



## 2020–2021 Student Health Insurance Plan for The New School

### Who is eligible to enroll?

All graduate and undergraduate degree (including online-only and non-matriculating), visiting, mobility (study abroad), maintenance-of-status, Lang and Parsons consortium, ESL + Certificate program, and graduate credit certificate students are automatically enrolled in the health insurance plan, unless a waiver is submitted and approved. International students are not eligible to waive. Eligible Dependents of enrolled students may participate in the plan on a voluntary basis. Eligible Dependents are the student's spouse or Domestic Partner and dependent children under 26 years of age. See the Who is Covered section of the Certificate of Coverage for the specific requirements needed to meet Domestic Partner eligibility.

### Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right before you enroll. The certificate of coverage provides details of the coverage including costs, benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the University and may be viewed at [www.uhcsr.com](http://www.uhcsr.com). This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2020-203363-1. The Policy is a Non-Renewable One-Year Term Policy.

### Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-866-948-8472 or [customerservice@uhcsr.com](mailto:customerservice@uhcsr.com).

## Highlights of Coverage offered by UnitedHealthcare StudentResources

### Coverage Dates and Plan Cost

Total Plan Cost and Coverage Dates	Annual 08-20-20 to 08-19-21	Fall 08-20-20 to 01-14-21	Spring/Summer 01-15-21 to 08-19-21
Student	\$2,983.00	\$1,215.00	\$1,768.00
Spouse	\$2,983.00	\$1,215.00	\$1,768.00
One Child	\$2,983.00	\$1,215.00	\$1,768.00
Two or More Children	\$5,966.00	\$2,430.00	\$3,536.00
Spouse and Two or More Children	\$8,949.00	\$3,645.00	\$5,304.00

**See the information below for the breakdown of premium and fees.**

Premium Rates*	Annual Premium**	Fall Premium**	Spring Premium**
Student	\$2,920.62	\$1,184.03	\$1,736.59
Spouse	\$2,920.62	\$1,184.03	\$1,736.59
One Child	\$2,920.62	\$1,184.03	\$1,736.59
Two or More Children	\$5,841.24	\$2,368.07	\$3,473.17
Spouse and Two or More Children	\$8,761.86	\$3,552.10	\$5,209.76

**\*The premium above is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include the following fees:**

- Annual Service fee of \$2.38 for UHC Global administration of the Assistance and Evacuation Benefits.
- Annual Service fee of \$60.00 charged by or at the direction of the school you are receiving coverage through to cover the costs of services provided by a non-insurer vendor or consultant.

\*\*Note: Fees are prorated for the coverage dates other than annual.

The Member must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Member's premium must be received within 30 days after the coverage expiration date. It is the Member's responsibility to make timely premium payments to avoid a lapse in coverage.

<b>Highlights of the Student Health Insurance Plan Benefits</b>		
<b>METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 89.070%</b>		
<b>In-Network Benefits</b>		
In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Choice Plus network. Participating Providers can be found using the following link: <a href="#">UHC Choice Plus</a>		
	<b>In Network Participating Provider Member Cost-Share</b>	<b>Out-of-Network Non-Participating Provider Member Cost-Share</b>
<b>Overall Plan Maximum</b>	There is no overall maximum dollar limit on the policy	
<b>Plan Deductible</b>	\$150 Per Member, per Plan Year	\$300 Per Member, per Plan Year
<b>Out-of-Pocket Limit</b> <i>After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.</i>	\$4,500 Per Member, per Plan Year \$8,500 For all Members in a Family, per Plan Year	There is no Out-of-Pocket Limit for Out-of-Network benefits.
<b>Coinsurance</b> <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.</i>	15% of Allowed Amount <sup>1</sup> for Covered Expenses	40% of Allowed Amount <sup>1</sup> for Covered Expenses
<b>Prescription Drugs</b> <i>Mail order through UHCP at 2.5 times the retail Copayment up to a 90-day supply.</i>	\$15 Copayment for Tier 1 \$40 Copayment for Tier 2 \$50 Copayment for Tier 3 Up to a 30 day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) not subject to Deductible	30% of Allowed Amount <sup>1</sup> for Generic Drug 30% of Allowed Amount <sup>1</sup> for Brand Name Drug Up to a 30 day supply per prescription not subject to Deductible

<p><b>Preventive Care</b>  <i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for complete details of the services provided for specific age and risk groups.</i></p>	<p>Covered in full</p>	<p>30% of Allowed Amount<sup>1</sup></p>
<p><b>The following services have per service Copayments</b>  <i>This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.</i></p>	<p>Office Visits: \$15  not subject to Deductible</p>	<p>Office Visits: \$15  after Deductible</p>
<p><b>Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs</b></p>	<p>Office Visits:  \$15 Copay per visit  0% Coinsurance  not subject to Deductible</p> <p>Other Outpatient Services:  15% Coinsurance  after Deductible</p>	<p>Office Visits:  40% Coinsurance  after Deductible</p> <p>Other Outpatient Services:  40% Coinsurance  after Deductible</p>
<p><b>Pediatric Dental and Vision Benefits</b></p>	<p>Refer to the plan Certificate of Coverage for details (age limits apply).</p>	

<sup>1</sup>The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Providers. The Allowed Amount for Non-Participating Providers will be determined on the Usual, Customary and Reasonable charge using the lesser of: 1) the 80<sup>th</sup> percentile of the Fair Health rate; 2) the facility or provider's charge; or 3) a rate based on information provided by a third-party vendor. We reserve the right to negotiate a lower rate with Non-Participating Providers.

## Exclusions and Limitations

No coverage is available under this Certificate for the following:

### A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

### B. Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

### C. Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

### D. Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

**E. Dental Services.**

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

**F. Experimental or Investigational Treatment.**

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

**G. Felony Participation.**

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

**H. Foot Care.**

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

**I. Government Facility.**

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

**J. Medically Necessary.**

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

**K. Medicare or Other Governmental Program.**

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

**L. Military Service.**

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

**M. Services Not Listed.**

We do not Cover services that are not listed in this Certificate as being Covered.

**N. Services Provided by a Family Member.**

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

**O. Services With No Charge.**

We do not Cover services for which no charge is normally made.

**P. Vision Services.**

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

**Q. War.**

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

## R. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

## Highlights of Assistance and Evacuation Benefits

### Medical Evacuation and Repatriation

If you are a student insured with this insurance plan, you and your insured spouse, Domestic Partner and insured minor child(ren) are eligible for Medical Evacuation and Repatriation Benefits. The requirements to receive these services are as follows:

International Students, insured spouse, Domestic Partner and insured minor child(ren): you are eligible to receive Medical Evacuation and Repatriation Benefits worldwide, except in your home country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren): you are eligible for Medical Evacuation and Repatriation Benefits when 100 miles or more away from your campus address or 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Medical Evacuation and Repatriation Benefits and related services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Assistance Benefits include:

- Emergency Evacuation
- Dispatch of Doctors/Specialists
- Medical Repatriation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Insured Person
- Return of Minor Children
- Repatriation of Remains

Check your certificate of coverage for details, descriptions and program exclusions and limitations.

## Highlights of Services offered by UnitedHealthcare StudentResources

### HealthiestYou: 24/7 Doctor Access

Starting on the effective date of your policy, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service. By calling the toll-free number listed on the front of your medical ID card or visiting [www.telehealth4students.com](http://www.telehealth4students.com), you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor's office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor's office, urgent care facility, or emergency room. As a Member with StudentResources, there is no consultation fee for this service.\* Every call with a HealthiestYou doctor is covered 100% during your policy period.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your SHC first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

\*If you are a Member under this insurance Plan, and you call prior to the plan effective date, you will be charged a \$40 service fee before being connected to a board-certified physician.

## 24/7 Student Support

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Members have immediate access to the Student Assistance Program, a service that coordinates counseling services offered by Licensed Clinicians who can provide Members with someone to talk to when everyday issues become overwhelming. More information about these counseling services is available by logging into **My Account** at [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount).

## HealthiestYou: Virtual Counselor Access

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Starting on the effective date of your coverage under the student insurance plan, you have access to mental health providers through a national virtual counseling service.\* Psychiatrists, psychologists and licensed therapists are available to you through a variety of communication methods, including phone and video.

When you sign up, you'll complete a questionnaire, choose your provider and select a date and time for your appointment. Appointments are available 7 days a week. Visits are secure, discreet and confidential, and you have ongoing support with the same provider.

As an insured with **StudentResources**, there is no consultation fee for this service. Every communication with a provider is covered 100% during your policy period.

\*Available to Member Students and their covered Dependent; age restrictions may apply, depending on your state.

## Broker Information

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### NEED MORE INFORMATION? PLEASE CONTACT:

Gallagher Student Health & Special Risk  
500 Victory Road  
Quincy, MA 02171  
Toll free 1-833-440-0571  
[www.gallagherstudent.com](http://www.gallagherstudent.com)

## ID Cards

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Insured students will receive emailed instructions on how to create a **My Account** and access their electronic ID card. From the [uhcsr.com/myaccount](http://uhcsr.com/myaccount) website, ID cards can be downloaded, faxed, emailed or printed. Additionally, students can request delivery of an ID card through the U.S. mail from their **My Account**. Access to ID card information is also available on the UHCSR mobile app, available on the App Store or Google Play.

This Summary Brochure is based on Policy #2020-203363-1.

**NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.**

## NON-DISCRIMINATION NOTICE

UnitedHealthcare **Student**Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

**LANGUAGE ASSISTANCE PROGRAM**

**We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.**

**English**

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

**Albanian**

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

**Amharic**

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**Arabic**

تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم 1-866-260-2723.

**Armenian**

Ձեզ մատչելի են անվճար լեզվաբան օգնություն և առաջադրություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

**Bantu- Kirundi**

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

**Bisayan- Visayan (Cebuano)**

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

**Bengali- Bangala**

সোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

**Burmese**

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

**Cambodian- Mon-Khmer**

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមមេស្តរំលឹកលេខ 1-866-260-2723។

**Cherokee**

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**Chinese**

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

**Choctaw**

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

**Cushite- Oromo**

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

**Dutch**

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

**French**

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

**French Creole- Haitian Creole**

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

**German**

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

**Greek**

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

**Gujarati**

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

**Hawaiian**

Kōkua manuahi ma kāu 'ōlelo i loa 'a 'ia. E kelepona i ka helu 1-866-260-2723.

**Hindi**

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

**Hmong**

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

**Ibo**

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpọọ 1-866-260-2723.

**Ilocano**

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

**Indonesian**

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

**Italian**

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

**Japanese**

無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

**Karen**

ကျိတ်တံခါးခါးဆီကီနုဆီသွဝဲလၢတလိၣ်ဟ့ၣ်ဆူၤတၢ်တၢ်(ခိၣ်)န့ၣ်လီၤ, ဝံသးတုၤဆဲးကျိတ်တၢ် 1-866-260-2723 တတၢ်.

**Korean**

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

**Kru- Bassa**

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba ye ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**

خزمتهكلنی یارمەتی زمانی بهخۆڕایی بۆ تۆ دابین دهکریڤ. تکایه تاملهخۆن بکه بۆ ژمارهی 1-866-260-2723.

**Laotian**

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃຫ້ທາງເບີ 1-866-260-2723.



