

# Benefit Details

## Benefit Change Highlights 2008-2009

### INCREASED COINSURANCE RATES

	<u>2008-2009</u>	<u>2007-2008</u>
Aetna-Preferred Providers		
Basic Plan	80%	80%
Comprehensive Plan / GSHIP	<b>90%</b>	80%
Non-Preferred Providers		
Basic Plan	50%	50%
Comprehensive Plan / GSHIP	<b>70%</b>	50%

### INCREASED ANNUAL PHARMACY BENEFITS

	<u>2008-2009</u>	<u>2007-2008</u>
Generic Drug Copay*	<b>\$5</b>	\$15
Brand Name - Aetna Preferred Drug*	<b>\$25</b>	\$35
Brand Name - Not Aetna Preferred*	<b>\$40</b>	\$45
Annual Maximum		
Basic	<b>\$1,250</b>	\$1,000
Comp / GSHIP	<b>\$2,000</b>	\$1,500

\* Pharmacy copays are the same for Basic, Comp and GSHIP plans.

### REDUCED OUT-OF-POCKET MAXIMUMS

	<u>2008-2009</u>	<u>2007-2008</u>
Aetna-Preferred Care		
Basic Plan	<b>\$3,000</b>	\$5,000
Comprehensive Plan / GSHIP	<b>\$2,000</b>	\$3,000
Non-Preferred Care		
Basic Plan	<b>\$6,000</b>	\$10,000
Comprehensive Plan / GSHIP	<b>\$4,000</b>	\$6,000

### REDUCED OFFICE VISIT COPAYS (Outside Student Health Center)

	<u>2008-2009</u>	<u>2007-2008</u>
Aetna-Preferred Providers		
Basic Plan	<b>\$15</b>	\$20
Comprehensive Plan / GSHIP	<b>\$10</b>	\$15
Non-Preferred Providers		
Basic Plan	<b>\$30</b>	\$40
Comprehensive Plan / GSHIP	<b>\$20</b>	\$30

(The copay for specialty care office visits at SHC remains at \$10.)

# Summary of Plan Benefits

BASIC PLAN	COMPREHENSIVE PLAN/GSHIP
<b>Lifetime Aggregate Maximum</b>	
\$250,000 per condition	\$1,000,000 per condition
<b>Out-of-Pocket Maximums</b>	
Preferred Care - \$3,000 per policy year	Preferred Care - \$2,000 per policy year
Non-Preferred Care - \$6,000 per policy year	Non-Preferred Care - \$4,000 per policy year
<i>See page 46 for definition of Out-of-Pocket Maximums</i>	
<b>INPATIENT BENEFITS *</b>	
<b>Room and Board</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter
<b>Other Hospital Services</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter
<b>Pre-Admission Testing</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter
<b>Inpatient Non-Surgical Physician Visits</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter
<i>* See the Student Health Insurance Handbook for Pre-Certification requirements at <a href="http://www.nyu.edu/health/insurance">www.nyu.edu/health/insurance</a></i>	
<b>SURGICAL BENEFITS</b> Outpatient & Inpatient	
<b>Surgeon's Fees</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter
<b>Anesthesia Fees</b>	
Preferred Care - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter	Preferred Care - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter
Non-Preferred Care - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter	Non-Preferred Care - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**BASIC PLAN**

**COMPREHENSIVE PLAN/GSHIP**

**OUTPATIENT BENEFITS**

*Primary Care office visits at SHC are covered 100%. This is not an insured benefit, but is provided by NYU to all matriculated students\* and Continuation Option enrollees.*

**Physician Visits**

**At SHC:** Specialists (including Psychiatric Services and Physical Therapy); 100% after \$10 copay.  
**Outside SHC:**  
**Preferred Care - 80%** of the negotiated charge; \$15 per visit copay  
**Non-Preferred Care - 50%** of reasonable charges; \$30 per visit deductible

**At SHC:** Comp Plan: Same as Basic Plan  
 GSHIP: Covered 100%  
**Outside SHC:**  
**Preferred Care - 90%** of the negotiated charge; \$10 per visit copay  
**Non-Preferred Care - 70%** of reasonable charges; \$20 per visit deductible

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

**At SHC:** 100% for an annual exam including limited tests  
**Outside SHC:** No coverage except for well baby care up to the age of 3

**Allergy Testing and Shots**

**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of the reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care - 90%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of the reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Routine Immunizations**

No coverage except for children up to the age of 12 as follows:

**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of the reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care - 90%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of the reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Hospital Outpatient**

**Preferred Care - 80%** of the negotiated charge; \$40 per visit copay  
**Non-Preferred Care - 50%** of reasonable charges; \$60 per visit deductible

**Preferred Care - 90%** of the negotiated charge; \$35 per visit copay  
**Non-Preferred Care - 70%** of reasonable charges; \$50 per visit deductible

**Hospital Emergency Room**

**Preferred Care - 80%** of the negotiated charge; \$50 per visit copay  
**Non-Preferred Care - 80%** of reasonable charges; \$50 per visit deductible

**Preferred Care - 90%** of the negotiated charge; \$50 per visit copay  
**Non-Preferred Care - 90%** of reasonable charges; \$50 per visit deductible

**Lab and X-ray**

*Some commonly performed lab tests at SHC will be covered 100%. This is not an insured benefit, but is provided by NYU to all matriculated students\* and Continuation Option enrollees.*

**Lab tests and X-rays for which there is a fee\*\*:**  
**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Lab tests and X-rays for which there is a fee\*\*:**  
**Preferred Care - 90%** of the negotiated charges up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

\*\* Includes pap smear screening.

\*Including students who waived the Student Health Insurance Plans.

**BASIC PLAN**

**COMPREHENSIVE PLAN/GSHIP**

**OUTPATIENT BENEFITS (continued)**

**Chiropractic Service**

Payable same as non-SHC physician visits

Payable same as non-SHC physician visits

**Radiation Therapy, Chemotherapy, Dialysis Treatment and Intravenous Home Therapy**

**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of the reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care - 90%** of the negotiated charges up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**WOMEN'S HEALTH BENEFITS**

**Well Woman Care**

*Women's Health office visits at SHC are covered 100%. This is not an insured benefit but is provided by NYU to all matriculated students\* and Continuation Option enrollees.*

**Routine Gynecologic Exam**

Outside SHC, covered as any other outpatient non-SHC physician visit (see page 13)

Outside SHC, covered as any other outpatient non-SHC physician visit (see page 29)

**Pap Smear Screening**

Covered as a laboratory expense (see page 13)

Covered as a laboratory expense (see page 29)

**Mammography**

**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care - 90%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Maternity**

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

In the event of an inpatient confinement, such benefits would be payable for inpatient care of the covered person, and any newborn child, as medically necessary. In the event of a hospital discharge earlier than 48 hrs. after a vaginal delivery, or 96 hrs. 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.

**Obstetric Services**

**Preferred Care - 80%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 50%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care - 90%** of the negotiated charge up to the out-of-pocket maximum, 100% thereafter  
**Non-Preferred Care - 70%** of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Designated Care - 100%** of negotiated charge\*\* up to the out-of-pocket maximum, 100% thereafter

**Designated Care - 100%** of negotiated charge\*\* up to the out-of-pocket maximum, 100% thereafter

\*\* for CPT Code 59400 (routine obstetric care including pre-natal visits, vaginal delivery and postpartum care) and CPT Code 59510 (routine obstetric care including pre-natal visits, cesarean delivery and postpartum care). For a list of designated providers, please call Student Health Insurance at 212-443-1020.

\*Including students who waived the Student Health Insurance Plans.

**BASIC PLAN**

**COMPREHENSIVE PLAN/GSHIP**

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

**Inpatient Room and Board for Maternity**

**Preferred Care** - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Designated Care** - 100%\*\* of negotiated charge up to the out-of-pocket maximum, 100% thereafter

**Preferred Care** - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Designated Care** - 100% of negotiated charge\*\* up to the out-of-pocket maximum, 100% thereafter

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

**Contraceptives**

**Oral Contraceptive Pills** Covered under the separate Prescription Drug Benefit (see page 33)

**Prescription Contraceptive Services (other than oral contraceptives)**

100% coverage for services only when performed at SHC Same as Basic Plan

Outside SHC: Coverage of Lunelle, Depo-Provera, Patch and Ring are provided under the separate Prescription Drug Benefit (see page 32)

Expenses incurred for physician office visits in conjunction with the administration of a covered prescription contraceptive are provided under the medical portion of the plan (see page 29)

**Emergency Contraception**

100% coverage for services only when performed at SHC Same as Basic Plan

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

**Termination of Pregnancy**

Covered medical expenses are payable as any other condition.

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

**Preferred Care** - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

**Preferred Care** - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter

\*Including students who waived the Student Health Insurance Plans.

**MENTAL HEALTH BENEFITS**

**Inpatient Mental Health**

**Preferred Care** - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to the annual maximum

**Non-Preferred Care** - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to the annual maximum

**Designated Care** - At NYU Tisch Hospital only, 100% of the negotiated charge

**Annual Maximums (Pref. and Non-Pref.)**  
Biologically Based Conditions\*: \$250,000  
Non-Biologically Based Conditions\*: 30 days

**Preferred Care** - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to the annual maximum

**Non-Preferred Care** - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to the annual maximum

**Designated Care** - At NYU Tisch Hospital only. Same as Basic Plan.

**Annual Maximums (Pref. and Non-Pref.)**  
Biologically Based Conditions: \$1,000,000  
Non-Biologically Based Conditions: \$1,000,000

**BASIC PLAN**

**COMPREHENSIVE PLAN/GSHIP**

**MENTAL HEALTH BENEFITS (continued)**

**Outpatient Mental Health Psychotherapy (outside SHC<sup>†</sup>)**

**Preferred Care** - 80% of the negotiated charge  
**Non-Preferred Care** - 50% of reasonable charges

**Preferred Care** - 90% of the negotiated charge (visits 11-30\*)  
**Non-Preferred Care** - 70% of reasonable charges (visits 11-30\*)

**Designated Care** - 100% after a \$5 copay. For a list of designated providers, please call Student Health Insurance at 212-443-1020.

**Annual Maximums (Pref. and Non-Pref.)**  
Biologically Based Conditions: Unlimited  
Non-Biologically Based Conditions: 20 visits\*

**Annual Maximums (Pref. and Non-Pref.)**  
Biologically Based Conditions: Unlimited  
Non-Biologically Based Conditions: 20 visits\*

\* In addition to the 10 visits available to all matriculated\*\* students, totaling 30 per year. The first 10 visits will be paid under the Mandatory Plan, as described on page 3, at 80% for Aetna-preferred providers and 50% for non-preferred providers.

<sup>†</sup> Short-term psychotherapy (talk therapy) visits are provided at no charge at SHC Counseling & Behavioral Health.

**Definitions:**

**Biologically Based Condition**

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

**Non-Biologically Based Condition**

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

**Inpatient Chemical Abuse and Dependence (annual maximum 7 days or \$10,000, whichever is greater)**

**Preferred Care** - 80% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to \$10,000

**Non-Preferred Care** - 50% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to \$10,000

**Preferred Care** - 90% of the negotiated charge up to the out-of-pocket maximum, 100% thereafter up to \$10,000

**Non-Preferred Care** - 70% of reasonable charges up to the out-of-pocket maximum, 100% thereafter up to \$10,000

**Outpatient Chemical Abuse and Dependence**

**Preferred Care** - 100% of the negotiated charge

Same as Basic Plan

**Non-Preferred Care** - 100% of reasonable charges

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

**Partial Hospitalization**

In exchange for full hospitalization

Same as Basic Plan

\*\* Including students who waived the Student Health Insurance Plans.

**BASIC PLAN**

**COMPREHENSIVE PLAN/GSHIP**

**ADDITIONAL BENEFITS**

**Prescription Drug [Aetna Pharmacy Management]**

Limit: **\$1,250** per policy year maximum

**Preferred Pharmacy:**

- 100% after a...
- **\$5** copay for generic drugs
- **\$25** copay for Aetna preferred brand name drugs
- **\$40** copay for Aetna non-preferred brand name drugs
- **\$15** copay for all diabetic supplies\*

**Non-Preferred Pharmacy:**

- 70% after a...
- **\$5** copay for generic drugs
- **\$25** copay for Aetna preferred brand name drugs
- **\$40** copay for Aetna non-preferred brand name drugs
- **\$15** copay for all diabetic supplies\*

\* *Diabetic supplies include insulin, syringes and testing supplies.*  
Benefits are not payable for more than a 30-day supply per prescription or refill without prior authorization. Off label prescription drugs for cancer treatment are included.

Limit: **\$2,000** per policy year maximum

**Preferred Pharmacy:**

- 100% after a...
- **\$5** copay for generic drugs
- **\$25** copay for Aetna preferred brand name drugs
- **\$40** copay for Aetna non-preferred brand name drugs
- **\$10** copay for all diabetic supplies\*

**Non-Preferred Pharmacy:**

- 70% after a...
- **\$5** copay for generic drugs
- **\$25** copay for Aetna preferred brand name drugs (\$30 for diabetic supplies\*).
- **\$40** copay for Aetna non-preferred brand name drugs.
- **\$10** copay for all diabetic supplies\*

**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 Specific Antigen (PSA) test. **Covered medical expenses** are payable on the same basis as any medical expense.

**Home Health Care**

**80%** to maximum of **\$75** per visit per policy year; 40 visits per policy year

**90%** to maximum of **\$75** per visit per policy year; 40 visits per policy year

**Orthopedic/Prosthetic Appliances/Braces**

**80%** of **reasonable charges** not to exceed **\$500** per policy year

**90%** of **reasonable charges** not to exceed **\$500** per policy year

**Durable Medical Equipment (annual maximum \$500)**

**80%** of allowable charges

**At SHC:**  
**Comp Plan:** 90% of all allowable charges  
**GSHIP:** Covered 100%  
**Outside SHC:** 90% of all allowable charges

**Diabetic Treatment Expense**

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

**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)**

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

**Preferred Care** - **80%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter

**Preferred Care** - **90%** of the **negotiated charge** up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - **50%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter

**Non-Preferred Care** - **70%** of **reasonable charges** up to the out-of-pocket maximum, 100% thereafter

**End of Life Care/Hospice Care**

Covered **medical expenses** include care provided at acute care facilities which 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.

**Medical and Mental Health Treatment Abroad**

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

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

**Traveler's Assistance Program**

Travel assistance services, medical, evacuation and return of mortal remains services up to policy limit.

Same as Basic Plan

Accidental death and dismemberment: \$10,000

**Vision Services**

**Annual Preventive Eye Examination** (no benefit outside SHC)

**Annual Preventive Eye Examination** - Same as Basic Plan

**At SHC:** 100% after \$10 copay

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

**Outside SHC:** No benefit

**Outside SHC:** No benefit

**Other Optical Services at SHC**

**Other Optical Services at SHC** - Same as Basic Plan

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