



BlueCross BlueShield of Texas

University of Texas 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 University of Texas Student Health Plan covering plans purchased between 05/01/2023 - 08/31/2024. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for University of Texas are listed below:

Coverage Period	Date
By Campus :	
Austin	07/01/23 - 08/31/24
MD Anderson/Houston	09/01/23 - 08/31/24
El Paso	08/15/23 - 08/14/24
San Antonio	08/01/23 - 08/31/24
Southwestern	07/01/23 - 08/14/24
Tyler	08/15/23 - 08/14/24
Tyler School of Medicine	07/01/23 - 06/30/24
Rio Grande Valley	08/01/23 - 08/31/24
Dallas	08/01/23 - 07/31/24
Arlington	08/15/23 - 08/14/24
Galveston	07/01/23 - 07/31/24
Permian Basin	08/15/23 - 08/14/24
HSC Houston	05/01/23 - 08/31/24
HSC San Antonio	07/01/23 - 08/14/24
Rio Grande Valley School of Med	07/01/23 - 06/30/24
Rio Grande Valley School of Podiatry	07/01/23 - 06/30/24
Dell Medical	07/01/23 - 06/30/24
Stephen F. Austin	08/15/23 - 08/14/24


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://utsystem.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?	<u>In-Network</u> : \$350 Individual / \$1,050 Family <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>copay</u> , <u>prescription drugs</u> , <u>In-Network preventive care</u> and emergency room services, 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>In-Network</u> : \$8,700 Individual / \$17,400 Family <u>Out-of-Network</u> : \$17,400 Individual / \$34,800 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>balanced-billed</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 1-855-267-0214 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	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	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>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None

* For more information about limitations and exceptions, see the plan or policy document at <https://utsystem.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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbstx.com	Generic drugs	\$15 retail - \$40 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$15 retail <u>copay</u> /prescription plus 40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Retail <u>copay</u> covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order <u>copay</u> covers a 90-day supply. ESN limited to 90-day supply <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, member must file <u>claim</u> .
	Non-preferred generic drugs	\$15 retail - \$40 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$15 retail <u>copay</u> /prescription plus 40% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Preferred brand drugs	\$30 retail - \$75 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$30 retail <u>copay</u> /prescription plus 40% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$50 retail - \$125 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$50 retail <u>copay</u> /prescription plus 40% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Preferred <u>specialty drugs</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Specialty drugs</u> are available at any retail pharmacy.
Non-preferred <u>specialty drugs</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply		

* For more information about limitations and exceptions, see the plan or policy document at <https://utsystem.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 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
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$150 <u>copay</u> /visit plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply ER Physician Charges: 20% <u>coinsurance</u> after <u>deductible</u>	Facility Charges: \$150 <u>copay</u> /visit plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply ER Physician Charges: 20% <u>coinsurance</u> after <u>deductible</u>	Emergency room <u>copay</u> waived if admitted. Non-emergency use of ER is \$150 <u>copay</u> plus <u>deductible</u> and <u>coinsurance</u> .
	<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>copay</u> /visit; <u>deductible</u> does not apply	40% <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)	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</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; refer to your benefit booklet* for details.
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None

* For more information about limitations and exceptions, see the plan or policy document at <https://utsystem.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 are pregnant	Office visits	\$30 PCP/ \$35 SPC copayment/visit; deductible does not apply	40% coinsurance after deductible	Copay 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	
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.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	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
If your child needs dental or eye care	Children's eye exam	Covered	Covered	Refer to benefits booklet for details.
	Children's glasses	Covered	Covered	Refer to benefits booklet for details.
	Children's dental check-up	Covered	Covered	Refer to benefits booklet for details.

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

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

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: the plan at 1-855-267-0214, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Blue Cross and Blue Shield of Texas at 1-855-267-0214 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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.texashealthoptions.com.

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 plan's overall deductible \$350
- Specialist copayment \$35
- 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
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 copayment \$35
- 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

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

- The plan's overall deductible \$350
- Specialist copayment \$35
- 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$950



Health care coverage is important for everyone.

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.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

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, Illinois 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/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



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.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બાજુ વ્યક્તને અસુખી અથવા કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee ní h odoonih. Ata'dahalne'ígíí bich'i' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.