



Student Health Insurance Handbook

2009-2010



Basic Plan

Comprehensive Plan

GSHIP

Underwritten by



Insurance Company
Nationwide Life Insurance
One Nationwide Plaza
Columbus, OH 43215

Policy Number
302-532-3107

Administered by



Plan Administrator
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(877) 373-1170

www.chpstudent.com/nyu



NYU Student Health Center

726 Broadway, 3rd & 4th Floor
New York, NY 10003-9580

(212) 443-1000

www.nyu.edu/health

Hours of Operation*

Student Health Center Clinical Operations

Monday & Tuesday • 8 a.m. - 8 p.m.; Summer Hours • 8 a.m.–6 p.m.

Wednesday & Thursday • 8 a.m. - 6 p.m.

Friday • 10 a.m. - 6 p.m.

Saturday • 10 a.m. - 4 p.m.

Sunday • Closed

Student Health Insurance Services

Monday -Thursday • 9 a.m. - 6 p.m.

Friday • 10 a.m. - 6 p.m.

Saturday & Sunday • Closed

**Hours of operation are subject to change. Please check our website at www.nyu.edu/health for up-to-date information.*

Emergencies and After-Hours Crisis Response

In a **life or limb threatening emergency**, dial 911 to reach New York City Emergency Medical Services.

For medical and mental health urgent needs when SHC is closed, call the Wellness Exchange Hotline at (212) 443-9999 or the NYU Office of Public Safety at (212) 998-2222. NYU has a team dedicated to assisting students with crisis 24/7.

If you have been sexually assaulted, we strongly encourage you to obtain help from a professional counselor as soon as you are ready by calling the Wellness Exchange Hotline (212-443-9999). The staff at the Wellness Exchange is available 24/7 to discuss your options and feelings. You don't have to give your name if you prefer to remain anonymous. For more information on what to do if you or someone you know has been sexually assaulted, visit www.nyu.edu/health/sexual.assault.

If you receive services in a Hospital emergency room:

You will be billed by the Hospital for emergency room services, and will be responsible for any co-pays, deductibles or coinsurance for those services. If you require follow-up care in Manhattan after emergency medical treatment, you must contact the New York University Student Health Center for evaluation by a medical provider. See page 6 for more details about the referral requirement.

During NYU Holiday Closings:

If you are enrolled in the Basic, Comprehensive or GSHIP plans and you require medical care during an NYU holiday closing, you may visit a healthcare provider without an SHC referral. Seeking services from an In-Network Provider in the MultiPlan network will reduce your out-of-pocket expenses.

Dental Emergency Treatment

Students have access to emergency dental treatment at no cost as follows:

- Monday - Thursday, 8 a.m. - 8 p.m. and Friday 8 a.m. - 4 p.m.:
Students should go to the NYU College of Dentistry Faculty Practice, 726 Broadway, Suite 350, (212) 443-1313.
- Saturdays and Sundays, 9 a.m. - 5 p.m.: The College of Dentistry provides limited emergency care at 345 East 24th Street at First Avenue.
- On holidays or after hours: Students can go directly to the Bellevue Hospital Center Emergency Room, 462 First Avenue at East 27th Street - (212) 562-3015.

Dental emergencies include the unexpected onset of a condition such as bleeding, swelling and or significant pain, requiring immediate dental care and not elective or routine care.

Got questions?

Get Answers at www.chpstudent.com/nyu

As a Consolidated Health Plans (CHP) student health insurance member, you have access to www.chpstudent.com/nyu, your secure member website. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into www.chpstudent.com/nyu, you can:

- Request member ID cards
- View claim Explanation of Benefits (EOB) statements
- Send an e-mail to CHP Customer Service at your convenience

Need help?

Assistance is available toll free, Monday through Friday, from 8:00 a.m. to 4:30 p.m. Eastern Time at (877) 373-1170.

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NYU-Sponsored Student Health Insurance Program

The NYU-sponsored Student Health Insurance Program consists of the Mandatory Plan and the optional NYU-sponsored Basic, Comprehensive, and GSHIP Plans. It is important that you **READ THIS BROCHURE CAREFULLY** since it discusses the details of these plans. Please note that this brochure is intended to be a summary of the benefits afforded under each plan. The actual benefits are governed by the Master Policy, which is on file with the NYU Insurance Department. The Master Policy is available for review by appointment only. To make an appointment, please call the NYU Insurance Department at (212) 998-2755.

In addition to the Plan's Aggregate Maximum, the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

Periods of Coverage

The following chart shows the maximum period of coverage by term for students enrolled in the NYU Plans:

Term	Coverage Begins	Coverage Ends
Annual - 2009-2010	12:01 a.m., August 21, 2009	12:01 a.m., August 21, 2010
Fall - 2009	12:01 a.m., August 21, 2009	12:01 a.m., January 9, 2010
Spring/Summer - 2010	12:01 a.m., January 9, 2010	12:01 a.m., August 21, 2010
Summer - 2010	12:01 a.m., May 14, 2010	12:01 a.m., August 21, 2010

The NYU-sponsored Student Health Insurance Program works in conjunction with the health services provided at the Student Health Center to all matriculated NYU students. Whether enrolled in the Basic Plan, Comprehensive Plan, GSHIP or maintaining alternate health insurance coverage, many services are provided at no or reduced cost both inside and outside NYU SHC including:

- Primary care and women's health office visits, counseling visits and commonly performed laboratory tests at the SHC, located at 726 Broadway. *
- The Mandatory Insurance Plan which provides limited health insurance coverage for Hospital emergency room treatment of Accidents, psychological and substance abuse emergencies, and up to 30 mental health outpatient visits per year (outside Counseling and Behavioral Health Services at SHC). See the complete description of the Mandatory Plan benefits below.
- Treatment of dental emergencies through the NYU College of Dentistry Faculty Practice.

Mandatory Plan

Eligibility - All students enrolled in a degree-granting, advanced certificate, or postgraduate certificate programs and registered for one (1) or more credits, or maintaining matriculation, are enrolled automatically in the Mandatory Plan. This plan cannot be waived. Students, spouses, domestic partners and Dependents electing coverage under an optional Student Health Insurance Plan will also be insured under this plan automatically.

Emergency Room Benefit

LIMIT	\$2,500 maximum per condition per Policy Year
DEDUCTIBLE	\$25 per condition

This plan covers outpatient treatment initiated in a Hospital emergency room for:

- Accidental injuries (not Sickness)
- Mental health emergencies
- Chemical abuse emergencies

Benefits are as follows:

In-Network Care: 100% of the Negotiated Charge

Out-of-Network Care: 100% of the Reasonable Charge

*Some procedures performed during the visit may incur a fee. See Sample of Services chart at www.nyu.edu/shc/about.

Outpatient Mental Health Benefit

This plan covers up to 30 mental health outpatient visits per year at a maximum as follows:

In-Network Care: 80% of the Negotiated Charge

Out-of-Network Care: 50% of the Reasonable Charge

Under the NYU-sponsored Student Health Insurance Program, the maximum number of covered mental health outpatient visits per policy year for the Mandatory, Basic, Comprehensive, and GSHIP Plans combined shall not exceed 30 visits for Non-Biologically Based Conditions.

Referral Requirement for Follow-up Care after Emergency Room Treatment

After the Covered Person has received initial treatment for emergency injuries, he or she may be required to seek additional treatment or evaluation.

1. *Prior to this follow-up medical care*, the Covered Student must contact New York University Student Health Center (SHC) for treatment or evaluation required in Manhattan.
2. SHC may require that the Covered Student seek follow-up care through SHC.
3. Referrals cannot be granted after treatment has been rendered.
(*IMPORTANT: see pages 20-21 for more details of the referral process.*)
4. Covered Dependents do not have access to SHC and therefore are not required to obtain a referral.
5. The Student Health Insurance Program will deny benefits to any Covered Student or to the provider if the Covered Student fails to receive proper authorization from SHC before receiving additional medical care.

Dental Injuries

The Mandatory Plan does not cover emergency treatment for dental injuries.

OPTIONAL STUDENT HEALTH INSURANCE PLANS

New York University sponsors several optional student health insurance plans: the Basic Plan, the Comprehensive Plan, and the GSHIP Plan. **Except for medical emergencies or when seeking services outside of the Manhattan area, Covered Students under any optional NYU-sponsored Student Health Insurance Plan are required first to seek treatment or be evaluated at SHC for most medical conditions.** (*For details about the referral process and other exclusions to the referral requirements, see pages 20-21.*)

Eligibility/Enrollment of Students

Basic and Comprehensive Plans

Eligible students are those who are registered for one (1) or more credits in a degree-granting program or who are maintaining matriculation, and all international students holding F1 or J1 visas. Students are enrolled in the optional student health insurance plans according to the automatic enrollment, selection and waiver processes described in the *2009-2010 Guide to Student Health Insurance at New York University* available at www.nyu.edu/health/insurance (see semester deadlines on page 7).

GSHIP Plan

If you are a Graduate Assistant, Research Assistant, Teaching Assistant or specifically designated fully-funded graduate student for whom the University has agreed to pay your student health insurance fee, you will be automatically enrolled in the Graduate Student Health Insurance Plan (GSHIP). An insurance fee may initially appear on your Bursar's Statement of Account, but will be cancelled upon notification of your eligibility to Student Health Insurance Services by your program administrator.

Post-Doctoral Research Fellows

All full-time Post-Doctoral Research Fellows (persons currently paid through NYU on stipends [code 542] or paid directly with funds from external sponsors) will be automatically enrolled in the Graduate Student Health Insurance Plan (GSHIP). They may waive the fees for this plan if they maintain health insurance coverage in an alternate plan which meets the University's requirements.

Special Eligibility/Enrollment

Leave of Absence

If you filed for a leave of absence that was approved by the Dean's Office of your school, you may be eligible for enrollment in an NYU-sponsored Student Health Insurance Plan. Applicants must have been enrolled in the plan for the immediately preceding semester to be eligible. Leave of Absence applications can be submitted online at www.chpstudent.com/nyu.

The official letter of approval from the dean's office must be submitted directly to Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104, or by fax to 413-214-6482 (see semester deadlines on page 7).

Extending Periods of Coverage—Continuation Option

Covered students who lose their eligibility to enroll due to graduation, transfer to another university, or dropping out of school entirely may be eligible to purchase University-sponsored coverage to continue their current plan for a 1-month, 3-month or 6-month period through the Continuation Option. Enrollment in the Continuation Option is available only to students covered under either the Basic Plan, Comprehensive Plan or GSHIP, for at least 30 days.

The Continuation Option Enrollment Application can be completed online at Consolidated Health Plan's website at www.chpstudent.com/nyu. The application with payment authorization must be submitted by August 31, 2009 if you are not returning for the fall semester, and January 15, 2010 if you are not returning for the spring semester.

Insurance for Dependents Enrollment

For an additional premium, Covered Students on the Basic, Comp, and GSHIP Plan may also enroll their eligible Dependents (*see glossary on page 27 for a definition of eligible Dependent*).

1. Dependents are not eligible to use any services at SHC.
2. NYU students who are not insured under an NYU-sponsored Student Health Insurance Plan may not enroll their Dependents.
3. Covered students and their Dependents must select the same plan.
4. Dependents must enroll at the same time as the Covered Student unless there is a qualifying life event.

To enroll a Dependent, complete and submit the Dependent Enrollment Application online at Consolidated Health Plan's website at www.chpstudent.com/nyu. The application with payment authorization must be submitted within the same enrollment period as the student's enrollment (see semester deadlines below).

Periods of Coverage

When enrolling a Dependent, the effective date of coverage is the date of the Covered Student's enrollment (during open enrollment) or the date of the Dependent's enrollment (in the event of a qualifying life event), whichever is later. Dependent coverage terminates on the same date the Covered Student's coverage ends or the date such Dependent ceases to meet the eligibility requirement, whichever occurs earlier.

Newborn Infant Coverage

All newborn children of a Covered Student or insured Dependent spouse are covered automatically at birth for 31 days for an Injury or Sickness. Coverage may be continued after 31 days by providing notification of birth and forwarding the appropriate payment to CHP within 31 days from the date of the birth.

Newly Adopted children

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days from the moment of placement, provided the child lives in the household of the Covered Student and is Dependent upon the Covered Student for support. To extend coverage for an adopted child past the 31 days, the Covered Student must 1) enroll the child within 31 days of placement of such child and 2) pay any additional premium, if necessary, starting from the date of placement.

Enrollment and Waiver Semester Deadlines

Fall Term	September 30, 2009
Spring Term	February 10, 2010
Summer Term	June 5, 2010

Petition to Change Insurance

Adding Insurance

If you were granted a waiver of any NYU-sponsored Student Health Insurance Plan and you then experience a significant life change that directly affects your insurance coverage, you may petition to enroll in an NYU-sponsored plan after the open enrollment period has ended. You must submit a Petition to Change Insurance Status Form along with acceptable proof of the loss of your insurance coverage (e.g., confirmation of insurance termination on employer or insurance company letterhead). Petition to Change Forms are available at the SHC Student Health Insurance Services Office. Coverage will become effective on the date the Petition to Change Form and accompanying documentation are received by the Student Health Insurance Services Office, and is contingent upon the approval of CHP.

Any student or Dependent who enrolls after the open enrollment period is considered a Late Enrollee, subject to the applicable policy provisions. Late Enrollees will be subject to the rules governing Pre-Existing Conditions, exclusions, and limitations, and will be charged the appropriate premiums. **Please note that premiums are not pro-rated.** (For additional information on Pre-existing Conditions, see page 20).

Late Waivers

If you had *extenuating circumstances* that caused you to miss the appropriate deadline for waiving coverage under the NYU-sponsored plans, you must file a Petition to Change Insurance Status Form. The petition requires a detailed explanation of the reason for lateness and will be reviewed by the plan administrator, CHP, on a case-by-case basis.

If the petition is approved, you will be billed directly for any medical services already received at SHC, 726 Broadway, during the entire policy period for which you waived coverage. If claims for service outside of SHC have been filed, there is no option to waive the Basic or Comprehensive Plan. You will remain covered and will be responsible for payment of premium.

Students will have the opportunity for a late petition to waive insurance only once during their academic career at NYU. Additional petitions will not be considered. Call the SHC Student Health Insurance Office at (212) 443-1020 for more information.

Health-Related Services for Matriculated Students

Student Health Center

726 Broadway, 3rd and 4th Floors

(212) 443-1000

www.nyu.edu/health

health.center@nyu.edu

All matriculated students may use the NYU Student Health Center (SHC). We encourage you to make appointments whenever possible and carry your NYU Card or health insurance identification card at all times.

The SHC is an award-winning student health care facility conveniently located on the Washington Square Campus. Through close collaboration, our multidisciplinary staff of board-certified Doctors and highly trained clinicians provide comprehensive health and wellness services in response to the health needs and concerns of the NYU community, and promote a healthier, safer campus. These include medical, psychological, pharmaceutical, educational, crisis response, and support services.

Whether your needs involve routine or urgent medical care, counseling, education about a specific wellness issue, prescriptions, or eyewear, the staff at SHC is prepared to provide quality confidential, caring service.

Health Services Provided at No or Reduced Cost

At the Student Health Center (726 Broadway) at no or reduced cost:

- primary care and women's health office visits*
- many diagnostic laboratory tests
- short term counseling and behavioral health services
- wellness and health education services
- starter doses of common medications

**Some procedures performed during the visit may incur a fee. See Sample of Services chart at www.nyu.edu/shc/about.*

Outside the Student Health Center

- **Mandatory Plan** - a health insurance plan with limited benefits described on pages 5 and 6.
- **Treatment of Dental Emergencies:**

Students have access to emergency dental treatment at no cost as follows:

Monday -Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 4 p.m.:

Students should go to the NYU College of Dentistry Faculty Practice, 726 Broadway, Suite 350, (212) 443-1313.

Saturdays and Sundays from 9 a.m. to 5 p.m.:

The College of Dentistry provides limited emergency care at 345 East 24th Street at First Avenue.

On holidays or after hours: Students can go directly to the Bellevue Hospital Center Emergency Room, 462 First Avenue at East 27th Street (212) 562-3015.

Dental emergencies include the unexpected onset of a condition, such as bleeding, swelling and/or significant pain, requiring immediate dental care and not elective or routine care.

SUMMARY OF BENEFITS

- BASIC PLAN
- COMPREHENSIVE PLAN
- GSHIP

This section describes benefits for all NYU-sponsored Student Health Insurance Plans. Please note this is ONLY a summary. The Master Policy further explains benefits and any exclusions or limitations. A copy of the Master Policy is on file at the NYU Insurance Department, 7 East 12th Street, 8th Floor. Where a discrepancy exists between this brochure and other printed matter regarding this program and the Master Policy, the Master Policy will take precedence. Call CHP at (877) 373-1170 for additional details about benefits.

The Basic, Comprehensive, and GSHIP Plans fulfill the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Should you wish to receive a certification of coverage at any time, please call Customer Service at CHP (877) 373-1170.

It is important that you **READ THIS BROCHURE** carefully. The NYU- sponsored Student Health Insurance Program provides limited benefits for health insurance ONLY. As defined by the New York State Insurance Department, it does NOT provide basic Hospital, basic medical, major medical insurance, Medicare supplement, long term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home health care insurance. The insurance policy itself sets forth the rights and obligations of both you and the insurance company.

Summary of Plan Benefits

The plan provides benefits as specifically listed below:

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Lifetime Aggregate Maximum	
\$250,000 per condition	\$1,000,000 per condition
Out-of-Pocket Maximums <i>See page 30 for definition of Out-of-Pocket Maximums.</i>	
In-Network Care - \$3,000 per policy year	In-Network Care - \$2,000 per policy year
Out-of-Network Care - \$6,000 per policy year	Out-of-Network Care - \$4,000 per policy year
<i>Once the Out-of-Pocket limit has been satisfied: Covered medical expenses will be payable at 100% for the remainder of the Policy Year up to any benefit maximum that may apply.</i>	
INPATIENT BENEFITS	
Room and Board	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
Other Hospital Services	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
Pre-Admission Testing	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
Inpatient Non-Surgical Doctor Visits	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
SURGICAL BENEFITS Outpatient & Inpatient	
Surgeon's Fees	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
Assistant Surgeon Fees, Anesthesia Fees	
In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter	In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum , 100% thereafter
Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter	Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum , 100% thereafter
OUTPATIENT BENEFITS	
Most Primary Care office visits at SHC are covered 100%. This is not an insured benefit, but is provided by NYU to all matriculated students (Including students who waived the Student Health Insurance Plans).	
Doctor Visits	
At SHC: Specialists (including Psychiatric Services and Physical Therapy); 100% after \$15 fee. CHANGE	At SHC: Comp Plan: Same as Basic Plan GSHIP: Covered 100%
Outside SHC: In-Network Care - 80% of the Negotiated Charge : \$15 per visit Co-pay	Outside SHC: In-Network Care - 90% of the Negotiated Charge : \$10 per visit Co-pay
Out-of-Network Care - 50% of Reasonable Charges : \$30 per visit Deductible	Out-of-Network Care - 70% of Reasonable Charges : \$20 per visit Deductible

BASIC PLAN**COMPREHENSIVE PLAN/GSHIP****OUTPATIENT BENEFITS (Continued)**

Routine/Preventative Annual Office Visit (See Well Woman Care below and on next page)

At SHC: 100% for an annual exam including limited tests.

Outside SHC: No coverage except for well baby care up to the age of 3.

Allergy Testing and Shots

In-Network Care - 80% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Routine Immunizations

Students:

NEW

No coverage except for:

Routine Flu Shots at SHC - 100%

Dependent children up to the age of 12 as follows:

In-Network Care - 80% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Hospital Outpatient

In-Network Care - 80% of the **Negotiated Charge**: \$40 per visit **Co-pay**

In-Network Care - 90% of the **Negotiated Charge**: \$35 per visit **Co-pay**

Out-of-Network Care - 50% of the **Negotiated Charge**: \$60 per visit **Deductible**

Out-of-Network Care - 70% of the **Negotiated Charge**: \$50 per visit **Deductible**

Hospital Emergency Room

In-Network Care - 80% of the **Negotiated Charge**: \$50 per visit **Co-pay**

In-Network Care - 90% of the **Negotiated Charge**: \$50 per visit **Co-pay**

Out-of-Network Care - 80% of **Reasonable Charges**: \$50 per visit **Deductible**

Out-of-Network Care - 90% of **Reasonable Charges**: \$50 per visit **Deductible**

Lab and X-Ray

Some commonly performed lab tests at SHC will be covered 100%. This is not an insured benefit, but is provided by NYU to all matriculated Students (Including students who waived the Student Health Insurance Plans).

Lab tests and X-rays for which there is a fee*:

Lab tests and X-rays for which there is a fee*:

In-Network Care - 80% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

**Includes pap smear screening.*

Chiropractic Service

Payable same as non-SHC Doctor visits.

Payable same as non-SHC Doctor visits.

Radiation Therapy, Chemotherapy, Dialysis Treatment and Intravenous Home Therapy

In-Network Care - 80% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of **Reasonable Charges** up to the **Out-of-Pocket Maximum**, 100% thereafter

Physical Therapy/Occupational Therapy

Payable same as non-SHC Doctor visits

Payable same as non-SHC Doctor visits

WOMEN'S HEALTH BENEFITS**Well Woman Care**

Most Women's Health office visits at SHC are covered 100%. This is not an insured benefit but is provided by NYU to all matriculated students (Including students who waived the Student Health Insurance Plans).

Routine Gynecologic Exam

Outside SHC, covered as any other outpatient non-SHC Doctor visit (see page 10)

Outside SHC, covered as any other outpatient non-SHC Doctor visit (see page 10)

WOMEN'S HEALTH BENEFITS (Continued)

Pap Smear Screening

Covered as a laboratory expense (see page 11)

Covered as a laboratory expense (see page 11)

Mammography

In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Maternity

Pays the same benefits for maternity, as well as for the complications of pregnancy, as afforded any Sickness.
(Well Baby visits are not covered.)

In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, as Medically Necessary. In the event of a Hospital discharge earlier than 48 hours after a vaginal delivery, or 96 hours after a cesarean delivery, coverage is available for at least one (1) home health care visit as Medically Necessary. This visit will be payable at 100% and will not be subject to any plan Co-pays or Deductibles, if applicable. Coverage also includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Obstetric Services

In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Designated Care - 100% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter**

Designated Care - 100% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter**

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

Inpatient Room and Board for Maternity

In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

At NYU Tisch Hospital

Designated Care - 100% of the Negotiated Charge**

At NYU Tisch Hospital

Designated Care - 100% of the Negotiated Charge**

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

Contraceptives

Oral Contraceptive Pills Covered under the separate Prescription Drug Benefit (see page 14).

Prescription Contraceptive Services (other than oral contraceptives)

100% coverage for services only when performed at SHC

Same as Basic Plan

Outside SHC: Coverage of Lunelle, Depo-Provera, Patch and Ring are provided under the separate Prescription Drug Benefit (see page 14).

Expenses incurred for Doctor office visits in conjunction with the administration of a covered prescription contraceptive are provided under the medical portion of the plan (see page 10).

Emergency Contraception

100% coverage for services only when performed at SHC

Same as Basic Plan

No coverage outside SHC unless SHC is not open and will remain unopened for a 24-hour period.

Termination of Pregnancy

Covered medical expenses are payable as any other condition.

Mastectomy, Lymph Node Dissection and Lumpectomy and Reconstructive Surgery as a result of Breast Cancer

In-Network Care - 80% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

In-Network Care - 90% of the Negotiated Charge up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 50% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

Out-of-Network Care - 70% of Reasonable Charges up to the Out-of-Pocket Maximum, 100% thereafter

BASIC PLAN**COMPREHENSIVE PLAN/GSHIP****MENTAL HEALTH BENEFITS****Inpatient Mental Health**

In-Network Care - 80% of the Negotiated Charge up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the Negotiated Charge up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of Reasonable Charges up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of Reasonable Charges up to the **Out-of-Pocket Maximum**, 100% thereafter

Designated Care - At NYU Tisch Hospital, 100% of the **Negotiated Charge**

Designated Care - At NYU Tisch Hospital, Same as Basic Plan

Benefit Maximum (In and Out-of-Network)

Biologically Based Conditions: Pay as any other Sickness
Non-Biologically Based Conditions**: 30 days per policy year

Benefit Maximum (In and Out-of-Network)

Biologically Based Conditions: Pay as any other Sickness
Non-Biologically Based Conditions**: Pay as any other sickness.

Outpatient Mental Health Psychotherapy (outside SHC)

In-Network Care - 80% of the Negotiated Charge
Out-of-Network Care - 50% of Reasonable Charges

In-Network Care - 90% of the Negotiated Charge, after visit 10*
Out-of-Network Care - 70% of Reasonable Charges, after visit 10*

Designated Care - 100% after a \$5 fee.

For a list of Designated Providers, please call Student Health Insurance at 212-443-1020.

* Visits 1-10 are paid under the Mandatory Plan (as described on pages 5-6) at 80% for In-Network Providers and 50% for Out-of-Network Providers.

Benefit Maximum (In and Out-of-Network)

Biologically Based Conditions: Pay as any other Sickness
Non-Biologically Based Conditions**: 30 visits per policy year

Benefit Maximum (In and Out-of-Network)

Biologically Based Conditions: Pay as any other Sickness
Non-Biologically Based Conditions**: 30 visits per policy year

**A total of 30 visits will be paid between the Mandatory Plan, and this plan.

Definitions:**Biologically Based Condition**

A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such Biologically Based Mental Health Conditions are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorders, obsessive compulsive disorders, bulimia and anorexia.

Non-Biologically Based Condition

Any mental health condition other than schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorders, obsessive compulsive disorders, bulimia and anorexia.

See page 16 for more information.

Please Note: Short-term psychotherapy (talk therapy) visits are provided at no charge at SHC Counseling & Behavioral Health.

Psychiatric Medication Assessment and Management

At SHC: 100% after \$15 fee **CHANGE**

At SHC: Comp: Same as Basic Plan
GSHIP: Covered 100%

Outside SHC: Payable same as non-SHC Doctor visit (see page 10)

Outside SHC: Payable same as non-SHC Doctor visit (see page 10)

Inpatient Chemical Abuse and Dependence (Maximum 7 days or \$10,000 per policy year, whichever is greater)

In-Network Care - 80% of the Negotiated Charge up to the **Out-of-Pocket Maximum**, 100% thereafter up to \$10,000

In-Network Care - 90% of the Negotiated Charge up to the **Out-of-Pocket Maximum**, 100% thereafter up to \$10,000

Out-of-Network Care - 50% of Reasonable Charges up to the **Out-of-Pocket Maximum**, 100% thereafter up to \$10,000

Out-of-Network Care - 70% of Reasonable Charges up to the **Out-of-Pocket Maximum**, 100% thereafter up to \$10,000

Outpatient Chemical Abuse and Dependence

In-Network Care - 100% of the Negotiated Charge

Same as Basic Plan

Out-of-Network Care - 100% of Reasonable Charges

Limit - 60 visits per policy year. A maximum of 20 of these visits are available for family counseling.

Partial Hospitalization

In exchange for full Hospitalization

Same as Basic Plan

Includes the charges made for treatment received during partial Hospitalization or intensive outpatient in a Hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial Hospitalization or intensive outpatient treatment may be exchanged for 1 day of full Hospitalization.

BASIC PLAN

COMPREHENSIVE PLAN/GSHIP

ADDITIONAL BENEFITS

Prescription Drug (Express Scripts)

Limit \$1,500 per policy year

NEW

Preferred Pharmacy:

100% after a...

- \$5 Co-pay for generic drugs
- \$25 Co-pay for preferred brand name drugs
- \$40 Co-pay for non-preferred brand name drugs
- \$15 Co-pay for all diabetic supplies*

Non-Preferred Pharmacy:

70% after a...

- \$5 Co-pay for generic drugs
- \$25 Co-pay for preferred brand name drugs
- \$40 Co-pay for non-preferred brand name drugs
- \$15 Co-pay for all diabetic supplies*

**Diabetic supplies include insulin, syringes and testing supplies*

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.

See page 26 for excluded medications.

Ambulance

100% coverage per transport to or from hospital

100% coverage per transport to or from hospital

Prostate Cancer Screening

Covered medical expenses include one annual (or more frequently if recommended by a Doctor) digital rectal exam and Prostate Specific Antigen (PSA) test. **Covered medical expenses** are payable on the same basis as any medical expense.

Home Health Care

80% to a maximum of \$75 per visit per policy year, 40 visits per policy year.

90% to a maximum of \$75 per visit per policy year, 40 visits per policy year.

Orthopedic/Prosthetic Appliance/Braces (Policy Year Benefit Maximum \$500)

80% of Reasonable Charges

90% of Reasonable Charges

Durable Medical Equipment (Policy Year Benefit Maximum \$500)

80% of allowable charges

At SHC:

Comp Plan: 90% of all allowable charges

GSHIP: Covered 100%

Outside SHC: 90% of all allowable charges

Diabetic Treatment Expense

Covered medical expenses including, but not limited to, equipment and self-management education are payable as follows:

In-Network Care - 80% of the **Negotiated Charge** up to the **out-of-pocket maximum**, 100% thereafter

In-Network Care - Same as Basic Plan

Out-of-Network Care - 50% of the **Negotiated Charge** up to the **out-of-pocket maximum**, 100% thereafter

Out-of-Network Care - Same as Basic Plan

Note: Insulin, testing supplies and syringes are payable under the prescription portion of the plan.

Speech and Hearing Therapy, Bone Density Screening Test, Enteral Formula for Home Use

In-Network Care - 80% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

In-Network Care - 90% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 50% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

Out-of-Network Care - 70% of the **Negotiated Charge** up to the **Out-of-Pocket Maximum**, 100% thereafter

End of Life Care/Hospice Care

Covered medical expenses include care provided at acute care facilities which specializes in the treatment of terminally ill patients for members diagnosed with advanced cancer.

Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement must be provided at 100% of the acute care facilities' reimbursement rate under the Medicare program, after any applicable deductible.

Same as Basic Plan

BASIC PLAN**COMPREHENSIVE PLAN/GSHIP****ADDITIONAL BENEFITS (Continued)****Medical and Mental Health Treatment Abroad**

Medical and mental health treatment will be covered according to the plan benefits at the 80% In-Network care rate. Prescription medications will also be covered 80%.

Medical and mental health treatment will be covered according to the plan benefits at the 90% In-Network care rate. Prescription medications will also be covered 90%.

Medex Travel Assistance Program

Travel assistance services, medical, evacuation and return of mortal remains services up to \$250,000.

Travel assistance services, medical, evacuation and return of mortal remains services up to \$1,000,000.

Accidental Death and Dismemberment \$10,000

Accidental Death and Dismemberment \$10,000

Vision Services**Annual Preventive Eye Examination****At SHC:**

100% after \$15 fee

Outside SHC: No benefit

Annual Preventive Eye Examination**At SHC:**

Comp: Same as Basic Plan

GSHIP: Covered 100%

Outside SHC: No benefit

Other Optical Services at SHC**Special discounts on:**

- New contact lens fittings (lenses not included)
- Re-evaluation of current contact lens prescriptions
- 10% discount on already discounted eyeglass frame and lenses package when prescribed by and purchased at SHC

Other Optical Services at SHC - Same as Basic Plan

Other Optical Services are not an insured benefit. SHC has agreed to provide discounts as an added service to students covered under these plans.

TREATMENT OF MENTAL HEALTH DISORDERS

Biologically Based Mental Illness and for Children with Serious Emotional Disturbances

“Biologically Based Mental Illness” means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such Biologically Based Mental Illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia.

“Children with Serious Emotional Disturbances” means: persons under the age of eighteen (18) years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- Serious suicidal symptoms or other life-threatening self-destructive behaviors;
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Inpatient

Covered Medical Expenses include expenses incurred by a Covered Person while confined as a full-time inpatient in a Hospital or **residential treatment facility** for the treatment of Biologically Based Mental Illness or Children with Serious Emotional Disturbances. See page 13 for mental health inpatient benefits.

Outpatient

Covered Medical Expenses include expenses while a Covered Person is not confined as a full-time inpatient in a Hospital, for the treatment of Biologically Based Mental Illness or Children with Serious Emotional Disturbances. See page 13 for mental health outpatient benefits.

Not Covered are Charges for Services:

- While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth.
- Provided solely because such services are ordered by a court.
- Deemed to be cosmetic in nature.

Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances

Inpatient

Covered Medical Expenses include expenses incurred by a Covered Person while confined as a full-time inpatient in a Hospital or residential treatment facility for the treatment of Mental Illness other than Biologically Based Mental Illness or Children with Serious Emotional Disturbances. See page 13 for mental health inpatient benefits.

Outpatient

Covered Medical Expenses include expenses while a Covered Person is not confined as a full-time inpatient in a Hospital, for the treatment of Mental Illness other than Biologically Based Mental Illness or Children with Serious Emotional Disturbances. See page 13 for mental health outpatient benefits.

Visits for outpatient treatment of Biologically Based Mental illness and Children with Serious Emotional Disturbances will count against and reduce this maximum.

Not Covered are Charges for Services:

- While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth.
- Provided solely because such services are ordered by a court.
- Deemed to be cosmetic in nature.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home.

Your MEDEX identification card is your key to travel security.

For general inquiries regarding our international assistance coverage, please call Consolidated Health Plans at 877-373-1170. If you have a medical or travel problem, simply call MEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation.

If you are in North America, call the Assistance Center *toll-free* at: 800-527-0218 or if you are in a foreign country, call *collect* at: 410-453-6330.

If the condition is an emergency, you should go immediately to the nearest Doctor or hospital without delay and then contact the 24-hour Assistance Center.

GENERAL TERMS AND CONDITIONS FOR ALL NYU-SPONSORED PLANS

COORDINATION OF BENEFITS

Benefits will be coordinated with any other group medical surgical or Hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

BENEFIT PERIOD

Reasonable Charges for medical expenses incurred by Covered Students or their insured Dependents are covered if they are incurred within the period of coverage up to the aggregate maximum benefit for each Injury or for each Sickness. Any expenses incurred beyond the period of coverage are not covered by this program.

EXTENSION OF BENEFITS

If a Covered Person is confined to a Hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that Hospital confinement shall be payable in accordance with the Master Policy, but only while they are incurred during the twelve (12) month period following such termination of insurance. Benefits will continue to be available for a Covered Person who incurs medical expenses directly relating to a pregnancy that began before coverage under the Policy ceased. This benefit will be covered only for the period of the pregnancy.

TERMINATION OF COVERAGE

For a Covered Student:

Insurance for a Covered Student will end on the date that the Covered Student withdraws from NYU to enter the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal. If withdrawal from NYU is for a reason other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term during which they are enrolled and for which the premium has been paid.

For a Covered Dependent:

Insurance for a Covered Dependent will end when insurance for the Covered Student ends. Before then, coverage will end:

For a child

1. upon the next premium due date after the date of the child's marriage; or
2. upon the next premium due date after the child's 19th birthday (25th birthday if in school);

However, if at the time at which insurance would otherwise cease the child is then incapable of self-sustaining employment due to mental or physical disability, coverage will end on the date the incapacity ends.

For a Spouse or Domestic Partner

upon the next premium date after the date the marriage ends in divorce or annulment.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

NEW YORK STATE-MANDATED BENEFITS

This Program will pay benefits in accordance with any applicable New York State Insurance Law(s).

End of Life Care Expenses

Covered Medical Expenses include care provided at an Acute Care Facility that specializes in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.

If We disagree with the admission of or the provision or continuation of care for the Covered Person by the facility, We will initiate an expedited External Appeal in accordance with External Appeal provision in this Policy. Until a decision is rendered on this Appeal, We will provide Benefits, subject to the provisions of this Policy.

The decision of the External Appeal agent is binding on the Covered Person and Us.

Enteral Formulas

When this Policy covers prescription drugs, as part of that Benefit, We will pay the Covered Expenses incurred for the cost of enteral formulas for home use when prescribed by a Doctor or other Provider. Any prescription from the Doctor or Provider must state the use of such formulas is clearly Medically Necessary and has been proven effective as a disease specific treatment for a Covered Person who is or who will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death.

Enteral formulas which are Medically Necessary and taken under written prescription from a Doctor for the treatment of specific diseases will be distinguished from nutritional supplements taken electively. Specific diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastro esophageal reflux with failure to thrive; disorders of the gastrointestinal motility such as chronic intestinal pseudo obstruction; and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation or death.

Coverage for certain inherited diseases of amino acid and organic acid metabolism will include modified solid food products that are low protein or which contain modified protein which are Medically Necessary.

Breast Cancer Benefit

Hospital Facility Services will be payable for such period of time as determined by the Doctor, in consultation with You, to be medically appropriate when You are undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Policy. Covered Expenses for a mastectomy include prosthesis and physical complications in all stages of mastectomy, including lymph edemas, in a manner determined in consultation with the Doctor and the patient. Such treatment will be subject to any Deductible and Coinsurance amounts shown in the Schedule of Benefits.

Second Medical Opinion

We will pay the Covered Expenses incurred for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Chiropractic Care Benefit

We will pay the Covered Expenses incurred for chiropractic care, performed by a doctor of chiropractic, to the same extent as would be payable for Doctor's services in a Doctor's office. Chiropractic care must be in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Experimental or Investigational Services Recommended by an External Appeal Agent

We will not exclude Benefits for health care services rendered or proposed to be rendered to a Covered Person on the basis that such service is Experimental or Investigational, is rendered as part of a clinical trial or is a pharmaceutical product prescribed by the Covered Person's attending Doctor for a use other than those uses for which the pharmaceutical product has been approved for marketing by the U.S. Federal Food and Drug Administration, if the services have been recommended by an External Appeals Agent in response to an appeal filed by an Covered Person or his or her attending Doctor. Such an External Appeal recommendation is binding upon the Covered Person, the Doctor and Us. Any Benefits provided will be subject to the terms and conditions applicable to other Benefits provided under the Policy.

Bone Mineral Density Tests

When this Policy provides prescription drugs, We will pay Covered Expenses for bone mineral density measurements, tests, drugs and devices approved by the Federal Food and Drug Administration or generic equivalents as approved substitutes. These Benefits will be paid according to the criteria of the Federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy x-ray absorptiometry.

Covered Expenses will be paid according to the criteria of the Federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Covered Persons qualifying for Benefits shall at a minimum, include Covered Persons:

- previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
- on a prescribed drug regimen posing a significant risk of osteoporosis; or
- with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Cancer Screening

We will pay the Covered Expenses incurred for mammography screening for occult breast cancer as follows:

- a mammogram at any age upon the recommendation of a Doctor, for Covered Persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;
- a single baseline mammogram for Covered Persons age 35 to 39 inclusive; and
- an annual mammogram for Covered Persons age 40 and older.

We will pay the Covered Expenses incurred for standard diagnostic testing for prostate cancer including but not limited to:

- a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and
- an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer factors.

We will pay the Covered Expenses incurred for an annual cervical cytology screening (PAP tests) for cervical cancer and its precursor states for women age 18 years and older. Such annual screening includes an annual pelvic exam, collection and preparation of the Pap smear and laboratory and diagnostic services provided in conjunction with examining and evaluating the Pap smear.

Pre-Hospital Medical Emergency Services

We will pay the Covered Expenses incurred for pre-hospital medical emergency services for the treatment of an emergency condition when such services are provided by a certified ambulance service.

As used above:

"Pre-hospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a Hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

"Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Treatment of Correctable Medical Conditions that Cause Infertility

This Policy does not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under this Policy solely because the medical condition results in infertility.

Autism Spectrum Disorder

This Policy does not exclude coverage for diagnosis and treatment of medical conditions otherwise covered under the Policy because the treatment is provided to diagnose or treat Autism Spectrum Disorder.

Second Surgical Opinion

We will provide coverage for a second surgical opinion by a qualified Doctor on the need for surgery, subject to the following:

1. A qualified Doctor must be a board-certified specialist who by reason of his specialty is an appropriate Doctor to consider the surgical procedure being proposed;
2. Obtaining the second surgical opinion will be at the insured's option;
3. The benefit is applicable to all in-patient surgical procedures of a non-emergency nature covered under this Policy;
4. The benefit is payable only if the insured is examined in person by the Doctor rendering the second surgical opinion and a written report is provided to Us; and
5. If the Board certified specialist who renders the second surgical opinion also performs the surgery, no second surgical opinion benefit is payable.

Pre-Admission Testing

This Policy includes coverage for Pre-Admission Testing ordered by a Doctor performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that:

1. The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
2. Reservations for a hospital bed and for an operating room were made prior to the performance of the tests;
3. The surgery actually takes place within seven days of the tests; and
4. The patient is physically present at the hospital for the tests.

Experimental Cancer Drugs

Coverage for prescribed drugs, approved by the Food and Drug Administration of the United States government for the treatment of certain types of cancer, will not exclude coverage of any such drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopoeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Coverage will not be provided for any experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. The provisions of this paragraph apply to cancer drugs only and nothing should be construed to create, impair, alter, limit, modify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

PRE-EXISTING CONDITIONS

Expenses incurred by a Covered Person as a result of a Pre-existing Condition will not be considered Covered Medical Expenses unless no charges are incurred or treatment rendered for the condition for a period of 6 months while covered under this Program, or the Covered Person has been covered under this Program for 12 consecutive months, whichever happens first.

If a person has creditable coverage and such coverage terminated within 63 days prior to the date enrolled in this Program, then any limitation as to a Pre-existing Condition under this Program will apply to only the extent that the limitation would have applied if the Covered Person had remained covered under the prior creditable coverage.

Creditable coverage means a Covered Person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefits Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5 (e) of Peace Corps Act.

Please note:

- Any student or Dependent that enrolls during the open enrollment period is not subject to the rules governing Pre-Existing Conditions.
- Any student or Dependent that enrolls after the open enrollment period is considered a late enrollee, subject to the rules governing Pre-Existing Conditions.

IN-NETWORK/DESIGNATED PROVIDER NETWORK

CHP along with MultiPlan has arranged for you to access their Network of Providers and certain Designated Providers in your local community. Acute care facilities and mental health networks are available nationally if you require Hospitalization outside the immediate area of the New York University campus. To maximize your savings and reduce your out-of-pocket expenses, select an In-Network Provider or Designated Provider. It is to your advantage to utilize an In-Network Provider or Designated Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. In-Network Providers/Designated Providers are independent contractors and are neither employees nor agents of CHP or MultiPlan.

To find a MultiPlan Provider, go to www.chpstudent.com/nyu. You also may contact CHP at (877) 373-1170.

REFERRAL REQUIREMENTS*

Students Seeking Medical Services IN Manhattan

Initial SHC Referral

Except for the situations listed below, all Covered Students in need of medical care in Manhattan are required, except in the case of a medical emergency, to first seek treatment and be evaluated at NYU Student Health Center (SHC) at 726 Broadway, New York, NY 10003. If evaluation by an SHC provider determines that you need services unavailable at SHC, you will be given a written off-site referral. If you receive non-emergency medical care anywhere in Manhattan without first being evaluated and referred by SHC, you will be denied benefits under this Student Health Insurance Program. *Referrals cannot be granted retroactively after treatment has been rendered.*

Referral Limitations

The referral is only valid for treatment of a specific condition, for the period of time stated on the referral. The referral may also limit the number of visits allowed within that time frame. **Your condition must be re-evaluated by your healthcare provider at SHC, 726 Broadway, before you seek additional outside treatment that exceeds these limits.**

Summer SHC Referrals

Whether or not a student is enrolled in summer courses at NYU, he or she must obtain authorization from SHC for outpatient medical benefits that take place in Manhattan and begin during the summer months (see referral sections above).

Referrals for Follow Up After Medical Emergency - (see page 6)

Referrals are not required for:

- Medical Emergency Treatment in a Hospital Emergency Room
- Gynecological Care
- Laboratory Tests
- Maternity Care
- Mental Health and Substance Abuse Services
- Treatment of TMJ
- Treatment when SHC is closed during NYU holidays and winter break

Students Seeking Medical Services **OUTSIDE** Manhattan

Although there is no referral requirement for covered services received outside Manhattan, we encourage students to first seek services by an SHC provider who will be able to supervise and coordinate care with minimal Out of Pocket Expense for Medically Necessary treatment at SHC.

If that is not possible, seek care from providers who participate in the MultiPlan network to ensure maximum benefits and reduced out-of-pocket expenses. To find a MultiPlan Provider go to www.chpstudent.com/nyu. You may also call CHP at (877) 373-1170 and a representative will assist you.

Students may, however, use any provider outside the borough of Manhattan without an off-site referral from SHC. In all cases, students will be responsible for any Co-payments, deductibles, and/or coinsurance fees incurred.

** Referral requirements are applicable to Covered Students only. Since Covered Dependents do not have access to SHC services, they do not need referrals to be covered for services outside SHC.*

Mental Health Services and Chemical Abuse and Dependence Services

Referrals are not required for mental health services and chemical abuse and dependence services.

SHC provides counseling services (talk therapy) to matriculated students free of charge, with no impact on the maximum number of visits in the outpatient mental health benefit. Call (212) 998-4780 for information about counseling services at SHC or for information about services and clinicians in the community.

Frequently Asked Questions About Referrals

What if the off-site provider tells me that I need additional procedures or services?

The health care provider to whom you are referred may determine that additional tests or procedures outside of his/her office are Medically Necessary to properly treat your condition.

1. You should contact SHC to find out if the necessary services are available at SHC. If the services are available, you should make an appointment at SHC for these services.
2. If the requested services are unavailable at SHC, you may make an appointment with the provider who is recommended by the requesting Doctor. It is your responsibility to find out if the medical provider is in- or out-of-network for Multiplan. An additional off site referral is not required as long as the services are received within the period of time stated on the referral and are related to the same diagnosed condition. (However, the health care provider or facility you are referred to may ask for a referral to ensure that they will get payment from the insurance company). To find a Multiplan Provider go to www.chpstudent.com/nyu. You may also call CHP at (877) 373-1170 and a representative will assist you.

I have been referred to an off-site specialist before, but I now have a new medical condition. Do I need another referral authorization to see the same specialist?

A referral indicates services requested for a specific condition. So, if a new or different medical condition arises, you will need to be evaluated by your SHC health care provider again in order to obtain a referral authorization for this new condition.

Does a referral guarantee payment of medical services rendered?

Even though a referral may be required for payment of benefits, it does not necessarily guarantee payment. Benefits are subject to all provisions and limitations as outlined in this handbook including, but not limited to: Deductibles, Co-pays, maximum policy limits, determination of Medical Necessity, Reasonable Charges, etc.

OTHER CONSOLIDATED HEALTH PLANS PROGRAMS

As a participant in one of the NYU-sponsored Student Health Insurance Plans, you have access to the following additional Consolidated Health Plan Programs:

Nationwide Taxi Card

A Taxi Card is a single-purpose prepaid debit card for taxicab transportation. You have access to a national network of taxis 24 hours a day, 7 days a week. A safe ride is just a toll-free call away. This is how it works:

1. **Load any amount \$10-\$500**
Like a prepaid phone card, just for taxis. Load funds with your credit or debit card. Arrives in 7-10 days.
2. **Call one number nationwide**
Our number is on the back of the card. We send a local taxi partner and confirm pickup via phone call and text message.
3. **Present your card**
The fare is deducted. Reload as you go or refund if not used.

Nurse Hotline

Good health starts with asking questions and knowing where to go for the answers.

Nurse Hotline offers toll-free access to experienced registered nurses. Nurses are available 24 hours a day, 7 days a week. Our hotline nurses are an immediate, reliable and caring source of health information, education and support. Our nurses provide information based on Doctor-approved guidelines, including:

- General information on all types of health concerns
- Answers about medication usage and interaction
- Translation services for non-English speaking callers
- TTY/TTD access for the hearing impaired
- Computerized record keeping system
- Medical Director on staff

Vision Discount Card

CHP is pleased to offer to students, at no additional cost, the Davis Vision Affinity Discount Program. This program provides savings on eyewear, eye exams and other services at locations nationwide. Students simply show their CHP ID card and any applicable services or merchandise they receive will be discounted right at the point of purchase. There are no claim forms to complete and no waiting for reimbursement. The NYU Student Health Center Optometry Department is not part of the Davis Affinity Discount Program, but provides independent discounts and reduced prices to students enrolled in the Basic, Comprehensive and GSHIP Plans.

EXCLUSIONS

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. War or act of war, participation in a riot or insurrection, and service in the Armed Forces or units auxiliary thereto;
2. Aviation, other than as a fare-paying passenger on a scheduled flight or charter flight operated by a scheduled airline;
3. Cosmetic Surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. Cosmetic surgery medical necessity determinations are subject to utilization review and external review;
4. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
5. Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable;
6. Treatment provided in a government hospital; benefits provided under Medicare or other governmental programs (except Medicaid); any state or federal worker' compensation, employers' liability or occupational disease law, unless where otherwise provided in State or Federal statute;
7. Coverage for services performed by a member of the insured's immediate family;
8. Coverage for services for which no charge is normally made;
9. Coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth and except for dental care or treatment necessary due to congenital disease or anomaly;
10. Coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof;
11. Coverage for custodial care as defined in 11 NYCRR 52.16(1) and for transportation;
12. Coverage for rest cures;
13. Losses to which a contributing cause was the insured's participation in a felony or attempted felony or engaged in an illegal occupation; and
14. Interscholastic sports.

FILING CLAIMS

It is the student's responsibility to obtain an appropriate referral for any medical treatment provided outside of SHC or for services not covered under our plans. If you are also eligible for benefits from a private health insurance carrier you must follow your carrier's instructions for filing a claim.

Many health care providers will bill CHP directly. Some health care providers may not accept the NYU-sponsored Student Health Insurance Plans and require either full or partial payment at the time service is rendered. This is most common when traveling abroad. Therefore, you should always be prepared to make such payment. After you have made payment, you then may submit a claim to CHP for reimbursement.

Follow These Steps to File a Claim:

1. A claim form is not required to submit a claim. However please submit:

- any itemized bills related to your treatment;
- indicate that you attend NYU;
- include your name, address and student identification number.

If you paid for any services, in full or in part, attach evidence of such payment (e.g., cash or credit card receipt, copy of canceled check, etc.) to the claim. Without such evidence, you will not be reimbursed. All documentation must be in English.

2. Keep a copy

For your records, keep a copy of your medical bills, and any other documentation submitted with your claim.

3. Mail itemized bills, receipts, etc. to:

Consolidated Health Plans
ATTN: NYU Unit
2077 Roosevelt Ave
Springfield, MA 01104

If after filing your claim you receive additional bills, submit them directly to CHP. Make certain that all your medical bills correctly show your name and Member ID number (make changes on the medical bills, if necessary). Medical bills and all other claim-related correspondence should be directed to CHP within 30 days of treatment.

If you have any problems in filing a claim and need assistance, please contact CHP at (877) 373-1170. If you need further assistance, contact the SHC Student Health Insurance Services Office at (212) 443-1020 or health.insurance@nyu.edu.

If Your Claim is Denied

If your claim has been denied, the reason will be included in the "Explanation of Benefits" that you will receive. Claims can be denied for several reasons. For example:

- The information you provided was not complete.
- You are not insured under the program.
- You failed to seek treatment at SHC when required.
- The medical services performed were not covered under the program.
- The maximum benefits under your plan have been paid to you already.

Complaint and Appeals Procedure

New York State mandates that the following information be provided to all insured:

The complaints and appeals process is designed to address coverage issues, complaints and problems. If you or your Covered Dependent has a coverage issue or other problem, call CHP Customer Services at (877) 373-1170. A representative will address your concern. If you or your Covered Dependent are dissatisfied with the outcome of the initial contact, the decision may be appealed.

You or your Covered Dependent may also submit a request, in writing, along with all pertinent correspondence, to:

Consolidated Health Plans
ATTN: NYU Unit
2077 Roosevelt Ave
Springfield, MA 01104

For purposes of the following section, the term "you" pertains to you or your Covered Dependent.

Internal Appeals Procedure

CHP has established a procedure for resolving appeals. If you have an appeal, please follow this procedure:

- An Appeal is defined as a written request for review of a decision that has been denied in whole or in part; after consideration of any relevant information; a request for: claim payment; certification; eligibility; referral; etc.

First Level Appeals Procedure

- An Appeal must be submitted to CHP within 180 days of the date CHP provides notice of denial. The address is on your ID card. The Appeal may be submitted by you, or by a representative; designated by you.
- You may submit an oral grievance in connection with:
- A denial of; or failure to pay for; a referral; or
- A determination as to whether a benefit is covered under this Plan; by calling Customer Services. The Customer Services telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

CHP will summarize the nature of the grievance in writing. You will be required to sign a written acknowledgement of the grievance. Such acknowledgement will be mailed promptly to you. You must sign and return the acknowledgement; with any amendments; in order to initiate the grievance. Upon receipt of the signed acknowledgement, the process below will be followed.

- An acknowledgment letter will be sent to you within one (1) day of CHP receipt of an oral Appeal, and within five (5) days of CHP receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to CHP within 15 days of the date of the letter.
- You will be sent a response within 30 days of CHP receipt of the Appeal. The response will be based on the information provided with; or subsequent to; the Appeal.
- If the Appeal concerns an eligibility issue; and if additional information is not submitted to CHP after receipt of CHP's response; the decision is considered CHP's final response 45 days after receipt of the Appeal. For all other Appeals; if additional information is to be submitted to CHP after receipt of CHP's response; it must be submitted within 15 days of the date of CHP's response letter.
- CHP's response will be sent within 30 days from the date of CHP's first response letter.

In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Customer Services. The Customer Services telephone number is on your ID card. A verbal response to the Appeal will be given to you and to your provider within two (2) days provided that all necessary information is available. Written notice of the decision will be sent within two (2) business days of CHP's verbal response.

Second Level Appeals Procedure

If you are dissatisfied with CHP's grievance determination; you or a representative designated by you, may submit a written appeal within 60 business days after receipt of such determination.

- An acknowledgement letter will be sent to you within 15 days of CHP's receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to CHP within 15 days of the date of the letter.
- CHP's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of CHP's receipt of all necessary information.

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, CHP will provide a written notification; indicating that additional time is needed; explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However; you are not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and CHP have agreed that the matter may proceed directly to an External Appeal.

CHP will keep the records of your complaint for three (3) years.

EXTERNAL APPEAL

Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically; if CHP has denied coverage on the basis that the service is not necessary; or is an experimental or investigational treatment; you may appeal that decision to an External Appeal Agent, an independent entity certified by the State, to conduct such appeals.

Right to Appeal a Determination That a Service is Not Necessary

If CHP has denied coverage on the basis that the service is not necessary, you may appeal to an External Appeal Agent, if you satisfy the criteria listed below:

- The service, procedure, or treatment, must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the internal review process and CHP must have upheld the denial or you and CHP must agree in writing to waive any internal appeal.

Right to Appeal a Determination That a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this Plan; and
- You must have received a final adverse determination through the first level of the internal appeal process; and
- CHP must have upheld the denial, or you and CHP must agree in writing to waive any internal appeal.

In addition, your attending Doctor must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of the attending Doctor, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a Dependent child under the age of 18, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending Doctor must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective, or medically inappropriate; or one for which there does not exist a more beneficial standard service or procedure covered under this Plan; or one for which there exists a clinical trial (as defined by law).

In addition; your attending Doctor must have recommended at least one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation - your attending Doctor should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending Doctor must be a licensed, board certified, or board eligible Doctor, qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If through CHP’s internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary, or is an experimental or investigational treatment; you have 45 days from receipt of such notice to file a written request for an external appeal. If you and CHP have agreed to waive any internal appeal, you have 45 days from the receipt of such waiver to file a written request for an external appeal. CHP will provide an external appeal application with the final adverse determination issued through CHP’s internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Insurance at **800-400-8882**. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which CHP based its denial, the External Appeal Agent will share this information with CHP in order for it to exercise its right to reconsider its decision. If CHP chooses to exercise this right, CHP will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), CHP does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from you, your Doctor or CHP. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within 2 business days.

If your attending Doctor certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and CHP by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns CHP’s decision that a service is not necessary, or approves coverage of an experimental or investigational treatment, CHP will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, CHP will only cover the costs of services required to provide treatment to you according to the design of the trial. CHP shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both you and CHP. The External Appeal Agent’s decision is admissible in any court proceeding.

You will be charged a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. CHP will also waive the fee if CHP determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage; the fee shall be refunded to you.

Responsibilities

It is your responsibility to initiate the external appeals process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your attending Doctor may file an expedited appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from CHP that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal appeal. CHP has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this Plan does not cover experimental or investigational treatments. However, this Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial; CHP will only cover the costs of services required to provide treatment to you; according to the design of the trial. CHP shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

PRESCRIPTION DRUG CLAIM PROCEDURE

Preferred Care: When obtaining a covered prescription, please present your CHP ID card to a Preferred Pharmacy along with your applicable co-pay. The Pharmacy will submit a claim to Express Scripts for the drug. For your convenience, SHC has a full service preferred Pharmacy on-site.

When you need to fill a prescription and do not have your ID card with you, you may obtain your prescription from a Preferred Pharmacy and be reimbursed by submitting a completed Prescription Drug claim form. A claim form is available at SHC Student Health Insurance Services or by calling (877) 373-1170. You will be reimbursed for covered medications directly by CHP. Please note, in addition to your Co-pay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount CHP would have paid if you had presented your ID card and the Pharmacy had billed CHP directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at www.chpstudent.com/nyu.

Non-Preferred Care: You may obtain your prescription from a non-preferred Pharmacy and be reimbursed by submitting a completed Prescription Drug claim form. You will be reimbursed for covered medications directly by CHP, less any coinsurance or co-pay. You will be responsible for any amount in excess of the Reasonable Charge.

Please note: You will be required to pay in full at the time of service for all prescriptions dispensed at a non-preferred Pharmacy.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting CHP at (877) 373-1170.

When submitting a claim, please include all prescription receipts; indicate that you attend NYU and include your name, address, and student identification number.

Medications Not Covered by Express Scripts

Medications not covered by this benefit include, but are not limited to:

- over-the-counter medications (does not include diabetic supplies)
- drugs whose sole purpose is to promote or stimulate hair growth
- drugs for cosmetic purposes
- smoking cessation medications
- appetite suppressants
- fertility medications
- preventative medicines or vaccines, except when Medically Necessary (i.e., rabies, Hepatitis B immunoglobulin)
- non-self injectables (covered by the medical portion of the plan)

Prior authorization is required for growth hormones and drugs for treatment of malaria. For assistance, or a complete list of excluded medications and drugs available with prior authorization, please contact CHP at (877) 373-1170.

Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive are provided under the medical portion of the plan (see page 10).

If Your Claim is Denied/How to Appeal a Claim

(See FILING CLAIMS section on pages 23-26)

Subrogation/Reimbursement Right to Recovery Provision

Please refer to the 2009-2010 Master Policy for information regarding Subrogation/Reimbursement and Right to Recovery.

GLOSSARY

Accident means an event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

Actual Charge

The charge made for a covered service by the provider who furnishes it.

Biologically Based Mental Health Conditions

A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such Biologically Based Mental Health Conditions are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorders, obsessive-compulsive disorders, bulimia, and anorexia.

Complications of Pregnancy

Conditions that require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy.

These conditions are:

- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these

Not included are:

- a) false labor, occasional spotting, or Doctor prescribed rest during the period of pregnancy;
- b) morning Sickness;
- c) hyperemesis gravidarum and preeclampsia; and
- d) similar conditions not medically distinct from a difficult pregnancy

Complications of pregnancy also include:

- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible (This does not include voluntary abortion).

Co-pay

The amount that must be paid by the Covered Person at the time services are rendered by an In-Network Provider (Co-pay amounts are the responsibility of the Covered Person).

Coinsurance

The percentage of Covered Medical Expenses payable by CHP under this Accident and Sickness plan.

Covered Dependent

A Covered Student's Dependent who is insured under this Program.

Covered Medical Expense

Those charges for any treatment, service, or supplies covered by this Program that are:

- not in excess of the Reasonable Charges; or
- not in excess of the charges that would have been made in the absence of this coverage; and
- incurred while the Program is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered Person

A Covered Student and any Covered Dependent while coverage under the Program is in effect.

Covered Student

A student of New York University who is insured under this Program.

Deductible

The specific amount of Covered Medical Expenses that must be incurred by, and paid for by, the Covered Person before benefits are payable under the Program (Deductible amounts are the responsibility of the Covered Person).

Dependent

a) the Covered Student's spouse residing with the Covered Student; or b) the person identified as a domestic partner in the "Declaration of Domestic Partnership," which is completed and signed by the Covered Student; and c) the Covered Student's unmarried child under the age of 19 years (or 25 if a student).

The child must reside with, and be fully supported by, the Covered Student.

The term "Child" includes a Covered Student's step-child, adopted Child, and a Child for whom a petition for adoption is pending and who is residing with the Covered Student and who is chiefly Dependent on the Covered Student for his or her full support.

The term "Dependent" does not include a person who is a) an eligible student or b) a member of the armed forces.

Designated Care

Care provided by a Designated Care Provider upon referral from SHC.

Designated Care Provider

A health care provider who is affiliated and has an agreement with SHC to furnish services and supplies at a Negotiated Charge.

Doctor

A legally qualified Doctor licensed by the state in which he or she practices, and any other practitioner that must by law be recognized as a Doctor legally qualified to render treatment.

Domestic Partner

A person with whom you have established a domestic partnership. A domestic partnership will be established when all of the following requirements are met:

- Registration as a domestic partnership or, in the case of retirees living outside of New York City, an alternative affidavit of domestic partnership;
- Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
- Evidence of two or more of the following:
 - A joint bank account
 - A joint credit card
 - Joint obligation on a loan
 - Status as an authorized signatory on the partner's bank account, credit card or charge card
 - Joint ownership of holdings or investments
 - Joint ownership of residence
 - Joint ownership of real estate other than residence
 - Listing of both partners as tenants on the lease of the shared residence
 - Shared rental payments of residence (need not be shared 50/50)
 - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
 - A common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
 - Shared household budget for purposes of receiving government benefits
 - Status of one as representative payee for the other's government benefits
 - Joint ownership of major items of personal property (e.g. appliances, furniture)
 - Joint ownership of a motor vehicle
 - Joint responsibility for child care (e.g. school documents, guardianship)
 - Shared child-care expenses, e.g. baby sitting, day care, school bills (need not be shared 50/50)
 - Execution of wills naming each other as executor and/or beneficiary
 - Designation as beneficiary under the other's life insurance policy
 - Designation as beneficiary under the other's retirement benefits account
 - Mutual grant of durable power of attorney
 - Mutual grant of authority to make health care decisions (e.g. health care power of attorney) affidavit by creditor of other individual able to testify to partner's financial interdependence
 - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Emergency Medical Condition

A medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate, medical attention to result in: a) placing the health of the person afflicted with such condition in severe jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy, b) serious impairment to such person's bodily functions; c) serious dysfunction of any bodily organ or part of such person; or d) serious disfigurement of such person.

Hospital

A facility that meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people;
- it provides room and board services and nursing services 24 hours a day;
- it has established facilities for diagnosis and major surgery;
- it is run as a Hospital under the laws of the jurisdiction in which it is located

Hospital does not include a place run mainly: a) for alcoholics or drug addicts; b) as a convalescent home; or c) as a nursing or rest home. The term "Hospital" includes a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person.

Hospital Confinement

A documented inpatient stay in a Hospital as a resident bed patient.

Injury

Bodily Injury caused by an Accident. (This includes related conditions and recurrent symptoms of such Injury.)

In-Network Care

Care provided by:

- an In-Network Provider following the referral by SHC; or
- an Out-of-Network Provider on the referral of SHC and if approved by CHP; or
- any health care provider for an emergency condition when travel to an In-Network Provider or referral by SHC prior to treatment is not feasible.

In-Network Care Provider (or In-Network Provider)

A health care provider who has contracted with MultiPlan to furnish services or supplies for a Negotiated Charge but only if the provider is, with CHPs consent, listed as an In-Network Provider for:

- the service or supply involved; and
- the class of Covered Persons of which you are member.

Late Enrollee

Any Student or Dependent that enrolls after the open enrollment period.

Lifetime Aggregate Maximum

The maximum benefit that will be paid under this Program for all Covered Medical Expenses incurred by a Covered Person that accumulate from one (1) Program year to the next.

Medically Necessary

A service or supply that is: necessary, and appropriate, for the diagnosis or treatment of a Sickness, or Injury, based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; CHP will take into consideration:

- information relating to the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to CHP's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- those furnished mainly for: the personal comfort, or convenience of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a Doctor's or a Dentist's office, or other less costly setting.

Negotiated Charge

The maximum charge an In-Network Provider, or a Designated Care Provider, has agreed to make as to any service or supply for the purpose of benefits under this Program.

Non-Biologically Based Mental Health Conditions

Any mental health condition other than schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorders, obsessive compulsive disorders, bulimia, and anorexia.

Non-Preferred Pharmacy

A pharmacy not party to a contract with CHP, or a pharmacy that is party to such a contract but which does not dispense prescription drugs in accordance with its terms.

Out-of-Network Care

A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not an In-Network Provider; if, as determined by CHP:

- the service or supply could have been provided by an In-Network Provider; and
- the provider is of a type that falls into one or more of the categories of providers; or
- a Designated Care Provider.

Out-of-Network Care Provider

An Out-of-Network Care Provider is:

- a health care provider that has not contracted to furnish services or supplies at a Negotiated Charge; or
- an In-Network Provider that is furnishing services or supplies without the referral of SHC; or
- a health care provider that is not a Designated Care Provider.

Out-of-Pocket Maximum Expenses

The maximum dollar amount an insured is required to pay out during a policy year subject to the limitations listed below:

Once an insured individual has reached the applicable Out-of-Pocket Maximum (as stated above) within a Policy Year for Covered Medical Expenses (not including prescription drugs), the Plan will pay 100% up to the overall Plan Maximum.

Any applicable In-Network Co-pays, Out-of-Network Deductibles, or expenses in excess of the Reasonable Charge do not apply towards meeting the Out-of-Pocket Maximum. Charges in excess of any specified maximum, and non-covered services are not applied toward meeting the Out-of-Pocket Maximum and are the responsibility of the insured.

Pre-Existing Condition

Any Injury, Sickness, or condition for which medical advice, diagnosis or treatment was recommended or received within 6 months prior to the Covered Person's effective date of insurance.

Preferred Pharmacy

A pharmacy which is party to a contract with Express Scripts to dispense drugs to persons covered under the program, but only while the contract remains in effect; and when the pharmacy dispenses a prescription drug under the terms of its contract with CHP and Express Scripts.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The Reasonable Charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge CHP determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge CHP determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, CHP may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that CHP will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area.

CHP may take into account factors, such as:

- the complexity
- the degree of skill needed
- the type of specialty of the provider
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas

Sickness

Disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy. All injuries or Sickness due to the same or a related cause are considered one Injury or Sickness.

Sound, Natural Teeth

Natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective.

GENERAL INFORMATION

New York State mandates that the following information be provided to all insured's:

Provider Reimbursement

Participating providers are reimbursed on a discounted fee-for-service basis. Where the student is responsible for a coinsurance payment based on a percentage of the bill, the Covered Person's obligation is to be determined on the basis of the charges established by contract, if any, rather than on the basis of the provider's billed charges.

Non-Participating providers, providing covered services, are compensated on a fee-for-service basis.

Express Scripts negotiates discounts from independent pharmacies and chain pharmacies that participate in the Express Scripts network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. The dispensing fee is a contractual fee negotiated between Express Scripts and the network pharmacy. With Internet access, you can conduct an on-line search for participating pharmacies through Express Scripts, which is available at www.expressscripts.com. A paper directory is also available to Covered Students.

Any charge for a service or supply furnished by a Participating provider in excess of such provider's Negotiated Charge for that service or supply will not be a covered expense under the contract. It will be the responsibility of CHP and the Participating provider to resolve the amount deemed to be excess.

Confidentiality

CHP protects the privacy of confidential Covered Person medical information. We require that participating providers keep student information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical records from Participating providers, at any time.

CHP (including its affiliates and authorized agents, collectively "CHP") and Participating providers require access to Covered Person medical information for a number of important and appropriate purposes, including claims payment, fraud prevention, coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, and early detection and disease management programs. Accordingly, for these purposes, Covered Persons authorize the sharing of student medical information about themselves and their Dependents between CHP and participating providers and health delivery systems.

Notice to Enrollees

While the paper provider directory (available upon request) is believed to be accurate as of the print date, it is subject to change without notice. Participating providers are independent contractors in private practice and are neither employees nor agents of CHP or NYU. The availability of any particular provider cannot be guaranteed for referred or In-Network benefits, and provider network composition is subject to change without notice. Certain primary care Doctors may be affiliated with an Independent Practice Association (IPA), a Physician Medical Group (PMG), an integrated delivery system or one of other provider groups.

Not every provider listed in the directory will be accepting new patients. Although CHP has identified providers who were accepting patients as known to CHP at the time this provider directory was created, the status of a provider's practice may have changed.

For the most current information, please contact the selected Doctor or Customer Service at (877) 373-1170.

In the event of a problem with coverage, Covered Persons should contact Customer Service at the toll-free number on their ID cards for information on how to utilize the complaint and appeal procedure when appropriate.

All Covered Person care and related decisions are the sole responsibility of participating providers. CHP does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Notice of Information Disclosure

CHP considers nonpublic personal member information ("NPI") confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use NPI internally, share it with our affiliates, and disclose it to health care providers (Doctors, Dentists, pharmacies, Hospitals and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep NPI confidential as provided by applicable law. In-Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the plan, you permit us to use and disclose this information as described above on behalf of yourself and your Dependents. To obtain a copy of our notice describing in greater detail our practices concerning use and disclosure of NPI, please call the toll-free Customer Service number on your ID card or visit CHP Student Health at www.chpstudent.com/nyu.

Health Plan Rates

Pricing for Students

NYU-Sponsored Student Health Insurance Plans*		
Coverage Period	Basic Plan	Comprehensive Plan
Annual 8/21/09 - 8/20/10	\$1,261	\$1,963
Fall Term 8/21/09 - 1/8/10	\$487	\$758
Spring/Summer Terms 1/9/10 - 8/20/10	\$774	\$1,205
Summer Term 5/14/10 - 8/20/10	\$341	\$530

Rates for Dependent Coverage*				
Coverage Period		Basic	Comprehensive	GSHIP
Spouse/Domestic Partner				
Annual	8/21/09 - 8/20/10	\$4,519	\$5,868	\$5,868
Fall Term	8/21/09 - 1/8/10	\$1,744	\$2,265	\$2,265
Spring/Summer Terms	1/9/10 - 8/20/10	\$2,775	\$3,603	\$3,603
Summer Term	5/14/10 - 8/20/10	\$1,220	\$1,584	\$1,584
Child/Children				
Annual	8/21/09 - 8/20/10	\$2,211	\$2,607	\$2,607
Fall Term	8/21/09 - 1/8/10	\$853	\$1,006	\$1,006
Spring/Summer Terms	1/9/10 - 8/20/10	\$1,358	\$1,601	\$1,601
Summer Term	5/14/10 - 8/20/10	\$597	\$704	\$704

*The rates include both premium for the student health plan administered by CHP as well as a New York University administrative fee.

Continuation Option pricing can be found at: www.nyu.edu/health/insurance

Stu-Dent Plan Dental Services	
\$225	Initial Student Enrollment
\$225	Initial Spouse/Partner Enrollment
\$185	Student/Spouse/Partner Renewal
\$80	Dependent

Quick Reference Guide

CONSOLIDATED HEALTH PLANS CONTACT INFORMATION

Consolidated Health Plans Customer Service Student health insurance claims, enrollment, and information about benefits	2077 Roosevelt Avenue Springfield, MA 01104 877-373-1170 Fax: 413-214-6482 www.chpstudent.com/nyu
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Express Scripts Pharmacy Network	1-800-633-7867
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Medex Travel Assistance	1-877-527-0218 Outside U.S.: 410-453-6330
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NEW YORK UNIVERSITY CONTACT INFORMATION

NYU STUDENT HEALTH CENTER (SHC)	726 Broadway, 3rd and 4th Floors New York, NY 10003-9580 www.nyu.edu/health
	General Info/Appointments 212-443-1000 Student Health Insurance 212-443-1020 Patient Accounts 212-443-1010 Pharmacy Services 212-443-1050 Wellness Exchange 212-443-9999

COUNSELING & BEHAVIORAL HEALTH SERVICES AT SHC <i>Appointments or information about services</i>	726 Broadway, 4th Floor New York, NY 10003-9580 212-998-4780 www.nyu.edu/counseling
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DENTAL FACULTY PRACTICE <i>Stu-Dent Plan/Urgent Dental Service</i>	726 Broadway, Suite 350 New York, NY 10003-6947 212-443-1313 www.nyu.edu/dental/patientinfo
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OFFICE FOR INTERNATIONAL STUDENTS AND SCHOLARS <i>General information for international students and scholars</i>	561 La Guardia Place New York, NY 10012-1402 212-998-4720 www.nyu.edu/osl/oiss
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OFFICE OF PUBLIC SAFETY <i>Emergencies/General Information</i>	14 Washington Place, 1st Floor New York, NY 10012-1402 212-998-2222 www.nyu.edu/public.safety
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HENRY & LUCY MOSES CENTER FOR STUDENTS WITH DISABILITIES	719 Broadway, 2nd Floor New York, NY 10003-6947 Phone and TTY: (212) 998-4980 www.nyu.edu/csd
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