

# The Citadel 2019-2020 Student Health Insurance Plan



## Eligibility

The following students are eligible to enroll for coverage in The Citadel Student Health Insurance Plan on a voluntary basis if they are enrolled at The Citadel:

1. Cadets who are enrolled in a minimum of six (6) credit hours; or
2. Graduate of Professional Students enrolled in the graduate or professional degree program, taking at least one graduate level course, in good academic standing and making appropriate progress toward graduation.
3. Evening Undergraduate Program students who are enrolled in a minimum of six (6) credit hours.

Please view the complete brochure on-line at [citadel.myahpcare.com](http://citadel.myahpcare.com) for full details of participation in the plan.

2019-2020 PREMIUM COSTS AND COVERAGE PERIODS		
Coverage Periods	Annual 08/01/2019 through 07/31/2020	Spring/Summer 01/01/2020 through 07/31/2020
Open Enrollment	06/25/2019 through 08/11/2019	11/30/2019 through 02/01/2020
Student	\$ 2,851.55	\$ 1,659.13
Spouse	\$ 2,851.55	\$ 1,659.13
Each Child	\$ 2,851.55	\$ 1,659.13
Three or More Children	\$ 8,554.65	\$ 4,977.39

To view all enrollment and coverage periods available, please visit [citadel.myahpcare.com](http://citadel.myahpcare.com) or call Academic HealthPlans at 1-855-850-4174.

## Additional Benefits

- Access to after hours nurse line
- Coverage when traveling
- Emergency Medical and Travel Assistance\*

## Additional Information

- [citadel.myahpcare.com](http://citadel.myahpcare.com)
- 1-855-850-4174
- [support@ahpcare.com](mailto:support@ahpcare.com)



BlueCross BlueShield of South Carolina is an independent licensee of the

\*Academic Emergency Services and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.

Academic HealthPlans, Inc. (AHP) is an independent company that provides program management and administrative services for the student health plans of Anthem BlueCross BlueShield.

AHP-OF(18) BCBSSC-Citadel

# The Citadel 2019-2020 Student Health Insurance Plan

This is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits and programs and does not constitute a contract. Covered Medical Expenses are subject to plan maximums, limitations, and exclusions as described in the Policy. Your Plan provides you with a higher level of coverage when you receive covered medical expenses from physicians who are part of Preferred Blue PPO Network.

## BENEFIT MAXIMUMS & DEDUCTIBLES

Benefit Maximum		Unlimited, per Insured Person, per Policy Year	
Individual Deductible		Network Provider: \$750 per Insured Person, per Policy Year	Non-Network Provider: \$1,500 per Insured Person, per Policy Year
Family Deductible		Network Provider: \$1,500 for all Insureds in a family, per Policy Year	Non-Network Provider: \$3,000 for all Insureds in a family, per Policy Year
Individual Out-of-Pocket Maximum		Network Provider & Student Health Services: \$6,350 per Insured Person, per Policy Year	Non-Network Provider: \$15,000 per Insured Person, per Policy Year
Family Out-of-Pocket Maximum		Network Provider & Student Health Services: \$12,700 for all Insureds in a family, per Policy Year	Non-Network Provider: \$30,000 for all Insureds in a family, per Policy Year
BENEFIT CATEGORY	*Infirmary only available to Cadets	Network Provider	Non-Network Provider
	Payments are based on the Preferred Allowance	Payments are based on the Preferred Allowance	Payments are based on Usual and Reasonable Charges (U&R)
In Office Physician's Visits Primary Care and Specialist	100%, \$20 Copay (if applicable)	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
Physician Services in the Office Includes Lab,X-Ray, Office Surgery, Allergy Injections, Treatment Modalities, IV's, Breathing Treatments and Other Diagnostic Services Includes Mental Health (MH) Benefits and Substance Use (SU) Office Visits	100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
Emergency Room Facility Charges Copayment waived if admitted	N/A	\$450 Copay, then Deductible, 80%	\$450 Copay, then Deductible, 80%
Diagnostic Imaging Services & Outpatient Lab Services	100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
Durable Medical Equipment	\$20 Copay, 100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
Mental Health & Substance Use Inpatient/Outpatient Facility Charges	N/A	Deductible, 80%	Deductible, 70%
Prescriptions Drug Benefit Includes diabetic supplies - no charge for contraceptives at SHC and In- Network Prescription Deductible: \$100 Retail (31 day supply)	N/A	Prescriptions should be filled at a Caremark participating Pharmacy: 100% after a: \$20 Copay for Generic Drug \$40 Copay for Preferred Brand Drug \$100 Copay for Non-Preferred Drug \$100 Copay for Specialty Drug	100% after a: \$20 Copay for Generic Drug \$40 Copay for Preferred Brand Drug \$100 Copay for Non-Preferred Drug
Pediatric Dental Care Benefit Under age 19 (Limited to 1 dental exam every 6 months)	N/A	Preventive: 100% Basic, Major, and Orthodontic Services: 50%	Preventive: 100% Basic, Major, and Orthodontic Services: 50%
Adult Dental Care Age 19 and older (Limited to 1 dental exam every 6 months)	N/A	Preventive: 100% Basic Services: 80%	Preventive: 100% Basic Services: 80%
Children's Eye Exam & Glasses Under age 19 (Limit 1 Visit & 1 Pair of Prescribed Lenses & Frames per Policy Year)	100%	100%	100%
Adult Eye Exam Age 19 and older (Limit 1 Routine Eye Exam per Policy Year)	\$0 Copay, 100%	\$20 Copay, 100%	Deductible, 100% Up to \$75 (balance billing may apply)
Adult Glasses Age 19 and older (Limit 1 Pair of prescribed lenses & frames or contact lenses in lieu of frames & lenses per Policy Year)	100% after a: Lenses: \$0 Copay, (if applicable) Up to: Single - \$60; Bifocal - \$80; Trifocal - \$500 Frames: \$20 Copay (if applicable) Up to \$200 Contact Lenses (if applicable: In lieu of lenses and frames): \$20 Copay, up to \$150	100% after a: Lenses: \$20 Copay, Up to: Single - \$50; Bifocal - \$70; Trifocal - \$400 Frames: \$20 Copay, Up to \$150 Contact Lenses (in lieu of lenses and frames): \$20 Copay, up to \$100	100% after Deductible (balance billing may apply) Lenses: Up to: Single - \$50; Bifocal - \$70; Trifocal - \$400 Frames: Up to \$150 Contact Lenses: Up to \$100
<sup>2</sup> Wellness/Preventive Benefits	100%	100%	100%

\*Plan Deductible Waived

<sup>2</sup>Please visit [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/) for more information.

This document contains a summary of your school's student health insurance policy benefits and restrictions as of the date of its publication; the summary document may differ from the benefits in the approved policy of insurance. The final policy may be pending approval by applicable federal and state regulatory authorities. The final approved policy of insurance is accessible upon approval at [citadel.myahpcare.com](http://citadel.myahpcare.com).