SUMMARY OF BENEFITS

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

	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Policy Year Maximum	Unlimited	Unlimited
Out-of-Pocket Limit	**In-Network** **Individual:** $5,000 per policy year **Family:** $10,000 per policy year **Out-of-Network** **Individual:** $10,000 per policy year **Family:** $20,000 per policy year *Once the out-of-pocket limit has been satisfied, eligible expenses will be payable at 100% for the remainder of the policy year up to any benefit maximum that may apply.*	
OUTPATIENT BENEFITS		
Doctor's Visits	**At SHC:** Specialists, 100% after a $30 per visit co-pay.* **In-Network:** 75% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges; $60 per visit co-pay up to the out-of-pocket limit, 100% thereafter	**At SHC**: Specialists, 100% after a $30 per visit co-pay for Comp; $10 for GSHIP.* **In-Network:** 90% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges; $60 per visit co-pay for Comp; $50 per visit co-pay for GSHIP; up to the out-of-pocket limit, 100% thereafter
Lab and X-ray Some lab tests at SHC are provided at no charge. This is not an insured benefit but is provided by NYU to all matriculated students including students who waive the NYU sponsored Plans.	**At SHC:** 80% of allowable charges **In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**At SHC:** 90% of allowable charges for Comp; 100% for GSHIP **In-Network:** 90% of the allowable charges up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
Preventive Services and Immunizations as specified by Health Care Reform (PPACA) *(see also Women's Health Benefits, page 12-13)*	**At SHC:** Preventive services available and rendered at SHC will be provided at 100% with no cost sharing **In-Network:** Preventive services that are not available at SHC will be covered at 100% of eligible expenses with no cost-sharing. **Out-of-Network:** No coverage (To view a list of covered preventive services go to www.healthcare.gov/prevention. Please note that coverage is age, gender, and risk appropriate.)	

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Allergy Testing and Shots	**At SHC:** 80% of the allowable charge **In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**At SHC:** 90% of the allowable charge **In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
Physical/ Occupational Therapy and Chiropractic Service *Physical/ Occupational Therapy is limited to 60 visits per condition per year.	**At SHC:** 100% after a $30 per visit co-pay. **In-Network:** 75% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges; $60 per visit co-pay up to the out-of-pocket limit, 100% thereafter	**At SHC:** 100% after a $30 per visit co-pay for Comp; $10 per visit copay for GSHIP **In-Network:** 90% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges; $60 per visit co-pay for Comp; $50 per visit co-pay for GSHIP; up to the out-of-pocket limit, 100% thereafter
Hospital Emergency Room	**In-Network:** 75% of the allowable charge; $100 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 75% of the reasonable and customary charges; $100 per visit copay; up to the out-of-pocket limit, 100% thereafter	**In-Network:** 90% of the allowable charge; $100 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 90% of the reasonable and customary charges; $100 per visit copay; up to the out-of-pocket limit, 100% thereafter
WOMEN'S HEALTH BENEFITS		
Routine Gynecologic Exam	**At SHC:** provided at 100% with no cost sharing	
	In-Network: covered at 100% of Eligible Expenses with no cost-sharing. **Out-of-Network:** 50% of reasonable and customary charges; $60 per visit co-pay up to the out-of-pocket limit, 100% thereafter	**In-Network:** covered at 100% of Eligible Expenses with no cost-sharing. **Out-of-Network:** 60% of reasonable and customary charges; $60 per visit co-pay for Comp; $50 per visit co-pay for GSHIP; up to the out-of-pocket limit, 100% thereafter

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Pap Smear/ Cervical Cancer Screening (See Laboratory Services)	**At SHC:** provided at 100% with no cost sharing **In-Network:** provided at 100% with no cost sharing **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter; $60 per visit co-pay	**At SHC:** provided at 100% with no cost sharing **In-Network:** provided at 100% with no cost sharing **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter; $60 per visit co-pay for Comp; $50 per visit co-pay for GSHIP
Mammography	**In-Network:** Covered at 100% of allowable charge with no cost sharing **Out-of-Network:** Payable same as Laboratory and X-ray expense (see page 11)	
Contraceptives *(Prescription Drugs and Devices)*	**At SHC:** Covered at 100% of eligible expenses with no cost sharing **In-Network:** Covered at 100% of eligible expenses with no cost-sharing at Preferred Pharmacies **Out-of-Network:** see Prescription Drug benefit for Non-Preferred Pharmacies Eligible Professional Expenses incurred for outpatient contraceptive service will be paid under the Out Patient benefit (i.e.: IUD Insertion) *Benefits are payable for a 90-day supply per prescription or refill without prior authorization.* Lost or stolen prescription drugs will not be covered.	
MATERNITY		
Obstetric Services	**In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter **Designated Provider:** 100% of negotiated charge* up to the out-of-pocket limit **For CPT Code 59400 and CPT Code 59510 (routine obstetric care for complete pregnancy including pre-natal visits, vaginal or cesarean delivery and postpartum care).* *For a list of designated providers, please call Student Health Insurance Services at (212) 443-1020.*	**In-Network:** 90% of the allowable charge up to the out-of pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of pocket limit, 100% thereafter **Designated Provider:** Same as Basic Plan.

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Inpatient Room and Board For Maternity	**In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter **Designated Provider:** At NYU Langone Hospital, 100% of negotiated charge up to the out-of-pocket limit	**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter **Designated Provider:** At NYU Langone Hospital, 100% of negotiated charge up to the out-of-pocket limit
TERMINATION OF PREGNANCY		
Termination of Pregnancy	**In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter Copays may apply. Only one elective termination covered per policy year.	**In-Network:** 90% of the allowable charge up to the out-of pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of pocket limit, 100% thereafter Copays may apply. Only one elective termination covered per policy year.
MENTAL HEALTH BENEFITS		
Outpatient Mental Health Psychotherapy (outside SHC)	**At SHC:** Short-term psychotherapy (talk therapy) visits at SHC are provided at no charge. This is not an insured benefit but is provided by NYU to all matriculated students including students who waive the NYU sponsored plans.	
	In-Network: 75% of the allowable charge; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter **Designated Provider:** 100% after a $5 per visit co-pay. For a list of Designated Providers, please call Student Health Insurance at 212-443-1020.	**In-Network:** 90% of the allowable charge; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter **Designated Provider:** Same as Basic Plan

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
Psychiatric Medication Assessment and Management	**At SHC:** 100% after a $20 per visit professional service fee. **In-Network:** 75% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges; $60 per visit co-pay up to the out-of-pocket limit, 100% thereafter	**At SHC:** Comp: 100% after a $20 per visit professional service fee; GSHIP: covered 100% **In-Network:** 90% of the allowable charge; $30 per visit copay; up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges; $60 per visit co-pay for Comp; $50 per visit co-pay for GSHIP; up to the out-of-pocket limit, 100% thereafter
Inpatient Mental Health	**In-Network:** 75% of the negotiated charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**In-Network:** 90% of the negotiated charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
	Designated Provider: At NYU Langone Hospital, 100% of the Negotiated Charge	
CHEMICAL ABUSE AND DEPENDENCE		
Outpatient	**In-Network:** 100% of the allowable charge **Out-of-Network:** 100% of reasonable and customary charge *Up to 20 of these visits available for family counseling*	
Inpatient	**In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter up to maximum **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter up to maximum	**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter up to maximum **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter up to maximum

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
PRESCRIPTION DRUGS		
Prescription Drugs	**Participating Pharmacy:** 100% after a: • $15 copay for generic drugs • $40 copay for preferred brand name drugs • $60 copay for non-preferred brand name drugs • $20 copay for all diabetic supplies (insulin, syringes and testing supplies) replacements for lost or stolen prescription drugs are not covered. **Non-Participating Pharmacy:** There is a 30% co-insurance in addition to the co-pays listed. *Benefits are not payable for more than a 30-day supply per prescription or refill without prior authorization.* *Off label prescription drugs for cancer treatment are included.*	
INPATIENT MEDICAL		
Room & Board, Pre-Admission Testing, Non-Surgical Physician Visit, Other Hospital Services	**In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
SURGICAL BENEFITS (Outpatient & Inpatient)		
Surgeon/ Assistant Surgeon Anesthesia Fees	**In-Network:** Covered at 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** Covered at 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
GENDER MEDICAL MODIFICATION BENEFITS		
Sexual Realignment Surgery	**In-Network:** Covered at 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** Covered at 50% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**In-Network:** Covered at 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** Covered at 60% of the reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
Hormone Therapy	Covered under Prescription Drugs Benefit (see above)	

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
ADDITIONAL BENEFITS		
Ambulance	100% coverage per transport to or from hospital.	
Vision Services *Over age 19*	**Annual Preventive Eye Exam (One per policy year)**	
	At SHC: 100% after a $30 per visit co-pay	**At SHC:** **Comp Plan:** 100% after a $30 per visit co-pay **GSHIP:** 100% after a $10 per visit co-pay
	Outside SHC: No benefit The following optical services are available at the Student Health Center, but are not covered under the Student Health Insurance Program: • New contact lens fittings (lenses not included) • Re-evaluation of current contact lens prescriptions • Eyeglass frames and lenses	
Vision Services *through the end of the month in which the student turns 19 years of age*	**Annual Preventive Eye Exam (one per policy year)**	
	At SHC: 100% with no per visit co-pay **In-Network:** Covered at 75% of allowable charges; up to the out-of-pocket limit, 100% thereafter. $30 per visit co-pay. **Out-of-Network:** Covered at 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter; $30 per visit co-pay	**At SHC:** **Comp Plan:** 100% with no per visit co-pay **GSHIP:** 100% with no per visit co-pay **In-Network:** Covered at 80% of allowable charges; up to the out-of-pocket limit, 100% there-after; Comp Plan - $30 per visit co-pay; GSHIP - $10 per visit co-pay **Out-of-Network:** Covered at 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter; Comp Plan - $30 per visit co-pay. GSHIP - $10 per visit co-pay.
	Lenses and Frames: (One per policy year)	
	At SHC: 80% of allowable charges; up to the out-of-pocket limit, 100% thereafter; $30 per visit co-pay **In-Network:** 60% of allowable charges; up to the out-of-pocket limit, 100% thereafter. $50 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit, 100% thereafter; $50 per visit co-pay	
	Contact Lenses (Preauthorization Required)	
	At SHC: 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $30 per visit co-pay **In-Network:** 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay	

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
ADDITIONAL BENEFITS (continued)		
Pediatric Dental *through the end of the month in which the student turns 19 years of age*	**Preventive Dental Care:** One dental exam and cleaning per 6-month period	
	At SHC: Not available **In-Network:** 75% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter; $75 per visit co-pay	**At SHC:** Not available **In-Network:** 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay **Out-of-network:** 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $75 per visit co-pay
	Routine Dental Care (Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6-12 month intervals)	
	At SHC: Not available **In-Network:** 75% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter; $75 per visit co-pay	**At SHC:** Not available **In-Network:** 80% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $50 per visit co-pay **Out-of-network:** 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $75 per visit co-pay
	Major Dental (Endodontics and Prosthodontics) *Preauthorization required.*	
	At SHC: Not available **In-Network:** 70% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $100 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter; $150 per visit co-pay	
	Orthodontia: *Preauthorization required.*	
	At SHC: Not available **In-Network:** 60% of allowable charges; up to the out-of-pocket limit; 100% thereafter; $100 per visit co-pay **Out-of-Network:** 60% of reasonable and customary charges; up to the out-of-pocket limit; 100% thereafter; $200 per visit co-pay.	

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	BASIC PLAN	COMPREHENSIVE PLAN (Comp) AND GSHIP
ADDITIONAL BENEFITS (continued)		
Diabetic Treatment Expense *Insulin, testing supplies and syringes are payable under the prescription portion of the plan (see page 16).*	**Covered medical expenses for self-management education are payable as follows:**	
	At SHC: 80% of the allowable charge up to the out-of-pocket limit, 100% thereafter **In-Network:** 75% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 50% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter	**At SHC:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **In-Network:** 90% of the allowable charge up to the out-of-pocket limit, 100% thereafter **Out-of-Network:** 60% of reasonable and customary charges up to the out-of-pocket limit, 100% thereafter
Durable Medical Equipment and Braces	**At SHC:** 80% of reasonable and customary charges **Outside SHC:** 75% of reasonable and customary charges	**At SHC:** Comp Plan: 90% of all reasonable and customary charges; GSHIP: Covered 100% **Outside SHC:** 90% of reasonable and customary charges
Medical and Mental Health Treatment Abroad	Medical and mental health treatment will be covered according to the plan benefits at the in-network level.	
Other Covered Services - sample listing	• Radiation Therapy, Chemotherapy, Dialysis Treatment, and Intravenous Home Therapy • Mastectomy, Lymph Node Dissection and Lumpectomy and Reconstructive Surgery as a result of Breast Cancer • Hospital Outpatient Services • Partial Hospitalization • Speech and Hearing Therapy, Bone Density Screening Test, Enteral Formula for Home Use • Home Health Care • End of Life Care • Travel Assistance Program	

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