or development centers at least seven (7) working days prior to submitting your bid response to the contracting agency. A list of trade organizations and development centers that have expressed an interest in receiving notices of subcontracting opportunities is available on the Statewide HUB Program's webpage at <http://www.window.state.tx.us/procurement/prog/hub/mwb-links-1/>.
- d. List two (2) trade organizations or development centers you notified regarding the subcontracting opportunity you listed in SECTION B-1. Include the date when you sent notice to it and indicate if it accepted or rejected your notice.

Trade Organizations or Development Centers	Date Notice Sent (mm/dd/yyyy)	Was the Notice Accepted?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

(Attachment B)

HSP Good Faith Effort - Method B (Attachment B) Cont.

Enter your company's name here: _____ Requisition #: _____

SECTION B-4: SUBCONTRACTOR SELECTION

Enter the item number and description of the subcontracting opportunity you listed in SECTION 2, Item b, of the completed HSP form for which you are completing the attachment.

a. Enter the item number and description of the subcontracting opportunity for which you are completing this Attachment B continuation page.

Item Number: _____ Description: _____

b. List the subcontractor(s) you selected to perform the subcontracting opportunity you listed in SECTION B-1. Also identify whether they are a Texas certified HUB and their VID number, the approximate dollar value of the work to be subcontracted, the expected percentage of work to be subcontracted, and indicate whether the company is a Texas certified HUB.

CompanyName	Texas certified HUB	VID Number (Required if Texas certified HUB)	Approximate Dollar Amount	Expected Percentage of Contract
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%
	<input type="checkbox"/> - Yes <input type="checkbox"/> - No		\$	%

c. If any of the subcontractors you have selected to perform the subcontracting opportunity you listed in SECTION B-1 is not a Texas certified HUB, provide written justification for your selection process (attach additional page if necessary):

REMINDER: As specified in SECTION 4 of the completed HSP form, if you (respondent) are awarded any portion of the requisition, you are required to provide notice as soon as practical to all the subcontractors (HUBs and Non-HUBs) of their selection as a subcontractor. The notice must specify at a minimum the contracting agency's name and its point of contact for the contract, the contract award number, the subcontracting opportunity it (the subcontractor) will perform, the approximate dollar value of the subcontracting opportunity and the expected percentage of the total contract that the subcontracting opportunity represents. A copy of the notice required by this section must also be provided to the contracting agency's point of contact for the contract no later than ten (10) working days after the contract is awarded.

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Voluntary Product Accessibility Template®

Version 1.3

The purpose of the **Voluntary Product Accessibility Template**, or **VPAT™**, is to assist Federal contracting officials and other buyers in making preliminary assessments regarding the availability of commercial “Electronic and Information Technology” products and services with features that support accessibility. It is assumed and recommended that offerers will provide additional contact information to facilitate more detailed inquiries.

The first table of the Template provides a summary view of the Section 508 Standards. The subsequent tables provide more detailed views of each subsection. There are three columns in each table. Column one of the Summary Table describes the subsections of subparts B and C of the Standards. The second column describes the supporting features of the product or refers you to the corresponding detailed table, e.g., “equivalent facilitation.” The third column contains any additional remarks and explanations regarding the product. In the subsequent tables, the first column contains the lettered paragraphs of the subsections. The second column describes the supporting features of the product with regard to that paragraph. The third column contains any additional remarks and explanations regarding the product.

Date:

Name of Product:

Contact for more Information (name/phone/email):

Summary Table		
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Voluntary Product Accessibility Template®		
Criteria	Supporting Features	Remarks and explanations
Section 1194.21 Software Applications and Operating Systems		

Section 1194.22 Web-based Internet Information and Applications		
Section 1194.23 Telecommunications Products		
Section 1194.24 Video and Multi-media Products		
Section 1194.25 Self-Contained, Closed Products		
Section 1194.26 Desktop and Portable Computers		
Section 1194.31 Functional Performance Criteria		
Section 1194.41 Information, Documentation and Support		

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Section 1194.21 Software Applications and Operating Systems – Detail

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<i>Criteria</i>	Supporting Features	Remarks and explanations
(a) When software is designed to run on a system that has a keyboard, product functions shall be executable from a keyboard where the function itself or the result of performing a function can be discerned textually.		
(b) Applications shall not disrupt or disable activated features of other products that are identified as accessibility features, where those		

<p>features are developed and documented according to industry standards. Applications also shall not disrupt or disable activated features of any operating system that are identified as accessibility features where the application programming interface for those accessibility features has been documented by the manufacturer of the operating system and is available to the product developer.</p>		
<p>(c) A well-defined on-screen indication of the current focus shall be provided that moves among interactive interface elements as the input focus changes. The focus shall be programmatically exposed so that Assistive Technology can track focus and focus changes.</p>		
<p>(d) Sufficient information about a user interface element including the identity, operation and state of the element shall be available to Assistive Technology. When an image represents a program element, the information conveyed by the image must also be available in text.</p>		
<p>(e) When bitmap images are used to identify controls, status indicators, or other programmatic elements, the meaning assigned to those images shall be consistent throughout an application's performance.</p>		
<p>(f) Textual information shall be provided through operating system functions for displaying text. The minimum information that shall be made available is text content, text input caret location, and text attributes.</p>		
<p>(g) Applications shall not override user selected contrast and color</p>		

selections and other individual display attributes.		
(h) When animation is displayed, the information shall be displayable in at least one non-animated presentation mode at the option of the user.		
(i) Color coding shall not be used as the only means of conveying information, indicating an action, prompting a response, or distinguishing a visual element.		
(j) When a product permits a user to adjust color and contrast settings, a variety of color selections capable of producing a range of contrast levels shall be provided.		
(k) Software shall not use flashing or blinking text, objects, or other elements having a flash or blink frequency greater than 2 Hz and lower than 55 Hz.		
(l) When electronic forms are used, the form shall allow people using Assistive Technology to access the information, field elements, and functionality required for completion and submission of the form, including all directions and cues.		

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Section 1194.22 Web-based Internet information and applications – Detail

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Criteria	Supporting Features	Remarks and explanations
(a) A text equivalent for every non-text element shall be provided (e.g., via "alt", "longdesc", or in element content).		
(b) Equivalent alternatives for any multimedia presentation shall be synchronized with the presentation.		
(c) Web pages shall be designed so that all information conveyed with color is also available without color, for example from context or markup.		
(d) Documents shall be organized so they are readable without requiring an associated style sheet.		
(e) Redundant text links shall be provided for each active region of a server-side image map.		
(f) Client-side image maps shall be provided instead of server-side image maps except where the regions cannot be defined with an available geometric shape.		
(g) Row and column headers shall be identified for data tables.		
(h) Markup shall be used to associate data cells and header cells for data tables that have two or more logical levels of row or column headers.		
(i) Frames shall be titled with text that facilitates frame identification and navigation		
(j) Pages shall be designed to avoid causing the screen to flicker with a frequency greater than 2 Hz and lower than 55 Hz.		
(k) A text-only page, with equivalent information or functionality, shall be provided to make a web site comply		

with the provisions of this part, when compliance cannot be accomplished in any other way. The content of the text-only page shall be updated whenever the primary page changes.		
(l) When pages utilize scripting languages to display content, or to create interface elements, the information provided by the script shall be identified with functional text that can be read by Assistive Technology.		
(m) When a web page requires that an applet, plug-in or other application be present on the client system to interpret page content, the page must provide a link to a plug-in or applet that complies with §1194.21(a) through (l).		
(n) When electronic forms are designed to be completed on-line, the form shall allow people using Assistive Technology to access the information, field elements, and functionality required for completion and submission of the form, including all directions and cues.		
(o) A method shall be provided that permits users to skip repetitive navigation links.		
(p) When a timed response is required, the user shall be alerted and given sufficient time to indicate more time is required.		

Note to 1194.22: The Board interprets paragraphs (a) through (k) of this section as consistent with the following priority 1 Checkpoints of the Web Content Accessibility Guidelines 1.0 (WCAG 1.0) (May 5 1999) published by the Web Accessibility Initiative of the World Wide Web Consortium: Paragraph (a) - 1.1, (b) - 1.4, (c) - 2.1, (d) - 6.1, (e) - 1.2, (f) - 9.1, (g) - 5.1, (h) - 5.2, (i) - 12.1, (j) - 7.1, (k) - 11.4.

Section 1194.23 Telecommunications Products

– Detail

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Criteria	Supporting Features	Remarks and explanations
(a) Telecommunications products or systems which provide a function allowing voice communication and which do not themselves provide a TTY functionality shall provide a standard non-acoustic connection point for TTYs. Microphones shall be capable of being turned on and off to allow the user to intermix speech with TTY use.		
(b) Telecommunications products which include voice communication functionality shall support all commonly used cross-manufacturer non-proprietary standard TTY signal protocols.		
(c) Voice mail, auto-attendant, and interactive voice response telecommunications systems shall be usable by TTY users with their TTYs.		
(d) Voice mail, messaging, auto-attendant, and interactive voice response telecommunications systems that require a response from a user within a time interval, shall give an alert when the time interval is about to run out, and shall		

provide sufficient time for the user to indicate more time is required.		
(e) Where provided, caller identification and similar telecommunications functions shall also be available for users of TTYs, and for users who cannot see displays.		
(f) For transmitted voice signals, telecommunications products shall provide a gain adjustable up to a minimum of 20 dB. For incremental volume control, at least one intermediate step of 12 dB of gain shall be provided.		
(g) If the telecommunications product allows a user to adjust the receive volume, a function shall be provided to automatically reset the volume to the default level after every use.		
(h) Where a telecommunications product delivers output by an audio transducer which is normally held up to the ear, a means for effective magnetic wireless coupling to hearing technologies shall be provided.		
(i) Interference to hearing technologies (including hearing aids, cochlear implants, and assistive listening devices) shall be reduced to the lowest possible level that allows a user of hearing technologies to utilize the telecommunications product.		
(j) Products that transmit or conduct information or communication, shall pass through cross-manufacturer, non-proprietary, industry-standard codes, translation protocols, formats or other information necessary to provide the information or communication in a usable format.		

Technologies which use encoding, signal compression, format transformation, or similar techniques shall not remove information needed for access or shall restore it upon delivery.		
(k)(1) Products which have mechanically operated controls or keys shall comply with the following: Controls and Keys shall be tactilely discernible without activating the controls or keys.		
(k)(2) Products which have mechanically operated controls or keys shall comply with the following: Controls and Keys shall be operable with one hand and shall not require tight grasping, pinching, twisting of the wrist. The force required to activate controls and keys shall be 5 lbs. (22.2N) maximum.		
(k)(3) Products which have mechanically operated controls or keys shall comply with the following: If key repeat is supported, the delay before repeat shall be adjustable to at least 2 seconds. Key repeat rate shall be adjustable to 2 seconds per character.		
(k)(4) Products which have mechanically operated controls or keys shall comply with the following: The status of all locking or toggle controls or keys shall be visually discernible, and discernible either through touch or sound.		

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Section 1194.24 Video and Multi-media

Products – Detail

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<i>Criteria</i>	Supporting Features	Remarks and explanations
<p>a) All analog television displays 13 inches and larger, and computer equipment that includes analog television receiver or display circuitry, shall be equipped with caption decoder circuitry which appropriately receives, decodes, and displays closed captions from broadcast, cable, videotape, and DVD signals. As soon as practicable, but not later than July 1, 2002, widescreen digital television (DTV) displays measuring at least 7.8 inches vertically, DTV sets with conventional displays measuring at least 13 inches vertically, and stand-alone DTV tuners, whether or not they are marketed with display screens, and computer equipment that includes DTV receiver or display circuitry, shall be equipped with caption decoder circuitry which appropriately receives, decodes, and displays closed captions from broadcast, cable,</p>		

videotape, and DVD signals.		
(b) Television tuners, including tuner cards for use in computers, shall be equipped with secondary audio program playback circuitry.		
(c) All training and informational video and multimedia productions which support the agency's mission, regardless of format, that contain speech or other audio information necessary for the comprehension of the content, shall be open or closed captioned.		
(d) All training and informational video and multimedia productions which support the agency's mission, regardless of format, that contain visual information necessary for the comprehension of the content, shall be audio described.		
(e) Display or presentation of alternate text presentation or audio descriptions shall be user-selectable unless permanent.		

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Section 1194.25 Self-Contained, Closed

Products – Detail

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<i>Criteria</i>	Supporting Features	Remarks and explanations
(a) Self contained products shall be usable by people with disabilities without requiring an end-user to attach Assistive Technology to the product. Personal headsets for private listening are not Assistive Technology.		
(b) When a timed response is required, the user shall be alerted and given sufficient time to indicate more time is required.		
(c) Where a product utilizes touchscreens or contact-sensitive controls, an input method shall be provided that complies with §1194.23 (k) (1) through (4).		
(d) When biometric forms of user identification or control are used, an alternative form of identification or activation, which does not require the user to possess particular biological characteristics, shall also be provided.		
(e) When products		

<p>provide auditory output, the audio signal shall be provided at a standard signal level through an industry standard connector that will allow for private listening. The product must provide the ability to interrupt, pause, and restart the audio at anytime.</p>		
<p>(f) When products deliver voice output in a public area, incremental volume control shall be provided with output amplification up to a level of at least 65 dB. Where the ambient noise level of the environment is above 45 dB, a volume gain of at least 20 dB above the ambient level shall be user selectable. A function shall be provided to automatically reset the volume to the default level after every use.</p>		
<p>(g) Color coding shall not be used as the only means of conveying information, indicating an action, prompting a response, or distinguishing a visual element.</p>		
<p>(h) When a product permits a user to adjust color and contrast settings, a range of color selections capable of producing a variety of contrast levels shall be provided.</p>		
<p>(i) Products shall be</p>		

<p>designed to avoid causing the screen to flicker with a frequency greater than 2 Hz and lower than 55 Hz.</p>		
<p>(j) (1) Products which are freestanding, non-portable, and intended to be used in one location and which have operable controls shall comply with the following: The position of any operable control shall be determined with respect to a vertical plane, which is 48 inches in length, centered on the operable control, and at the maximum protrusion of the product within the 48 inch length on products which are freestanding, non-portable, and intended to be used in one location and which have operable controls.</p>		
<p>(j)(2) Products which are freestanding, non-portable, and intended to be used in one location and which have operable controls shall comply with the following: Where any operable control is 10 inches or less behind the reference plane, the height shall be 54 inches maximum and 15 inches minimum above the floor.</p>		
<p>(j)(3) Products which are freestanding, non-portable, and intended to be used in one location and which have operable</p>		

controls shall comply with the following: Where any operable control is more than 10 inches and not more than 24 inches behind the reference plane, the height shall be 46 inches maximum and 15 inches minimum above the floor.		
(j)(4) Products which are freestanding, non-portable, and intended to be used in one location and which have operable controls shall comply with the following: Operable controls shall not be more than 24 inches behind the reference plane.		

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**Section 1194.26 Desktop and Portable
Computers – Detail**

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Criteria	Supporting Features	Remarks and explanations
(a) All mechanically operated controls and keys shall comply with §1194.23 (k) (1) through (4).		
(b) If a product utilizes touchscreens or touch-		

operated controls, an input method shall be provided that complies with §1194.23 (k) (1) through (4).		
(c) When biometric forms of user identification or control are used, an alternative form of identification or activation, which does not require the user to possess particular biological characteristics, shall also be provided.		
(d) Where provided, at least one of each type of expansion slots, ports and connectors shall comply with publicly available industry standards		

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Section 1194.31 Functional Performance

Criteria – Detail

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Criteria	Supporting Features	Remarks and explanations
(a) At least one mode of operation and information retrieval that does not require user vision shall be provided, or support for Assistive Technology		

used by people who are blind or visually impaired shall be provided.		
(b) At least one mode of operation and information retrieval that does not require visual acuity greater than 20/70 shall be provided in audio and enlarged print output working together or independently, or support for Assistive Technology used by people who are visually impaired shall be provided.		
(c) At least one mode of operation and information retrieval that does not require user hearing shall be provided, or support for Assistive Technology used by people who are deaf or hard of hearing shall be provided		
(d) Where audio information is important for the use of a product, at least one mode of operation and information retrieval shall be provided in an enhanced auditory fashion, or support for assistive hearing devices shall be provided.		
(e) At least one mode of operation and information retrieval that does not require user speech shall be provided, or support for Assistive Technology used by people with disabilities shall be provided.		

(f) At least one mode of operation and information retrieval that does not require fine motor control or simultaneous actions and that is operable with limited reach and strength shall be provided.		
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**Section 1194.41 Information, Documentation
and Support – Detail**

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Criteria	Supporting Features	Remarks and explanations
(a) Product support documentation provided to end-users shall be made available in alternate formats upon request, at no additional charge		
(b) End-users shall have access to a description of the accessibility and compatibility features of products in alternate formats or alternate methods upon request, at no additional charge.		
(c) Support services for products shall accommodate the communication needs of		

end-users with disabilities.		
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