College of Charleston

Domestic Voluntary

2026-2027

Student Coverage With Care

Eligibility

All registered Undergraduate Students enrolled in six (6) or more semester hours; and, 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.

For more information, visit **cofcvol.myahpcare.com**.

Coverage Periods & Rates

	ANNUAL 08/01/2026 - 07/31/2027	FALL 08/01/2026 - 12/31/2026	SPRING/SUMMER 01/01/2027 - 07/31/2027	SUMMER 05/01/2027 - 07/31/2027
Enrollment Periods	07/08/2026 - 09/04/2026	07/08/2026 - 09/04/2026	11/02/2026 - 02/01/2027	03/03/2027 - 05/17/2027
Student	$5,491.00	$2,313.83	$3,177.17	$1,421.37
Spouse	$5,491.00	$2,313.83	$3,177.17	$1,421.37
Each Child	$5,491.00	$2,313.83	$3,177.17	$1,421.37
Three or More Children	$16,473.00	$6,941.49	$9,531.51	$4,264.11

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

WHAT'S INCLUDED?

- Telehealth solutions through AcademicLiveCare (ALC)
- Access to after-hours Nurse Line
- Coverage while traveling with Academic Emergency Services (AES)*
- Access to Academic Student Assistance Program (ASAP)
- Urgent Care Benefits

Questions

To view Frequently Asked Questions or submit a request, please visit help.ahpcare.com

ID Cards

To access your ID Card, please visit cofcvol.myahpcare.com

Academic HealthPlans, Inc. (AHP), Part of the Brown & Brown Team, is an independent company that provides program management and administrative services for the student health plans of BCBSSC.

*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, Inc. (AHP), Part of the Brown & Brown Team.

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BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Benefit Maximum *per Insured Person, per Policy Year*	Unlimited	
Individual Deductible *per Insured Person, per Policy Year*	$500	$3,000
Family Deductible *for all Insureds in a Family, per Policy Year*	$1,000	$6,000
	PARTICIPATING PROVIDER & STUDENT HEALTH SERVICES	NON-PARTICIPATING PROVIDER
Individual Out-of-Pocket Maximum *per Insured Person, per Policy Year*	$9,200	$15,000
Family Out-of-Pocket Maximum *for all Insureds in a Family, per Policy Year*	$15,000	$30,000
In Office Physician's Visits *Primary Care and Specialist*	$25 Copayment, then Deductible, 80%	$40 Copayment, 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.*	$25 Copayment, then Deductible, 80%	$40 Copayment, then Deductible, 70%
Emergency Room Facility Charges *Copayment waived if admitted*	$200 Copayment, then Deductible, 80%	$200 Copayment, then Deductible, 80%
Diagnostic Imaging Services & Outpatient Lab Services	Deductible, 80%	Deductible, 70%
Durable Medical Equipment	$25 Copayment, then Deductible, 80%	$40 Copayment, then Deductible, 70%
Mental Health & Substance Use *Inpatient/Outpatient Facility Charges*	Deductible, 80%	Deductible, 70%
Mental Health & Substance Abuse Office Visits	$40 Copayment, then 100%	$40 Copayment, then Deductible, 70%
Prescriptions Drug Benefit *Up to a 31-day supply* *Includes diabetic supplies - no charge for contraceptives In-Network* *Prescription Deductible: $100*	Prescriptions should be filled at an OptumRx participating Pharmacy: 100% after a: Generic Drug: $20 Copayment Preferred Brand Drug: $40 Copayment Non-Preferred Brand Drug: $100 Copayment Specialty Drug: $100 Copayment	100% after a: Generic Drug: $20 Copayment Preferred Brand Drug: $40 Copayment Non-Preferred Brand Drug: $100 Copayment
Pediatric Dental Care Benefit *Under age 18* *(Limited to one dental exam every six months)*	Preventive: 100% Basic & Major Services: 50%	Preventive: 100% Basic & Major Services: 50%
Adult Dental Care *Age 18 and older* *(Limited to one dental exam every six months)*	Preventive: 100% Basic Services: 80%	Preventive: 100% Basic Services: 80%
Children's Eye Exam & Glasses *Under age 18* *(Limit one Visit & one Pair of Prescribed Lenses & Frames per Policy Year)*	100%	100%
Adult Vision Care *Age 19 and older* *(Limit one Pair of prescribed lenses & frames or contact lenses in lieu of frames & lenses per Policy Year)* *Coverage is through the EyeMed Insight Network*	Exams: $20 Copay Lenses: $20 Copay Frames: $0 Copay, up to $150 Contacts: $0 Copay, up to $150	Reimbursed up to: Exams: $30 Frames: $75 Contacts: $150
Wellness/Preventive Benefits For more information, please visit healthcare.gov/coverage/preventive-care-benefits	100%	100%

**Plan Deductible Waived

This document is for informational purposes only and does not constitute an offer of coverage, a contract, nor medical advice. It provides a general overview of plan benefits, programs, and limitations, which are subject to plan maximums, exclusions, and regulatory approval. The benefits described herein may differ from the final policy of insurance, which will be available at cofcvol.myahpcare.com upon approval by federal and state authorities.