AcademicBlue℠

2016-2017 Navigating Your University of Texas System Student Health Insurance Plan

An easy-to-use guide to help you understand your Student Health Insurance benefits.

The University of Texas System

FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

The University of Texas System Policy Number: 101464
725533.0516

Table of Contents

THE UNIVERSITY OF TEXAS SYSTEM

Attending college is a big step that can mean many changes and new challenges, like learning about health insurance and how it works. You're on your own health plan now, and it is important to learn how to take control of your health care and get the most from your plan. Keep this available throughout the year and it will guide you whether you are sick or just have a question about your health insurance plan at The University of Texas System.

The The University of Texas System Student Health Insurance Plan is underwritten by Blue Cross and Blue Shield of Texas plan and is administered by Academic HealthPlans. It covers certain routine medical care, lab work, prescription drugs, and care for a serious illness, injury, surgery or a hospital stay. In addition to coverage for eligible medical care at your on-campus student health center, you can be referred to other healthcare providers when you need care that is not available at your campus Student Health Center.

Who is Eligible?

Health Institution Students (Hard Waiver) and International Students (Mandatory)

All international students holding non-immigrant visas, and Health Institution Students are eligible and are required to purchase this Student Health Insurance Plan in order to complete registration, except for those students who certify in writing that comparable coverage is in effect under another plan as approved by The University of Texas System (UT System). The Board of Regents has authorized the assessment of a health insurance fee to each such international student who cannot provide evidence of continuing coverage under another approved plan. This fee will be the amount of the premium approved for the UT System Student Health Insurance Plan.

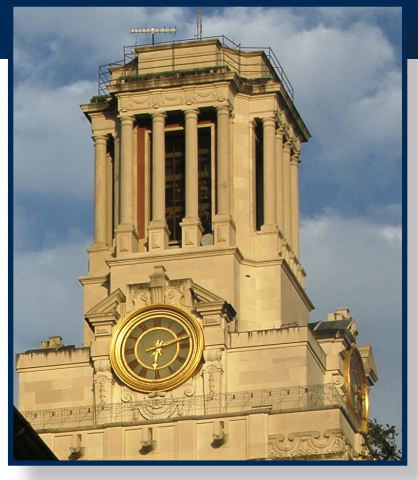
Required Student Health Insurance coverage for international students includes repatriation and medical evacuation benefits.

All Other Students (Voluntary)

Coverage is voluntary for all other fee-paying students at an institution of the UT System who are taking credit hours and actively attending classes through at least the Census Day of the period for which coverage is purchased; fee-paying graduate students who are taking credit hours and are working on research/dissertation or thesis; fellows, including post-doctoral fellows; and scholars, including visiting scholars. We maintain the right to investigate student status and attendance records to verify that the eligibility requirements have been met. If it is discovered the eligibility requirements have not been met, premium will be refunded.

How the Plan Works

This guide highlights some of the features of The University of Texas System Student Health Insurance Plan underwritten by Blue Cross and Blue Shield of Texas and administered by Academic HealthPlans.



Health Insurance 101

Health insurance is a way to protect yourself from the high medical costs that can arise with illnesses or injuries. You may have heard terms like "PPO," "schedule of benefits" and "exclusions." Understanding terms like these will help you understand your health insurance plan.

What is a PPO or a Network Provider?

PPO stands for Preferred Provider Organization and PPO plans are a type of health insurance plan sometimes referred to as managed care. Blue Cross and Blue Shield of Texas (BCBSTX) has negotiated discounts with physicians and facilities nationwide. This group is collectively referred to as "Network Providers."

PPO plans encourage you to get treatment from a Network Provider. They can help you save money. Usually, you'll pay a Copayment, and then pay a certain amount up front (the Deductible) before the insurance company begins to pay the provider.

After you've paid your Deductible, the insurance company will begin to pay for a certain percentage of eligible expenses. It's less expensive to visit one of the Network Providers. You can also go outside the plan's list, to an "Out-of-Network Provider," but your share of the bill will be higher.

Your plan includes an out-of-pocket maximum, which is the amount of money you pay for your percentage of eligible health care services before the insurance company pays 100% of eligible services up to the Policy's maximum benefit.

IMPORTANT: BCBSTX should be notified of all hospital confinements prior to admission in order to avoid a penalty for that care.

Your Schedule of Benefits

The Schedule of Benefits (SOB) outlines what services are included in your plan. No single plan will cover all costs associated with medical care, but some cover more than others.

Since your plan is a PPO, your SOB will include network and out-of-network Coinsurance percentages. Becoming familiar with your SOB is the first step in understanding your plan and its benefits. Before seeking treatment for a non-emergency condition, it is a good idea to review the SOB.

If you have any questions about what your plan will pay for, you should call Customer Service at 855-267-0214. Understanding your benefits up front will allow you to make informed choices about your care.

The Plan Pays Eligible Expenses:
- 80% of the Allowable Amount for Network Providers
- 60% of the Allowable Amount for Out-of-Network Providers

When you've paid your out-of-pocket maximum* ($6,600 for a Network Provider, and $13,200 for an Out-of-Network Provider for individual and $12,700 for a Network Provider, and $37,500 for an Out-of-Network Provider), the plan pays 100% of the Allowable Amount for all remaining eligible expenses.

To Summarize:

Annual Deductibles for both Individual and Family.

	Provider	Out-of-Network Provider
Deductible (Per Covered Person, Per Policy Year)	$500 Student / $1,500 Family	$1,000 Student / $3,000 Family
Up to the per Policy year *Out-of-pocket maximum of:	$6,600 Student / $12,700 Family	$13,200 Student / $37,500 Family

* The out-of-pocket limit does not include Deductible, Copayments or any charges exceeding the Allowable Amount.

Understanding the Network

The University of Texas System Student Health Insurance is a PPO plan. Network Providers have agreed to provide their services at a discounted rate to you.

The plan encourages you to use Network Providers to maximize your health care dollars. Using Network Providers results in a lower out-of-pocket maximum. Out-of-Network service charges by physicians and facilities are also higher since they have not agreed to provide a discount on their services.

Want to see if your doctor is in the BCBSTX BlueChoice® PPO Network? Go to **utsystem.myahpcare.com** and select your campus to search for participating providers. You can also call Customer Service at 855-267-0214 between the hours of 8 a.m. and 6 p.m. Central time.

An Overview of Your Plan Benefits *Deductible applies unless otherwise noted.*

Benefit	Network Provider	Out-of-Network Provider
After you meet the Deductible, the plan pays eligible expenses at:		
Doctor Office Visit/Consultation	100% of Allowable Amount after: $20 Primary Care Copayment per visit; $40 Specialty Copayment per visit;	60% of Allowable Amount
X-ray and Laboratory Procedures	80% of Allowable Amount	60% of Allowable Amount
Emergency Care and Accidental Injury • Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply). • Physician Services	80% of Allowable Amount after $150 Copayment. (Deductible waived) 80% of Allowable Amount	
Non-Emergency Care • Facility Services: (Copayment is waived if the Insured Facility is admitted; Inpatient hospital expenses will apply). • Physician Services	80% of Allowable Amount after $150 Copayment 80% of Allowable amount	60% of Allowable Amount after $150 Copayment 60% of Allowable amount
Surgical Expenses	80% of Allowable Amount	60% of Allowable Amount
Prescription Drugs Benefits include diabetic supplies. Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available at three (3) times the Copayment. Copayment amounts will apply to Out-of-Pocket maximum. Generic acne medications are now available. Prescriptions filled at the SHC: 100% of Allowable Amount after: • $15 Copayment for each Generic Drug • $30 Copayment for each Preferred Brand-Name Drug • $50 Copayment for each Non-Preferred Brand-Name Drug	At pharmacies contracting with the Prime Therapeutics Network 100% of Allowable Amount after a $15 Copayment for each Generic Drug $30 Copayment for each Preferred Brand-Name Drug* $50 Copayment for each Non-Preferred Brand-Name Drug* 80% of Allowable Amount for each Specialty Drug	60% of Allowable Amount after a $15 Copayment for each Generic Drug $30 Copayment for each Preferred Brand-Name Drug* $50 Copayment for each Non-Preferred Brand-Name Drug* 60% of Allowable Amount for each Specialty Drug
Prescriptions are limited to a 30 day retail supply at (1) one times the Copayment, or a 90 day retail supply at (3) three times the Copayment. 90 day supply may be purchased through the Prime Therapeutics Network Mail Order Program at a $40 Copayment for each Generic Drug, $75 for each Preferred Brand* and a $125 Copayment for each Non-Preferred Brand*.		

This chart presents highlights of your plan only. For plan details please refer to pages 15-18.
Students are responsible for paying amounts that exceed the Allowable Amount.

*Copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

The relationship between Blue Cross and Blue Shield of Texas (BCBSTX) and contracting pharmacies is that of independent contractors, contracted through a related company, Prime Therapeutics LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSTX, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Receiving Medical Care

There are a variety of situations in which you might need to receive medical care; they are outlined in this section.

Services at the Student Health Center

Staying healthy is important during your college years. Getting routine physicals on a regular basis can help prevent problems from developing later on. Preventive care encompasses everything from annual checkups and immunizations to X-rays and lab
work. If your campus has a Student Health Center, the Deductible may be waived and some benefits may be paid at 100% of the Allowable Amount of Covered Expenses incurred at the Student Health Center.

The Student Health Center can help keep you healthy with services such as:

- Gynecological exams
- Health education
- Immunizations
- Lab tests
- Nutrition Services
- Pregnancy tests
- Referrals
- STD/HIV antibody testing
- Telephone advice
- Throat cultures
- Tuberculosis screening

Tips for Choosing a Doctor

If you are far from home, you may not be able to see your family doctor for non-routine visits. Here is some advice on how to select a doctor in your area:

- Search the provider database at **utsystem.myahpcare.com**.
- Ask your family doctor for a referral in your new city/region. Talk with friends and associates about their physician recommendations.
- Once you've found a doctor that fits your criteria, call to confirm his or her office hours and admitting privileges at network hospitals.
- Remember that if you are not comfortable with your chosen physician, you are free to search the provider database and select a different physician at any time.

When You Are Sick or Injured

It can be difficult to determine if a sudden illness or accident requires emergency care or can be treated by making an appointment to see a doctor. There are certain cases that usually require emergency care. Some examples are listed in the "Is It an Emergency?" section on page 7.

Do I Need to go to the Emergency Room?

If, after reviewing the guidelines under "Is It an Emergency", you still have questions about whether you need emergency care, you can call the 24/7 Nurseline, anytime, day or night, 365 days a year. Registered nurses, licensed professional counselors and master's-level social workers are available to answer your health questions at 866-412-8795 (toll free).

If you need emergency care, go to the nearest emergency facility immediately or dial 911. **You do not have to worry about ensuring you are going to a Network Provider facility in an emergency; you will receive the same level of benefit either way.**

If, after evaluating your situation, you determine that you need to see a physician, you may visit the Student Health Center on your campus.

You can also go to a physician who participates in the BCBSTX BlueChoice® PPO Network to receive maximum benefits under the plan. If appropriate, consider use of urgent care centers in your Network. Urgent care centers can provide care when your doctor is not available and you don't have a true emergency, but need immediate care. For example, they can treat sprained ankles, fevers, and minor cuts and injuries. Plan pays 100% of allowable amount with a $75 Copayment for eligible services In-Network at Urgent Care clinics.

Is it an Emergency?

No one wants to go to the emergency room if it can be avoided. Using the emergency room for non-emergencies costs you money because emergency room benefits are paid only for true emergencies.

However, in a life-threatening emergency, seek immediate attention by calling 911 or going to the emergency room at your nearest hospital.

Here is a list of situations that may be life threatening:

- Choking
- Not breathing or difficulty breathing
- Suspected poisoning or overdose
- Severe injuries, such as suspected broken bones, head injuries or heavy bleeding
- Seizures or convulsions
- Domestic violence or sexual assault
- Numbness or paralysis of an arm, leg or one side of the body
- A sudden, severe headache, especially if there is neck pain or a change in consciousness at the same time
- A change in mental ability, such as not knowing where you are or being unable to recognize familiar people

Emergency room visits are subject to a $150 Copayment per visit, in lieu of the plan Deductible, plus Coinsurance. For further details of your coverage, please refer to pages 15 to 18.

When You Need Care for Illness or Chemical Dependency.

Your emotional and mental well-being are just as important as your physical well-being. The stress of schoolwork and other commitments may cause some students to feel depressed, lonely or confused. If you think your mental health might be suffering and that counseling would be beneficial, help is available to you.

To learn more about your benefits, call the toll-free number on your ID card.

Follow-Up Care: In Your Hands

It is important to follow your doctor's advice for ongoing treatment of your condition. A successful outcome is largely in your hands. To make sure that additional treatment recommended by the doctor is covered under your plan, please call Customer Service at the number on your ID card.

If you are referred to another physician, specialist or facility, please go to **utsystem.myahpcare.com** and click on your campus. At this website, you can check the provider directory to ensure that the provider is within the BCBSTX BlueChoice® PPO Network. If not, your physician may be able to recommend an alternative provider who is a member of the network.

If your condition requires surgery or hospitalization, try to gather as much information as possible to ensure that this is the appropriate course of treatment. You may want to get a second opinion, and if you use a network physician to do this, it may minimize your additional cost.

I Need a Specialist!

Your Student Health Insurance Plan does not require referrals to visit a specialist. Go to **utsystem.myahpcare.com** and click on your campus to search the BCBSTX BlueChoice® PPO Network for specialists.

Health Resources Available 24/7 Online or by Phone

Information is power, and the more you know before you seek care, the better your health care decisions will be. BCBSTX provides several resources through the Blue Care Connection® Program:

Blue Care® Advisor — a team of registered nurses, licensed professional counselors and master's-level social workers who assist selected members in navigating the health care system. These advisors help to coordinate members' health care and benefits; educate and empower members to make informed choices; and promote wellness by encouraging self-management according to preventive care guidelines. Please call 866-412-8795 for more information.

24/7 Nurseline — call 24/7 to ask questions about your health and get guidance on a wide variety of health care issues. Please call 800-581-0368 for more information.

Case Management and Special Beginnings® — Are you a student who is married, has children or is planning to have children? Pregnant members can enroll to receive a prenatal risk assessment, educational information and case management. These services can help reduce the risk of having an infant with low birth weight or a premature delivery. Please call 866-412-8795 for more information.

Blue Access for Members℠ (BAM) — log on to **utsystem.myahpcare.com** and click on your campus to register for BAM and get personalized information about your health care coverage. This can include the date and amount of claims payments, prescription drug lists and more. BAM also can help you find a physician, hospital or pharmacy.

Lifestyle Management and Wellness programs — targeted wellness initiatives that can help prevent diseases or identify them early when they are more treatable. Please call 866-412-8795 for more information.

Using Your Prescription Drug Benefit

You may need to fill a prescription during your time as a student. This section explains the prescription drug benefits available under the plan.

Online Account Access

Prime Therapeutics is the pharmacy benefit manager for your plan. Pharmacies contracting with the Prime Therapeutics Network provide competitive prescription drug pricing and plan management. Online access to prescription information, a pharmacy locator, and prescription pricing is available at **utsystem.myahpcare.com**. Select your campus, then "Find a Pharmacy" from the menu under the "Benefits" tab. Then follow the onscreen prompts.

Three Cost Options - In-Network Benefits

Prescription medications are categorized within three cost options. Each cost option is assigned a Copayment, which is an amount you pay when you fill a prescription at a participating retail pharmacy or refill your ongoing prescription through the network mail-order pharmacy service.

Your health plan sets the actual Copayment and Coinsurance amounts for the medications covered under your pharmacy benefit. Consult **utsystem.myahpcare.com** for further details of the Policy about the Copayment and Coinsurance that may apply to your pharmacy benefit coverage.

Your Lowest Cost Option

Generic drugs are your lowest Copayment option, at $15 per prescription. For the lowest out-of-pocket expense, you should always consider generic drug medications if you and your doctor decide they are appropriate for your treatment.

Your Middle Drug Cost Option*

Preferred brand-name drugs are your middle Copayment option, at $30 per prescription. Consider these if you and your doctor decide that a preferred brand-name drug is the most appropriate choice to treat your condition. However, if there is a generic drug available you will be responsible for the copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

Your Highest Drug Cost Option*

Non-preferred brand-name drugs are your highest Copayment option, at $50 per prescription. Consider these if you and your doctor decide that a non-preferred brand-name drug is the most appropriate choice to treat your condition. You can also call 800-423-1973 to determine the cost option into which your current prescription falls. However, if there is a generic drug available you will be responsible for the copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

Specialty Drugs

Specialty drugs are 80% of Allowable Amount per prescription and are used in the treatment of medical conditions such as hepatitis, hemophilia, multiple sclerosis and rheumatoid arthritis. Specialty drugs may be oral, topical or injectable medications that can either be self- administered or administered by a health care professional. For a current list of specialty medications, visit myprime.com or bcbstx.com and log in to Blue Access for Members.

Out-of-Network Benefits

If you go to a pharmacy that does not contract with the Prime Therapeutics Network, your covered prescription will be processed at 60% of the Allowable Amount after:

- a $15 Copayment for each Generic Drug
- a $30 Copayment for each Preferred Brand-Name Drug*
- a $50 Copayment for each Non-Preferred Brand-Name Drug*

Preferred Brand-Name Drugs - A drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

*Copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

Generic Drugs - A medication that is comparable to brand/ reference listed drug product, has the same active ingredient(s), is expected to have the same clinical effect, and is available by multiple manufacturers.

Non-Preferred Brand-Name Drugs - These are drugs for which generic equivalents are not available. They have been in the market for a time and are widely accepted.

Specialty Drugs - 60% of Allowable Amount for each Specialty Drug

Mail-order Prescriptions

If you take a certain drug for an ongoing condition such as allergies or diabetes, you can save money by using the Mail Order Prescription Program. See the chart for an overview of your prescription drug benefits, including mail-order costs.

Prescription Drug Category for a Network Provider	How much you pay for up to a 30 day supply (per prescription)	How much you pay for up to a 90 day supply through the mail order drug program (per prescription)
Generic Drug	100% after a $15 Copayment	100% after a $40 Copayment
Preferred Brand Name Drug*	100% after a $30* Copayment	100% after a $75 Copayment
Non-Preferred Brand Name Drug*	100% after a $50* Copayment	100% after a $125 Copayment
Specialty Drug	80% of Allowable Amount	60% of Allowable Amount

How Much Do Prescription Drugs Really Cost?

Although you pay a fixed fee — $15, $30 or $50 — at the pharmacy counter, your Student Health Insurance Plan pays the majority of the cost of your prescription, so you may be surprised to learn how much your medications really cost. Each time you fill a prescription, the plan pays the difference between the true drug cost and your Copayment.

How to Fill A Prescription

With participating pharmacies nationwide and a convenient mail-order program, it is easy for you to get your prescription filled.

Retail Pharmacy (30 day supply)	Mail Order Prescriptions (90 day supply)
1. Locate a participating pharmacy at **utsystem.myahpcare.com**. Click on your campus, go to the Benefits tab, click on Find a Pharmacy and follow the prompts provided. Or you can call 800-423-1973. 2. Present your ID card, along with your prescription, at the pharmacy counter. 3. Pay the applicable Copayment at the pharmacy, and you're done.	1. The first time your doctor prescribes medication that you will take on a regular basis, ask for two prescriptions. The first prescription should be for one month that can be immediately filled at a pharmacy contracting with Prime Therapeutics. The second should be written for a 90 day supply with refills. Use t he 90 day prescription to obtain your medication from the mail-order pharmacy. 2. Use the process that is most convenient for you to fill mail order prescriptions: • FAX — Give your doctor your ID number. Then have your doctor call 800-423-1973 to get instructions on how to fax your prescription to the pharmacy. • MAIL — Go to **utsystem.myahpcare.com** to download the PrimeMail Refill Prescription Order Form. Click on Mail Order Prescriptions under the Benefits tab then look under Pharmacy Programs for Mail Service Program. 3. Your prescription will arrive within 7 to 11 days.

* Copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

Refill Your Order

When you have only a two-week supply of your medication left, it's time to reorder. Have your ID number, prescription number (the 12-digit number on your refill slip), and credit card ready. Go to **utsystem.myahpcare.com**, click on your campus, then look under the Benefits tab to access prescription refills by clicking on Mail Order Prescriptions. Then look under Mail Service Program, and you will find the PrimeMail Refill Prescription Order Form to complete and mail. You may also call Prime Therapeutics Network by phone at 800-423-1973. When ordering your refill by phone, be sure to record your confirmation number.

Paying For Your Prescriptions

You can pay by check, money order or credit card for prescription refills by mail. For more information on payment types call 800-423-1973.

Always Show Your ID Card

Be sure to present your ID card whenever you seek health care services or purchase a prescription at the pharmacy. This will ensure that you receive the benefits under your plan, and that the provider will submit a claim on your behalf.

Blue Access for Members (BAM)

Each Insured student is given access to their plan online through BAM. Go to **utsystem.myahpcare.com** and click on your campus to Register for Blue Access for Members.

You will be required to do the following:

- Click on "New User? Register Now"
- Fill in the boxes with the required information

Once you have registered, you will be able to log on as a member and go directly to your BAM page. If you need more assistance, you may call Customer Service at 855-267-0214.

Plan Management at Your Fingertips

BAM can help you manage your plan at your convenience. Go to **utsystem.myahpcare.com** and click on your campus. Look under the Claims tab, then log on to BAM to access plan and account information. Some details of what to look for:

- Track your claims status
- View Explanations of Benefits
- Print a temporary ID card or request a permanent replacement ID card
- Locate Network Providers
- Link to the pharmacy information to manage your prescriptions

Submitting a Claim

Typically, for network and out-of-network benefits, the physician or facility will file a medical claim on your behalf. Once you've met the Deductible, the insurance company will pay the provider the agreed-upon amount, based on negotiated discounts and your plan benefits. You will receive an Explanation of Benefits (EOB) detailing the amounts paid to the provider. You will then receive a bill for any remaining balance from the provider, which you pay directly to that provider.

Stretching Your Health Care Dollars

Included in your plan is the Blue365® money-saving program. This program is not insurance, but provides discounts on the following health and wellness services:

- Complementary alternative medicine
- Davis Vision | TruVision
- Jenny Craig
- Life Time Fitness
- Procter & Gamble dental products
- Seattle Sutton's Healthy Eating
- TruHearing

Go to **utsystem.myahpcare.com** to get detailed information about the Blue365 program. To use Blue365, simply show your ID card to a participating provider to receive your discount.

If You Choose to Remain on The University of Texas Plan

If you are a hardwaiver or mandatory student who remains on the UT System Student Health Insurance Plan, the annual cost for coverage, $2,185, will automatically be added to your student account for 2016-2017. Voluntary students cannot add the cost of their premium to their student account and must pay AHP directly. If you have a spouse or child(ren) whom you would like to cover under the UT System Student Health Insurance Plan, students, your annual cost for health care insurance is listed in the chart below.

The costs are the same whether you voluntarily enroll or are required to have coverage.

If you want coverage for	Annual Cost
Yourself only	$2,185.00
You and spouse	$4,370.00
You and children	$5,947.00
You, spouse and children	$8,132.00

To purchase Dependent coverage, or if your situation changes during the year, go to **utsystem.myahpcare.com** and click on your campus. Please note that insurance premiums for your Dependents are paid separately, not as part of your tuition. You may cover your Dependents only if you are also enrolled in the plan. Please see the glossary on page 23 for the definition of "Dependent."

Academic HealthPlans (AHP) is pleased to offer students the option of paying for their Student Health Insurance premium through monthly installments. This will enable payment over the course of the academic year through more affordable monthly premium charges. Information and guidelines on how this process works can be found on AHP's website. Go to utsystem.myahcare.com and click your campus to review the process.

If You Leave the University

To be eligible for insurance coverage under the UT System Student Health Insurance Plan, you must be enrolled through the Census Day for which premium has been paid. If you are not enrolled through the Census Day, or if you leave the university prior to the Census Day of your enrollment as a student, your coverage under the UT System Health Insurance Plan will end.

If you are out of school due to a medical leave, please contact Academic HealthPlans for information on our Medical Leave Policy.

Continuing Coverage

If your insurance under the UT System Student Health Insurance Plan ends for any reason, you may be eligible to continue your medical coverage. To qualify, you must have participated in the UT System Student Health Insurance Plan for the six (6) months immediately preceding the date your coverage ended. Continuation coverage can be purchased for up to six (6) months. Enrollment must be made and the applicable premium must be paid directly to Academic HealthPlans and be received within 30 days after the expiration date of your student coverage.

To learn more about continuation coverage, contact Academic HealthPlans at 855-247-7587 before your student coverage ends.

Schedule of Medical Expense Benefits - Injury and Sickness

	Network Provider	Out-of-Network
Plan Maximum (per Covered Person, per Policy Year)	Unlimited	
Deductible (per Covered Person, per Policy Year)	$500 Student / $1,500 Family	$1,000 Student / $3,000 Family
Out-of-Pocket Maximum (per Covered Person, per Policy Year)	$6,600 Student / $12,700 Family	$13,200 Student / $37,500 Family

The Network Provider for this plan is Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® PPO Network.

If the institution has a Student Health Center, the Deductible may be waived and some benefits will be paid at 100% of the Allowable Amount of Covered Expenses incurred at the Student Health Center. However, some Copayments may apply.

After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at 80% of the Allowable Amount for services rendered by Network Providers in the BCBSTX BlueChoice® PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network Providers (any provider outside the BCBSTX BlueChoice® PPO Network) will be paid at 60% of the Allowable Amount, unless otherwise specified in the Policy. Benefits will be paid up to the maximum for each service as specified below regardless of the provider selected.

Out-of-pocket Maximum means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services under the terms of a coverage plan.

Once the Out-of-pocket limit has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Policy year, up to any maximum that may apply. **The Out-of-pocket limit does not include Deductible, Copayments or any charges exceeding the Allowable Amount.**

Deductible applies unless otherwise noted.

Inpatient	Network Provider Plan Pays	Out-of-Network Provider Plan Pays
Hospital expenses, include the daily semi-private room rate; intensive care; general nursing care provided by the hospital; and hospital miscellaneous expenses such as the cost of the operating room, laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take-home drugs) or medicines, physical therapy, therapeutic services and supplies.	80% of Allowable Amount	60% of Allowable Amount
Surgical expenses, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure.	80% of Allowable Amount	60% of Allowable Amount
Assistant Surgeon	80% of Allowable Amount	60% of Allowable Amount

Inpatient (continued)	Network Provider Plan Pays	Out-of-Network Provider Plan Pays
Anesthetist	80% of Allowable Amount	60% of Allowable Amount
Doctor's Visits	80% of Allowable Amount	60% of Allowable Amount
Routine Well-Baby Care	80% of Allowable Amount	60% of Allowable Amount
Mental Illness / Chemical Dependency	Paid as any other covered Sickness	Paid as any other covered Sickness
Outpatient	**Network Provider Plan Pays**	**Out-of-Network Provider Plan Pays**
Surgical expenses, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure.	80% of Allowable Amount	60% of Allowable Amount
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.	80% of Allowable Amount	60% of Allowable Amount
Assistant Surgeon	80% of Allowable Amount	60% of Allowable Amount
Anesthetist	80% of Allowable Amount	60% of Allowable Amount
Doctor Office Visit/Consultation Doctor Copayment Amount: For office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians. Specialty Care Copayment Amount: For office visit/consultation when services rendered by a Specialty Care Provider refer to Medical/Surgical Expenses section for more information.	100% of Allowable Amount after: $20 Copayment per visit (Deductible waived) $40 Copayment per visit (Deductible waived)	60% of Allowable Amount
Physical Medicine Services: Physical therapy or chiropractic care – office services. Physical medicine services include, but are not limited to, physical, occupational and manipulative therapy.	80% of Allowable Amount	60% of Allowable Amount
Benefit Period Visit Maximum	Benefits for physical medicine services will be limited to 35-visits per Benefit Period.	

Outpatient (continued)	Network Provider Plan Pays	Out-of-Network Provider Plan Pays
Emergency Care and Accidental Injury Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply). Physician Services	80% of Allowable Amount after $150 Copayment. (Deductible waived) 80% of Allowable Amount	
Non-Emergency Care Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply). Physician Services	80% of Allowable Amount after $150 Copayment 80% of Allowable Amount	60% of Allowable Amount after $150 Copayment 60% of Allowable Amount
Radiation Therapy and Chemotherapy, includes dialysis and respiratory therapy.	80% of Allowable Amount	60% of Allowable Amount
Urgent Care Services	100% of Allowable Amount after $75 Copayment	60% of Allowable Amount
Tests & Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits.	80% of Allowable Amount	60% of Allowable Amount
Prescription Drugs, diabetic supplies are covered and included (Deductible Waived). Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available at three (3) times the Copayment. Copayment amounts will apply to Out-of-Pocket maximum. Generic acne medications are now available. Prescriptions filled at the SHC: 100% of Allowable Amount after a $15 Copayment for each Generic Drug $30 Copayment for each Preferred Brand-Name Drug $50 Copayment for each Non-Preferred Brand-Name Drug 90 day supply may be purchased through the Prime Therapeutics Network Mail Order Program at a $40 Copayment for each Generic Drug, a $75 Copayment for each Preferred Brand-Name Drug* and $125 for each Non-Preferred Name Drug*.	At pharmacies contracting with the Prime Therapeutic Network: 100% of Allowable Amount after a $15 Copayment for each Generic Drug $30 Copayment for each Preferred Brand-Name Drug* $50 Copayment for each Non-Preferred Brand-Name Drug* 80% of Allowable Amount for each Specialty Drug	60% of Allowable Amount after a $15 Copayment for each Generic Drug $30 Copayment for each Preferred Brand-Name Drug* $50 Copayment for each Non-Preferred Brand-Name Drug* 60% of Allowable Amount for each Specialty Drug
Mental Illness / Chemical Dependency	Paid as any other covered Sickness	Paid as any other covered Sickness
Extended Care Expenses: All services must be pre-authorized	80% of Allowable Amount	60% of Allowable Amount
Home Health Care ..... Skilled Nursing ..... Hospice Care ..... Private Duty Nursing	Limited to 60 visit maximum each Benefit Period Limited to 25 days maximum each Benefit Period No Benefit Period Visit Maximum Not Covered	

*Copayment plus the cost difference between the brand-name drug or supplies per prescription for which there is a generic drug or supply available.

Other	Network Provider Plan Pays	Out-of-Network Provider Plan Pays
Ground and Air Ambulance Service	80% of Allowable Amount	80% of Allowable Amount
Durable Medical Equipment, when prescribed by a Doctor and a written prescription accompanies the claim when submitted.	80% of Allowable Amount	60% of Allowable Amount
Maternity/Complications of Pregnancy	80% of Allowable Amount	60% of Allowable Amount
Speech and Hearing Services to restore loss of hearing/speech. or correct an impaired speech or hearing function.	80% of Allowable Amount	60% of Allowable Amount
Hearing Aids / Hearing Aid maximum	Hearing aids are limited to one hearing aid per ear, per 36-month period.	
Dental, made necessary by Injury to sound, natural teeth only.	80% of Allowable Amount	80% of Allowable Amount
Pediatric Vision, up to age 19: See benefit flier for details. Pediatric Routine Dental Care, up to age 19: See benefit flier for details. Pediatric Basic & Major Dental, up to age 19: See benefit flier for details. Pediatric Medically Necessary Orthodontia, up to age 19: See benefit flier for details.	100% of Allowable Amount 80% of Allowable Amount 50% of Allowable Amount 50% of Allowable Amount	See Fee Schedule 80% of Allowable Amount 50% of Allowable Amount 50% of Allowable Amount
Needle Stick, only for students doing course work or Hospital training.	100% of Allowable Amount	60% of Allowable Amount
Organ and Tissue Transplant Services: The transplant must meet the criteria established by BCBSTX for assessing and performing organ or tissue transplants as set forth in BCBSTX's written medical policies.	80% of Allowable Amount	60% of Allowable Amount
Preventive Care Services, includes but are not limited to: a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); c. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and d. With respect to women, such additional preventive care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA. Preventive Care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Texas for more information at (855) 267-0214.	100% of Allowable Amount (Deductible Waived)	60% of Allowable Amount

Go to **utsystem.myahpcare.com** and click on your campus to download the 2016-2017 University of Texas System Student Health Insurance Plan brochure, which contains additional essential information about the Policy features. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued.

Exclusions and Limitations

Except as specified in this Policy, coverage is **not** provided for loss or charges incurred by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
3. Acne; including acne prescription drugs covered under Outpatient prescription drugs;
4. Acupuncture procedures;
5. Biofeedback procedures; except as needed to treat acquired brain injuries;
6. Breast augmentation or reduction;
7. Routine circumcision, unless the procedure is Medically Necessary for treatment of a sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an accident or except for covered infants within 28 days of birth;
8. Testing or treatment for sleep disorders;
9. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that We determine are experimental or investigational;
10. Expenses incurred for Injury or Sickness, arising out of or in the course of a Covered Person's employment, regardless if benefits are, or could be, paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
11. Treatment, services or supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
12. Expenses in connection with services and prescriptions for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;
13. Sinus or other nasal surgery, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered Injury;
14. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
    - a covered Injury that occurred while the Covered Person was insured;
    - an infection or other diseases of the involved part; or
    - a covered child's congenital defect or anomaly;
15. Injuries arising from Interscholastic Activities and Qualifying Intercollegiate Sports;
16. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
17. Injury resulting from sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping;
18. War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces of any country or international authority;
19. Elective abortion, including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
20. Any expenses incurred in connection with sexual dysfunction, sterilization reversal, vasectomy reversal and sexual reassignment;
21. In-vitro fertilization;
22. Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer;
23. Donor expenses for a Covered Person in connection with an organ and tissue transplant if the recipient is not covered under this Policy;

Exclusions and Limitations continued

24. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury;
25. Foot care including: flat foot conditions, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency;
26. Hirsutism;
27. Alopecia;
28. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;
29. Surgery for the removal of excess skin or fat;
30. Nutrition programs, except as related to treatment for diabetes;
31. Custodial care;
32. Long-term care service;
33. Bariatric surgery;
34. Private duty nursing services, except for covered extended care expenses;
35. Weight loss programs;
36. Prescription drug coverage is not provided for:
    a. Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;
    b. Administration of insulin, or non-medical substances regardless of their intended use; for hair growth, anabolic steroids for body building, anorectics for weight control, etc;
    c. Drugs labeled "Caution- limited by federal law to investigational use" or experimental drugs;
    d. Immunizing agents, biological sera, blood or blood products administered on an Outpatient basis, except as specifically provided in this Policy;
    e. Any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
    f. Drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control; etc;
    g. Fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;
    h. Lost or stolen prescriptions;
    i. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control;
    j. Non-sedating antihistamines drugs and combination medications containing a non- sedating antihistamine decongestant;
    k. Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non- commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with the United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers;
    l. Brand Name proton pump inhibitors;
    m. Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.is given, except as required by law or regulation.

The Affordable Care Act *and how it relates to The University of Texas (UT) System Student Health Insurance Plan*

FAQs

Below are some answers to frequently asked questions (FAQs) about what this may mean to you and your Blue Cross and Blue Shield of Texas UT System Student Health Insurance Plan.

If I already enrolled in the UT System Health Insurance Plan, do I need to do anything?

No, you are set. The UT System Student Health Insurance Plan meets all ACA requirements.

Do I need to sign up through the Health Insurance Marketplace in November?

No, your UT-sponsored student plan is not on the Marketplace, as it is available to UT students only. Your premium is based on the UT student population, and your benefit package was designed specifically for students at your school. If the institution has a Student Health Center, the Deductible may be waived and some benefits will be paid at 100% of the Allowable Amount of Covered Expenses incurred at the Student Health Center. However, some Copayments may apply.

If I am not a member of the UT System Health Insurance Plan, do I need to do anything?

Yes, individuals who don't have minimum essential coverage by January 1, 2016, may have to pay a tax penalty. The UT System Student Health Insurance Plan is considered minimum essential coverage under ACA.

Can I buy the UT System Student Health Insurance Plan on the Health Insurance Marketplace and get a premium tax credit or cost-sharing assistance?

No, you cannot buy the UT System Student Health Insurance Plan on the Marketplace, nor can you get a premium tax credit or cost-sharing assistance for the UT System Student Health Insurance Plan. Student plans under ACA are treated separately because the cost of coverage and benefits reflect the student population and should be more affordable than many of the individual plans on the Marketplace.

What is the benefit of the UT System Student Health Insurance Plan compared to the individual plans on the Marketplace?

With the UT System Student Health Insurance Plan, you have:

- the benefit of having an insurance plan that the University endorses.
- if the institution has a Student Health Center, the Deductible may be waived and some benefits will be paid at 100% of the Allowable Amount of Covered Expenses incurred at the Student Health Center. However, some Copayments may apply.
- easy access to basic health care services along with office visits, prescriptions and many preventive services at no additional out-of-pocket cost.
- if you need to see a doctor off-campus, you have the assurance of Blue Cross and Blue Shield of Texas' comprehensive network of doctors, hospitals and specialists.
- The UT System Student Health Insurance Plan network list may be greater than the network list you would have on a Marketplace plan and is made up of providers across the nation and worldwide through our BlueCard℠ program.

Keep in mind that even if you are covered as a Dependent under your parent's plan, the UT System Health Insurance Plan may be a better option due to the low cost and coverage by a plan that meets ACA requirements.

For more information about your UT System Student Health Insurance Plan, go to **utsystem.myahpcare.com**.

If you would like more information on the Affordable Care Act, please visit **bcbstx.com/Reformandyou**.

Glossary

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

For hospitals, Doctors and other providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan – The Allowable Amount is based on the terms of the Network Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For hospitals, Doctors and other providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) – The Allowable Amount will be the lesser of:

(i) The provider's billed charges, or;

(ii) The BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than **75 percent** and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for home health care is developed from base Medicare national per-visit amounts for low utilization payment adjustment, or LUPA, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by Us. Such factor shall be not less than **75 percent** and shall be updated on a periodic basis. When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non- contracting providers will represent an average contract rate in aggregate for network providers adjusted by a predetermined factor established by Us. Such factor shall be not less than **75 percent** and shall be updated not less than every two years.

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

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

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

Glossary continued

For prescription drugs as applied to Network Provider and Out-of-Network Provider pharmacies - The Allowable Amount for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSTX and the pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

Benefit Period means the period of time starting with the effective date of this policy through the termination date as shown on the face page of the policy. The Benefit Period is as agreed to by the policyholder and the Insurer.

Coinsurance means a percentage of an eligible expense that the Covered Person is required to pay toward a Covered Expense.

Company means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (also referred to herein as "BCBSTX").

Copayment means a fixed dollar amount that the Covered Person must pay before benefits are payable under the policy.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the policy. Coverage under the policy must remain continuously in force from the date of the accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained.

Covered Person means any eligible student or an eligible dependent who applies for coverage, and for whom the required premium is paid to the Company.

Deductible means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a policy term basis before benefits are payable under the policy.

Dependent means an Insured's lawful spouse; or an Insured's child, stepchild, foster child, dependent grandchild or spouse's dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's immediate family or household.

Glossary continued

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

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

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

Injury means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a covered accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Inpatient means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

Insured means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid, making insurance in effect for that person. An Insured is not a dependent covered under the policy.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

Medically Necessary means those services or supplies covered under the plan that are:

- Essential to, consistent with, and provided for in the diagnosis or in the direct care and treatment of the condition, Sickness, disease, Injury, or bodily malfunction; and
- Provided in accordance with, and are consistent with, generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Insured, his physician, behavioral health practitioner, the hospital, or other provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Insured. When applied to hospitalization, this further means that the Insured requires acute care as a bed patient due to the nature of the services provided or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities; the guidelines and practices of Medicare, Medicaid, or other government-financed programs; and peer-reviewed literature. Although a physician, behavioral health practitioner or professional other provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition

Glossary continued

Network Provider means a hospital, Doctor or other provider who has entered into an agreement with BCBSTX (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Out-of-Network Provider means a hospital, Doctor or other provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

Outpatient means that a Covered Person is receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility.

Out-of-Pocket Maximum means the maximum liability that may be incurred by a Covered Person in a Benefit Period before benefits are payable at 100 percent of the Allowable Amount.

Pre-authorization means the process that determines in advance the Medical Necessity or experimental, investigational and/or unproven nature of certain care and services under this Policy.

Qualifying Intercollegiate Sport means a sport: a.) which has been accorded varsity status by the Institution as an NCAA sport; and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which the eligibility of the participating student athlete is reviewed and certified in accordance with NCAA legislation, rules, or regulations; and (d.) which entitles qualified participants to receive the Institution's official awards.

Sickness means an illness, disease or condition causing a Covered Person to incur medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

We, Our, Us means Blue Cross and Blue Shield of Texas or its authorized agent.

How to Get More Information

If you have questions or specific requests, use the contact information in this chart to get the answers you need.

If you...	Contact
Want to download your plan brochure	Go to **utsystem.myahpcare.com**.
Want to voluntarily purchase coverage for yourself and your dependents	If you are not required to have coverage but want to buy it for yourself or dependents, go to the Insurance link at **utsystem.myahpcare.com** and click on your campus, then look under the Enrollment tab.
Want to find a doctor, hospital or pharmacy	Go to **utsystem.myahpcare.com** and click on your campus 855-267-0214 for Network Providers or hospitals 800-423-1973 for pharmacies contracting with the Prime Therapeutics Network
Want to speak to a nurse about a health concern	24/7 Nurseline (24 hours a day, 7 days a week), 800-581-0368 Blue Care Connection, 866-412-8795
Have a concern about mental health	Blue Care Connection, 866-412-8795
Need to verify coverage	Academic HealthPlans **utsystem.myahpcare.com** 855-247-7587 or e-mail info@ahpcare.com
Have a question about a claim	BCBSTX Customer Service, 855-267-0214

This guide highlights some of the features of The University of Texas System Student Health Insurance Plan underwritten by Blue Cross and Blue Shield of Texas and administered by Academic HealthPlans.

Please go to **utsystem.myahpcare.com** and click on your campus to download the 2016-2017 Student Health Insurance Plan brochure, which contains additional essential information about the Policy and plan features.

For more detailed information on this plan, go to **utsystem.myahpcare.com** or call 855-247-7587

AcademicBlue℠

THE UNIVERSITY of TEXAS SYSTEM

FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

UT Benefits