CLEMSON UNIVERSITY
MANDATORY STUDENTS

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 Children	$ 3,785.22	Three or more Children	$ 5,166.78	Three or more Children	$ 2,357.10

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**

CLEMSON UNIVERSITY

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

*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.

AHP-PHF(22) BCBSSC-CLEMSON-MAND

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.**

BENEFIT MAXIMUMS & DEDUCTIBLES

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Benefit Maximum per Insured Person, per Policy Year	Unlimited	
Individual Deductible per Insured Person, per Policy Year	$ 1,500	$ 3,000
Family Deductible for all Insureds in a Family, per Policy Year	$ 3,000	$ 6,000
	PARTICIPATING PROVIDER & STUDENT HEALTH SERVICES	NON-PARTICIPATING PROVIDER
Individual Out-of-Pocket Maximum per Insured Person, per Policy Year	$ 7,500	$ 15,000
Family Out-of-Pocket Maximum for all Insureds in a Family, per Policy Year	$ 15,000	$ 30,000

BENEFIT CATEGORY	**STUDENT HEALTH SERVICES Payments are based on the Preferred Allowance	PARTICIPATING PROVIDER Payments are based on the Preferred Allowance	NON-PARTICIPATING PROVIDER 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.	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	N/A	$25 Copay, then Deductible, 80%	$40 Copay, then Deductible, 70%
Mental Health & Substance Use Inpatient/Outpatient Facility Charges	N/A	Deductible, 80%	Deductible, 70%
Mental Health & Substance Abuse Office Visits	$20 Copay, 100%	$40 Copay, 100%	$40 Copay, then Deductible, 70%
Prescriptions Drug Benefit Includes diabetic supplies - no charge for contraceptives at SHC and In-Network Prescription Deductible: $100 Up to a 31-day supply [1]Prescription deductible does not apply	[1]Prescriptions filled at the on-campus pharmacy: 100% after a: Generic Drug: $10 Copay Preferred Drug: $20 Copay Non-Preferred Drug: $20 Copay Specialty Drug: $20 Copay	Prescriptions should be filled at an OptumRx participating Pharmacy: 100% after a: Generic Drug: $20 Copay Preferred Brand Drug: $40 Copay Non-Preferred Drug: $100 Copay Specialty Drug: $100 Copay	100% after a: Generic Drug: $20 Copay Preferred Brand Drug: $40 Copay Non-Preferred Drug: $100 Copay
Pediatric Dental Care Benefit Under age 19 (Limited to one dental exam every six months)	N/A	Preventive: 100% Basic, Major, & Orthodontic Services: 50%	Preventive: 100% Basic, Major, & Orthodontic Services: 50%
Adult Dental Care Age 19 and older (Limited to one dental exam every six months)	N/A	Preventive: 100% Basic Services: 80%	Preventive: 100% Basic Services: 80%
Children's Eye Exam & Glasses Under age 19 (Limit one Visit & one Pair of Prescribed Lenses & Frames per Policy Year)	N/A	100%	100%
Adult Eye Exam Age 19 and older (Limit one Routine Eye Exam per Policy Year)	N/A	$20 Copay, 100%	Deductible, 100% Up to $75 (balance billing may apply)
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	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
Wellness/Preventive Benefits For more information, please visit healthcare.gov/coverage/preventive-care-benefits/	100%	100%	100%

**Plan Deductible Waived