

A STUDENT HEALTH PLAN FOR YOU!

AM I ELIGIBLE?

All graduate students enrolled in nine (9) or more credit hours on the main campus; All students classified as graduate assistants; and all international students are automatically enrolled in the Student Health Insurance Plan, unless proof of other comparable coverage can be provided.

Please view the complete brochure on-line at clemson.myahpcare.com for full details of participation in the plan.

COVERAGE PERIOD & COST

Fall	08/01/22 - 12/31/22	Spring/Summer	01/01/23 - 07/31/23	Summer	05/01/23 - 07/31/23
Enrollment Deadline	07/26/22 - 08/31/22	Enrollment Deadline	11/22/22 - 01/31/23	Enrollment Deadline	04/25/23 - 05/26/23
Student	\$ 1,261.74	Student	\$ 1,722.26	Student	\$ 785.70
Spouse	\$ 1,261.74	Spouse	\$ 1,722.26	Spouse	\$ 785.70
Each Child	\$ 1,261.74	Each Child	\$ 1,722.26	Each Child	\$ 785.70
Three or more	\$ 3,785.22	Three or more	\$ 5,166.78	Three or more	\$ 2,357.10
Children		Children		Children	

To view all enrollment and coverage periods available, please visit clemson.myahpcare.com.

ADDITIONAL BENEFITS

- · Access to after hours nurse line
- Telehealth Services*
- Urgent Care Benefits
- · Coverage when traveling
- Emergency Medical and Travel Assistance**





^{*}Mental health telehealth visits through Blue CareonDemand will be covered at a \$20 copay and in-person mental health office visits will be covered at a \$40 copay In-Network.

^{**}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.

CLEMSON UNIVERSITY - MANDATORY STUDENTS 2022 - 2023

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**.

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Payments are based on the Preferred Allowance Preferred	Family Out-of-Pocket Maximum for all Insureds in a Family, per Policy Year		\$ 15,000	\$ 30,000			
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cludes Lab.X-Ray. Office Surgery, Allergy Injections, settlement Modifiels, NS, Breathing Treatments and her Diagnostic Services. **Modified Surgery Room Facility Charges** N/A	n Office Physician's Visits Primary Care and Specialist	100%, \$20 Copay (if applicable)	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%			
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Prescriptions Drug Benefit Prescriptions filled at the on-campus pharmacy: 100% after a: 100% af	Diagnostic Imaging Services & Outpatient Lab Services	100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%			
ental Health & Substance Abuse Office Visits \$20 Copay, 100% \$40 Copay,	Durable Medical Equipment	N/A	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%			
Prescriptions Drug Benefit cludes diabetic supplies - no charge for intraceptives at SHC and in-Network escription Deductible: \$100 to a 31-day supply Preferred Drug: \$20 Copay Preferred Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Specialty Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Specialty Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Specialty Drug: \$20 Copay Non-Preferred Drug: \$20 Copay Specialty Drug: \$20 Copay Non-Preferred Drug: \$20 Copay	Mental Health & Substance Use npatient/Outpatient Facility Charges	N/A	Deductible, 80%	Deductible, 70%			
rescriptions Drug Benefit cludes diabetic supplies - no charge for no-campus pharmacy: 100% after a:	Mental Health & Substance Abuse Office Visits	\$20 Copay, 100%	\$40 Copay, 100%	\$40 Copay, then Deductible, 70%			
Preventive: 100% Basic, Major, & Orthodontic Services: 50% dult Dental Care ge 19 and older imited to one dental exam every six months) hildren's Eye Exam & Glasses nder age 19 imit one Visit & one Pair of Prescribed Lenses & ames per Policy Year) dult Eye Exam ge 19 and older imit one Routine Eye Exam per Policy Year) dult Glasses ge 19 and older imit one Pair of prescribed lenses & frames or initat clenses in lieu of frames & lenses per olicy Year) felleness/Preventive Benefits or more information, please visit N/A Preventive: 100% Basic, Major, & Orthodontic Services: 50% Basic, Major, & Orthodontic Services: 50% Preventive: 100% Basic, Major, & Orthodontic Services: 50% Basic, Major, & Orthodontic Services: 50% Preventive: 100% Basic, Major, & Orthodontic Services: 50* Preventive: 100% Basic, Major, & Orthodontic Services: 50% Basic, Major, & Orthodontic Services: 50% Preventive: 100% Basic, Major, & Orthodontic Services: 50* Basic, Major, & Orthodontic Services: 50* Basic, Major, & Orthodontic Services: 50* Basic Services: 80% Preventive: 100% Preventive: 100% Preventive: 100% 100% Preventive: 100% Basic, Major, & Orthodontic Services: 50* Basic, Major, & Orthodontic Services: 50* Preventive: 100% Basic, Major, & Orthodontic Services: 50* Basic, Major, & Orthodontic Services: 40% Preventive: 100% Basic Services: 80% Preventive: 100% Ba	Prescriptions Drug Benefit noludes diabetic supplies - no charge for contraceptives at SHC and In-Network Prescription Deductible: \$100 Up to a 31-day supply Prescription deductible does not apply	on-campus pharmacy: 100% after a: Generic Drug: \$10 Copay Preferred Drug: \$20 Copay Non-Preferred Drug: \$20 Copay	OptumRx participating Pharmacy: 100% after a: Generic Drug: \$20 Copay Preferred Brand Drug: \$40 Copay Non-Preferred Drug: \$100 Copay	Generic Drug: \$20 Copay Preferred Brand Drug: \$40 Copay			
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Inder age 19 mint one Visit & one Pair of Prescribed Lenses & ames per Policy Year) Industry Exam Seg 19 and older Simit one Routine Eye Exam per Policy Year) Industry Exam Seg 19 and older Simit one Routine Eye Exam per Policy Year) Industry Exam Seg 19 and older Simit one Pair of prescribed lenses & frames or of prescribed lenses & frames or of prescribed lenses & frames or of prescribed lenses in lieu of frames & lenses per Solicy Year) Industry Exam Seg 19 and older Seg	Adult Dental Care lge 19 and older Limited to one dental exam every six months)	N/A					
ye 19 and older imit one Routine Eye Exam per Policy Year) Section 1	Children's Eye Exam & Glasses Under age 19 Limit one Visit & one Pair of Prescribed Lenses & Frames per Policy Year)	N/A	100%	100%			
Lenses: \$20 Copay, Up to Single - \$20 and older \$30; Bifocal - \$70; Trifocal - \$400 Frames: \$20 Copay, Up to \$150 Contact Lenses in lieu of frames and frames): \$20 Copay, Up to \$150 Contact Lenses (in lieu of lenses and frames): \$20 Copay, Up to \$150 Contact Lenses (in lieu of lenses and frames): \$20 Copay, Up to \$150 Contact Lenses: Up to \$100 **Vellness/Preventive Benefits** or more information, please visit** Lenses: \$20 Copay, Up to Single - \$50; Bifocal - \$70; Trifocal - \$400 Frames: Up to \$150 Contact Lenses: Up to \$150 Contact Lenses: Up to \$100	Adult Eye Exam Ige 19 and older Limit one Routine Eye Exam per Policy Year)	N/A	\$20 Copay, 100%	Up to \$75			
or more information, please visit 100% 100%	Adult Glasses Age 19 and older Limit one Pair of prescribed lenses & frames or contact lenses in lieu of frames & lenses per Policy Year)	N/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	(balance billing may apply) Lenses: Up to: Single - \$50; Bifocal - \$70; Trifocal - \$400 Frames: Up to \$150			
	Wellness/Preventive Benefits For more information, please visit healthcare.gov/coverage/preventive-care-benefits/	100%	100%	100%			

^{**}Plan Deductible Waived