

SUMMARY OF BENEFITS

Availability of services at SHC locations vary, please verify location when making appointments.

	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Policy Year Maximum	Unlimited	Unlimited
Out-of-Pocket Limit	<p>In-Network</p> <p>Individual: \$5,000 per policy year</p> <p>Family: \$10,000 per policy year</p> <p>Out-of-Network</p> <p>Individual: \$10,000 per policy year</p> <p>Family: \$20,000 per policy year</p> <p><i>Once the out-of-pocket limit has been satisfied, eligible expenses will be payable at 100% for the remainder of the policy year up to any benefit maximum that may apply.</i></p>	

OUTPATIENT BENEFITS

Doctor's Visits	<p>At SHC: Specialists, 100% after a \$20 per visit co-pay</p> <p>In-Network: 75% of the allowable charge; \$30 per visit copay; up to the out-of-pocket limit, 100% thereafter</p> <p>Out-of-Network: 50% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter</p>	<p>At SHC: Specialists, 100% after a \$20 per visit co-pay for Comp; \$10 for GSHIP</p> <p>In-Network: 90% of the allowable charge; \$30 per visit copay; up to the out-of-pocket limit, 100% thereafter</p> <p>Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter</p>
<p>Lab and X-ray</p> <p>Some lab tests at SHC are provided at no charge. This is not an insured benefit but is provided by NYU to all matriculated students including students who waive the NYU sponsored Plans.</p>	<p>At SHC: 80% of allowable charges</p> <p>In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter</p> <p>Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter</p>	<p>At SHC: 90% of allowable charges for Comp; 100% for GSHIP</p> <p>In-Network: 90% of the allowable charges up to the out-of-pocket limit, 100% thereafter</p> <p>Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter</p>

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BASIC PLAN**COMPREHENSIVE PLAN (Comp)
AND GSHIP**

Preventive Services and Immunizations as specified by Health Care Reform (PPACA)
(see also Women's Health Benefits, page 13)

At SHC: Preventive services available and rendered at SHC will be provided at 100% with no cost sharing

In-Network: Preventive services will be covered 100% of eligible expenses with no cost-sharing.

Out-of-Network: 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Allergy Testing and Shots

At SHC: 80% of the allowable charge

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

At SHC: 90% of the allowable charge

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Physical/ Occupational/ Speech/Hearing Therapy and Chiropractic Service*

*Limited to 60 visits per condition per plan year for all therapies combined

At SHC: 100% after a \$20 per visit co-pay

In-Network: 75% of the allowable charge; \$30 per visit copay; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

At SHC: 100% after a \$20 per visit co-pay for Comp; \$10 per visit copay for GSHIP

In-Network: 90% of the allowable charge; \$30 per visit copay; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

Hospital Emergency Room

In-Network: 75% of the allowable charge; \$100 per visit co-pay; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 75% of the reasonable and customary charges; \$100 per visit co-pay; up to the out-of-pocket limit, 100% thereafter

In-Network: 90% of the allowable charge; \$100 per visit co-pay; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 90% of the reasonable and customary charges; \$100 per visit co-pay; up to the out-of-pocket limit, 100% thereafter

Referrals from CHP are required for follow-up treatment after an emergency.

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
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WOMEN'S HEALTH BENEFITS

<p>Routine Gynecologic Exam</p>	<p>At SHC: provided at 100% with no cost sharing</p> <p>In-Network: covered at 100% of Eligible Expenses with no cost-sharing</p> <p>Out-of-Network: 50% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter</p>	<p>In-Network: covered at 100% of Eligible Expenses with no cost-sharing</p> <p>Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter</p>
<p>Pap Smear/ Cervical Cancer Screening (See Laboratory Services)</p>	<p>At SHC: provided at 100% with no cost sharing</p> <p>In-Network: provided at 100% with no cost sharing</p> <p>Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter</p>	<p>At SHC: provided at 100% with no cost sharing</p> <p>In-Network: provided at 100% with no cost sharing</p> <p>Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter</p>
<p>Mammography Screening and Diagnostic Imaging for the Detection of Breast Cancer</p>	<p>In-Network: Covered at 100% of allowable charge with no cost sharing</p> <p>Out-of-Network: Payable same as Laboratory and X-ray expense (see page 11)</p>	
<p>Contraceptives (Prescription Drugs and Devices)</p>	<p>At SHC: Covered at 100% of eligible expenses with no cost sharing</p> <p>In-Network: Covered at 100% of eligible expenses with no cost-sharing at Preferred Pharmacies</p> <p>Out-of-Network: see Prescription Drug benefit for Non-Preferred Pharmacies</p> <p>Eligible Professional Expenses incurred for outpatient contraceptive service will be paid under the Out Patient benefit (i.e.: IUD Insertion)</p> <p><i>Benefits are payable for a 90-day supply per prescription or refill without prior authorization</i></p> <p>Lost or stolen prescription drugs will not be covered</p>	

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BASIC PLAN**COMPREHENSIVE PLAN (Comp)
AND GSHIP****MATERNITY****Obstetric Services**

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Designated Provider: 100% of negotiated charge* up to the out-of-pocket limit

**For CPT Code 59400 and CPT Code 59510 (routine obstetric care for complete pregnancy including pre-natal visits, vaginal or cesarean delivery and postpartum care).*

For a list of designated providers, please call Student Health Insurance Services at (212) 443-1020.

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Designated Provider: Same as Basic Plan.

Inpatient Room and Board For Maternity

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Designated Provider: At NYU Langone Hospital, 100% of negotiated charge up to the out-of-pocket limit

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Designated Provider: At NYU Langone Hospital, 100% of negotiated charge up to the out-of-pocket limit

TERMINATION OF PREGNANCY**Termination of Pregnancy**

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Only one elective termination covered per policy year

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Only one elective termination covered per policy year

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BASIC PLAN**COMPREHENSIVE PLAN (Comp)
AND GSHIP****MENTAL HEALTH BENEFITS****Outpatient
Mental Health
Psychotherapy**

At SHC: Short-term psychotherapy (talk therapy) visits at SHC are provided at no charge. This is not an insured benefit but is provided by NYU to all matriculated students including students who waive the NYU sponsored plans

In-Network: 75% of the allowable charge; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

Designated Provider: 100% after a \$5 per visit co-pay. For a list of Designated Providers, please call Student Health Insurance at 212-443-1020

In-Network: 90% of the allowable charge; up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

Designated Provider: Same as Basic Plan

**Inpatient
Mental Health**

In-Network: 75% of the negotiated charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Designated Provider: At NYU Langone Hospital, 100% of the Negotiated Charge

In-Network: 90% of the negotiated charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

CHEMICAL ABUSE AND DEPENDENCE**Outpatient**

In-Network: 100% of the allowable charge

Out-of-Network: 100% of reasonable and customary charge
Up to 20 of these visits available for family counseling

Inpatient

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter up to maximum

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter up to maximum

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter up to maximum

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter up to maximum

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BASIC PLAN**COMPREHENSIVE PLAN
(Comp) AND GSHIP****PRESCRIPTION DRUGS****Prescription Drugs****Participating Pharmacy:** 100% after a:

\$15 copay for generic drugs

\$40 copay for preferred brand name drugs

\$60 copay for non-preferred brand name drugs

Replacements for lost or stolen prescription drugs are not covered.

Non-Participating Pharmacy: There is a 30% co-insurance.*Benefits are not payable for more than a 30-day supply per prescription or refill without prior authorization.**Off label prescription drugs for cancer treatment are included.***INPATIENT MEDICAL****Room & Board,
Pre-Admission
Testing, Non-
Surgical Physician
Visit, Other
Hospital Services****In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter**Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter**Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter**SURGICAL BENEFITS (Outpatient & Inpatient)****Surgeon/
Assistant Surgeon
Anesthesia Fees****In-Network:** Covered at 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter**Out-of-Network:** Covered at 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter**Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter**ADDITIONAL BENEFITS****Ambulance**

100% coverage per transport to or from hospital.

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BASIC PLAN

**COMPREHENSIVE PLAN
(Comp) AND GSHIP**

ADDITIONAL BENEFITS (continued)

Vision Services
*Member over
age 18*

Annual Preventive Eye Exam (One per policy year)

At SHC: 100% after a \$20 per visit co-pay

At SHC:
Comp Plan: 100% after a \$20 per visit co-pay
GSHIP: 100% after a \$10 per visit co-pay

Outside SHC: No benefit

Vision Services
*through the end
of the month
in which the
student turns 19
years of age*

Annual Preventive Eye Exam (one per policy year)

At SHC: 100% with no per visit co-pay

In-Network: Covered at 75% of allowable charges; up to the out-of-pocket limit, 100% thereafter. \$30 per visit co-pay

Out-of-Network: Covered at 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

At SHC:
Comp Plan: 100% with no per visit co-pay

GSHIP: 100% with no per visit co-pay

In-Network: Covered at 80% of allowable charges; up to the out-of-pocket limit, 100% thereafter; Comp Plan - \$30 per visit co-pay; GSHIP - \$10 per visit co-pay

Out-of-Network: Covered at 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

Lenses and Frames: (One per policy year)

At SHC: 80% of allowable charges; up to the out-of-pocket limit, 100% thereafter; \$30 per visit co-pay

In-Network: 60% of allowable charges; up to the out-of-pocket limit, 100% thereafter. \$50 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter

Contact Lenses (Preauthorization Required)

At SHC: 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$30 per visit co-pay

In-Network: 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$50 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter

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BASIC PLAN**COMPREHENSIVE PLAN
(Comp) AND GSHIP****ADDITIONAL BENEFITS (continued)**

Pediatric Dental
*through the end
of the month in
which the student
turns 19 years of
age*

Preventive Dental Care: One dental exam and cleaning per 6-month period

At SHC: Not available

In-Network: 75% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$50 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter

At SHC: Not available

In-Network: 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$50 per visit co-pay

Out-of-network: 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter

Routine Dental Care (Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6-12 month intervals)

At SHC: Not available

In-Network: 75% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$50 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter

At SHC: Not available

In-Network: 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$50 per visit co-pay

Out-of-network: 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter

Major Dental (Endodontics, Periodontics, Oral Surgery, and Prosthodontics)
Preauthorization required.

At SHC: Not available

In-Network: 70% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$100 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter

Orthodontia: Preauthorization required.

At SHC: Not available

In-Network: 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; \$100 per visit co-pay

Out-of-Network: 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter

BASIC PLAN

**COMPREHENSIVE PLAN
(Comp) AND GSHIP**

ADDITIONAL BENEFITS (continued)

Diabetic Treatment Expense

Diabetic Equipment, Supplies and Self-Management Education:

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional.

At SHC: \$20 co-pay per prescription

In-Network: \$20 co-pay per prescription

Out-of-Network: 70% co-insurance

Covered medical expenses for self-management education are payable as follows:

At SHC: 80% of the allowable charge up to the out-of-pocket limit, 100% thereafter

In-Network: 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

At SHC: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

In-Network: 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter

Out-of-Network: 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter

Durable Medical Equipment (DME) and Braces

At SHC: 80% of reasonable and customary charges

Outside SHC: 75% of reasonable and customary charges

At SHC: Comp Plan: 90% of all reasonable and customary charges; GSHIP: Covered 100%

Outside SHC: 90% of reasonable and customary charges

Breast Feeding DME

In-Network: Covered at 100%

Out-of-Network: 50% of reasonable and customary charges after deductible up to the out-of-pocket limit, 100% thereafter

In-Network: Covered at 100%

Out-of-Network: 60% of reasonable and customary charges after deductible up to the out-of-pocket limit, 100% thereafter

Medical and Mental Health Treatment Away

Medical and mental health treatment will be covered according to the plan benefits at the in-network level.

Other Covered Services - sample listing

- Radiation Therapy, Chemotherapy, Dialysis Treatment, and Intravenous Home Therapy
- Mastectomy, Lymph Node Dissection and Lumpectomy and Reconstructive Surgery as a result of Breast Cancer
- Hospital Outpatient Services
- Partial Hospitalization
- Speech and Hearing Therapy, Bone Density Screening Test
- Home Health Care
- End of Life Care
- Travel Assistance Program through Travel Guard

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