

Student Health Insurance Plan



Eligibility

All medical students attending the Albert Einstein College of Medicine are required to enroll in the Student Health Insurance Plan at registration, unless proof of comparable coverage is furnished.


Eligible dependents of those enrolled in the plan may participate in the plan on a Voluntary basis.


Please view the complete brochure on-line at einstein.myahpcare.com for full details of participation in the plan.

Additional Benefit

- Access to a 24/7 Student Assistance Program

Additional Information

 einstein.myahpcare.com

 1-855-856-4198

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This is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits and programs and does not constitute a contract. Covered Medical Expenses are subject to plan maximums, limitations, and exclusions as described in the Policy. Your Plan provides you with a higher level of coverage when you receive covered medical expenses from physicians who are part of UnitedHealthcare Choice Plus.

BENEFIT MAXIMUMS & DEDUCTIBLES

Benefit Maximum	Unlimited, per Member, per Policy Year
Deductible	In-Network Provider: \$400 per Insured Person, per Policy Year Out-of-Network Provider: \$400 per Insured Person, per Policy Year
Individual Out-of-Pocket Maximum	In-Network Provider: \$3,300 per Insured Person, per Policy Year Out-of-Network Provider: N/A
Family Out-of-Pocket Maximum	In-Network Provider: \$6,600 per Family, per Policy Year Out-of-Network Provider: N/A

BENEFIT CATEGORY	In-Network Provider	Out-of-Network Provider
	Participating Provider Member Responsibility	Non- Participating Provider Member Responsibility
Hospital Room and Board Expense	20% after Deductible	40% after Deductible
Inpatient/Outpatient Surgery	20% after Deductible	40% after Deductible
In-Office Physician Fees <i>(Deductible waived)</i>	\$20 Copayment	30% after a \$30 Copayment
Specialists In-Office Physician Fees <i>(Deductible waived)</i>	\$20 Copayment	30% after a \$40 Copayment
Habilitation/Rehabilitative Services (Physical, Occupational and Speech Therapy)	20% after Deductible	40% after Deductible
Diagnostic X-ray Services & Laboratory Procedures <i>(Deductible waived)</i>	20% Coinsurance	40% Coinsurance
Emergency Services Expense <i>Copayment waived if admitted/deductible waived</i>	20% after a \$150 Copayment per visit	20% after a \$150 Copayment per visit
Prescription Drugs <i>(Deductible waived)</i>	Covered in full following: \$15 Copayment for Tier 1 \$30 Copayment for Tier 2 \$30 Copayment for Tier 3	Covered in full following: \$15 Copayment for Generic Drugs \$30 Copayment for Brand Name Drugs
Preventive Care Services	Covered in full	30% after Deductible

2017-2018 PREMIUM COSTS AND COVERAGE PERIODS

Coverage Periods	Fall 2nd through 4th Year 07/01/2017 through 12/31/2017	Spring/Summer 2nd through 4th Year 01/01/2018 through 06/30/2018	Fall 1st Year 08/15/2017 through 12/31/2017	Spring/Summer 1st Year 01/01/2018 through 06/30/2018
Open Enrollment	04/15/2017 through 07/01/2017	N/A	07/15/2017 through 08/15/2017	N/A
Student	\$ 2,883.00	\$ 2,883.00	\$ 2,196.00	\$ 2,883.00
Spouse	\$ 2,883.00	\$ 2,883.00	\$ 2,196.00	\$ 2,883.00
Child	\$ 2,883.00	\$ 2,883.00	\$ 2,196.00	\$ 2,883.00