



BlueCross BlueShield
of Texas

University of Houston 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 University of Houston System Student Health Plan covering plans purchased between 07/01/2025 - 06/30/2026 in accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for University of Houston System vary by semester but overall coverage periods are listed below:

Coverage Periods	Dates
College of Medicine	07/01/2025 - 06/30/2026
	09/01/2025 - 08/31/2026
Clear Lake Campus	08/01/2025 - 07/31/2026
	08/27/2025 - 08/26/2026
Downtown Campus	08/01/2025 - 07/31/2026
	08/15/2025 - 08/14/2026
Main Campus	08/01/2025 - 07/31/2026
	09/01/2025 - 08/31/2026
Language Culture Center	09/09/2025 – 09/08/2026


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 uhsystem.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?	For <u>In-Network</u> : \$350 Individual / \$1,050 Family For <u>Out-of-Network</u> : \$700 Individual / \$2,100 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services that charge a <u>copayment</u> , <u>prescription drugs</u> , emergency room services, and certain <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$100 Individual <u>prescription drug deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	For <u>In-Network</u> : \$8,150 Individual / \$15,800 Family For <u>Out-of-Network</u> : \$15,800 Individual / \$31,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and healthcare this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening</u> /immunization	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Office visit <u>copayment</u> may apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	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 More information about <u>prescription drug coverage</u> is available at www.bcbstx.com	Generic drugs	\$20 retail/\$50 mail order <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$20 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Prescription drug deductible</u> applies to In-network and Out-of-Network: \$100 Individual.
	Non-preferred generic drugs	\$20 retail/\$50 mail order <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$20 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	Retail covers a 30-day supply. Mail order covers a 90-day supply with 1 copayment per 30-days.
	Preferred brand drugs	\$50 retail/\$125 mail order <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$50 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	ESN limited to 90-day supply.
	Non-preferred brand drugs	\$70 retail/\$175 mail order <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$70 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Out-of-Network</u> mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For <u>Out-of-Network</u> pharmacy, member must file <u>claim</u> .
	Preferred <u>Specialty drugs</u>	\$100 <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$100 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	A separate <u>Prescription drug deductible</u> only applies to mail service <u>In-network</u> and <u>Out-of-Network</u> : \$250 Individual.
	Non-preferred <u>Specialty drugs</u>	\$100 <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$100 <u>copayment</u> /prescription plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	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	<u>Emergency room care</u>	\$250 <u>copayment</u> /visit plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$250 <u>copayment</u> /visit plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Emergency room copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Ground and air transportation covered.
	<u>Urgent care</u>	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copayment</u> /visit plus 20% <u>coinsurance</u> after <u>deductible</u>	\$100 <u>copayment</u> /visit plus 40% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copayment</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> after <u>deductible</u> for other outpatient services	40% <u>coinsurance</u> after <u>deductible</u>	Certain services must be preauthorized; See your benefit booklet* for details
	Inpatient services	\$100 <u>copayment</u> /visit plus 20% <u>coinsurance</u> after <u>deductible</u>	\$100 <u>copayment</u> /visit plus 40% <u>coinsurance</u> after <u>deductible</u>	None
If you are pregnant	Office visits	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy).
	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	\$100 <u>copayment</u> /visit plus 20% <u>coinsurance</u> after <u>deductible</u>	\$100 <u>copayment</u> /visit plus 40% <u>coinsurance</u> after <u>deductible</u>	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 help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required; See your benefit booklet* for details. Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Limited to 25 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	No Charge; up to \$30 <u>deductible</u> does not apply	See your benefit booklet* for details
	Children's glasses	No Charge; <u>deductible</u> does not apply	No Charge; up to \$75 <u>deductible</u> does not apply	See your benefit booklet* for details
	Children's dental check-up	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> 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 (limited to 1 aid per ear 36-month period)
- Routine eye care (Adult)
- Routine foot care

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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) both	\$100 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$400
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,960

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) both	\$100 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$450
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) both	\$100 + 20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$400
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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



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., 35 th Floor Chicago, IL 60601	Phone: TTY/TDD: Fax:	855-664-7270 (voicemail) 855-661-6965 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: TTY/TDD: Complaint Portal: Complaint Forms:	800-368-1019 800-537-7697 https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf 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	للتلقي المساعدة اللغوية أو التواصل مجاًناً، 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 કોલ 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'áájiik'eh bee náhaz'á. 1-866-560-4042 jil' 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، براہ 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.