WINTHROP UNIVERSITY
DOMESTIC STUDENTS

A STUDENT HEALTH PLAN **FOR YOU!**

AM I ELIGIBLE?

All registered Undergraduate students taking six (6) or more credit hours; Graduate or professional students taking at least one (1) graduate-level course, in good academic standing and making appropriate progress toward graduation are eligible to enroll in the Student Health Insurance Plan on a voluntary basis.

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

COVERAGE PERIOD & COST

Fall	08/01/21 - 12/31/21
Enrollment Deadline	07/02/21 - 09/24/21
Student	$ 1,441.50
Spouse	$ 1,441.50
Each Child	$ 1,441.50
Three or more Children	$ 4,324.50

Spring Graduating Students Only	01/01/22 - 05/31/22
Enrollment Deadline	11/30/21 - 02/01/22
Student	$ 1,412.50
Spouse	$ 1,412.50
Each Child	$ 1,412.50
Three or more Children	$ 4,237.50

Spring/Summer	01/01/22 - 07/31/22
Enrollment Deadline	11/30/21 - 02/01/22
Student	$ 1,992.50
Spouse	$ 1,992.50
Each Child	$ 1,992.50
Three or more Children	$ 5,977.50

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

ADDITIONAL BENEFITS

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

WINTHROP UNIVERSITY

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

*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.

WINTHROP UNIVERSITY - DOMESTIC STUDENTS **2021 - 2022**

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. 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 an OptumRx 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 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