



BlueCross BlueShield of Texas

Texas Tech University 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 is the SBC for the Texas Tech University Student Health Plan covering plans purchased between 7/01/25 - 08/31/26. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for Texas Tech University are listed below:

| Coverage Period | Date |
|------------------------|-------------------------|
| TTU Domestic | 08/01/2025 – 07/31/2026 |
| TTU International | 08/01/2025 – 07/31/2026 |
| TTUHSC | 08/01/2025 – 08/31/2026 |
| Angelo State | 08/15/2025 – 08/14/2026 |
| El Paso | 07/01/2025 – 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://tusystem.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: |
|--|--|---|
| <u>What is the overall deductible?</u> | In-Network: \$500 Individual / \$1,500 Family Out-of-Network: \$1,000 Individual / \$3,000 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> . |
| <u>Are there services covered before you meet your deductible?</u> | Yes. Services that charge a <u>copayment</u> , <u>prescription drugs</u> , emergency room services, <u>diagnostic test</u> , 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 preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| <u>Are there other deductibles for specific services?</u> | No. | You don't have to meet <u>deductibles</u> for specific services. |
| <u>What is the out-of-pocket limit for this plan?</u> | In-Network: \$7,900 Individual / \$15,800 Family Out-of-Network: \$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. |
| <u>What is not included in the out-of-pocket limit?</u> | Premiums, <u>balance-billing</u> charges, and health care 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> . |
| <u>Will you pay less if you use a network provider?</u> | 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 charge</u> 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. |
| <u>Do you need a referral to see a specialist?</u> | 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$50 <u>copayment</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | <u>Specialist</u> visit | \$50 <u>copayment</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u> | No Charge; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | Imaging (CT/PET scans, MRIs) | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <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/\$60 mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$20 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | Retail covers a 30-day supply. Mail order covers a 90-day supply. |
| | Non-preferred generic drugs | \$20 retail/\$60 mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$20 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. |
| | Preferred brand drugs | \$60 retail/\$180 mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$60 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | Certain drugs require approval before they will be covered. |
| | Non-preferred brand drugs | \$100 retail/\$300 mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$100 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | The <u>cost-sharing</u> 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. |
| | Preferred <u>Specialty drugs</u> | \$100 retail <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$100 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | <u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. |
| | Non-preferred <u>Specialty drugs</u> | \$200 retail <u>copayment/prescription</u> ; <u>deductible</u> does not apply | \$200 retail <u>copayment/prescription</u> plus 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | Physician/surgeon fees | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <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> | \$200 <u>copayment</u> /visit plus 25% <u>coinsurance</u> ; <u>deductible</u> does not apply | \$200 <u>copayment</u> /visit plus 25% <u>coinsurance</u> ; <u>deductible</u> does not apply | Emergency room <u>copayment</u> waived if admitted. |
| | <u>Emergency medical transportation</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 25% <u>coinsurance</u> after <u>deductible</u> | Ground and air transportation covered. |
| | <u>Urgent care</u> | \$50 <u>copayment</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | Physician/surgeon fees | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 <u>copayment</u> /office visit; <u>deductible</u> does not apply 25% <u>coinsurance</u> after <u>deductible</u> for other outpatient services | 50% <u>coinsurance</u> after <u>deductible</u> | Certain services must be preauthorized; See your benefit booklet* for details. |
| | Inpatient services | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| If you are pregnant | Office visits | \$50 <u>copayment</u> /office visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> after <u>deductible</u> | <u>Copayment</u> applies to first prenatal visit (per pregnancy). <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 professional services | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | |
| | Childbirth/delivery facility services | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |

* For more information about limitations and exceptions, see the plan or policy document at <https://ttusystem.myahpcare.com>

| 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> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Limited to 60 visits per benefit period. <u>Preauthorization</u> is required; See your benefit booklet* for details. |
| | <u>Rehabilitation services</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Limited to 35 visits combined for all therapies per benefit period. Includes, but is not limited to, occupational, physical, and manipulative therapy. |
| | <u>Habilitation services</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | |
| | <u>Skilled nursing care</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Limited to 25 days per benefit period. |
| | <u>Durable medical equipment</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | <u>Hospice services</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 50% <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 up to \$130; <u>deductible</u> does not apply | No Charge up to \$65; <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
- Routine foot care
- 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)

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, kwijjigo 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 overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$50 |
| ■ <u>Hospital (facility) coinsurance</u> | 25% |
| ■ <u>Other coinsurance</u> | 25% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$60 |
| <u>Coinsurance</u> | \$2,700 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,320 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$50 |
| ■ <u>Hospital (facility) coinsurance</u> | 25% |
| ■ <u>Other coinsurance</u> | 25% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$70 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,490 |

Mia's Simple Fracture

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

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$50 |
| ■ <u>Hospital (facility) coinsurance</u> | 25% |
| ■ <u>Other coinsurance</u> | 25% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$400 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,300 |

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: 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.

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|------------|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | للتلقى المساعدة اللغوية أو التواصل مجاناً، 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 મહતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો. |
| ਨਿੰਹਾਂਡੀ | ਨਿ:ਸ਼ੁਲਕ ਭਾਸ਼ਾ ਯਾ ਸੰਚਾਰ ਸਹਾਯਤਾ ਪ੍ਰਾਸ ਕਰਨੇ ਕੇ ਲਿਏ, ਕ੃ਪਾ ਕਰੋ 855-710-6984 ਪਰ ਕੋਲ ਕਰੋ। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984 번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinit'sá'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 ji' hodíilni. |
| فارسی | برای دریافت کمک زیانی یا ارتباطی را بگان، 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 مواصلات کی مدد موصول کرنے کے لیے، براو کرم بیٹن 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. |