CHP Student HEALTH

2017-2018 Student Health Insurance Plan prepared for:

Marist College

Poughkeepsie, NY

Consolidated Health Plans welcomes the opportunity to provide this quotation. As your insurance partner, we encourage your ideas regarding plan modifications. We also welcome the opportunity to provide you with recommendations based upon our extensive experience with similar college and university plans.

Insured*	Plan Insurance Premium
Student Annual	$2,470
Spring	$1,434

*Please Note: Dependent Coverage is available at the same rate as the student coverage.

Enrollment Method			Hard Waiver
Coverage Period			
	Annual	08/01/17 -	07/31/18
	Fall	08/01/17 -	12/31/17
	Spring	01/01/18 -	07/31/18
Preferred Provider Organization			Cigna
Prescription Plan			Cigna PBM
****Broker**			Allen J. Flood Co.
Claims Administrator			Consolidated Health Plans (CHP)
Coverage Underwritten By			Atlanta International Insurance Co.

Notable Plan Changes:

1. **Inpatient pre-certification and Step Therapy are now included in Plan**
2. **Carrier: Atlanta International Insurance Co.**

Note: This is a summary of the Injury and Sickness Benefits. Please refer to the Student Injury & Sickness Insurance Plan Brochure & Policy upon issuance for a listing of all benefits, limitations, definitions and exclusions.

Preventive Services: The Deductible is not applicable to Preventive Services. Benefits for services provided by a Network Provider are paid at 100% of the PPO Allowance of Covered Medical Expenses. Benefits for services provided by a Non-Network Provider are provided at the Coinsurance Amount shown below.

Deductible	**Network**	$100
	Non-Network	$200
Out-of-Pocket Expense Limit	**Network**	$6,600 Ind / $13,200 Family
	Non-Network	No Maximum
Coinsurance	**Network**	95% of PA
	Non-Network	85% of R&C

SCHEDULE OF BENEFITS
Marist College

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible			
• Individual	$100	$200	
Out-of-Pocket Limit			
• Individual	$6,600	Unlimited	
• Family	$13,200	Unlimited	
Accidental Death and Dismemberment Benefits $5,000 Annual Maximum			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Specialist Office Visits (or Home Visits)	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in full	15% Coinsurance after deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	15% Coinsurance after deductible	
Adult Immunizations*	Covered in full	15% Coinsurance after deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	15% Coinsurance after deductible	
Mammography Screenings*	Covered in full	15% Coinsurance after deductible	
Sterilization Procedures for Women*	Covered in full	15% Coinsurance after deductible	
Vasectomy	0% Coinsurance after deductible	15% Coinsurance after deductible	
Bone Density Testing*	Covered in full	15% Coinsurance after deductible	
Screening for Prostate Cancer	Covered in full	15% Coinsurance after deductible	

All other preventive services required by USPSTF and HRSA. *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	15% Coinsurance after deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Non-Emergency Ambulance Services	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Emergency Department Copayment waived if Hospital admission	$100 Copayment 5% Coinsurance after deductible	$100 Copayment 5% Coinsurance after deductible	See benefit for description
Urgent Care Center	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Anesthesia Services (all settings)	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Autologous Blood Banking	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefits for description

Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible Included as part of inpatient Hospital service Cost-Sharing	 15% Coinsurance after deductible 15% Coinsurance after deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Chiropractic Services	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	5% Coinsurance after deductible	15% Coinsurance after deductible	60 visits per Plan Year
Home Health Care	5% Coinsurance after deductible	15% Coinsurance after deductible	40 visits per Plan Year
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description

Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Medications administrated in Office • Performed in a PCP Office • Performed in a Specialist Office	 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible	
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery	 Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early

• Breast Pump • Postnatal Care	Covered in full 5% Coinsurance after deductible	15% Coinsurance after deductible 15% Coinsurance after deductible	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Preadmission Testing	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 5% Coinsurance after deductible 5% Coinsurance after deductible	 15% Coinsurance after deductible 15% Coinsurance after deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	5% Coinsurance after deductible	15% Coinsurance after deductible	60 visits per Plan Year Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other	5% Coinsurance after deductible	15% Coinsurance after deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)			See benefit for description

• Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible 5% Coinsurance after deductible	15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible 15% Coinsurance after deductible	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (up to a 90-day supply) • Diabetic Education	 See the Prescription Drug Cost-Sharing 5% Coinsurance after deductible	 See the Prescription Drug Cost-Sharing 15% Coinsurance after deductible	See benefit for description See Prescription Drug benefit
Durable Medical Equipment and Braces	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
External Hearing Aids	5% Coinsurance after deductible	15% Coinsurance after deductible	
Cochlear Implants	5% Coinsurance after deductible	15% Coinsurance after deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	5% Coinsurance after deductible 5% Coinsurance after deductible	15% Coinsurance after deductible 15% Coinsurance after deductible	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Prosthetic Devices • External • Internal	5% Coinsurance after deductible 5% Coinsurance after deductible	15% Coinsurance after deductible 15% Coinsurance after deductible	One (1) prosthetic device, per limb, per lifetime Unlimited; See benefit for description
Shoe Inserts	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description

INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization Required. However, Preauthorization is not required for emergency admissions.**	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Observation Stay	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required.**	5% Coinsurance after deductible	15% Coinsurance after deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required.**	5% Coinsurance after deductible	15% Coinsurance after deductible	
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required. However, Preauthorization is Not Required for emergency admissions.**	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.**	5% Coinsurance after deductible	15% Coinsurance after deductible	See benefit for description

Outpatient Substance Use Services	5% Coinsurance after deductible	15% Coinsurance after deductible	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	See Benefit description
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy Tier 1 Tier 2 Tier 3	 $15 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible	 15% Coinsurance after Deductible 15% Coinsurance after Deductible 15% Coinsurance after Deductible	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $15 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible	 15% Coinsurance after Deductible 15% Coinsurance after Deductible 15% Coinsurance after Deductible	See benefit for description

PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and Major Dental Require Preauthorization**	0% Coinsurance after Deductible 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	0% Coinsurance after Deductible 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One (1) dental exam and cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses	0% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	0% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year
Emergency Medical Evacuation	0% coinsurance of - Actual Cost	0% coinsurance of - Actual Cost	Unlimited
Repatriation of Remains	0% coinsurance of - Actual Cost	0% coinsurance of - Actual Cost	Unlimited
Accidental Death and Dismemberment Benefits	N/A	N/A	$5,000 See Benefit for Description