BlueCross BlueShield of Texas

The Texas A&M University System - Student Health Insurance Plan

Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan.

Attached are the SBC for the Texas A&M University System Student Health Plan covering plans purchased between 08/01/2025 - 07/31/2026. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for The Texas A&M University System Student Health Plan are listed below:

| **Coverage Period** | **Dates** |
|---|---|
| Early Arrival | 08/01/2025 – 12/31/2025 |
| Graduates | 09/01/2025 – 08/31/2026 |
| Fall | 9/01/2025 – 12/31/2025 |
| Spring/Summer | 01/01/2026 – 08/31/2026 |
| Summer | 05/17/2026 – 08/31/2026 |

If you have any questions regarding your coverage or the length of time you purchased, please contact customer service at 855-267-0214.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-267-0214 or at https://tamus.myahpcare.com/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $350 Individual / $1,050 Family<br>Out-of-Network: $1,000 Individual / $3,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Services that charge a copayment, prescription drugs, emergency room services, and certain preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: $7,900 Individual / $15,800 Family<br>Out-of-Network: $15,800 Individual / $31,600 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | None |
| | Specialist visit | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | None |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | 40% coinsurance after deductible | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.<br>No Charge for child immunizations Out-of-Network through the 6th birthday. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 40% coinsurance after deductible | Office visit copayment may apply. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.bcbstx.com | Generic drugs | $10 retail and mail order copayment/prescription; deductible does not apply | $10 copayment/prescription plus 40% coinsurance; deductible does not apply | Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply.<br><br>Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.<br><br>For Out-of-Network pharmacy, member must file claim.<br><br>The cost-sharing for insulin included in the drug list will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. |
| | Non-preferred generic drugs | $10 retail and mail order copayment/prescription; deductible does not apply | $10 copayment/prescription plus 40% coinsurance; deductible does not apply | |
| | Preferred brand drugs | $35 retail and mail order copayment/prescription; deductible does not apply | $35 copayment/prescription plus 40% coinsurance; deductible does not apply | |
| | Non-preferred brand drugs | $60 retail and mail order copayment/prescription; deductible does not apply | $60 copayment/prescription plus 40% coinsurance; deductible does not apply | |
| | Preferred Specialty drugs | $10/$35/$60 copayment/prescription; deductible does not apply | $10/$35/$60 copayment/prescription plus 40% coinsurance; deductible does not apply | For In-Network benefit, must obtain specialty drugs from In-Network specialty pharmacy provider. Specialty drugs are limited to a 30-day supply except for certain FDA-designated dosing regimens. Mail order is not covered. |
| | Non-preferred Specialty drugs | $10/$35/$60 copayment/prescription; deductible does not apply | $10/$35/$60 copayment/prescription plus 40% coinsurance; deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $150 copayment/visit; plus 20% coinsurance; deductible does not apply | $150 copayment/visit; plus 20% coinsurance; deductible does not apply | Emergency room copayment waived if admitted. Non-emergency use of the emergency room is covered at the plans Out-of-Network coinsurance and deductible. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Ground and air transportation covered. |
| | Urgent care | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copayment/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services | $25 copayment/office visit; deductible does not apply 40% coinsurance after deductible for other outpatient services | Certain services must be preauthorized; See your benefit booklet* for details. |
| | Inpatient services | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you are pregnant** | Office visits | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible | None |

* For more information about limitations and exceptions, see the plan or policy document at tamu.myahpcare.com/benefits.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 60 visits per calendar year. Preauthorization is required; See your benefit booklet* for details. |
| | Rehabilitation services | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy. |
| | Habilitation services | $25 copayment/visit; deductible does not apply | $25 copayment/visit; plus 40% coinsurance; deductible does not apply | |
| | Skilled nursing care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 25 days per calendar year. |
| | Durable medical equipment | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| | Hospice services | 20% coinsurance after deductible | 40% coinsurance after deductible | None |

* For more information about limitations and exceptions, see the plan or policy document at tamu.myahpcare.com/benefits.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | $10 copayment/visit; deductible does not apply | No Charge; Up to $30; deductible does not apply | See your benefit booklet* for details. |
| | Children's glasses | No Charge; Up to $130; deductible does not apply | No Charge; Up to $65; deductible does not apply | See your benefit booklet* for details. |
| | Children's dental check-up | No Charge; deductible does not apply | No Charge; deductible does not apply | See your benefit booklet* for details. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care (35 visits per year)
- Hearing aids (1 per ear per 36-month period)
- Routine eye care (Adult)
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at tamu.myahpcare.com/benefits.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-855-267-0214 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-855-267-0214 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-855-267-0214 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-267-0214.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-267-0214.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-267-0214.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist *copayments*** | **$25** |
| **Hospital (facility) *coinsurance*** | **20%** |
| **Other *coinsurance*** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $40 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,850** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist *copayments*** | **$25** |
| **Hospital (facility) *coinsurance*** | **20%** |
| **Other *coinsurance*** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,170** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **Specialist *copayments*** | **$25** |
| **Hospital (facility) *coinsurance*** | **20%** |
| **Other *coinsurance*** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$950** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

**Health care coverage is important for everyone.**

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

| | **To receive language or communication assistance free of charge, please call us at 855-710-6984.** |
|---|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |