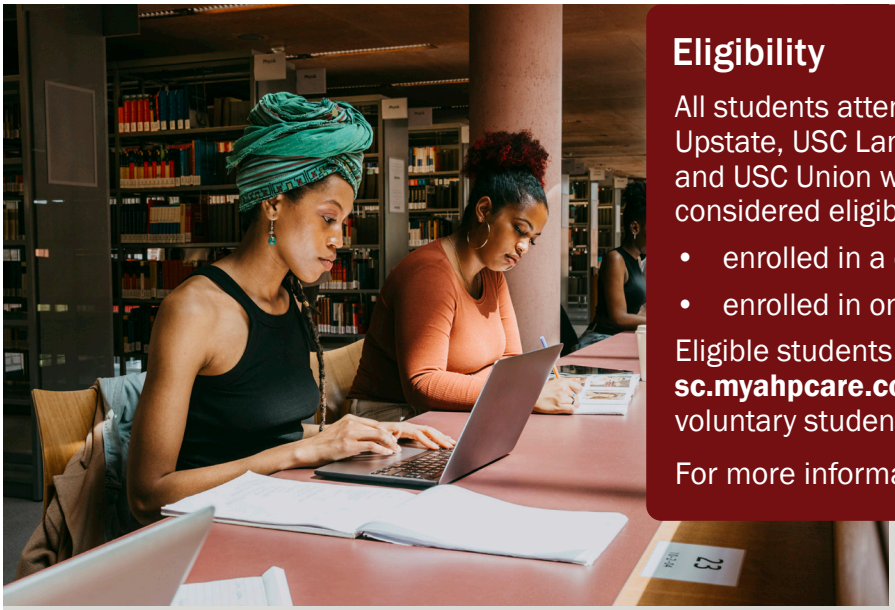
University of South Carolina
Satellite Campus

UNIVERSITY OF South Carolina

Student Coverage With Care



Eligibility

All students attending USC Aiken, USC Beaufort, USC Upstate, USC Lancaster, USC Salkehatchie, USC Sumter, and USC Union who meet the following criteria are considered eligible:

- enrolled in a degree seeking program
- enrolled in one (1) or more credit hours

Eligible students can voluntarily enroll by visiting **sc.myahpcare.com/enrollment** and selecting the voluntary student option.

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

Coverage Periods & Rates

	FALL 08/01/2026 – 12/31/2026	SPRING/SUMMER 01/01/2027 – 07/31/2027	SUMMER 05/01/2027 – 07/31/2027
Enrollment Periods	06/08/2026 – 09/07/2026	11/02/2026 – 02/01/2027	04/01/2027 – 05/15/2027
Student	$2,313.83	$3,177.17	$1,421.37
Spouse	$2,313.83	$3,177.17	$1,421.37
Each Child	$2,313.83	$3,177.17	$1,421.37
Three or More Children	$6,941.49	$9,531.51	$4,264.11

To view all enrollment and coverage periods available, please visit sc.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
- The PPO network is Preferred Blue PPO Network

Questions

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

ID Cards

To access your ID Card, please visit sc.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.

University of South Carolina Satellite Campus 2026-2027

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
	**STUDENT HEALTH SERVICES Payments are based on the Allowable Charge	PARTICIPATING PROVIDER Payments are based on the Allowable Charge	NON-PARTICIPATING PROVIDER Payments are based on the Allowable Charge
In Office Physician's Visits *Primary Care and Specialist*	100%, $20 Copayment (if applicable)	$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.*	100%	$25 Copayment, then Deductible, 80%	$40 Copayment, then Deductible, 70%
Emergency Room Facility Charges *Copayment waived if admitted*	N/A	$200 Copayment, then Deductible, 80%	$200 Copayment, then Deductible, 80%
Diagnostic Imaging Services & Outpatient Lab Services	100%	Deductible, 80%	Deductible, 70%
Durable Medical Equipment	$20 Copayment, 100%	$25 Copayment, then Deductible, 80%	$40 Copayment, then Deductible, 70%
Mental Health & Substance Use *Inpatient/Outpatient Facility Charges*	N/A	Deductible, 80%	Deductible, 70%
Mental Health & Substance Abuse Office Visits	$20 Copayment, then 100%	$25 Copayment, then 100%	$40 Copayment, then Deductible, 70%
Prescription Drug Benefit *Up to a 31-day supply* *Includes diabetic supplies - no charge for contraceptives at SHC and In-Network* *Prescription Deductible: $100* [1]*Prescription deductible does not apply*	[1]Prescriptions filled at the on-campus pharmacy: 100% after a: Generic Drug: $10 Copayment Preferred Drug: $20 Copayment Non-Preferred Brand Drug: $20 Copayment Specialty Drug: $20 Copayment	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)*	N/A	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)*	N/A	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)*	N/A	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*	N/A	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%	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 sc.myahpcare.com upon approval by federal and state authorities.