

# Medical University of South Carolina

## Student Health Insurance Plan 2023-2024

### Eligibility

The following students attending the Medical University of South Carolina are eligible for and will be automatically enrolled in the Medical University of South Carolina Student Health Insurance Plan and the insurance premium will be added to their tuition bill each semester along with tuition and fees, unless a waiver of coverage is submitted online at [musc.myahpcare.com](https://musc.myahpcare.com) showing proof of alternate insurance that meets the University's requirements before the waiver deadline:

1. Students who are enrolled in a minimum of six (6) semester hours; and
2. Students who are enrolled in a graduate or professional degree program, in good academic standing and making appropriate progress toward graduation.

### What's Included?

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

### Rates

	FALL 08/01/2023 - 12/31/2023	SPRING/SUMMER 01/01/2024 - 07/31/2024	SUMMER (NEW STUDENTS ONLY) 05/01/2024 - 07/31/2024
Enrollment Periods	06/28/2023 - 09/08/2023	11/15/2023 - 02/02/2024	04/01/2024 - 04/30/2024
Student	\$1,302.80	\$1,788.20	\$810.58
Spouse	\$1,302.80	\$1,788.20	\$810.58
Each Child	\$1,302.80	\$1,788.20	\$810.58
Three or More Children	\$3,908.40	\$5,364.60	\$2,431.74



\*\*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).

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



### More Information

For full details of participation in the plan, enrollment, and coverage periods, please view the complete brochure online at: [musc.myahpcare.com](https://musc.myahpcare.com)

### Questions

To view Frequently Asked Questions or submit a request, please visit: [help.ahpcare.com](https://help.ahpcare.com)

### Insurance ID Card

To access your ID card, please [click here](#).

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 Expenses are subject to plan maximums, limitations, and exclusions as described in the Policy. The PPO network is **Preferred Blue PPO Network**.

# MUSC 2023-2024

## BENEFITS

		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		\$ 500	\$ 3,000
<b>Family Deductible</b> for all Insureds in a Family, per Policy Year		\$ 1,000	\$ 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
	**STUDENT HEALTH SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	Payments are based on the Preferred Allowance	Payments are based on the Preferred Allowance	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> 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 Drug: \$40 Copay Non-Preferred Drug: \$100 Copay Specialty Drug: \$100 Copay	100% after a:  Generic Drug: \$20 Copay Preferred Drug: \$40 Copay Non-Preferred Drug: \$100 Copay
<b>Pediatric Dental Care Benefit</b> Under age 19 (Limited to one dental exam every six months)	N/A	Preventive: 100% Basic & Major Services: 50%	Preventive: 100% Basic & Major 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)	\$0 Copay See "Find a Provider" for additional details	\$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