BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Lifetime Aggregate Maximum	
$100,000 per condition CHANGE	**$250,000 per condition** CHANGE This can be increased to $500,000 through enrollment in the Catastrophic Option.
Out-of-Pocket Maximums	
Preferred Care - $5,000 per policy year **Non-Preferred Care** - $10,000 per policy year	**Preferred Care** - $3,000 per policy year **Non-Preferred Care** - $6,000 per policy year

INPATIENT BENEFITS

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Room and Board	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan
Other Hospital Services	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan
Pre-Admission Testing	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan
Inpatient Non-Surgical Physician Visits	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan

SURGICAL BENEFITS Outpatient & Inpatient

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Surgeon's Fees	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan
Anesthesia Fees	
Preferred Care - **80%** of the **negotiated charge** up to the Out-of-Pocket Maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the Out-of-Pocket Maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan

OUTPATIENT BENEFITS

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Per Condition Combined Maximum	
$10,000 per policy year CHANGE	**$30,000 per policy year**
Physician Visits	
CHANGE *Primary Care office visits at SHC are covered 100% by the health service fee paid by all matriculated students.*	
At SHC: Specialists and Physical/Occupational Therapy 100% after $10 copay. CHANGE **Outside SHC:** **Preferred Care** - **80%** of the **negotiated charge**; $20 per visit **copay** **Non-Preferred Care** - **50%** of **reasonable charges**; $40 per visit **deductible**	**At SHC:** **Comp Plan:** Same as Basic Plan CHANGE **GSHIP:** Covered 100% **Outside SHC:** **Preferred Care** - **80%** of the **negotiated charge**; $15 per visit **copay** **Non-Preferred Care** - **50%** of **reasonable charges**; $30 per visit **deductible**
Hospital Outpatient	
Preferred Care - **80%** of the **negotiated charge**; $40 per visit **copay**	**Preferred Care** - **80%** of the **negotiated charge**; $35 per visit **copay**
Non-Preferred Care - **50%** of **reasonable charges**; $60 per visit **deductible**	**Non-Preferred Care** - **50%** of **reasonable charges**; $50 per visit **deductible**
Hospital Emergency Room	
Preferred Care - **80%** of the **negotiated charge**; $50 per visit **copay**	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **80%** of **reasonable charges**; $50 per visit **deductible**	**Non-Preferred Care** - Same as Basic Plan
Lab and X-ray	
CHANGE *Some commonly performed lab tests and X-rays at SHC will be covered 100% by the health service fee paid by all matriculated students.*	
Lab tests and X-rays not covered by Health Service Fee*: **Preferred Care** - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter **Non-Preferred Care** - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter	**Lab tests and X-rays not covered by Health Service Fee*:** **Comp Plan:** Same as Basic Plan **GSHIP:** *Lab:* Same as Basic Plan *X-Rays:* **At SHC** - Covered 100% **Outside SHC** - Same as Basic Plan

* *Includes Pap smear screening.*

WOMEN'S HEALTH BENEFITS

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Well Woman Care	
CHANGE *Women's Health office visits at SHC are covered 100% by the health service fee paid by all matriculated students (see page 14 for coverage of pap smear screening).*	
Routine Gynecologic Exam Outside SHC, covered as any other outpatient non-SHC physician visit	Same as Basic Plan

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP

WOMEN'S HEALTH BENEFITS (continued)

Well Woman Care

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Pap Smear Screening	
Covered medical expenses include coverage for two pap smear screenings per policy year for women age 18 and older, payable on the same basis as any other outpatient laboratory expense outside SHC. Coverage is provided more frequently upon a **physician's** recommendation.	Same as Basic Plan
Mammography	
Preferred Care - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan
Payable as any other outpatient x-ray expense. The plan will cover one baseline mammogram for women between the ages of 35 and 40. Women age 40 and over have coverage for one mammogram per policy year thereafter. Coverage is provided more frequently upon a **physician's** recommendation.	

Maternity

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
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 home health care visit as **medically necessary**; this visit will be payable at 100% and will not be subject to any plan **copays** 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.	Same as Basic Plan

Contraceptives

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Oral Contraceptive Pills	
Covered as a pharmacy benefit (see page 16). 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 16).	Same as Basic Plan

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP

WOMEN'S HEALTH BENEFITS (continued)

Contraceptives *(continued)*

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Prescription Contraceptive Services (other than oral contraceptives)	
100% coverage for services 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 portion of the plan (see page 16). 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 13).	
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

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Covered medical expenses are payable as any other condition.	Same as Basic Plan

MENTAL HEALTH BENEFITS

Inpatient Mental Health

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Preferred Care - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter up to $10,000	**Preferred Care** - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter up to $250,000
Non-Preferred Care - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter up to $10,000	**Non-Preferred Care** - **50%** of **R&C charges** up to the out-of-pocket maximum, 100% thereafter up to $250,000

Inpatient Chemical Abuse and Dependence

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Preferred Care - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter up to $10,000	Same as Basic Plan
Non-Preferred Care - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter up to $10,000	

Partial Hospitalization

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
In exchange for full hospitalization	Same as Basic Plan

Outpatient Chemical Abuse and Dependence

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Preferred Care - **100%** of the **negotiated charge***	Same as Basic Plan
Non-Preferred Care - **100%** of **reasonable charges***	

**Limit - 60 visits per policy year for outpatient treatment; and 20 of these outpatient visits must be available per policy year for counseling.*

Outpatient Mental Health

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Up to **$35** per visit up to a maximum of 20 visits per policy year (in addition to the 10 visits included in the Mandatory Plan, for a total of 30 visits).	Same as Basic Plan

See page 44 for Counseling & Behavioral Health Services at SHC.

ADDITIONAL BENEFITS

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Ambulance	
100% coverage up to **$150** per transport to or from hospital	**100%** coverage up to **$250** per transport to or from hospital
Prostate Cancer Screening	
Covered medical expenses include one annual (or more frequently if recommended by a physician) digital rectal exam and Prostate Antigen Specific (PSA) test. **Covered medical expenses** are payable on the same basis as any medical expense.	Same as Basic Plan
Home Health Care	
80% to maximum of **$75** per visit per policy year; 40 visits per policy year	Same as Basic Plan
Orthopedic/Prosthetic Appliances/Braces	
80% of **reasonable charges** not to exceed **$500** per policy year	Same as Basic Plan
Durable Medical Equipment	
80% of allowable charges not to exceed **$500** per policy year	**At SHC:** **Comp Plan:** Same as Basic Plan **GSHIP:** Covered 100%, not to exceed $500 per policy year **Outside SHC:** Same as Basic Plan
Prescription Drug [Aetna Pharmacy Management]	
Limit: **$1,000** per policy year maximum	Limit: **$1,500** per policy year maximum CHANGE
Preferred Pharmacy: 100% after a... - **$15** copay for generic drugs - **$35** copay for Aetna preferred brand name drugs ($20 for diabetic supplies*). - **$45** copay for Aetna non-preferred brand name drugs ($20 for diabetic supplies*). CHANGE	**Preferred Pharmacy:** 100% after a... - **$15** copay for generic drugs - **$35** copay for Aetna preferred brand name drugs ($15 for diabetic supplies*). - **$45** copay for Aetna non-preferred brand name drugs ($15 for diabetic supplies*).
Non-Preferred Pharmacy: 70% after a... - **$15** copay for generic drugs - **$35** copay for Aetna preferred brand name drugs. - **$45** copay for Aetna non-preferred brand name drugs ($40 for diabetic supplies*). CHANGE	**Non-Preferred Pharmacy:** 70% after a... - **$15** copay for generic drugs - **$35** copay for Aetna preferred brand name drugs ($30 for diabetic supplies*). - **$45** copay for Aetna non-preferred brand name drugs ($30 for diabetic supplies*).

Benefits are not payable for more than a 30-day supply per prescription or refill without prior authorization.

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

Diabetic Treatment Expense

Covered medical expenses including, but not limited to, Equipment and Self-Management Education are payable as follows:

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Preferred Care: 80% of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter	**Preferred Care** - Same as Basic Plan
Non-Preferred Care: 50% of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter	**Non-Preferred Care** - Same as Basic Plan

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

ADDITIONAL BENEFITS (continued)

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
Traveler's Assistance Program	
Travel assistance services, medical evacuation and return of mortal remains services up to policy limit Accidental death and dismemberment: $10,000	Same as Basic Plan
Vision Services	
Ophthalmology Office Visits: 100% after $10 copay when medically necessary (i.e. conjunctivitis, corneal abrasions, etc.) **At SHC:** 100% after $10 copay **Outside SHC:** See Page 13 "Physicians Visits Outside SHC"	**Ophthalmology Office Visits** **At SHC:** **Comp Plan:** 100% after $10 copay **GSHIP:** Covered 100% **Outside SHC:** See Page 13 "Physicians Visits Outside SHC"
Annual Preventive Eye Examination **At SHC: 100%** after **$10** copay **Outside SHC:** No Benefit	**Annual Preventive Eye Examination** **At SHC:** **Comp Plan:** 100% after $10 copay **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.

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
End of Life Care	
Covered **medical expenses** include care provided at acute care facilities which specialize 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
Radiation Therapy, Chemotherapy, Dialysis Treatment and Intravenous Home Therapy	
Preferred Care - **80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter **Non-Preferred Care** - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter. Covered medical expenses do not count towards meeting the per condition outpatient maximum.	Same as Basic Plan