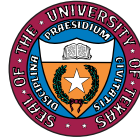




**BlueCross BlueShield
of Texas**



UT SELECT

QUICK REFERENCE GUIDE EFFECTIVE SEPTEMBER 1, 2007

Group Name	The University of Texas System
Group Number	071778
Alpha Prefix	UTS
Plan Type	PPO
PCP Referral Required	No
Customer Service	1-866-882-2034
Preauthorization	1-800-441-9188
Behavioral Health Care (INROADS®)	1-800-528-7264
Special Beginnings Prenatal Program	1-800-462-3275
Medco	1-800-818-0155
Web site	www.bcbstx.com/ut

Subscriber
JANE Q SAMPLE
Identification No.
UTS0JA4RC16P

Group No.	071778	Family Care Copay	\$25
Coverage Date	08-01-07	Specialist Copay	\$30
Network No.	PTXOA	Emergency Room Copay	\$100
BC Plan 400	BS Plan 900	Rx Deductible/Person	\$50
Rx BIN:	610014	Rx Retail Copay	\$10/\$30/\$45
Rx Group No.	UTSYSRX		

UT PPO

SAMPLE ID CARD

**UT-specific ID with leading zero
and an 8-digit alpha/number**

(AxNAANxx where A will always be an alpha,
N will always be numeric and x can be either)

**Medical and prescription
drug copayment information**

**Magnetic stripe
(card reader/pilot program in
progress in select areas)**

**Phone numbers and
important plan information**

www.bcbstx.com/ut

Network coverage is available through participating network providers. Non-network services will be covered at a lower level. Some services must be preauthorized before you receive them. Your online benefits booklet has more information. All mental health and chemical dependency treatment must be preauthorized. For claims filing address refer to the online benefits booklet.

Customer Service	1-866-882-2034
BlueCard Access	1-800-810-2583
Preauthorization (Medical)	1-800-441-9188
Preauthorization (MH/CD)	1-800-528-7264
Special Beginnings	1-800-462-3275
Condition Management	1-800-462-3275
24/7 Nurseline	1-888-315-9473
Pharmacy Benefits*	1-800-818-0155

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, provides claims payment services only and assumes no financial risk with respect to claims.

*Administered by Medco Health Solutions, Inc., www.medco.com, not a BlueCross BlueShield product

UT SELECT PLAN HIGHLIGHTS FOR UT SYSTEM EMPLOYEES, RETIREES AND THEIR DEPENDENTS EFFECTIVE SEPTEMBER 1, 2007

*Please note that this is only a summary of the UT SELECT benefits. For a complete description of the benefits offered, including procedures, exclusions and limitations, please consult the UT SELECT Benefits Booklet found on the UT SELECT Web site.
If you have any questions, please feel free to contact UT SELECT Customer Service at (866) 882-2034.*

TYPE OF SERVICE	PATIENT PAYS (All benefits are paid on the BCBSTX allowable amount)	
	NETWORK	OUT-OF-NETWORK
PHYSICIAN OFFICE VISITS Family Care Physician (FCP) Specialist	\$25 copay per visit \$30 copay per visit	40%, after plan year deductible
PLAN YEAR DEDUCTIBLE (office visit and related services are not subject to plan year deductible)	\$250 per person \$750 family	\$500 per person \$1,500 family
ANNUAL OUT-OF-POCKET MAXIMUM (included plan year deductible)	\$1,750 per person \$5,250 family	\$4,000 per person \$12,000 family
COINSURANCE	20%, after plan year deductible	40%, after plan year deductible
HOSPITAL SERVICES	<u>Inpatient</u> <ul style="list-style-type: none"> • \$100 copay per day (\$500 max per admission) • 20%, after plan year deductible <u>Outpatient</u> <ul style="list-style-type: none"> • 20%, after plan year deductible <u>Outpatient Surgery</u> <ul style="list-style-type: none"> • \$100 copay • 20%, after plan year deductible 	40%, after plan year deductible
HOSPITAL EMERGENCY ROOM VISIT	\$100 copay per visit; all remaining services received at emergency room are covered at 100%	
AMBULANCE SERVICES	20%, after plan year deductible	
PREVENTIVE CARE SERVICES (Well woman exam, one annually, physical exam, one annually, well child care, unlimited up to age 2)	\$25 copay per visit with FCP \$30 copay per visit with Specialist	40%, after plan year deductible
IMMUNIZATIONS	Covered at 100%	
Dependents up to age 6 (no office visit)		
Dependents up to age 6 (with office visit)	\$25 copay per visit with FCP \$30 copay per visit with Specialist	40% of office visit only, after plan year deductible
All covered persons age 6 and older	\$25 copay per visit with FCP \$30 copay per visit with Specialist	40%, after plan year deductible
MATERNITY CARE (Physician charges only) Prenatal care	\$25 copay for initial visit or \$30 copay for initial visit with Nurse Midwife (ANP)	40%, after plan year deductible
Delivery charges	20%, after plan year deductible	40%, after plan year deductible



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