

Student Health Insurance HANDBOOK

2006-2007



Student Health Insurance Services
726 Broadway, Suite 346
New York, NY 10003
(212) 443-1020 • www.nyu.edu/health/insurance
health.insurance@nyu.edu

Basic Plan
Comprehensive Plan
GSHIP



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 including hospital transport, counseling, follow-up and coordination of care.

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 copays, 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 a preferred provider in the Aetna 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, 8am - 8pm and Friday 8am - 6pm:** Students should go to the Dental Faculty Practice, 418 Lafayette Street, Suite 350, (212) 443-1313.
- **Saturdays and Sundays, 9am - 5pm:** 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 with Chickering's Aetna Navigator™

As a Chickering student health insurance member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:

- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Request that EOB statements do not get mailed to your permanent address.
- Send an e-mail to Chickering Customer Service at your convenience.

How do I register?

- Go to www.aetnavigators.com
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

Need help registering onto Aetna Navigator?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800-225-3375.

INSURANCE COMPANY

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

GROUP POLICY NUMBER

711103

PLAN ADMINISTRATOR

The Chickering Group is an internal business unit of Aetna Life Insurance Company
Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
800-466-4148
617-218-8400 (when outside the United States)
www.chickering.com

NYU Student Health Center

726 Broadway, 3rd & 4th Floors
New York, NY 10003-9580
212-443-1000
www.nyu.edu/health

Hours of Operation*

Year-Round

Monday & Tuesday • 8am - 8pm
Wednesday & Thursday • 8am - 6pm
Friday - Saturday • 10am - 6pm
Sunday • Closed

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

Table of Contents

NYU-SPONSORED STUDENT HEALTH INSURANCE PROGRAM

Periods of Coverage	5
Mandatory Emergency Plan	5-6
• Eligibility	5
• Benefit Description	5
• Referral Requirement.....	6
• Dental Injuries.....	6
Optional Student Health Insurance Plans	7-9
• Eligibility/Enrollment of Students	7
• Special Eligibility/Enrollment	7
• Leave of Absence.....	7
• Extending Periods of Coverage.....	7
• Insurance for Dependents	8
• Enrollment	8
• Periods of Coverage.....	8
• Newborn Infant Coverage	8
• Newly Adopted Children	9
• Petition to Change Insurance	9
• Adding Insurance.....	9
• Late Waivers	9
Catastrophic Student Health Insurance Plan	10
• Eligibility	10
• Period of Coverage	10
• Maximum Injury and Sickness Benefit	10
Summary of Benefits	11-18
• Health-Related Services for Matriculated Students.....	12
• Summary of Benefits Chart.....	13-18
• Inpatient Benefits	13-14
• Surgical Benefits	13-14
• Outpatient Benefits	14
• Women's Health Benefits	14-16
• Mental Health Benefits.....	16
• Additional Benefits.....	17-18

Worldwide Travel Assistance Services	19-20
• Traveler's Assistance Program.....	19
• Medical Evacuation and Repatriation Benefit.....	20
• Accidental Death and Dismemberment Benefit	20
General Terms and Conditions	20-23
• Coordination of Benefits.....	20
• Benefit Period	20
• Extension of Benefits.....	21
• Termination of Coverage	21
• Inpatient Hospital Admission	21-22
• Pre-Existing Conditions.....	22-23
• Preferred/Designated Provider Network.....	23
Referral Requirements	23-25
• Medical Services Inside Manhattan	23
• Initial New York University Health Center Referral.....	23
• Referral Limitations.....	23
• Summer Referrals	23
• Follow-up After Medical Emergency	24
• Medical Services Outside Manhattan	24
• Mental Health and Chemical Abuse and Dependence Services.....	24
• Frequently Asked Questions.....	24-25
Other Aetna Programs	25
Exclusions	26-28
Filing Claims	29-35
• Follow These Steps to File a Claim.....	29
• If Your Claim is Denied.....	30
• How to Appeal a Claim	30-35
Prescription Drug Claim Procedure	35-36
• Medications Not Covered by NYU-Sponsored Student Health Insurance Plans	36
• If Your Claim is Denied/How to Appeal a Claim.....	36
Glossary	37-42
<i>Provides definitions of all coverage-related terms in bold print throughout this brochure</i>	
General Information	43-45
Pricing	46
• Optional NYU-Sponsored Student Health Insurance Plans	46
• Catastrophic Student Health Insurance Plan.....	46
• Continuation Option.....	46
Quick Reference Guide	47

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.

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 2006-2007	12:01 a.m., August 21, 2006	12:01 a.m., August 21, 2007
Fall 2006	12:01 a.m., August 21, 2006	12:01 a.m., January 9, 2007
Spring/Summer 2007	12:01 a.m., January 9, 2007	12:01 a.m., August 21, 2007
Summer 2007	12:01 a.m., May 14, 2007	12:01 a.m., August 21, 2007

Mandatory Plan

Eligibility - All students enrolled in a degree-granting, advanced certificate, or postgraduate certificate program 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, same sex 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:

- Preferred Care:** 100% of the negotiated charge
Non-Preferred Care: 100% of the reasonable charge

If an emergency results in an inpatient admission, notification to Chickering Claims Administrators, Inc. is required (see pages 21-22 for additional information).

Outpatient Mental Health Benefit

This plan covers up to 10 mental health outpatient visits per year at a maximum of \$35 per visit.

Referral Requirement for Follow-up Care after Emergency Room Treatment

After the covered person has received initial treatment for emergency injuries, mental health emergencies and chemical abuse emergencies, 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 page 23-25 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 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 details about the referral process, see page 23-25.)

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 F-1 or J-1 visas. Students are enrolled in the optional student health insurance plans according to the automatic enrollment, selection and waiver processes described in the *2006-2007 Guide to Student Health Insurance at New York University*, distributed earlier to all eligible students, and available at www.nyu.edu/health/insurance.

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.

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. Spring insurance applicants must have been enrolled in the plan for the immediately preceding fall semester to be eligible. The Leave of Absence Enrollment Form can be downloaded from www.nyu.edu/health/insurance or requested from the SHC Student Health Insurance Services Office (212-443-1020) or Chickering Claims Administrators, Inc. (800-466-4148). *Forms received after the semester deadline (Fall-Sept. 30th or Spring-Feb. 10th) will not be accepted.*

The enrollment form, together with payment must be submitted directly to Chickering Benefit Planning Insurance Agency, Inc., P.O. Box 15706, Boston, MA 02215-0014. Payment must be made by check, money order, or credit card (MasterCard or Visa only). *Checks or money orders should be made payable to Chickering Benefit Planning Insurance Agency, Inc.*

Extending Periods of Coverage

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.

The Continuation Option Enrollment Application can be completed online at NYU's Student Health Insurance website: www.nyu.edu/health/insurance or Chickering Claims Administrators' website: www.chickering.com. Method of payment must be submitted along with online application. The application must be received by August 20, 2006 if you are not returning for the fall semester, and January 8, 2007 if you are not returning for the spring semester.

You must have been covered under the Basic, Comprehensive or GSHIP Plans for at least 30 days in order to enroll in the Continuation Option.

Insurance for Dependents

Enrollment

For an additional premium, **covered students** may also enroll their eligible **dependents** (see glossary on page 38 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 NYU's Student Health Insurance website: www.nyu.edu/health/insurance or Chickering Claims Administrators' website: www.chickering.com.

Periods of Coverage

When enrolling a dependent, the effective date of coverage is the date of the covered student's enrollment or the date of the dependent's enrollment, 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 Chickering Benefit Planning Insurance Agency, Inc. 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.

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 Chickering Claims Administrators, Inc.

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 22-23.)

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, The Chickering Group, 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.

Catastrophic Option

Eligibility

At the time of fall enrollment, any student and his or her **dependents** already enrolled in the Comprehensive Plan of the NYU-sponsored Student Health Insurance Program are eligible to add the Catastrophic Option. At the time of spring enrollment, coverage under the Catastrophic Option is available only to eligible new enrollees. Catastrophic Option enrollment is available online at www.chickering.com. Please call The Chickering Group at 800-466-4148 if you need assistance.

Period of Coverage

Coverage under the Catastrophic Option becomes effective in accordance with the following:

- (a) If the eligible student's Catastrophic Option Enrollment Form and premium are received by Chickering Claims Administrators, Inc. on or before August 21, 2006 for annual coverage, coverage becomes effective on August 21, 2006. If the eligible student's Catastrophic Option Enrollment Form and premium are received on or before January 9, 2007, for spring coverage, coverage becomes effective on January 9, 2007.
- (b) If the eligible student's Catastrophic Option Enrollment Form and premium are received after August 21, 2006, for annual coverage, or after January 9, 2007, for spring coverage, coverage becomes effective on the postmarked date of the Catastrophic Option Enrollment Form, but will not be accepted after the appropriate deadline (Fall - Sept. 30; Spring - Feb 10). Note: the period of coverage for this plan may differ from that of the Comprehensive Plan.

Lifetime Aggregate Maximum

Limit:	Covered students:	\$500,000 lifetime maximum aggregate
	Covered dependents:	\$250,000 lifetime maximum aggregate
Deductible:	\$150,000 per condition (see below)	

When the **covered person** incurs **covered medical expenses** as the result of an **injury** or **sickness**, this plan will pay 100% of the covered charges of a **preferred care, designated care, or non-preferred care** provider to a combined maximum benefit of \$500,000 for each covered student and \$250,000 for each covered dependent subject to a \$150,000 deductible (satisfied by the Comprehensive Plan).

The maximum benefit is payable for those **covered medical expenses** incurred within the period of coverage. This plan is subject to the definitions, inpatient admission pre-certification requirement, **Preferred Provider Network**, referral requirements, general terms and conditions, and exclusions applicable to the Student Health Insurance Program.

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 Chickering Claims Administrators, Inc. at 800-466-4148 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 Chickering Claims Administrators, Inc. 800-466-4148.

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.

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 health care facility conveniently located on the Washington Square Campus. Through close collaboration, our multidisciplinary staff of board-certified physicians and highly trained clinicians provides 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 and radiology services
 - 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.*

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:

Weekdays from 8 am to 8 pm:

Students should go to the Dental Faculty Practice, 418 Lafayette Street, Suite 350, (212) 443-1313.

Saturdays and Sundays from 9 am to 5 pm:

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.

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	Preferred Care - \$3,000 per policy year
Non-Preferred Care - \$10,000 per policy year	Non-Preferred Care - \$6,000 per policy year

INPATIENT BENEFITS

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

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

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
OUTPATIENT BENEFITS	
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 provided to all matriculated students at no charge. Some procedures performed during the visit may incur a fee.	
At SHC: Specialists and Physical/Occupational Therapy 100% after \$10 copay. CHANGE	At SHC: Comp Plan: Same as Basic Plan CHANGE GSHIP: Covered 100%
Outside SHC: Preferred Care - 80% of the negotiated charge; \$20 per visit copay	Outside SHC: Preferred Care - 80% of the negotiated charge; \$15 per visit copay
Non-Preferred Care - 50% of reasonable charges; \$40 per visit deductible	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 are provided to all matriculated students at no charge.	
Lab tests and X-rays not covered by Health Service Fee*:	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	Comp Plan: Same as Basic Plan GSHIP: Lab: Same as Basic Plan X-Rays: At SHC - Covered 100% Outside SHC - Same as Basic Plan
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	
* Includes Pap smear screening.	

WOMEN'S HEALTH BENEFITS

Well Woman Care	
CHANGE Women's Health office visits at SHC are provided to all matriculated students at no charge. Some procedures performed during the visit may incur a fee. (See page 15 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	
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 (see page 14 for lab benefit).	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	
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	
Oral Contraceptive Pills Covered as a pharmacy benefit (see page 17). 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 14).	Same as Basic Plan

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
------------	--------------------------

WOMEN'S HEALTH BENEFITS (continued)	
-------------------------------------	--

Contraceptives (continued)	
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 17). 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 14).	
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.	Same as Basic Plan

MENTAL HEALTH BENEFITS	
------------------------	--

Inpatient Mental Health	
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	
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	
In exchange for full hospitalization	Same as Basic Plan
Outpatient Chemical Abuse and Dependence	
Preferred Care - 100% of the negotiated charge*	Same as Basic Plan
Non-Preferred Care - 100% of reasonable charges*	
<i>*Limit - 60 visits per policy year. A maximum of 20 of these visits are available for family counseling.</i>	
Outpatient Mental Health	
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 47 for Counseling & Behavioral Health Services at SHC.	

BASIC PLAN

COMPREHENSIVE PLAN/GSHIP

ADDITIONAL BENEFITS

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.
- **\$45** copay for Aetna non-preferred brand name drugs. **CHANGE**
- **\$20** copay for all diabetic supplies*

Preferred Pharmacy:

- 100% after a...
- **\$15** copay for generic drugs
- **\$35** copay for Aetna preferred brand name drugs.
- **\$45** copay for Aetna non-preferred brand name drugs.
- **\$15** copay for all diabetic supplies*

Non-Preferred Pharmacy:

- 70% after a...
- **\$15** copay for generic drugs
- **\$35** copay for Aetna preferred brand name drugs. **CHANGE**
- **\$45** copay for Aetna non-preferred brand name drugs.

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.

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:

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.

BASIC PLAN

COMPREHENSIVE PLAN/GSHIP

ADDITIONAL BENEFITS (continued)

Traveler's Assistance Program

See page 19 for a complete description of this benefit.

Same as Basic Plan

Vision Services

Ophthalmology Office Visits: 100% after \$10 copay when medically necessary (i.e. conjunctivitis, corneal abrasions, etc.)

Ophthalmology Office Visits

At SHC:
Comp Plan: 100% after \$10 copay
GSHIP: Covered 100%

At SHC: 100% after \$10 copay
Outside SHC: See Page 14 "Physicians Visits Outside SHC"

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.

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.

Same as Basic Plan

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.

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

Same as Basic Plan

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.

Worldwide Emergency Travel Assistance Services

This benefit is designed to protect New York University students and their eligible **dependents** at home or while traveling. The benefit provides accidental death and dismemberment coverage up to \$10,000 underwritten by Unum Provident. It also includes unlimited medical evacuation and repatriation coverage (coordinated by Assist America, Inc.) with a medical assistance program designed to help locate medical care while traveling worldwide.

Insurance Company: Unum Provident Life Insurance Company of America

Group Policy Number: 01-AA-UNM-CHK

Plan Administrator: Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014

800-466-4148 (within the United States)

If outside the U.S., call collect by dialing the U.S. access code plus 617-218-8400.

Traveler's Assistance and Medical Evacuation and Repatriation Services Provided by:

Assist America, Inc.
800-872-1414 (within the United States)
If outside the U.S., call collect by dialing the U.S. access code plus 301-656-4152.
medservices@assistamerica.com

An Assist America ID card will be supplied to you upon request once you enroll in the NYU-Sponsored Basic, Comprehensive, or GSHIP Plans. Please remember to carry your Assist America card and call toll free within the U.S. at 800-872-1414 or outside the U.S. call collect (dial U.S. access code) +301-656-4152 in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

Note: Assist America pays for all assistance services it provides. All assistance services must be arranged and provided by Assist America. Assist America does not reimburse for services not provided by Assist America.

The Assist America program meets and exceeds the U.S. Department of State requirements for international students and scholars.

Travel Assistance Services

These services are designed to protect NYU students and their eligible dependents when traveling more than 100 miles from home anywhere in the world.

If you experience a medical emergency while traveling more than 100 miles from

home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible participants have immediate access to doctors, hospitals, pharmacies and other services when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; prescription assistance; lost luggage assistance; legal and interpreter assistance; and travel information such as visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. *Please note: Any third party expenses incurred are the responsibility of the Participant.*

Accidental Death and Dismemberment Benefit

This insurance coverage provides accidental death and dismemberment coverage underwritten by Unum Provident Life Insurance Company of America.

Benefits are payable for the accidental death and dismemberment of the eligible insureds up to a maximum of \$10,000 (exclusions and limitations may apply). For definitions of eligibility and a complete loss schedule detailing the benefits received for accidental death, dismemberment, loss of sight, speech or hearing, please refer to your Master Policy available at your school by appointment at the NYU Insurance Department, 7 East 12 Street, 8th Floor, 212-998-2755.

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at 800-466-4148 for the appropriate claim forms.

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 ninety (90)-day 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 (23rd 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 Same Sex 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.

INPATIENT HOSPITAL ADMISSION

Pre-certification will be coordinated by the Program's Plan Administrator:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
Telephone: 800-466-4148
617-218-8400 (when outside of the United States)

Pre-Certification of Non-Emergency Inpatient Admissions

Inpatient Admission Pre-Certification is required by all NYU-sponsored Student Health Insurance Plans. If you do not secure pre-certification for non-emergency **hospital** admissions or do not provide notification for emergency hospital admissions, your covered expenses will be subject to a \$200 per admission deductible. The patient, doctor, or **hospital** must telephone Chickering Claims Administrators, Inc., the plan administrator, at least three (3) business days prior to the planned admission. You are responsible for advising your **physician** of the pre-admission certification requirement of this program. Pre-certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Master Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Program.

Notification of Emergency Hospital Admissions

The patient, patient's representative, doctor, or hospital must telephone Chickering Claims Administrators, Inc. within one (1) business day following admission. All inpatient admissions will be monitored by Chickering Claims Administrators, Inc.

NEW YORK STATE-MANDATED BENEFITS

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

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.

PREFERRED/DESIGNATED PROVIDER NETWORK

The Chickering Group has arranged for you to access a **Preferred Provider Network** 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 a **preferred provider or designated provider**. It is to your advantage to utilize a preferred 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. **Preferred providers/designate providers** are independent contractors and are neither employees nor agents of Chickering Claims Administrators Inc. or Aetna Life Insurance Company.

To find an Aetna Network Provider, go to www.chickering.com. Click on **Find Your School** and enter 711103 as your policy number. You also may contact Chickering Claims Administrators, Inc. at 800-466-4148.

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
- Maternity Care
- Mental Health and Substance Abuse Services
- 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 **no out-of-pocket expense** for medically necessary treatment at SHC.

If that is not possible, seek care from providers who participate in the Aetna network to ensure maximum benefits and minimal out-of-pocket expenses. To find an Aetna Network Provider go to www.chickering.com. Click on **Find Your School** and enter 711103 as your policy number. You may also call Chickering Claims Administrators, Inc. at 800-466-4148 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 copayments, 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 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 physician. *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.)

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, copays, maximum policy limits, determination of medical necessity, reasonable charges, etc.

OTHER AETNA PROGRAMS

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

Vision One® Discount Program

In addition to services available at SHC Optometry Services, the Vision One® Discount Program helps you save on many eye care products, including eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call **(800) 793-8616** for additional Program information and provider locations, or simply log onto www.chickering.com to find a Vision One provider near you. Click on **Find Your School** and enter 711103 as your Policy Number.

Fitness Program

Aetna's Fitness Program, offered in conjunction with GlobalFit™, offers discounted membership rates at over 1,500 independent fitness clubs nationwide, as well as discounts on certain home exercise equipment. There are no long-term contracts and GlobalFit™ offers convenient payment options. Contact Chickering Claims Administrators, Inc. for more information.

Alternative Health Care Programs

Save money on alternative therapies and products through our Alternative Health Care Programs. Take advantage of discounted rates on chiropractic manipulation, acupuncture and massage therapy, and nutritional counseling. Through participating retailers, you can also save on vitamins, supplements, and natural products such as aromatherapy, yoga tools, and homeopathy.

EXCLUSIONS

The following is a partial summary of the expenses neither provided for nor covered by the NYU-sponsored Student Health Insurance Plans. Additional exclusions may apply. Please refer to the Master Policy on file at the NYU Insurance Department, 7 East 12th Street, 7th Floor or contact Chickering Claims Administrators, Inc. at 800-466-4148.

1. Expense incurred as a result of dental treatment, except for treatment resulting from **injury to sound, natural teeth** as provided elsewhere in the Program.
2. Expense incurred for services normally provided without charge by SHC or University Counseling Service.
3. Expense incurred for eye refractions, vision therapy, eyeglasses, contact lenses (except when required after cataract surgery) or other vision or hearing aids, or prescriptions or examinations except as required for repair caused by a covered **injury**.
4. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are provided under any Workers' Compensation or Occupational Disease Law.
7. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the policyholder.
8. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance
9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons. This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease 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.
10. Expenses for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not claim is made for such benefits.

11. Expense incurred as a result of commission of a felony.
12. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
13. Expense incurred for any services rendered by a member of the **covered person's** immediate family
14. Expenses that are not **medically necessary**.

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 outcomes 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; Aetna 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 Aetna'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 **physician's** or a dentist's office; or other less costly setting.

15. Expense incurred for **injury** resulting from the play or practice of interscholastic sports officially sanctioned by NYU's Department of Athletics, Intramural, and Recreation.
16. Expenses for treatment of injury or sickness to the extent that payment is made, as a judgement or settlement, by any person deemed responsible for injury or sickness (or their insurers).
17. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational.
18. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
19. Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
20. Expenses incurred for the use of orthotics.

FILING CLAIMS

It is the student's responsibility to obtain and complete the appropriate claim form for any medical treatment provided outside of SHC or for services not covered under our plans. If you are 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 Chickering Claims Administrators Inc. 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 Chickering Claims Administrators, Inc. for reimbursement.

Follow These Steps to File a Claim:

1. Obtain a claim form

- download claim form from www.nyu.edu/health/insurance;
- pick up a claim form at:
SHC Student Health Insurance Services Office
726 Broadway, Suite 346; or
- request that a claim form be mailed to you by contacting:
SHC Student Health Insurance Services Office at 212-443-1020; or
Chickering Claims Administrators, Inc. at 800-466-4148.

2. Complete the claim form

- attach 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 form. Without such evidence, you will not be reimbursed. All documentation must be in English.

(Please note: You need to submit only one claim form for each condition, even if you have multiple bills, receipts, etc. related to that condition.)

3. Keep a copy

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

4. **Mail the completed claim form** and any attached itemized bills, receipts, etc. to:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014

If after filing your claim form you receive additional bills, submit them directly to Chickering Claims Administrators, Inc. Make certain that all your medical bills correctly show your name and social security number (make changes on the medical bills, if necessary). Claim forms, medical bills, and all other claim-related correspondence should be directed to Chickering Claims Administrators, Inc. within 30 days of treatment.

If you have any problems in filing a claim and need assistance, please contact Chickering Claims Administrators, Inc. at 800-466-4148. 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:

- You did not complete the appropriate claim form.
- You are not insured under the program.
- You failed to seek treatment at SHC when required (except for prescriptions).
- The medical services performed were not covered under the program (except for prescriptions).
- 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 have a coverage issue or other problem, call Chickering Customer Services at 800-466-4148. 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:

Chickering Claims Administrators, Inc.
P.O. Box 15717
Boston, MA 02215-0014

For purposes of the following section, the term "you" pertains to you or your covered dependent.

Internal Appeals Procedure

Aetna 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 Aetna within 180 days of the date Aetna 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.

Aetna 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 1 day of Aetna's receipt of an oral Appeal; and within 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so; the additional information must be submitted to Aetna within 15 days of the date of the letter.
- You will be sent a response within 30 days of Aetna's 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 Aetna after receipt of Aetna's response; the decision is considered Aetna's final response 45 days after receipt of the Appeal. For all other Appeals; if additional information is to be submitted to Aetna after receipt of Aetna's response; it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's response will be sent within 30 days from the date of Aetna'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 2 days provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.

Second Level Appeals Procedure

If you are dissatisfied with Aetna'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 Aetna's receipt of the written appeal. This letter may request additional information. If so; the additional information must be submitted to Aetna within 15 days of the date of the letter.
- Aetna'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 Aetna's receipt of all necessary information.

If additional time is needed to resolve an Appeal; except in an urgent or emergency situation; Aetna 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 Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of your complaint for 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 Aetna 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 Aetna 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 Aetna must have upheld the denial; or you and Aetna 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 Aetna must have upheld the denial; or you and Aetna must agree in writing to waive any internal appeal.

In addition; your attending physician 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 physician; 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 physician 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 physician 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 physician 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 physician must be a licensed; board certified; or board eligible physician; qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If through Aetna'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 Aetna 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. Aetna will provide an external appeal application with the final adverse determination issued through Aetna'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 Aetna based its denial; the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right; Aetna will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below); Aetna 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 physician or Aetna. 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 physician 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 Aetna 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 Aetna's decision that a service is not necessary; or approves coverage of an experimental or investigational treatment; Aetna 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; Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna 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 Aetna. 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. Aetna will also waive the fee if Aetna 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 physician 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 Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal appeal. Aetna 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; Aetna will only cover the costs of services required to provide treatment to you; according to the design of the trial. Aetna 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 Chickering ID card to an Aetna Preferred Pharmacy along with your applicable copay. The Pharmacy will submit a claim to Aetna 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 I.D. card with you, you may obtain your prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at SHC Student Health Insurance Services or by calling (800) 238-6279. You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing the Internet at www.chickering.com. Click on Student Connection and under Find Your School enter 711103 as your Policy Number.

Non-Preferred Care: You may obtain your prescription from a non-preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the reasonable charge allowance, less any applicable deductible, directly by Aetna. 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 Aetna Pharmacy Management at **(800) 238-6279**.

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 the Aetna Pharmacy Management Network

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

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 Aetna Pharmacy Management Network at 800-238-6279.

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 pages 12-13).

If Your Claim is Denied/How to Appeal a Claim

(See FILING CLAIMS section on pages 29-35.)

Subrogation/Reimbursement Right to Recovery Provision

Please refer to the 2005-2006 Master Policy for information regarding Subrogation/Reimbursement and Right to Recovery.

GLOSSARY

Actual Charge

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

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 physician 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:

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

Copay

The amount that must be paid by the **covered person** at the time services are rendered by a **preferred provider** (**copay** amounts are the responsibility of the covered person.)

Coinsurance

The percentage of covered medical expenses payable by Aetna 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 23 if a student)

The child must reside with, and be fully supported by, the covered student.

The term "**child**" includes a **covered student's** stepchild, 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**

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.)

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 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; Aetna 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 Aetna'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 physician's or a dentist's office; or other less costly setting

Negotiated Charge

The maximum charge a **preferred care 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-Preferred Care

A health care service or supply furnished by a health care provider that is not a **designated care provider**; or that is not a **preferred care provider**; if, as determined by Aetna:

- the service or supply could have been provided by a **preferred care provider**; and
- the provider is of a type that falls into one or more of the categories of providers; or a **designated care provider**

Non-Preferred Care Provider

A non-preferred care provider is:

- a health care provider that has not contracted to furnish services or supplies at a **negotiated charge**; or
- a **preferred care provider** that is furnishing services or supplies without the referral of SHC; or
- a health care provider that is not a **designated care provider**

Non-Preferred Pharmacy

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

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 Preferred Care Copays, Non-Preferred Care Deductibles, or expenses in excess of the Reasonable Charge do not apply towards meeting the Out-of-Pocket Maximum. Any amount payable as a result of failure to secure Pre-Certification for inpatient admissions also does 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.

Physician

A legally qualified physician 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

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 Care

Care provided by:

- a **preferred care provider** following the referral by SHC; or
- a **non-preferred care provider** on the referral of SHC and if approved by Aetna; or
- any health care provider for an emergency condition when travel to a **preferred care provider** or referral by SHC prior to treatment is not feasible

Preferred Care Provider (or Preferred Provider)

A health care provider who has contracted with Aetna to furnish services or supplies for a **negotiated charge** but only if the provider is, with Aetna's consent, listed as a **preferred care provider** for:

- the service or supply involved; and
- the class of **covered persons** of which you are member

Preferred Pharmacy

A pharmacy which is party to a contract with Aetna Pharmacy Management Network 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 Aetna

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 Aetna 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 Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished

In some circumstances; Aetna may have an agreement; either directly or indirectly through a third party; with a provider which sets the rate that Aetna 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

Aetna 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. Sound, natural teeth shall not include capped teeth.

GENERAL INFORMATION

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

Patient Management Program

Aetna has developed a Patient Management Program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

Patient Management staff use national guidelines and resources to guide the precertification, concurrent review, and retrospective review processes. On the basis of information collected from providers, Patient Management staff applies Millman and Robertson Health Care Management Guidelines when conducting concurrent U.C. review. If there is no applicable Millman & Robertson Guideline, Patient Management staff applies InterQual ISD criteria. Aetna's Coverage Policy Bulletins (CPBs) are also used as a guide in making coverage determinations. CPBs do not cover every aspect of medicine, and may not apply to your specific Plan, but have been developed to address new approaches to care, including new technologies, new treatment approaches, and procedures. CPBs are based on peer-review medical literature, the recommendations of leading medical organizations, and, where appropriate, the Health Care Financing Administration's Medicare coverage policies. You can view CPBs at www.aetna.com. Since CPBs can be highly technical and are designed to be used by our professional staff in making coverage determinations, you may want to review the CPBs of interest with your physician. CPBs do not constitute medical advice and treating providers are solely responsible for medical advice and treatment of members. CPBs are a tool to be interpreted in conjunction with the member's specific benefit plan and after consultation with the treating physician; CPBs contain only a partial, general description of benefit and do not constitute a contract. CPBs are regularly updated and are, therefore, subject to change.

Only Medical Directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria standards and guidelines, and inform the provider and member of the appeal process.

The Aetna Patient Management plan includes the following components:

- **Pre-certification**

You must obtain pre-certification for certain types of care rendered by preferred or non-preferred providers to avoid a reduction in benefits paid for that care.

To request pre-certification, you must call the number shown on your ID card. Such pre-certification must be obtained before care is received, or in the case of an emergency admission, procedure or treatment, within one business day after the start of a confinement as a full-time inpatient or the performance of the procedure or treatment, or as soon as reasonably possible.

- **Concurrent Review**

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for covered persons receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

- **Discharge Planning**

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during pre-certification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the covered person upon discharge from an inpatient stay.

- **Retrospective Record Review**

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all inpatient concurrent review decisions. Aetna's effort to manage the services provided to covered persons includes the retrospective review of claims submitted for payment, and medical records submitted for potential quality and utilization concerns.

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.

Aetna Pharmacy Management negotiates discounts from independent pharmacies and chain pharmacies that participate in the Aetna 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 Aetna Pharmacy Management and the network pharmacy. With Internet access, you can conduct an on-line search for participating pharmacies through DocFind, which is available at www.aetna.com/docfind. 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 Aetna and the Participating provider to resolve the amount deemed to be excess.

Confidentiality

Aetna 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.

Aetna (including its affiliates and authorized agents, collectively "Aetna") 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 Aetna 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 Aetna, NYU, or Chickering Claims Administrators, Inc. 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 physicians 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 Aetna has identified providers who were accepting patients as known to Aetna 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 physician or Customer Services at 800-466-4148.

In the event of a problem with coverage, covered persons should contact Customer Services 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. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Notice of Information Disclosure

Aetna 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. Participating 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 Services number on your ID card or visit Chickering Student Connection Link at www.chickering.com.

Pricing

NYU-sponsored Student Health Insurance Plans

PLAN:	BASIC	COMPREHENSIVE
Annual in the Fall 2006 8/21/2006 - 8/20/2007		
Student	\$1,376	\$2,049
Spouse*	\$6,169	\$7,535
Child(ren)	\$2,735	\$3,342

Fall Term 8/21/2006 - 1/8/2007		
Student	\$532	\$792
Spouse*	\$2,383	\$2,911
Child(ren)	\$1,057	\$1,291

Spring and Summer Terms 1/9/2007 - 8/20/2007		
Student	\$844	\$1,257
Spouse*	\$3,786	\$4,624
Child(ren)	\$1,678	\$2,051

Summer Term 5/14/2007 - 8/20/2007		
Student	\$373	\$556
Spouse*	\$1,673	\$2,044
Child(ren)	\$742	\$906

CATASTROPHIC OPTION

In addition to the Comprehensive Plan rates above:

	ANNUAL 8/21/2006 - 8/20/2007	SPRING/SUMMER 1/9/2007 - 8/20/2007
Student	\$81	\$49
Spouse*	\$249	\$151
Each Child	\$139	\$84

* Spouse or same-sex domestic partner

QUICK REFERENCE GUIDE

Contact Information	
CHICKERING CLAIMS ADMINISTRATORS, INC. <i>Student health insurance claims, enrollment, and information about benefits</i>	P.O. Box 15708 Boston, MA 02215-0014 800-466-4148, or 617-218-8400 when outside of the United States www.chickering.com
AETNA PHARMACY MANAGEMENT NETWORK	800-238-6279
ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS & WORLDWIDE TRAVEL ASSISTANCE	Assist America, Inc. 800-872-1414 When outside of the U.S., dial U.S. access code + 301-656-4152 (You may call collect.)
NEW YORK UNIVERSITY 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 Exchange212-443-9999
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
DENTAL FACULTY PRACTICE <i>Stu-Dent Plan/Urgent Dental Service</i>	418 Lafayette Street, 3rd Floor New York, NY 10003-6947 212-443-1313 www.nyu.edu/dental
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
OFFICE OF PUBLIC SAFETY <i>Emergencies/General Information</i>	14 Washington Place, 1st Floor New York, NY 10003-6696 212-998-2222 www.nyu.edu/public.safety
HENRY & LUCY MOSES CENTER FOR STUDENTS WITH DISABILITIES	240 Greene Street, 4th Floor New York, NY 10012-9873 212-998-4980 (Voice/TTY) www.nyu.edu/osl/csd