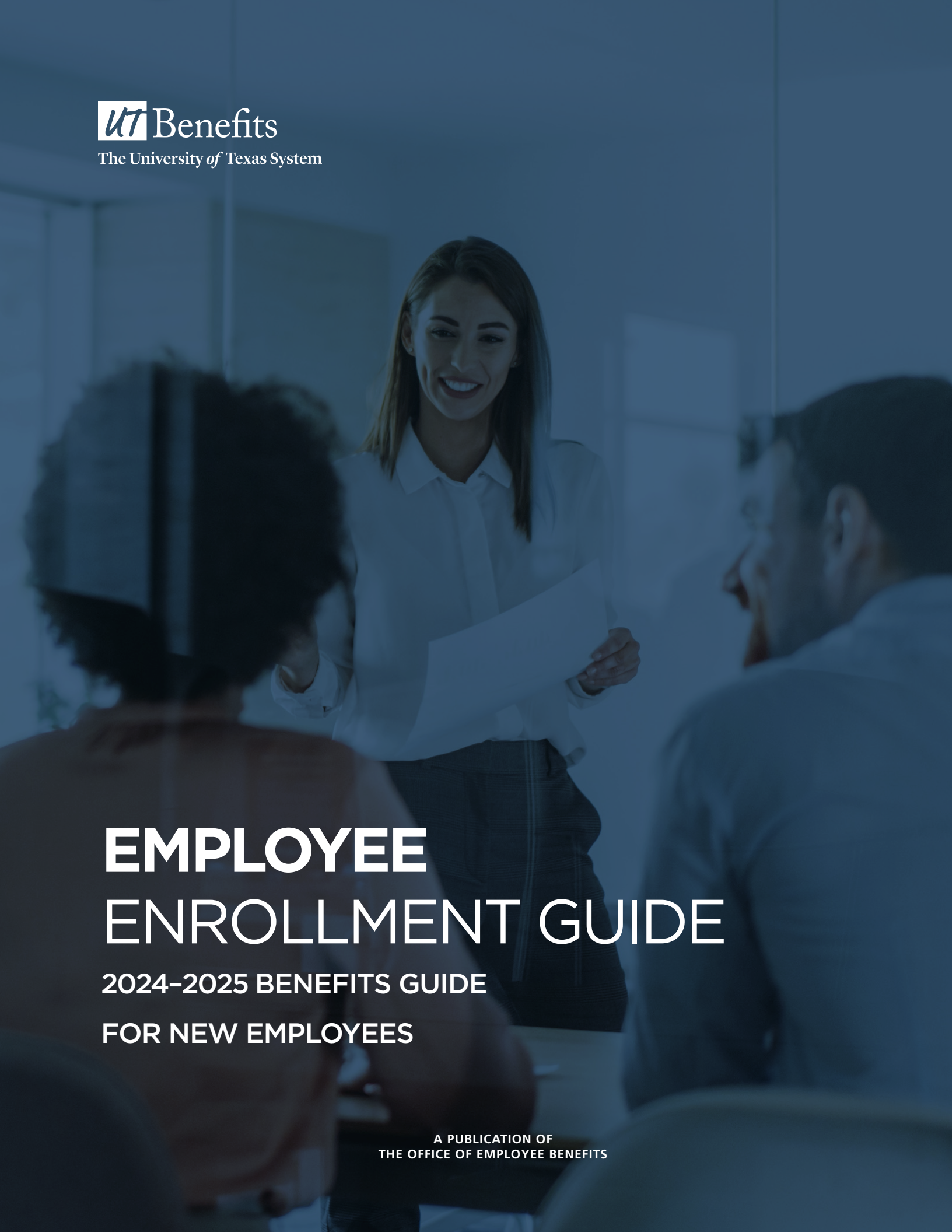

UT Benefits
The University of Texas System

EMPLOYEE ENROLLMENT GUIDE

2024–2025 BENEFITS GUIDE FOR NEW EMPLOYEES

A PUBLICATION OF
THE OFFICE OF EMPLOYEE BENEFITS

UT Benefits Enrollment Guide

FOR PLAN YEAR BEGINNING SEPTEMBER 1, 2024

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

Date of hire/initial Benefits eligibility date

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

My basic coverage is effective

My voluntary coverage is effective

My Benefits ID Number is

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

NAME OF BENEFITS REPRESENTATIVE

PHONE

EMAIL

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Welcome to UT Benefits

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

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

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

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

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

CAMPUS BENEFITS OFFICE	UT SYSTEM OFFICE OF EMPLOYEE BENEFITS (OEB)	INSURANCE VENDORS
Address Change	Legal Notices	Plan Details
Life Events / Change of Status	Plan Guides	ID Cards
Eligibility	Annual Enrollment	Value Added Benefits
Payroll / Premium Billing		Claim Issues
		Customer Service

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

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

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

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

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

These publications can be found online at **www.utsystem.edu/offices/employee-benefits/forms-and-publications** or may be obtained by request from your institution's Benefits Office.

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

Effective September 1, 2024 this Booklet supersedes all previous editions, including undated mailings and revisions as well as all other University of Texas System policies either written or oral that refer to UT Benefits. The University of Texas System reserves the right to interpret the provisions of the Booklet and to amend any provisions thereof. The controlling document is the version found online at: ***www.utsystem.edu/offices/employee-benefits/forms-and-publications****. If there is any ambiguity or inconsistency between a printed copy of the document and the online version, the terms of the online document will control and are final. If there is any ambiguity or inconsistency between this document and Chapter 1601 or current policy, the current policy or terms of Chapter 1601 control and are final. You may request a printed copy of the latest edition at any time.*

Enrollment Checklist

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

Group Insurance Benefits
Eligibility and Enrollment

Eligibility

EMPLOYEES

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

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

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

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

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

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

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

DEPENDENTS

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

Eligibility to participate in certain UT Benefits coverage as a dependent is determined by law. Eligible dependents are:

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

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

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

PREMIUM SHARING

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

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

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

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

If you are a part-time employee who is eligible for benefits because of your status as a graduate student, UT and the State of Texas will pay 50% of your premiums for the basic coverage package, and up to 25% of the premiums for your dependents' medical coverage. Your institution may also choose to supplement premiums for its graduate student employees. For more information, contact your institution's Benefits Office.

If you are a benefits-eligible employee with coverage under another group health plan and elect to waive the basic coverage package, you are eligible to use state premium sharing (50% if you are full-time and 25% if you are part-time) to purchase one or more of the following optional coverages that are paid on a pre-tax basis: Dental, Vision, and Voluntary Accidental Death and Dismemberment (AD&D). You may use TRICARE coverage or outside Medicare coverage to waive your UT Medical insurance. Veterans Affairs (VA) Healthcare benefits do not qualify to waive the UT SELECT medical plan. If you waive, you will not be enrolled in Basic Group Life Insurance or Basic Accidental Death and Dismemberment (AD&D) insurance. **Important:** Those who wish to waive the Basic Coverage Package and receive partial Premium Sharing for eligible optional coverages, must submit proof of other group health insurance to their employing institution.

Rates are available on page 50.

SURVIVING DEPENDENT BENEFITS

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

A surviving spouse may only continue UT Benefits Medical, Dental, or Vision coverage they are enrolled in at the time of the employee's or retired employee's death. They may not add coverage at that time, and if the coverage is ever dropped or terminated for any reason, it may not be reinstated. Surviving dependents are not eligible for Premium Sharing. Coverage may continue for the remainder of the surviving spouse's life. A dependent child may continue until the child loses his or her status as a dependent child. The dependent of an individual who has not met the service requirements at the time of death may elect COBRA coverage for a period not to exceed 36 months.

OVERAGED INCAPACITATED DEPENDENTS

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

WHEN BOTH SPOUSES WORK FOR UT

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

BASIC COVERAGE PACKAGE

In general, it is best to enroll separately in UT medical so that each person can take advantage of your premium sharing and to get the $50,000 Life and AD&D coverage that is included in the basic employee package.

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

DENTAL AND VISION

You may not be enrolled as both the employee AND dependent spouse on the dental and/or vision plans and dependent children may not be enrolled twice in the dental and/or vision plans.

- For the lowest overall premium cost, one spouse should cover the whole family, including the other spouse and child(ren), for dental and vision.

VOLUNTARY LIFE AND VOLUNTARY AD&D

Employees with a UT employee spouse may both cover dependent children and each other as spouses on voluntary life and AD&D.

FLEX FLEXIBLE SPENDING ACCOUNTS

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

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

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

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

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

Dependent Daycare Reimbursement Accounts (DCRA) – For daycare expenses

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

Enrollment

INITIAL PERIOD OF ELIGIBILITY FOR EMPLOYEES

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

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

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

WAITING PERIOD

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

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

EVIDENCE OF INSURABILITY (EOI)

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

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

DEPENDENT DOCUMENTATION

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

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

BENEFICIARY INFORMATION

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

For your UT Benefits group term life and AD&D insurance (which you receive even if you only have the basic coverage), you can review your current beneficiary information by contacting Blue Cross Blue Shield of Texas Life and AD&D Customer Service at (866) 628-2606 (available Monday through Friday from 7 a.m. to 7 p.m. central time) If you have not designated a beneficiary or you need to revise your designation, you will need to complete a beneficiary designation form, available in the forms section of this site: **utbenefits.link/LifeDisability.** Complete the form and mail it to the address listed on the bottom of the form.

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

If you are a participant in the Optional Retirement Program (ORP), or the voluntary UTSaver Tax-Sheltered Annuity (TSA) or UTSaver Deferred Compensation Plan (DCP), you should always be sure that a current beneficiary is on file for each of these retirement accounts. You can download the appropriate beneficiary designation form and return the completed form directly to your specific retirement provider. For more information, please go to **www.utsystem.edu/offices/employee-benefits/approved-providers**.

CHANGE OF STATUS

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

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

- marriage, divorce, annulment, or spouse's death;
- birth, adoption, medical child-support order, or dependent's death;
- significant change in residence if the change affects you or your dependents' current plan eligibility;
- starting or ending employment, starting or returning from FMLA, or other change of job status (e.g., from non-benefits eligible part-time to full-time) affecting eligibility;
- change in dependent's eligibility (e.g., reaching age 26 or gaining or losing eligibility for any other reason); or
- significant change in coverage or cost of other benefit plans available to you and your family.

Special rules apply for an employee whose dependent:

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

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

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

You may enroll in or make changes to benefits within the applicable time frame through your institution's HR/Benefits Office. Please refer to "Legal Notices" section at the back of this booklet for more information on "Special Enrollment Rights".

Plan Information

BASIC COVERAGE PACKAGE

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

UT SELECT MEDICAL PLAN, WITH PRESCRIPTION DRUG COVERAGE

$50,000 BASIC GROUP LIFE INSURANCE

$50,000 BASIC ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

OPTIONAL COVERAGE

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

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

UT SELECT DENTAL INSURANCE

UT SELECT DENTAL PLUS INSURANCE

DELTACARE USA DENTAL HMO

SUPERIOR VISION INSURANCE

SUPERIOR VISION PLUS INSURANCE

VOLUNTARY GROUP TERM LIFE INSURANCE

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

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

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

UT FLEX HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

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

TOBACCO PREMIUM PROGRAM (TPP)

The use of tobacco is one of the leading preventable health risks worldwide. Because UT System is committed to promoting a culture of wellness and disease prevention, and also recognizes the costs associated with treating tobacco related health conditions, a monthly surcharge applies for tobacco users enrolled in the UT SELECT Medical plan. This $30 charge is in addition to the regular monthly premium costs and will be applied separately for the employee and spouse as well as for any dependent children aged 16 and over who use tobacco, up to a maximum of $90 per family per month. As a condition of enrollment in the UT SELECT Medical plan, members must provide a declaration regarding tobacco use as described below.

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

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

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

EXCEPTION TO TOBACCO USE PREMIUM

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

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

UT SELECT Medical Plan

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

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

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

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

UT SELECT AND MEDICARE

ACTIVE EMPLOYEES

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

UT SELECT Benefit Summary Chart

SEPTEMBER 1, 2024 - AUGUST 31, 2025

IN-AREA PLAN

In-area network and non-network benefits apply to eligible members residing in Texas, New Mexico and Washington, DC.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
ANNUAL DEDUCTIBLE (applicable when coinsurance is required)	**$600 / individual**** **$1,800 / family**	**$1,800 / individual** **$5,400 / family**
ANNUAL MEDICAL COINSURANCE MAXIMUM	**$3,500 / individual** **$10,500 / family** (does not include deductible)	**Unlimited**
ANNUAL OUT-OF-POCKET MAXIMUM	**$9,100 / individual** **$18,200 / family** (includes medical and prescription drug deductibles, copayments, and coinsurance)	**Unlimited**
PRE-EXISTING CONDITION LIMITATION	**None**	**None**
LIFETIME MAXIMUM BENEFIT	**No Limit**	**No Limit**
OFFICE SERVICES		
VIRTUAL VISIT WITH MDLIVE®****	**$0 copay**	**N/A**
PREVENTIVE CARE	**Plan pays 100%** (no copayment required)	**60% Plan/40% Member**
DIAGNOSTIC OFFICE VISIT (Family Care Physician (FCP) is Family Practice, Internal Medicine, OB/GYN, Behavioral Health Practitioner, Pediatrics)	**FCP $30 Copay**	**60% Plan /40% Member**
SPECIALIST OFFICE VISIT	**$50 Copay**	**60% Plan /40% Member**
URGENT CARE	**$50 Copay**	**60% Plan /40% Member**
DIAGNOSTIC LAB AND X-RAY	**Included in Office Visit Copay**	**60% Plan /40% Member**
OTHER DIAGNOSTIC TESTS (Bone Scan, Cardiac Stress Test, CT Scan (with or without Contrast) MRI, Myelogram, PET Scan)	**$150 Copay**	**60% Plan /40% Member**
ALLERGY TESTING	**FCP $30 Copay; Specialist $50 Copay**	**60% Plan /40% Member**
ALLERGY SERUM/INJECTIONS (if no office visit billed)	**Plan pays 100%** (no copayment required)	**60% Plan /40% Member**

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
EMERGENCY CARE		
AMBULANCE SERVICE (if transported)	**80% Plan / 20% Member**	
HOSPITAL EMERGENCY ROOM	**$500 Copay / Visit** If admitted, ER services are added to claims for inpatient services	
OUTPATIENT CARE		
OBSERVATION	**80% Plan / 20% Member**	**60% Plan / 40% Member**
SURGERY – FACILITY	**$200 Copay;** **then 80% Plan / 20% Member**	**60% Plan / 40% Member**
SURGERY – PHYSICIAN	**80% Plan / 20% Member**	**60% Plan / 40% Member**
DIAGNOSTIC LAB AND X-RAY	**100% Covered** (except when billed with surgery; then 80% Plan/20% Member)	**60% Plan / 40% Member**
OTHER DIAGNOSTIC TESTS (Bone Scan, Cardiac Stress Test, CT Scan (with or without Contrast) MRI, Myelogram, PET Scan)	**$150 Copay**	**60% Plan / 40% Member**
OUTPATIENT PROCEDURES	**80% Plan / 20% Member**	**60% Plan / 40% Member**
INPATIENT CARE		
HOSPITAL – SEMIPRIVATE ROOM AND BOARD***	**$200 Copay/Day ($1,000 max/admission);** **then 80% Plan / 20% Member**	**60% Plan / 40% Member**
HOSPITAL INPATIENT SURGERY***	**80% Plan / 20% Member**	**60% Plan / 40% Member**
PHYSICIAN	**80% Plan / 20% Member**	**60% Plan / 40% Member**
OBSTETRICAL CARE		
PRENATAL AND POSTNATAL CARE OFFICE VISITS	**FCP $30 Copay; Specialist $50 Copay** (initial visit only)	**60% Plan / 40% Member**
DELIVERY – FACILITY/INPATIENT CARE***	**$200 Copay/Day ($1,000 max/admission);** **then 80% Plan/20% Member**	**60% Plan / 40% Member**
OBSTETRICAL CARE AND DELIVERY – PHYSICIAN	**80% Plan / 20% Member**	**60% Plan / 40% Member**

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
THERAPY		
PHYSICAL THERAPY / CHIROPRACTIC CARE (max. 35 visits / year / condition)	**$50 Copay / Visit**	**60% Plan / 40% Member**
OCCUPATIONAL THERAPY (max. 35 visits / year / condition)		
SPEECH AND HEARING THERAPY (max. 60 visits / year / condition)		
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**
BEHAVIORAL HEALTH (MENTAL ILLNESS, SERIOUS MENTAL ILLNESS, AND SUBSTANCE USE DISORDER)		
VIRTUAL VISIT WITH MDLIVE®** **	**$0 copay**	**N/A**
SERIOUS MENTAL ILLNESS – OFFICE VISIT	**FCP $30 Copay; Specialist $50 Copay**	**60% Plan / 40% Member**
SERIOUS MENTAL ILLNESS – OUTPATIENT* **	**80% Plan /20% Member**	**60% Plan / 40% Member**
SERIOUS MENTAL ILLNESS – INPATIENT* **	**$200 Copay / Day ($1,000 max / admission) then 80% Plan / 20% Member**	**60% Plan / 40% Member**
MENTAL ILLNESS – OFFICE	**FCP $30 Copay; Specialist $50 Copay**	**60% Plan / 40% Member**
MENTAL ILLNESS – OUTPATIENT* **	**80% Plan /20% Member**	**60% Plan / 40% Member**
MENTAL ILLNESS – INPATIENT* **	**$200 Copay / Day ($1,000 max / admission) then 80% Plan / 20% Member**	**60% Plan / 40% Member**
SUBSTANCE USE DISORDER – OFFICE	**FCP $30 Copay; Specialist $50 Copay**	**60% Plan / 40% Member**
SUBSTANCE USE DISORDER – OUTPATIENT TREATMENT* **	**80% Plan /20% Member**	**60% Plan / 40% Member**
SUBSTANCE USE DISORDER – INPATIENT TREATMENT* **	**$200 Copay / Day ($1,000 max / admission) then 80% Plan / 20% Member**	**60% Plan / 40% Member**
APPLIED BEHAVIOR ANALYSIS* **	**FCP $30 Copay, Specialist $50 Copay 80% Plan / 20% Member Outpatient or Home Health Services**	**60% Plan / 40% Member**

COVERAGE	IN-NETWORK	OUT-OF-NETWORK*
OTHER SERVICES		
DURABLE MEDICAL EQUIPMENT* **	**80% Plan / 20% Member**	**60% Plan / 40% Member**
PROSTHETIC DEVICES	**80% Plan / 20% Member**	**60% Plan / 40% Member**
HEARING AIDS (ADULT) ($1,000 per ear; once every 3 years)	**80% Plan / 20% Member** Deductible does not apply	**80% Plan / 20% Member** Deductible does not apply
HEARING AIDS (PEDIATRIC) (Once per ear every 3 years)	**80% Plan / 20% Member** Deductible does not apply	**80% Plan / 20% Member** Deductible does not apply
BARIATRIC SURGERY* (pre-determination recommended)	**$3,000 deductible** (does not apply to plan year deductible or out-of-pocket maximum) After $3,000 bariatric surgery deductible, plan pays 100% of covered services—for example: surgeon, assistant surgeon, anesthesia and facility charges—when using network providers. (For non-network providers, after $3,000 deductible, plan pays 100% up to the allowable amount; member pays charges exceeding the allowable amount). Individual must have been continuously enrolled in an employee health plan offered through The University of Texas System for 36 continuous months prior to the date of the surgery to receive benefits.	
FERTILITY AND FAMILY BUILDING BENEFIT	The person(s) receiving fertility treatment must be a covered primary subscriber or covered spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Get started and activate your benefit by contacting Progyny at **1-844-535-0711**.	

* For services provided out-of-network, any charges over the allowable amount are the patient's responsibility.
** J Visa holders have a $500 individual deductible and a $1,500 family deductible.
*** These services require preauthorization to establish medical necessity.
**** MDLIVE charges a $50 fee for missed, cancelled or rescheduled behavioral health appointments. A $50 fee is only charged for cancelled and rescheduled behavioral health appointments with less than 24 hours' notice, or for missed behavioral health appointments. The $50 fee is an out-of-pocket expense and is not covered by your plan.

UT HEALTH NETWORK FOR UT SELECT PARTICIPANTS

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

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

Current points of service for the UT Health Network include:

- UT Medical Branch Galveston facilities & providers;
- UT Health Northeast (Tyler) facilities & providers;
- UT Rio Grande Valley providers and facilities;
- UT Austin, UT Health Houston, and UT Health San Antonio Employee & Nursing Clinics and University Health System in San Antonio; and
- UT Dallas Callier Center for audiology and hearing aids

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

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

OUT-OF-AREA PLAN

Out-of-Area Benefits apply to any eligible UT SELECT members whose residence of record is outside of the State of Texas, New Mexico or Washington, D.C. Payment for services is limited to the allowable amount as determined by Blue Cross and Blue Shield. ParPlan (Texas) and Traditional Indemnity Network (outside of Texas) providers accept the allowable amount. To maximize your benefits and to avoid charges over the allowable amount, seek care through a BCBSTX provider when possible. **Any charges over the allowable amount are the patient's responsibility and will be in addition to deductible, coinsurance and out-of-pocket maximums.**

COVERAGE	IN-NETWORK
ANNUAL DEDUCTIBLE (applicable when coinsurance is required)	**$600 / individual** **$1,800 / family**
ANNUAL MEDICAL COINSURANCE MAXIMUM	**$3,500 / individual** **$10,500 / family** (does not include deductible)
ANNUAL OUT-OF-POCKET MAXIMUM	**$9,100 / individual** **$18,200 / family** (All member medical and prescription drug allowed cost share)
PREVENTIVE CARE	**Plan pays 100%** (no copayment required)
VIRTUAL VISIT WITH MDLIVE	**$0 copay**
OTHER COVERED MEDICAL SERVICES	**75% Plan / 25% 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 have been continuously enrolled in an employee health plan offered through The University of Texas System plan for 36 continuous months prior to the date of the surgery to receive benefits.
FERTILITY BENEFIT	The person(s) receiving fertility treatment must be a covered primary subscriber or covered spouse enrolled for 12 months continuously in an employee health plan offered through The University of Texas System immediately prior to accessing the benefit. Enrollment in the Student Health Plan does not count towards the 12 months of continuous coverage. Get started and activate your benefit by contacting Progyny at **1-844-535-0711**.

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

The full UT SELECT guide as well as other insurance plan documents can be found at:
www.utsystem.edu/offices/employee-benefits/forms-and-publications

UT SELECT Prescription Drug Plan

Your prescription drug benefits under UT SELECT is administered by Express Scripts and require a $200 annual deductible per plan participant, per plan year. This deductible is separate from the medical plan deductible. The deductible and allowed member cost share (copayment) apply to the whole plan out-of-pocket limit.

UT SELECT PRESCRIPTION DRUG PLAN BENEFITS

ANNUAL DEDUCTIBLE (does not apply to medical plan annual deductible)	$200/person/year		
ACCESS OPTIONS	**GENERIC DRUG COPAYMENT**	**PREFERRED DRUG COPAYMENT**	**NON-PREFERRED DRUG COPAYMENT**
RETAIL NETWORK PHARMACY: Up to a 30-day supply. Refills allowed as prescribed. (good option for new prescriptions)	**$10**	**$35**	**$60**
HOME DELIVERY PHARMACY / 90-DAY AT WALGREENS, UT PHARMACY OR EXPRESS SCRIPTS HOME DELIVERY: Up to a 90-day supply. Refills allowed as prescribed. (best option for maintenance medication)	**$20**	**$87.50**	**$150**

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

If you purchase a preferred or non-preferred drug when a less expensive generic alternative drug is available, you must pay the difference between the cost of the brand name drug and the generic drug **plus the applicable generic copayment**. This difference does NOT count toward your annual deductible. Sometimes the cost difference is quite large. Below is an example of how this type of claim would process if you had already met your $200 annual deductible:

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

The generic, preferred, or non-preferred list of covered drugs is reviewed periodically resulting in changes to the prescription drug list throughout the year. Please refer to the Express Scripts website (**www.express-scripts.com/ut**) or call Express Scripts Customer Service (1-800-818-0155) for current information on specific medications.

YOUR PRESCRIPTION DRUG PLAN AND MEDICARE PART D

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

All retired UT plan participants are enrolled in a UT sponsored Medicare Part D Plan so anyone already enrolled in a separate Part D or Advantage plan will have to choose to drop UT medical plan coverage (including medical) or drop their other plan because no one may be enrolled in more than one Medicare plan. Please note also, that depending on the amount of your modified adjusted gross income when you are enrolled in a Medicare Part D Plan, you may be subject to a Part D income-related monthly adjustment amount (Part D-IRMAA). Social Security will contact you if you are responsible for Part D-IRMAA. The Part D-IRMAA amount goes directly to Medicare, not to your plan.

To view a chart listing the D-IRMAA amount by income, see www.Medicare.gov and search for the page titled "Monthly Premium for Drug Plans" where D-IRMAA is also discussed. If you are notified by Social Security that you are responsible for D-IRMAA and you disagree (for example, if your income goes down), you should contact Social Security directly and let them know you wish to appeal their determination.

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

Please see the Medicare Part D Notice of Creditable Coverage in the Legal Notices section of this handbook. For more information about the low income subsidy, call 1-800-772-1213 or visit **www.socialsecurity.gov**.

Dental

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

DENTAL PPO PLANS

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

UT SELECT DENTAL PLAN
(STANDARD SELF-FUNDED DENTAL PPO PLAN)
– good for standard dental insurance needs

UT SELECT DENTAL PLUS PLAN
(ENHANCED SELF-FUNDED DENTAL PPO PLAN)
– greater benefits than the standard UT SELECT Dental Plan

DENTAL PPO PLAN COMPARISON

BENEFITS AND COVERED SERVICES	UT SELECT DENTAL*	UT SELECT DENTAL PLUS*
SERVICE AREA**	**Use any licensed dentist, but save with the Delta Dental DPO or Delta Premier networks**	
DEDUCTIBLE	**$25**	**Plan pays deductible**
MAXIMUM BENEFITS (per enrollee per plan year)	**$1,250**	**$3,000**
ORTHODONTIC MAXIMUM BENEFITS (Lifetime)	**$1,250**	**$3,000**
DIAGNOSTIC & PREVENTIVE SERVICES (D&P) Exams, cleanings, x-rays, sealants	**100%**	**100%**
BASIC SERVICES (Endodontics, Periodontics, and Oral Surgery)	**80%**	**100%**
MAJOR SERVICES (Crowns, inlays, onlays and cast restorations, bridges and dentures)	**50%**	**80%**
ORTHODONTIC BENEFITS Adults and dependent children	**50%**	**80%**

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

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

DENTAL HMO PLAN

The **DeltaCare USA Dental HMO Plan** (fully-insured) is available in Austin, Dallas/Ft. Worth, Galveston, Houston, and San Antonio. There is also limited availability in El Paso, Tyler, and part of the Rio Grande Valley. Plan eligibility is based on your zip code; ask your institution's Benefits Office if you are eligible to enroll in the DeltaCare Dental HMO. You must select and receive services from a DeltaCare plan dentist to use the benefits under this plan.

DeltaCare USA plans feature:

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

Choosing your DeltaCare USA dentist

When you enroll, you choose a DeltaCare USA Primary Family Dentist. You must visit your selected dentist to receive benefits under your plan. If you do not select a dentist, Delta Dental will select a dentist for you. Family members may select a different dentist for treatment within the covered service area. Refer to your plan booklet for details.

To find the most current listing of network dental offices:

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

You can also call Customer Service for help in finding a dentist.

Vision

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

SUPERIOR VISION (STANDARD PLAN)	SUPERIOR VISION PLUS (ENHANCED PLAN)

BOTH PLANS FEATURE THE FOLLOWING COPAYMENTS:	
EXAM	$35
MATERIALS	$0
CONTACT LENS FITTING	$35

SERVICES/FREQUENCY LIMITS FOR BOTH PLANS:	
EXAM	1 per plan year
FRAMES	
CONTACT LENS FITTING	
LENSES	
CONTACT LENSES	

VISION PLANS COMPARISON

SERVICES	SUPERIOR VISION (STANDARD PLAN)		SUPERIOR VISION PLUS (ENHANCED PLAN)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
EXAM (MD)	Covered in full[1]	Up to $42	Covered in full[1]	Up to $42
EXAM (OD)	Covered in full[1]	Up to $37	Covered in full[1]	Up to $37
FRAMES	$140 retail allowance	Up to $53	$165 retail allowance	Up to $81
CONTACT LENS FITTING (STANDARD[2])	Covered in full[1]	Not covered	Covered in full[1]	Not covered
CONTACT LENS FITTING (SPECIALTY[2])	$50 retail allowance[1]	Not covered	$50 retail allowance[1]	Not covered
LENSES (STANDARD) PER PAIR:				
SINGLE VISION	Covered in full	Up to $32	Covered in full	Up to $32
BIFOCAL	Covered in full	Up to $46	Covered in full	Up to $46
TRIFOCAL	Covered in full	Up to $61	Covered in full	Up to $61

POLYCARBONATE (DEPENDENT CHILDREN UP TO AGE 26)	**Not Covered**	**Not covered**	**Covered in full**	**Not covered**
SCRATCH COAT (FACTORY, SINGLE SIDED)	**Not Covered**	**Not covered**	**Covered in full**	**Not covered**
ULTRAVIOLET COAT	**Not Covered**	**Not covered**	**Covered in full**	**Not covered**
PROGRESSIVE LENS	**See description[3]**	**Up to $61**	**$120 retail allowance[5]**	**Up to $61**
ELECTIVE CONTACT LENSES[4]	**$125 retail allowance**	**Up to $100**	**$150 retail allowance**	**Up to $100**

[1] After co-pays. Co-pays apply to in-network benefits only.

[2] See your benefits materials for definitions of standard and specialty contact lens fittings.

[3] Covered at the provider's in-office retail price for a standard lined trifocal; member pays difference between the progressive and the trifocal, plus applicable co-pay.

[4] Contact lenses are in lieu of eyeglass lenses and frames benefit.

[5] Overages on standard progressive lenses will be the member's responsibility.

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

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

Group Term Life and Accidental Death and Dismemberment Insurance

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

BASIC GROUP TERM LIFE (GTL) BENEFITS

Basic group term life insurance in the amount of $50,000 is a part of the basic coverage package. Eligible employees enrolled in one of the UT medical plans are automatically enrolled in the basic GTL at no additional cost and without Evidence of Insurability (EOI).

VOLUNTARY GROUP TERM LIFE OPTIONS

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

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

The dependent voluntary GTL premium provides coverage of $10,000 for each eligible dependent regardless of how many dependents are covered. Employee Voluntary GTL and Additional Spouse Voluntary GTL premium is based on the enrolled person's age and benefit coverage level. Please see the rates in the Resources section of this guide.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Basic accidental death and dismemberment (AD&D) insurance in the amount of $50,000 is a part of the basic coverage package. Eligible employees enrolled in one of the UT medical plans are automatically enrolled in the basic AD&D at no additional cost and without Evidence of Insurability (EOI).

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT OPTIONS

COVERAGE LEVEL	BENEFIT AMOUNT
EMPLOYEE VOLUNTARY AD&D (available with or without Basic AD&D)	**1 to 10 times annual compensation (to a maximum total of $2,000,000)**
SPOUSE VOLUNTARY AD&D**	**Up to one-half of the employee voluntary AD&D benefit in force (to a maximum of $1,000,000, rounded down to the nearest $10,000).**
DEPENDENT CHILD COVERAGE**	**$10,000 (benefit per eligible child)**

**Employee must have at least $20,000 Employee Voluntary AD&D coverage in order to elect Voluntary AD&D coverage for spouse and/or dependent children. Employees with a UT employee spouse may both cover dependent children and each other as spouses on voluntary AD&D.

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

Disability Insurance

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

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

SHORT-TERM DISABILITY (STD)

WEEKLY BENEFIT	**60% of weekly earnings up to a maximum benefit of $850 per week (subject to reduction by deductible sources of income or disability earnings)**
ELIMINATION PERIOD	**Accident/Injury: Seven (7) days or until sick leave has been exhausted** **Sickness: Seven (7) days or until sick leave has been exhausted**
SICK LEAVE	**You must exhaust all of your accrued sick leave before benefits are payable.**
MAXIMUM PERIOD PAYABLE	**22 Weeks; 4 weeks for pre-existing conditions**

LONG-TERM DISABILITY (LTD)

MONTHLY BENEFIT	**60% of your monthly earnings up to a maximum gross monthly benefit of $15,000 per month, subject to deductible sources of income or other disability earnings.**	
ELIMINATION PERIOD	**90 days from onset of disability, during which you are continuously disabled.**	
SICK LEAVE	**You must exhaust all of your accrued sick leave before benefits are payable.**	
MAXIMUM PERIOD PAYABLE	**Age at Disability** **Less than age 60** **Age 60 through 64** **Age 65 through 69** **Age 70 and over**	**Maximum Period Payable** **To age 65, but not less than 5 years** **5 years** **To age 70, but not less than 1 year** **1 year**

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

IMPORTANT

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

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

UT FLEX

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

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

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

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

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

IMPORTANT INFORMATION ABOUT UT FLEX

"USE IT OR LOSE IT."

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

COORDINATION WITH FEDERAL CHILD AND DEPENDENT CARE EXPENSES TAX CREDIT

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

PLAN CAREFULLY

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

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

*A detailed list of eligible and ineligible expenses is available at **noexcuses.myutflex.com**

UT FLEX BENEFIT SUMMARY

	HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)	DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT (DCRA)
WHAT CAN BE REIMBURSED?*	Medically necessary health care expenses, including dental and vision related expenses incurred and paid during your period of coverage. Expenses paid by insurance are not eligible for reimbursement.	For children under age 13 or qualified disabled dependents of any age who are claimed as dependents for federal income tax purposes. Dependent day care expenses that are necessary for you and your spouse (if married) to work or attend school full-time, such as child care services in a home, licensed day care, and adult day care.
HOW MUCH CAN I CONTRIBUTE?	$15 minimum contribution per month. Total contributions cannot exceed **$3,200** per plan year per employee for federal income tax filing purposes.	$15 minimum per month up to a maximum of $5,000 per plan year; or up to a maximum of **$2,500** per plan year if married filing separate federal income tax returns.
ADMINISTRATIVE FEE	$0	$0
DEBIT CARD FEE	No fee	N/A; debit card is not available for DCRA
HOW DO I GET REIMBURSED FOR ELIGIBLE EXPENSES?	Mobile app: Apple iOS or Android Store - Inspira Mobile® Pay with a UT FLEX debit card File Online at **www.myUTFLEX.com** Mail or fax a paper claim	Mobile app: Apple iOS or Android Store - Inspira Mobile® File Online at **www.myUTFLEX.com** Mail or fax a paper claim
WHEN CAN I GET REIMBURSED?	The first day of your enrollment in the plan.	As soon as your first contribution is deducted from your pay and put into your account. Reimbursement can be made only up to your available account balance.
LAST DAY TO INCUR EXPENSES	November 15 after the end of the plan year	August 31 (The last day of the plan year)
CLAIM FILING DEADLINE	November 30 after the end of the plan year	November 30 after the end of the plan year

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Living Well: Health & Wellness Program

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

Our mission is to improve the health and well-being of Texans through achieving optimal levels of health for University of Texas System employees, retirees and dependents at all institutions.

Learn more about all of these programs at our Living Well website: **utbenefits.link/LivingWell**

24/7 NURSELINE

Get answers to your health care questions, information about major medical issues, chronic illness support, and lifestyle change support 24 hours a day, 7 days a week.

UT SELECT: 1 (888) 315-9473

SPECIALIZED PHARMACISTS

If you take medications to treat high cholesterol, diabetes, or one of several other conditions, specialized pharmacists can answer your questions and offer improvements in the quality and affordability of your pharmacy care. Learn more: **(800) 818-0155**.

HEALTH ADVOCACY SOLUTIONS

All UT SELECT medical plan members have access to a health advocate through the Health Advocacy Solution. Health advocates can assist with questions about your benefits and help manage complicated or chronic conditions, such as coronary artery disease, asthma, and diabetes. You can call a Health Advocate at **(866) 882-2034**.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a confidential program offered at **no cost** and can help you and your dependents successfully deal with life's challenges impacting personal life or job performance. Learn more about this free program at: **utbenefits.link/EAP**

REIMBURSEMENT FOR EXERCISE EXPENSES

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

ONSITE FLU SHOTS

Onsite flu shot clinics may be available at your institution at **no cost**. Plan members can also receive a flu shot by visiting a physician or at a local retail network pharmacy.

UT SYSTEM WELLNESS ACTIVITY CHALLENGES

Team up with your institution for the UT System Team Wellness Challenges every fall and spring available on the UT Living Well Platform. You'll receive a weekly goal and can work with colleagues towards earning your institution the coveted traveling trophy.

WONDR HEALTH

Wondr Health is an online program that helps you lose weight and improve your overall health – all while eating the foods you love. With Wondr Health , you'll learn that you don't have to starve yourself or count calories to be healthy, lose weight, and keep it off forever.

TOBACCO CESSATION RESOURCES

The journey to quitting can be challenging and unpredictable. For that reason, the UT SELECT Medical plan offer members a variety of tobacco cessation resources at no out-of-pocket cost. These resources include professional counseling and pharmaceutical therapy. See the Living Well website for details: **utbenefits.link/LivingWell**

UT LIVING WELL PLATFORM POWERED BY LIMEADE

The well-being and engagement platform is designed to help you achieve your physical, emotional, financial, and work well-being goals with personalized activities. Register at **ut.limeade.com** and complete the Well-Being Assessment to personalize your experience.

Once you've registered, download the **UT Living Well app** powered by ***Limeade ONE*** (available for iOS or Android) and enter "UTX" or "University of Texas System" to get started.

Download on the App Store

GET IT ON Google Play

The UT Living Well platform powered by Limeade is available to UT SELECT and UT CARE members (employees, retirees, and dependents) ages 18+.

LEARN 2 LIVE

Learn to Live (L2L) is a behavioral health digital platform available to UT SELECT members which offers condition-specific programs, each delivered in a user-paced multimedia experience. Services are also available on demand with the options for one-to-one clinician coaching services.

These self-directed programs are available in English and Spanish covering the following areas:

- Depression
- Stress, Anxiety & Worry
- Social Anxiety
- Insomnia
- Substance Use
- Panic
- Resilience

FITNESS DISCOUNT PROGRAM

The Fitness Program offers flexible options and access to a nationwide network of fitness locations, as well as access to live and pre-recorded digital content.

For more information, log on to Blue Access for Members at **bcbstx.com/ut** or **888-762-BLUE (2583)**.

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If Employment or Eligibility Ends

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

Your Rights to Continuation of Coverage Under COBRA

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

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

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

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under one or more of the Plans when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Benefits Guide or contact the HR or Benefits Office at your UT Institution. Please see contact information for the HR/Benefits Offices at each UT Institution at the back of this guide.

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

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

WHAT IS CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the appropriate UT Institution's HR or Benefits office within 31 days after the qualifying event occurs and provide appropriate documentation of the qualifying event, such as a copy of a finalized divorce decree.

HOW IS COBRA COVERAGE PROVIDED?

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

HOW LONG WILL CONTINUATION COVERAGE LAST?

For medical, dental, and vision coverage:

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying

event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. The COBRA Application shows the maximum period of continuation coverage available to the qualified beneficiaries.

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

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

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

For UT FLEX Health Care Reimbursement Accounts (HCRAs):

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

DISABILITY

An 11-month extension of medical, dental, and vision COBRA coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of your SSA disability determination letter along with a written request to extend the COBRA period must be provided directly to the plan administrator prior to the end of the initial 18-month period of coverage in order to extend the maximum period for medical, dental and/or vision coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

FOR MORE INFORMATION

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

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

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

Life Insurance

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

CONVERSION

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

PORTABILITY

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

Long Term Disability

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

UT FLEX

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

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Retirement Program for Active Employees

Your Future, Your Choice

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

MANDATORY PLANS

TEACHER RETIREMENT SYSTEM OF TEXAS (TRS)

OPTIONAL RETIREMENT PROGRAM (ORP) (For eligible employees)

VOLUNTARY PLANS

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

UTSAVER 457(B)
DEFERRED COMPENSATION PLAN (DCP)

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

NOTICE

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

Mandatory Retirement Programs

THE TEACHER RETIREMENT SYSTEM OF TEXAS (TRS)

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

THE OPTIONAL RETIREMENT PROGRAM (ORP)

WHAT IS ORP?	The Optional Retirement Program (ORP) may be chosen by certain employees as an alternative to TRS based on their appointment to certain positions. This program is a defined contribution plan governed by Internal Revenue Code Section 403(b).
WHO IS ELIGIBLE FOR ORP?	Eligibility for ORP is determined by the job performed. Your institution Benefits Office will notify you if you are in an ORP-eligible position. To be eligible to participate in ORP, an employee must: (1) initially be appointed on a full-time basis for 4 ½ months or more; and (2) be appointed to a position otherwise eligible to participate in ORP. Employees who are eligible to participate in a retirement program who are not eligible to participate in ORP must participate in TRS. Examples of eligible positions include faculty positions, specialized professional positions such as physicians, engineers or attorneys, and executive-level administrative positions.
WHEN CAN I ELECT TO PARTICIPATE IN ORP?	You have 90 days from the date you first become eligible for the ORP to make your enrollment decision. If you are reclassified or assume a new job and become ORP-eligible for the first time after your initial employment date, the 90-day election period begins on the day your reclassification becomes effective. The decision to elect ORP is a once-per-lifetime, irrevocable decision.
HOW DOES ORP WORK?	A set percentage of your salary is directed to whichever of the five authorized retirement providers you chose to work with. Your contributions and the state matching funds are then invested according to your directions with that authorized provider. After vesting (one year and one day of participation), the benefit you receive at the time of retirement will be your personal contributions and state matching funds, plus or minus any investment returns.
WHAT DOES "DEFINED CONTRIBUTION PLAN" MEAN?	ORP is called a "defined contribution plan" because the retirement benefit is based on the actual amount contributed to the individual participant's account and the rate of return on investment rather than a formula. At the time of retirement, you are eligible to receive your accumulated contributions and state matching funds plus or minus investment returns.
IF ELIGIBLE, HOW DO I CHOOSE ORP OR TRS?	All ORP-eligible employees should receive An Overview of TRS and ORP. A copy can be found at: **utbenefits.link/ORP** You may also wish to discuss both options with your local benefits office, a representative of TRS, or one of the five authorized providers.
HOW DO I ENROLL IN ORP?	To enroll in ORP, follow these steps: 1. Choose your retirement provider(s) from the currently authorized provider list. You may select more than one vendor for your ORP participation. 2. Go to **www.myretirementmanager.com** Log in and click on ORP Enroll/Change and follow the prompts. 3. If you have never used UTRM you will need to establish a new Security Profile first at **utbenefits.link/getstarted**. 4. Complete the appropriate retirement provider application(s) to open an account with that company and mail the application(s) directly to the provider. 5. Complete TRS Form 28 (Notice to Elect to Participate in Optional Retirement Program and/or Refund) and mail it to your institution Benefits Office.

UTSaver Voluntary Retirement Programs

	UTSAVER TSA		UTSAVER DCP	
	TRADITIONAL 403(b)	ROTH 403(b)	TRADITIONAL 457(b)	ROTH 457(b)
ELIGIBILITY	All Employees		All Employees	
EMPLOYEE CONTRIBUTION	Pre-tax dollars	After-tax dollars	Pre-tax dollars	After-tax dollars
EMPLOYER CONTRIBUTION	None		None	
EMPLOYEE WITHDRAWALS	Taxable when withdrawn	Tax free when withdrawn as a "qualified" distribution	Taxable when withdrawn	Tax free when withdrawn as a "qualified" distribution
GENERAL CONTRIBUTION LIMITS*	$23,000 IRS maximum (2024) for both Traditional and Roth sources. (Each dollar of a Roth contribution reduces the amount that can be contributed pretax, and vice versa.)		$23,000 IRS maximum (2024) for both Traditional and Roth sources. (Each dollar of a Roth contribution reduces the amount that can be contributed pretax, and vice versa.)	
OVER AGE 50 CATCH-UP CONTRIBUTION	$7,500 (either Roth or Traditional)		$7,500 (either Roth or Traditional)	
15-YEAR CATCH-UP CONTRIBUTION	$3,000 combined with Roth (lifetime total of $15,000)	$3,000 combined with Roth (lifetime total of $15,000)	N/A	
THREE YEARS PRIOR TO YEAR OF RETIREMENT CATCH-UP (SPECIAL CATCH-UP)**	N/A	N/A	Up to $23,000 (may not be used simultaneously with age 50 catch-up)	
DISTRIBUTIONS UPON SEPARATION OF EMPLOYMENT	Distributions made prior to age 59 ½ will be subject to ordinary income tax and a possible 10% penalty	"Nonqualified" distributions made prior to age 59 ½ will be subject to ordinary income tax on earnings and possibly a 10% penalty	Distributions will be subject to ordinary income tax	"Nonqualified" distributions will be subject to ordinary income tax for any earnings on the account

* Contribution limits shown are IRS maximums for 2024. The 2023 limit was $22,500.

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

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

Your UTRetirement Programs Authorized Providers

AUTHORIZED PROVIDER	FIDELITY (800) 343-0860 www.netbenefits.com/ut	VOYA (800) 584-6001 utsaver.com/voya	LINCOLN (800) 454-6265 *8 www.lfg.com/ut	TIAA (800) 842-2776 www.tiaa.org/public/tcm/utexas/home	COREBRIDGE (formerly AIG) (800) 448-2542 www.corebridgefinancial.com/rs/utsystem
PRODUCTS	MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS	ANNUITIES MUTUAL FUNDS LIFESPAN MODELS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.	ANNUITIES MUTUAL FUNDS LIFECYCLE FUNDS SELF-DIRECTED BROKERAGE ACCT.
SERVICES AVAILABLE AT NO COST TO THE EMPLOYEE					
FACE-TO-FACE COUNSELING	Yes	Yes	Yes	Yes. On campus or at our local offices in Austin, Houston, Dallas.	Yes. By on-staff Corebridge financial advisor.
DISCUSS UT RETIREMENT PLAN OPTIONS	Yes	Yes	Yes	Yes. By phone or in person.	Yes
ASSESS EMPLOYEE RISK TOLERANCE AND RETIREMENT GOALS	Yes	Yes	Yes	Yes. Comprehensive services and tools are available online, by phone, or in person.	Yes. Educational materials and financial analysis online or in person.
CONSIDER OUTSIDE ASSETS WITH NO ADVICE ON THOSE ASSETS	Yes	Yes	Yes	Yes. The Advice tool/service considers outside assets, which can also be tracked via our 360 Degree Net Worth tool on the participant website.	Yes. Online aggregator helps track assets. Rollover help on request.
PROVIDE ASSET ALLOCATION MODELS AND THE LIST OF AVAILABLE COMPANY FUNDS	Yes	Yes	Yes	Yes. Objective Advice and allocation recommendations available online, by phone, or in person.	Yes. Allocation modeling and investment planning online or in person.
ADVICE ON FUND SELECTION	Yes. Online or in person.	Yes	Yes	Yes. Objective Advice is available online, by phone, or in person.	Yes. Online or in person.
FREE FINANCIAL PLANNING SERVICES	Yes	Yes	Yes. Receive retirement analysis at no cost from local Retirement Consultants.	Yes. Full Financial and Wealth Planning services at no additional cost.	Yes. Receive retirement analysis at no cost from on-staff advisor.
INTERACTIVE CALCULATORS	Yes	Yes	Yes, www.lfg.com	Yes. www.tiaa-cref.org/utexas	Yes, www.corebridgefinancial.com/rs/utsystem
FINANCIAL WORKSHOPS AND SEMINARS	Yes. Online, on campus, & at local Fidelity Investor Centers.	Yes	Yes, online or in person at no additional cost.	Yes. Online or in person at no cost.	Yes. Online or in person. No cost.
ACCESS, MANAGE, FOLLOW	Online, mobile apps, Facebook, and Twitter	Yes	Online, Facebook, Twitter	Online, mobile apps, Facebook, and Twitter	Online, mobile apps, Facebook, Twitter
INVESTMENT FUND ENROLLMENT	Online enrollment or downloadable forms at www.netbenefits.com/ut	Online or by downloadable form at: https://utexas.prepare4myfuture.com/	Forms may be downloaded at: www.lfg.com/ut	Online from the TIAACREF UT site at: www.tiaa.org/public/tcm/utexas/home	Easy enrollment online at: www.corebridgefinancial.com/rs/utsystem or with a Corebridge financial advisor
SERVICES AVAILABLE FOR A FEE TO THE EMPLOYEE					
ACTIVELY MANAGE COMPANY ACCOUNTS	No	Yes - mutual funds only	No	Yes	Yes

CALL A HEALTH ADVOCATE & SAVE!
(866) 882-2034

Call a UT SELECT Health Advocate for help finding providers who can save you money on covered services.

Resources and Value Added Services

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

Wise Healthcare Consumer Resources

COST COMPARISON

Blue Cross and Blue Shield of Texas wants you to know that you have a choice when selecting where to go for health care. Many times you can choose between different providers or facilities and receive the same procedure at a lower cost. This is where **Health Advocate** comes in for UT SELECT members.

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

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

A Health Advocate can also help you:

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

SMART90 RETAIL PRESCRIPTIONS

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

PATIENT ASSURANCE PROGRAM

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

AUTOMATIC FILLS

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

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

GAPS IN CARE ALERTS

Gaps in care, such as poor patient adherence with essential medication instruction have been associated with poorer clinical outcomes and higher total costs. There is an 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 59 Express Scripts Pharmacy®. If you wish to access the Gaps in Care feature, register at **express-scripts.com/ut**.

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

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

BLUE ACCESS FOR MEMBERS℠ (BCBSTX)

UT SELECT: www.bcbstx.com/ut

Log onto Blue Access for Members, and:

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

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

COST ESTIMATOR (BCBSTX)

UT SELECT: www.bcbstx.com/ut

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

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

To use the Cost Estimator, log into Blue Access for Members℠ then click the My Coverage tab and select Estimate Treatment Costs.

Discounts & Value-Added Services

MDLIVE: VIRTUAL DOCTOR VISITS $0 COPAYMENT*

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

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

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

*** MDLIVE charges a $50 fee for missed, cancelled or rescheduled behavioral health appointments**. A $50 fee is only charged for cancelled and rescheduled behavioral health appointments with less than 24 hours' notice, or for missed behavioral health appointments. The $50 fee is an out-of-pocket expense and is not covered by your plan.

BLUE365

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

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

INTERNATIONAL TRAVEL INFORMATION

When you travel abroad, always carry your UT SELECT Medical Identification Card which has the telephone number to the BlueCard Worldwide® program, and contains important information about your plan. With BlueCard Worldwide®, you have access to a large number of hospitals on almost every continent and to a broad range of medical assistance services.

BlueCard Worldwide® provides the following services to UT SELECT Medical Participants:

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

Call BlueCard® Access toll-free at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week to locate a participating physician or hospital.

You may also visit www.bcbsglobalcore.com and enter "UTS" to search for participating physicians and hospitals at your destination.

For University sponsored international travel, the UT System-wide On Call International program is available. This service can connect you with an international network of medical and security professions, and services are available at no cost to individuals on official university business. Additional information is available through your institution s Office of Risk Management.

IDENTITY PROTECTION SERVICES

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

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

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

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

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

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Enrollment Tools

PLAN YEAR 2024-2025

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

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

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

BENEFITS COST WORKSHEET FOR EMPLOYEES

MEDICAL OUT-OF-POCKET COST PER MONTH *Full-Time Employees:*					*BLUE CROSS BLUE SHIELD OF TEXAS*
Plan Available – Worldwide	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	**MEDICAL**
UT SELECT (OUT-OF-POCKET)	$0	$335.94	$351.36	$661.56	***(FULL-TIME)*** **TOTAL**
Medical Plan Rates include: **Prescription benefit coverage + $50,000 Life + $50,000 AD&D**			***Full-time*** *= Appointed for at least 30 hours per week*		**$**

OR

MEDICAL OUT-OF-POCKET COST PER MONTH *Part-Time Employees:*					*BLUE CROSS BLUE SHIELD OF TEXAS*
Plan Available – Worldwide	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	**MEDICAL**
UT SELECT (OUT-OF-POCKET)	$362.90	$865.62	$811.44	$1,291.36	***(PART-TIME)*** **TOTAL**
Medical Plan Rates include: **Prescription benefit coverage + $50,000 Life + $50,000 AD&D**					**$**

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

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

DENTAL OUT-OF-POCKET COST PER MONTH					*DELTA DENTAL*
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
NATIONWIDE					
UT SELECT Dental	$28.52	$54.14	$59.66	$84.84	
UT SELECT Dental Plus	$61.40	$116.60	$128.66	$183.30	**DENTAL TOTAL**
CERTAIN AREAS IN TEXAS					
DeltaCare Dental HMO	$8.71	$16.74	$18.50	$26.40	**$**

VISION OUT-OF-POCKET COST PER MONTH					*SUPERIOR VISION*
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
Superior Vision	$5.02	$7.90	$8.10	$12.84	**VISION TOTAL**
Superior Vision Plus	$7.64	$11.98	$12.82	$18.10	**$**

LIFE OUT-OF-POCKET COST PER MONTH	*BLUE CROSS BLUE SHIELD OF TEXAS*	
Enter your basic annual earnings (or contract salary) rounded up to the next $1,000 increment (e.g. $51,454 = $52,000).	A	
Select from 1-10 times basic annual earnings and enter how many times your earnings you desire for coverage amount. Enter a number from 1 to 10 (see [1] below for details about Evidence of Insurability requirements).	B	
Enter Elected Coverage Amount: Multiply **A x B** and enter amount here. If **C** is greater than $2 million, enter $2 million.	C	
Divide total in **C** by 1,000 to determine units of $1,000 for premium calculation. Enter here.	D	
Refer to Employee Rate Chart below. Enter the rate that corresponds with your age on September 1, 2024.	E	
To determine the premium cost per month, multiply **D x E**.	F	

The remainder of the Life Out-of-Pocket calculation section relates to eligible dependents of Employees.

If you are electing the $10,000 Family Coverage option, enter $2.87 (see [2] below). Otherwise, enter zero.	G	
If you are eligible and choose to elect Spouse Coverage of $25,000, enter $15,000 (see [1] below); **OR** **If you are eligible** and choose to elect Spouse Coverage of $50,000, enter $40,000 (see [1] below); **OR** Enter zero if you do not choose to elect Spouse Coverage.	H	
Divide total in **H** by 1,000 to determine units of $1,000 for premium calculation. Otherwise, enter zero.	I	
Refer to Spouse Rate Chart below. Enter the rate that corresponds to your Spouse's age on September 1, 2024. Otherwise, enter zero.	J	
To determine the total Spouse Coverage premium cost per month, multiply **I x J**. Otherwise, enter zero.	K	
To determine total Dependent Coverage premium cost per month, add **G + K**. Otherwise, enter zero.	L	
Add F + L	**LIFE TOTAL**	**$**

EMPLOYEE RATE CHART	
AGE OF SUBSCRIBER ON 9/01/2024	RATE PER $1,000 COVERAGE
15 - 34	$0.035
35 - 39	$0.045
40 - 44	$0.059
45 - 49	$0.092
50 - 54	$0.142
55 - 59	$0.221
60 - 64	$0.345
65 - 69	$0.616
70 - 74	$0.713
75 - 79	$0.884
80 and over	$1.549

SPOUSE RATE CHART	
AGE OF SPOUSE ON 9/01/2024	RATE PER $1,000 COVERAGE
15 - 24	$0.053
25 - 29	$0.054
30 - 34	$0.057
35 - 39	$0.072
40 - 44	$0.101
45 - 49	$0.154
50 - 54	$0.241
55 - 59	$0.376
60 - 64	$0.574
65 - 69	$0.857
70 - 74	$1.167
75 - 79	$1.446
80 and over	$2.536

1 If you are adding or increasing your Life coverage amount to a level of 4X-10X annual salary or if are electing Spouse coverage, Evidence of Insurability (EOI) is always required.

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

ACCIDENTAL DEATH & DISMEMBERMENT OUT-OF-POCKET COST PER MONTH		*BLUE CROSS BLUE SHIELD OF TEXAS*
Enter desired coverage amount in $10,000 increments. *Coverage is available up to 10 times your basic annual earnings or contract salary. Basic annual earnings should be rounded up to the next $1,000 increment (e.g. $51,454 would be rounded to $52,000, maximum coverage amount of $520,000).* *Total employee coverage cannot exceed $2,000,000.*	**A**	
Enter desired Spouse coverage amount in increments of $10,000. The maximum Spouse coverage is 50% of the amount in item **A** (rounded down to nearest $10,000). Employee must have $20,000 Voluntary AD&D coverage to elect Spouse AD&D coverage.	**B**	
If you desire Dependent child(ren) coverage, enter $10,000 in item **C**. *Employee must have $20,000 Voluntary AD&D coverage to elect Dependent AD&D coverage. All of your eligible children are covered for one monthly premium cost.* If not electing Dependent coverage, enter zero.	**C**	
Enter the sum of **A** plus the greater of **B** or **C**	**D**	
Multiply amount in **D** x $.000012 for Total AD&D	**AD&D TOTAL**	**$**

SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH	*BLUE CROSS BLUE SHIELD OF TEXAS*
Multiply Basic **MONTHLY** earnings (cannot exceed $6,139) x $0.0030.	**STD TOTAL**
*To calculate basic **MONTHLY** earnings, divide annual contract salary (including longevity and hazardous duty pay) by 12 months.*	**$**

LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH	*BLUE CROSS BLUE SHIELD OF TEXAS*
Multiply Basic **MONTHLY** earnings (cannot exceed $25,000) x $0.0034.	**LTD TOTAL**
*To calculate basic **MONTHLY** earnings, divide annual contract salary (including longevity and hazardous duty pay) by 12 months.*	**$**

UT FLEX SALARY REDUCTIONS PER MONTH					*UT FLEX*
Type of Account	**Minimum**	**Maximum**	**Monthly Contribution**		
Health Care Reimbursement Account [1]	**$15** per month	$3,200 Annual Election		**A**	
Dependent Day Care Reimbursement Account [2]	**$15** per month	$5,000 Annual Election If single or married filing jointly on your Federal Income Tax Return $2,500 Annual Election If married filing separately on your Federal Income Tax Return		**B**	**FLEX TOTAL A + B** **$**

1 **Health Care Reimbursement Account (HCRA):**

Maximum Election – HCRA deductions cannot exceed $3,200 per employee per plan year for federal income tax filing purposes.

2 **Dependent Day Care Reimbursement Account (DCRA):**

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

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

REQUIRED DOCUMENTATION FOR DEPENDENT ENROLLMENT

TYPE OF DEPENDENT	REQUIRED DOCUMENTS
SPOUSE	· Valid marriage certificate between subscriber and spouse issued by any state; OR · Declaration of Informal Marriage of subscriber and spouse issued by a Texas clerk or utilizing the form promulgated by Texas Department of Health and Human Services; OR · Declaration of Informal Marriage issued by another state; OR · Other documentation deemed acceptable by OEB
BIOLOGICAL CHILD	· Birth Certificate of Child proving relationship to Subscriber; OR · Certification of Vital Records proving relationship to Subscriber; OR · Verification of Birth Facts Form* proving relationship to Subscriber; OR · Valid Medical Support Order requiring Subscriber to provide medical coverage; OR · Paternity test* accompanied by Court Order, Medical Support Order, or reissued Birth Certificate
ADOPTED CHILD	· Valid Court Order of Adoption; OR · Valid Pre-Adoption Placement Order issued by a Licensed Child Placement Agency; OR · Valid Court Order naming Subscriber as Managing Conservator of Child; OR · Birth Certificate of Child with Adoptive Parent(s); OR · Valid Medical Support Order requiring Subscriber to provide medical coverage
STEPCHILD	· Birth Certificate of Child; AND · Marriage Certificate of Subscriber and Spouse (Biological Parent)
FOSTER CHILD	· Valid Court Order establishing a parent-child relationship between Subscriber and Foster Child
GRANDCHILD	· Birth Certificate of Grandchild or Verification of Birth Facts Form* proving relationship to Subscriber; AND · Birth Certificate of Biological Parent; AND · Grandchild Certification Form*; AND · Most recent tax return indicating Grandchild is the financial dependent of Subscriber
INCAPACITATED OVER AGE DEPENDENT	· Valid Document (e.g., birth certificate, adoption papers) proving relationship to Subscriber; AND · Application For Coverage of Incapacitated Over Age Dependent Form*; AND · Supporting Medical Records Less Than One Year Old* · Most recent tax return indicating financial dependence may also be required.
WARD	· Valid Court Order naming Subscriber as Guardian or Conservator
IMPORTANT	1. A Power of Attorney is not adequate legal documentation for establishing a Dependent relationship. 2. A complete copy (all pages) of a Court Order may be required to be provided, depending on eligibility and documentation requirements. 3. If Subscriber is unable to provide the above document(s) but has other documentation that may establish a Dependent relationship, the institution HR Manager should review and determine that the alternative documentation is adequate. 4. A document in a language other than English must be accompanied by a notarized, sworn affidavit by an independent third party indicating the document has been reviewed and translated.

Your Benefits Plan
Value Added Services

UT SELECT Value Added Services

HEALTH ADVOCACY SOLUTIONS (HAS)

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

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

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

HINGE HEALTH

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

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

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

OVIA HEALTH: A DIGITAL SUPPORT PROGRAM

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

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

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

Download the app that's right for you:

Ovia Fertility – Health & Fertility

Ovia Pregnacy – Pregnancy & Postpartum

Ovia Parenting – Family & working parents

To create an account, choose "I have Ovia Health as a benefit" before tapping "Sign up" and make sure to select BCBSTX as your health plan and enter your employer name.

You can also contact a health advocate at **(866) 882-2034** for more information or should you have any questions.

SEASONS OF LIFE

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

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

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

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

CANCER SERVICES AND SUPPORT

Getting a cancer diagnosis is never easy, but we are here to help.

The Cancer Services and Support program is available to you at **no additional cost** through your Blue Cross and Blue Shield of Texas health plan. In collaboration with AccessHope (a new cancer support service), this program gives you the tools, resources and experts to help you before, during and after cancer treatment.

We provide these services to you and your families:

CANCER SUPPORT

Our skilled cancer care nurses are on hand to help you prepare for doctor office visits, share treatment information or give emotional support—wherever you are in your cancer journey.

CANCER EXPERT ADVISORY REVIEW AND SUPPORT

With AccessHope, you can ask that a medical expert reviews your case. This specialist will keep in touch with your doctor to discuss your treatment plan and possible clinical trials.

AUTOMATIC EXPERT REVIEW FOR RARE OR COMPLEX CANCERS

If you've received a rare or complex cancer diagnosis, your case will be automatically sent to AccessHope. You do not have to call to start this process; it will be started for you. One of our cancer specialists will review your case and use leading cancer expertise to give recommendations to your oncologist, so you can stay with your local support system.

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Legal Notices

You have the right to obtain a printed copy free of charge of any or all of these notices at any time by contacting the Office of Employee Benefits at benefits@utsystem.edu or (512) 499-4616; toll-free (800) 888-6824.

Uniform Summary of Benefits and Coverage

The uniform Summary of Benefits and Coverage (SBC) provision of the Affordable Care Act requires all insurers and group health plans to provide consumers with an SBC to describe key plan features in a mandated format, including limitations and exclusions. The provision also requires that consumers have access to a uniform glossary of terms commonly used in health care coverage.

The UT insurance SBCs are available online.

UT SELECT PPO or Out-of-Area coverage:
www.bcbstx.com/ut/coverage

You can view the glossary at
www.healthcare.gov/sbc-glossary

To request a copy of these documents free of charge, you may call the **SBC Hotline at 1 (855) 756-4448**.

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

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

1. Standards related to benefits for mothers and newborns.

2. Parity in the application of certain limits to mental health benefits.

3. Required coverage for reconstructive surgery following mastectomies.

The exemption from these federal requirements will be in effect for the 2024-2025 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.

Group Health Plan Special Enrollment Rights Notice

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

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

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

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

University of Texas System Notice of Privacy Practices

Revised Effective August 2023

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

I. PURPOSE OF THIS NOTICE

This Notice of Privacy Practices (this "Notice") describes the privacy practices of the UT SELECT, UT SELECT Dental and Dental Plus and UT FLEX Self-funded Group Health Plans ("the Plans") which are funded by The University of Texas System and administered by the Office of the Employee Benefits (OEB) within The University of Texas System Administration (System). Federal law requires OEB to make sure that any medical information that it collects, creates or holds on behalf of the Plans that identifies you remains private. Federal law also requires OEB to maintain this Notice of OEB's legal duties and privacy practices with respect to your medical information. Specifically, this Notice describes how OEB may use or disclose your medical information (see Section II), your rights concerning your medical information (see Section III), how you may contact System regarding OEB's privacy policies (see Section VI), and OEB's right to revise this Notice (see Section VII). OEB will abide by the terms of this Notice as long as it is in effect. This Notice applies to any use or disclosure of your medical information occurring on or after the effective date written at the top of this page, even if OEB created or received the information before the effective date. This Notice will no longer apply once a revised version of this Notice becomes effective.

II. HOW SYSTEM MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION

OEB may use or disclose your medical information only as described in this Section II.

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

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

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

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

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

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

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

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

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

J. Disclosures to Business Associates. OEB may contract or otherwise arrange with other entities or OEB offices to perform services on behalf of the Plans. OEB may then disclose your medical information to these "Business Associates," and these Business Associates will use or disclose your medical information only to the extent OEB would be able to do so under the terms of this Section II. These Business Associates are also required to comply with federal law that regulates your medical information privacy.

K. Other Disclosures. OEB may also disclose your medical information to:

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

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

M. Written Authorization. OEB may use or disclose your medical information under circumstances that are not described above only if you provide permission by "written authorization." After you provide written authorization, you may revoke that authorization, in writing, at any time by sending notice of the revocation to the Privacy Officer identified in Section VI of this Notice. If you revoke an authorization, OEB will no longer use or disclose your medical information under the circumstances permitted by that authorization. However, OEB cannot take back any disclosures already made under that authorization.

III. RESTRICTIONS

A. OEB will not use your medical information for fundraising purposes.

B. OEB will never use your genetic medical information about you for underwriting purposes. Using or disclosing your genetic information is prohibited by federal law.

C. OEB does not use your medical information for marketing purposes. "Marketing" does not include face to face communications with you, or any communications for which the Plan receives no remuneration such as refill reminders, treatment plans, alternatives to treatment, case management, value added services provided in connection with a Plan, and other purposes related to treatment and health care operations. "Marketing" also excludes promotional gifts of nominal value provided by the Plan.

D. OEB does not sell your medical information.

IV. YOUR RIGHTS CONCERNING YOUR MEDICAL INFORMATION

You have the following rights associated with your medical information:

A. Right To Request Restrictions. Although OEB is generally permitted to use or disclose your medical information for treatment, payment, health care operations, and notification to individuals involved with your health care, you have the right to request that OEB limit those uses and disclosures of medical information. You must make your request in writing to the Privacy Officer. Your request must state (1) the information you want to limit, (2) to whom you want the limit to apply, (3) the special circumstances that support your request for a restriction on Plan disclosures, and (4) if your request would impact payment, how payment will be handled. OEB will consider your request but does not have to agree to it. If OEB does agree, OEB will comply with your request (unless the disclosure is for your emergency treatment or is required by law) until you or OEB cancels the restriction. There is a form you can use to make this request which is available on the System website **www.utsystem.edu/documents/docs/special-notices-other/hipaa-request-restriction-use-or-disclosure-protected-health-in** or by contacting the Privacy Officer or the Benefits Office at The University of Texas System institution that you contact for assistance with your System insurance benefits.

B. Right To Confidential Communications. You have the right to request that OEB communicate your medical information to you by a certain method (for example, by e-mail) or at a certain location (for example, at a post office box). You must make your request in writing to the Privacy Officer. Your request must include the method or location desired. If your request would impact payment, you must describe how payment will be handled. Your request must indicate why disclosure of your medical information by another method or to another location could endanger you.

C. Right To Inspect and Copy. You have the right, in most cases, to inspect and copy your medical information maintained by or for OEB. You must make your request in writing to the Privacy Officer. If OEB denies your request, you may have the right to have the denial reviewed by a licensed health care professional selected by OEB. If OEB (or a licensed health care professional performing the review on behalf of OEB) grants your request OEB will provide you with the requested access. You may request copies of such information but OEB may charge may charge you a reasonable fee.

D. Right to Amend. If you feel that medical information OEB has about you is incorrect or incomplete, you may ask OEB to amend the information. You have the right to request an amendment for as long as the information is kept by or for OEB. You must make your request in writing to the Privacy Officer, and you must give a reason that supports your request. If the Privacy Officer denies your request for an amendment, they will explain to you its reasons for denial and your appeal rights following denial.

E. **Right to an Accounting of Disclosures.** You have the right to request a list of disclosures of your medical information that have been made by OEB and its Business Associates. You must make your request in writing to the Privacy Officer. Your request must state the time period during which the disclosures were made, which may not include dates more than six years prior to the request. OEB may charge you a fee for the list of disclosures if you request more than one list within 12 months. OEB does not have to list the following disclosures:

- Disclosures for treatment;
- Disclosures for payment;
- Disclosures for health care operations;
- Disclosures of a limited data set for health care operations, research, or public health activities;
- Disclosures to you;
- Disclosures to individuals involved with your health care;
- Disclosures to authorized federal officials for national security activities;
- Disclosures that occur incidentally with other permissible uses and disclosures;
- Disclosures made under your written authorization; and
- In certain circumstances, disclosures to law enforcement officials or health oversight agencies.

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

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

V. BREACH NOTIFICATIONS

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

VI. WHOM TO CONTACT REGARDING OEB'S PRIVACY POLICIES

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

Privacy Officer c/o
Systemwide Compliance Office
The University of Texas System
210 West 7th Street
Austin, Texas 78701-2902
(512) 852-3264
Email: Privacyofficer@utsystem.edu

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

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

c. **Electronic Copy of This Notice.** You may obtain an electronic copy of the most current version of this Notice at the following website: **utbenefits.link/HIPAA**.

VII. OEB'S RIGHT TO REVISE THIS NOTICE

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

Medicare Part D Notice of Creditable Coverage

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The University of Texas System and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

Medicare-eligible retirees and their Medicare-eligible dependents covered under the UT medical plans are automatically enrolled in the UT CARE PDP Employer Group Waiver Plan (EGWP), also known as UT CARE Part D.

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The University of Texas System Office of Employee Benefits has determined that the coverage offered by the UT prescription drug plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join an Outside Medicare Drug Plan?

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

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

Contact your institution Benefits Office for additional information. NOTE: You'll get this notice each year and if this coverage through the UT medical plans changes. You also may request a copy of this notice at any time from The Office of Employee Benefits at **(800) 888-6824** or from your institution Benefits Office.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

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

ALASKA – The AK Health Insurance Premium Payment Program
Website: myakhipp.com/ Phone 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA – Medicaid
Website: Health Insurance Premium Program
www.dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-4676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+:
www.colorado.gov/pacific/hcpf/childhealth-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
A HIPP Website: medicaid.georgia.gov/health-insurance-premiumpayment-program-hipp
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website: Medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64:
Website: www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid:
Website: www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Website: www.dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gov/benefits/s/?language+en_US formsapplications-forms
Phone: 1-800-442-6003 TTY Maine relay 711
Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Website: dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll-Free number for the HIPP program: 1-800-852-3345, ext 5218

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

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

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347,
or 401-462-0311 (Direct RIte Share Line)

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

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

TEXAS – Medicaid
Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: medicaid.utah.gov
CHIP: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: www.dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Websites: coverva.dmas.virginia.org/learn/premium-assistance/famis-select
coverva.dmas.virginia.org/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Websites: dhhr.wv.gov/bms & mywvhipp.com/
Medicaid Phone: 1-304-558-1700
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid and CHIP
Website:
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any more States have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Nondiscrimination Notice

Discrimination is Against the Law

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

The UT System Office of Employee Benefits provides:

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

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

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

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

If you need these services, contact the UT System Office of Talent and Innovation.

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

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

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

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

Accessibility Requirements Notice

Spanish

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

Vietnamese

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

Chinese

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

Korean

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

Arabic

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

Urdu

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

Tagalog

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

French

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

Hindi

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

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ [UT SELECT Medical UT SELECT Prescription Drug UT SELECT Medicare Part D]

Persian (Farsi)

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

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

German

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

Gujarati

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

Russian

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

Japanese

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

UT SELECT Medical 1-866-882-2034
UT SELECT Prescription Drug 1-800-818-0155
UT CARE 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

UT Institutions

UT ARLINGTON
Office of Human Resources
(817) 272- 5554
Fax: (817) 272-6271
benefits@uta.edu

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

UT DALLAS
Office of Human Resources
(972) 883-2221
Fax: (972) 883-2156
benefits@utdallas.edu

UT EL PASO
Office of Human Resources
(915) 747-5202
Fax: (915) 747-5815
benefits@utep.edu

UT HEALTH SCIENCE CENTER HOUSTON
Employee Benefit Services
(713) 500-3935
Fax: (713) 500-0342
benefits@uth.tmc.edu

UT HEALTH SAN ANTONIO
Office of Human Resources
(210) 567-2600
Fax: (210) 567-6791
benefits@uthscsa.edu

UT MD ANDERSON CANCER CENTER
Human Resources Benefits
(713) 745-myHR (6947)
Fax: (713) 745-7160
HRBenefits@mdanderson.org

Faculty & Executive Benefits (FEB)
(713) 792-7600
Fax: (713) 794-4812
FacExecBenefits@mdanderson.org

UT MEDICAL BRANCH AT GALVESTON
Employee Benefits Services
(409) 772-2630
Toll Free: (866) 996-8862
Fax: (409) 772-2754
benefits.services@utmb.edu

UT PERMIAN BASIN
Human Resources
(432) 552-2753
Fax: (432) 552-3747
benefits@utpb.edu

UT RIO GRANDE VALLEY
Brownsville
Office of Human Resources-Benefits
(956) 882-8205
Fax: (956) 882-7476
benefits@utrgv.edu
Edinburg
Office of Human Resources-Benefits
(956) 665-2451
Fax: (956) 665-3289
benefits@utrgv.edu

UT SAN ANTONIO
People Excellence
(210) 458-4250
hr@utsa.edu

UT SOUTHWESTERN MEDICAL CENTER
Human Resources Benefits Division
(214) 648-9830
benefits@utsouthwestern.edu

UT SYSTEM ADMINISTRATION
Office of Talent & Innovation
(512) 499-4587
Fax: (512) 499-4395
grp-hrsp@utsystem.edu

UT TYLER MAIN & HEALTH CAMPUSES
Office of Human Resources
(903) 566-7234
Fax: (903) 565-5690
benefits@uttyler.edu

STEPHEN F. AUSTIN STATE UNIVERSITY
Human Resources Benefits
(936) 468-2304
Fax: (936) 468-1104
benefits@sfasu.edu

Plan Administrators

UT SELECT MEDICAL
(Blue Cross and Blue Shield of Texas)
Group: 71778
(866) 882-2034
M-F 8:00 AM-6:00 PM CT
www.bcbstx.com/ut

UT SELCT PRESCRIPTION DRUG PLAN
(Express Scripts)
Group: UTSYSRX
(800) 818-0155
24hrs a day 7 days a week
www.express-scripts.com/ut

MEDICARE PART D PRESCRIPTION DRUG PLAN
(Express Scripts)
Group: 7454MDRX
(800) 860-7849
24hrs a day 7 days a week
www.express-scripts.com/ut

UT FLEX
(Inspira Financial Health, Inc.)
(844) UTS-FLEX (887-3539)
M-F 7:00 AM-7:00 PM CT
Sat 9:00 AM-2:00 PM CT
noexcuses.myutflex.com

LIVING WELL HEALTH PROGRAM
livingwell@utsystem.edu
utbenefits.link/LivingWell

UT SELECT DENTAL
UT SELECT DENTAL PLUS
(Delta Dental)
Group: 05968
(800) 893-3582
M-F 6:15 AM-6:30 PM CT
www.deltadentalins.com/universityoftexas

DELTACARE USA DENTAL HMO
(Delta Dental)
Group: 76690
(800) 893-3582
M-F 7:00 AM-8:00 PM CT
www.deltadentalins.com/universityoftexas

SUPERIOR VISION
Group: 26856
(800) 549-2603
M-F 7:00 AM-8:00 PM CT
Sat 10:00 AM-3:30 PM CT
www.superiorvision.com/ut

GROUP TERM LIFE, AD&D, AND DISABILITY
(Blue Cross Blue Shield of Texas)
Group: GFZ71778
(866) 628-2606
M-F 7:00 AM-7:00 PM CT
www.bcbstx.com/ancillary-ut

COBRA
(Voya)
(833) 232-4673
premiumbilling.voya.com
hasinfo@voya.com

COREBRIDGE (formerly AIG Retirement)
(800) 448-2542
M-F 8:00 AM-7:00 PM CT
www.corebridgefinancial.com/rs/utsystem

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

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

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

VOYA FINANCIAL
(800) 584-6001
M-F 7:00 AM-9:00 PM CT
Sat 7:00 AM-3:00 PM CT
utsaver.com/voya

The University *of* Texas System

benefits@utsystem.edu

Office of Employee Benefits | The University of Texas System
210 W. 7th Street | Austin, TX 78701

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

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