University of South Carolina 2019-2020 EPI
Student Health Insurance Plan

Proof of Insurance Requirements

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 and enter your health insurance information.

Please view the complete brochure on-line at sc.myahpcare.com for full details of the health benefits offered through participation in the plan.

2019-2020 COVERAGE PERIODS					
Coverage Periods	Fall 1 08/01/2019 through 10/15/2019	Fall 2 10/16/2019 through 01/07/2020	Spring 1 01/08/2020 through 03/10/2020	Spring 2 03/11/2020 through 05/19/2020	Summer Only 05/20/2020 through 07/31/2020

To view all enrollment and coverage periods available, please visit sc.myahpcare.com or call Academic HealthPlans at 1-855-844-3015.

Additional Benefits

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

Additional Information

sc.myahpcare.com
1-855-844-3015
support@ahpcare.com

UNIVERSITY OF SOUTH CAROLINA

South Carolina
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.

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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	*Student Health Services *Payments are based on the Preferred Allowance*	Network Provider *Payments are based on the Preferred Allowance*	Non-Network 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 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) [1]Prescription deductible does not apply	[1]Prescriptions filled at the on-campus pharmacy: 100% after a: $10 Copay for Generic Drug $20 Copay for Preferred, Non-Preferred, and Specialty Drug	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
[2]Wellness/Preventive Benefits	100%	100%	100%

*Plan Deductible Waived

[2]Please visit 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 sc.myahpcare.com.