



## A STUDENT HEALTH PLAN FOR YOU!

### AM I ELIGIBLE?

All EPI students enrolled in one (1) or more credit hours are considered eligible and are required to provide proof of health insurance.

Students are automatically enrolled in the Student Health Insurance Plan, unless proof of other comparable coverage is provided. To waive out of the Student Health Insurance Plan go to [sc.myahpcare.com](https://sc.myahpcare.com) and enter your health insurance information.

Please view the complete brochure on-line at [sc.myahpcare.com](https://sc.myahpcare.com) for full details of the health benefits offered through participation in the plan.

### COVERAGE PERIODS

Fall I	Fall 2	Spring 1	Spring 2	Summer
08/01/22 - 10/12/22	10/13/22 - 01/04/23	01/05/23 - 03/08/23	03/09/23 - 05/17/23	05/18/23 - 07/31/23

To view all enrollment and coverage periods available, please visit [sc.myahpcare.com](https://sc.myahpcare.com).

### ADDITIONAL BENEFITS

- Access to After Hours Nurse Line | Telehealth Services\*
- Urgent Care Benefits | Coverage when traveling | Emergency Medical and Travel Assistance\*\*



UNIVERSITY OF  
**SOUTH CAROLINA**



**South Carolina**

\*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 (22) BCBSSC-USC-EPI

# UNIVERSITY OF SOUTH CAROLINA | EPI 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
<b>Benefit Maximum</b> per Insured Person, per Policy Year	Unlimited	
<b>Individual Deductible</b> per Insured Person, per Policy Year	\$ 1,500	\$ 3,000
<b>Family Deductible</b> for all Insureds in a Family, per Policy Year	\$ 3,000	\$ 6,000
	PARTICIPATING PROVIDER & STUDENT HEALTH SERVICES	NON-PARTICIPATING PROVIDER
<b>Individual Out-of-Pocket Maximum</b> per Insured Person, per Policy Year	\$ 7,500	\$ 15,000
<b>Family Out-of-Pocket Maximum</b> for all Insureds in a Family, per Policy Year	\$ 15,000	\$ 30,000

## BENEFIT CATEGORY

\*\*STUDENT HEALTH SERVICES

PARTICIPATING PROVIDER

NON-PARTICIPATING PROVIDER

Payments are based on the Preferred Allowance

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Payments are based on Usual and Reasonable Charges (U&R)

<b>In Office Physician's Visits</b> Primary Care and Specialist	100%, \$20 Copay (if applicable)	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
<b>Physician Services in the Office</b> 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%
<b>Emergency Room Facility Charges</b> Copayment waived if admitted	N/A	\$450 Copay, then Deductible, 80%	\$450 Copay, then Deductible, 80%
<b>Diagnostic Imaging Services &amp; Outpatient Lab Services</b>	100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
<b>Durable Medical Equipment</b>	\$20 Copay, 100%	\$25 Copay, then Deductible, 80%	\$40 Copay, then Deductible, 70%
<b>Mental Health &amp; Substance Use</b> Inpatient/Outpatient Facility Charges	N/A	Deductible, 80%	Deductible, 70%
Mental Health & Substance Abuse Office Visits	100%	\$40 Copay, 100%	\$40 Copay, then Deductible, 70%
<b>Prescriptions Drug Benefit</b> Includes diabetic supplies - no charge for contraceptives at SHC and In-Network Prescription Deductible: \$100  Retail 31-day supply <sup>1</sup> Prescription deductible does not apply	<sup>1</sup> <u>Prescriptions filled at the on-campus pharmacy</u>  100% after a:  Generic: \$10 Copayment Preferred: \$20 Copayment Non-Preferred: \$20 Copayment Specialty: \$20 Copayment	<u>Prescriptions should be filled at an OptumRx participating Pharmacy</u>  100% after a:  Generic: \$20 Copayment Preferred: \$40 Copayment Non-Preferred: \$100 Copayment Specialty: \$100 Copayment	100% after a:  Generic: \$20 Copayment Preferred: \$40 Copayment Non-Preferred: \$100 Copayment
<b>Pediatric Dental Care Benefit</b> 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%
<b>Adult Dental Care</b> Age 19 and older (Limited to one dental exam every six months)	N/A	Preventive: 100% Basic Services: 80%	Preventive: 100% Basic Services: 80%
<b>Children's Eye Exam &amp; Glasses</b> Under age 19 (Limit one Visit & one Pair of Prescribed Lenses & Frames per Policy Year)	N/A	100%	100%
<b>Adult Eye Exam</b> 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)
<b>Adult Glasses</b> 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
<b>Wellness/Preventive Benefits</b> For more information, please visit <a href="https://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a>	100%	100%	100%

\*\*Plan Deductible Waived

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 [sc.myahpcare.com](https://sc.myahpcare.com).