CHP Student

PROPOSAL

2017-2018 Student Health Insurance Proposal prepared for

Ochsner Clinical School

New Orleans, LA

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 1		Plan 2	
	Insurance Premium	Contract Total*	Insurance Premium	Contract Total*
Student	$1,632	$1,742	$2,005	$2,115
Actuarial Value	**65.13%**		**83.33%**	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**
Plan Maximum	Unlimited		Unlimited	
Deductible	$2,000	$2,000	$250	$500
Out-of-Pocket Maximum	$6,850 Ind/ $13,700 Family	$6,850 Ind/ $13,700 Family	$6,850 Ind/ $13,700 Family	$6,850 Ind/ $13,700 Family
Coinsurance	70% of PA	50% of R&C	80% of PA	60% of R&C
OV Co-pay	$25 then 70%	$25 then 50%	$25 then 80%	$25 then 60%
ER Co-pay	$100 then 70%	$100 then 70%	$100 then 80%	$100 then 80%
Rx Co-pays	$50/$75/$100	$50/$75/$100	$20/$40/$60/$60	$20/$40/$60/$60
Preventive/ Wellness	100% of PA	50% of R&C	100% of PA	50% of R&C

16-17 Contract Total	$1,565.00	**Current Actuarial Value**	63.38%
Rate Increase	11.31%		

Please Note: *A complete list of benefits and rates will be available on the Letter of Agreement (LOA).*

The above rates do not include any school administrative fees.

Voluntary enrollment is not available.

CHP Student

PROPOSAL

Taxes and Fees included in the Contract Total		
Commission	0%	
***Broker Admin Fee**	$100	
***Stat Doc**	$10	
Enrollment Method		Hard Waiver
Coverage Period		
	Annual	01/01/17 - 12/31/17
Preferred Provider Organization		Cigna
Prescription Plan		Cigna PBM
***Broker**		The Benefits Planning Group
Claims Administrator		Consolidated Health Plans (CHP)
Coverage Underwritten By		National Guardian Life

Consolidated Health Plans and the *Broker will be responsible for:

- Member Advocacy
- Student Orientations
- Enrollment/Waiver Administration
- Customer Service
- Issuing ID Cards
- Plan Reviews
- On-Site Consultations
- Processing Claims
- Brochure Development

Value Added Services:

- International Travel Assistance
- Davis Vision Affinity Discount Program
- School Specific Homepage with Enrollment and Claim view access
- Future Health

The following offerings are available at an additional cost to the student. Please inquire regarding pricing.

- Life Insurance
- Dental Insurance

Options (Please select Option(s))	Additional Cost per Student
❑ Campus-Wide Health	$20.00

Please note that our quote is based upon information that we know of today. We reserve the right to adjust or amend premiums if legislative, judicial and/or regulatory requirements materially impact or change the scope of our services or responsibilities. Recently, the federal government through Health and Human Services (HHS), the Department of Labor, and the I.R.S. have been providing additional guidance on a variety of issues related to the Affordable Care Act. Key pieces of guidance revolve around various taxes and assessments on health insurers. If additional taxes or assessments are levied, we may have to provide you with an updated quote that includes these taxes or assessments.

Conformity with State Statutes: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued or in which the Insured resides, is hereby amended to conform to minimum requirements of such statutes.

Please note Actuarial Values may differ from Company to Company.

***The Broker is a representative of the College/University. The Broker is compensated exclusively by the College/University for services performed in relation to this LOA. College/University's compensation of Broker is presumed to be in accordance with CMS Technical Guidance CCIIO 2015-0001, as stated below.**

1. The law of the state in which the policy is sitused does not deem the agent or broker to be a representative of the issuer;

2. The policyholder is not required to utilize an agent or broker to purchase insurance and may purchase a policy directly from the issuer;

3. The policyholder selects, retains, and contracts with the agent or broker on his or her own accord;

4. The policyholder negotiates and is responsible for the fee or commission separate and apart from premium;

5. The issuer does not include these agent or broker commissions and fees in rate filings submitted to the applicable regulatory agency;

6. The policyholder voluntarily chooses to pass the fee or commission through the issuer and is not required to do so, or the policyholder pays the fees or commission directly to the agent or broker; and

7. The policyholder issues the 1099 to the agent or broker, if a 1099 is required.

Proposal Release Date 11/14/2016 **Proposal Expiration Date** 12/14/2016

***Beyond this date, coverage may need to be re-priced based upon updated experience data.**

2016-2017 Student Health Insurance Plan Letter of Agreement (LOA) prepared for:

Ochsner Clinical School

New Orleans, LA

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 1 Insurance Premium	Plan 1 Contract Total*
Student	$1,632	$1,742

Commission	0.00%
***Broker Admin Fee**	$100
Stat Doc	$10
Enrollment Method	Hard Waiver
Coverage Period	
Annual	01/01/17 - 12/31/17
Preferred Provider Organization	Cigna
Prescription Plan	Cigna PBM
***Broker**	The Benefits Planning Group
Claims Administrator	Consolidated Health Plans (CHP)
Coverage Underwritten By	National Guardian Life

Plan 1 **Actuarial Value:** **65.13%**

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**	$2,000
	Non-Network	$2,000
Out-of-Pocket Expense Limit	**Network**	$6,850 Ind/ $13,700 Family
	Non-Network	$6,850 Ind/ $13,700 Family
Coinsurance	**Network**	70% of PA
	Non-Network	50% of R&C

Please note that our quote is based upon information that we know of today. We reserve the right to adjust or amend premiums if legislative, judicial and/or regulatory requirements materially impact or change the scope of our services or responsibilities. Recently, the federal government through Health and Human Services (HHS), the Department of Labor, and the I.R.S. have been providing additional guidance on a variety of issues related to the Affordable Care Act. Key pieces of guidance revolve around various taxes and assessments on health insurers. If additional taxes or assessments are levied, we may have to provide you with an updated quote that includes these taxes or assessments.

We agree to provide written notice of any adjustment or amendment to premium thirty (30) days prior to the change taking effect, unless otherwise mutually agreed upon in writing by the Parties. If the Parties are unable to agree upon the fees and/or performance guarantees, in good faith, within the thirty (30) day period, either Party may terminate this Agreement thirty (30) days from the day written notice of termination is received.

Note: Under the ACA States retain the ability to mandate benefits beyond those established by the federal mandate. For additional detail regarding Essential Health Benefit provisions for a Student Health Insurance Plan in any given state, please feel free to review that state specific information at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Conformity with State Statutes

Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued or in which the Insured resides, is hereby amended to conform to minimum requirements of such statutes.

***The Broker is a representative of the College/University. The Broker is compensated exclusively by the College/University for services performed in relation to this LOA. College/University's compensation of Broker is presumed to be in accordance with CMS Technical Guidance CCIIO 2015-0001, as stated below.**

1. The law of the state in which the policy is sitused does not deem the agent or broker to be a representative of the issuer;

2. The policyholder is not required to utilize an agent or broker to purchase insurance and may purchase a policy directly from the issuer;

3. The policyholder selects, retains, and contracts with the agent or broker on his or her own accord;

4. The policyholder negotiates and is responsible for the fee or commission separate and apart from premium;

5. The issuer does not include these agent or broker commissions and fees in rate filings submitted to the applicable regulatory agency;

6. The policyholder voluntarily chooses to pass the fee or commission through the issuer and is not required to do so, or the policyholder pays the fees or commission directly to the agent or broker; and

7. The policyholder issues the 1099 to the agent or broker, if a 1099 is required.

LOA Release Date 11/14/2016 **LOA Expiration Date** 12/14/2016

***Beyond this date, coverage may need to be re-priced based upon updated experience data.**

Please confirm your acceptance of this quotation by indicating the plan of choice and returning this signed and dated form to an authorized CHP representative.

Signature of College/University Representative	Signature of Agent
Print Name & Job Title	Print Name & Job Title
Date	Date

SCHEDULE OF BENEFITS
PLAN

Benefit Period: When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins:

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of: the Policy Term (+ Extension of Benefits - when appropriate)

Preventive Services:
Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the PPO Allowance charge when services are provided through a Network Provider.

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum. Benefits are paid at 50% of the Usual and Reasonable charge.

Deductible:	Network	$2,000
	Non-Network	$2,000

Out-of-Pocket Expense Limit:	Network Provider:	Individual: $6,850 Family: $13,700
	Non-Network Provider:	Individual: $6,850 Family: $13,700

Coinsurance Amount:

Network Provider:	70% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider:	50% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers
This policy provides benefits based on the type of health care provider selected. This Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

Hospital Inpatient Facility Copayment:
Network $0.00
Non-Network $0.00

PREFERRED PROVIDER ORGANIZATION:

To locate a Cigna Network Provider in Your area, consult Your Provider Directory or call toll free 800-633-7867 or visit www.cigna.com.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Inpatient Benefits		
Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Preadmission Testing	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Physician's Visits while Confined	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Inpatient Surgery: Surgeon Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Registered Nurse Services for private duty nursing while confined	The PPO Allowance stated above	The Usual and Reasonable Charge stated above

Physical Therapy (inpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Skilled Nursing Facility Expense Benefit	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Outpatient Benefits		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	The PPO Allowance stated above The PPO Allowance stated above The PPO Allowance stated above	The Usual and Reasonable Charge stated above The Usual and Reasonable Charge stated above The Usual and Reasonable Charge stated above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy Habilitative Services are covered to the extent that they are Medically Necessary	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00
Chiropractic Care	The PPO Allowance stated above Copayment: $25.00 Deductible waived	The Usual and Reasonable Charge stated above Copayment: $25.00

Emergency Services Expenses	70% of the PPO Allowance Copayment: $100.00 Copayment waived if admitted	70% of the Usual and Reasonable Charge Copayment: $100.00 Copayment waived if admitted
In Office Physician's Visits	100% of the PPO Allowance Copayment: $25.00 Deductible waived	The Usual and Reasonable Charge stated above Copayment: $25.00
Urgent Care Centers or Facilities	The PPO Allowance stated above Copayment: $50.00	The Usual and Reasonable Charge stated above Copayment: $50.00
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Private-Duty Nursing Up to $10,000.00 per Policy Year	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Diagnostic X-ray Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Laboratory Procedures (Outpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Prescription Drugs	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00 Generic Copayment: $75.00 Preferred Brand Copayment: $100.00 Brand	100% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $50.00 Generic Copayment: $75.00 Preferred Brand Copayment: $100.00 Brand
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Home Health Care Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospice Care Coverage	The PPO Allowance stated above	The Usual and Reasonable Charge stated above

Other Benefits		
Ambulance Service	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Braces and Appliances	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Durable Medical Equipment including Prosthesis and Orthotics	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Maternity Benefit	Same as any other Covered Sickness	
Routine Newborn Care	Same as any other Covered Sickness	
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Consultant Physician Services	100% of the PPO Allowance Copayment: $25.00 Deductible waived	The Usual and Reasonable Charge stated above Copayment: $25.00
Sickness Dental Expense for Insured Persons up to $150.00 per tooth maximum $500 per Benefit Period	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Medical Evacuation Expense – International Students and/or their Dependents	The Usual and Reasonable Charge stated above Subject to $50,00.00 maximum per Benefit Period	
Repatriation Expense – International Students and/or their Dependents	The Usual and Reasonable Charge stated above Subject to $50,00.00 maximum per Benefit Period	
Non-emergency Care While Traveling Outside the United States	The Usual and Reasonable Charge stated above	

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Pediatric Dental Care Benefit Preventive Dental Care Limited to 1 dental exam every 6 months *The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:*	See Benefit for Limitations 100% of PPO Allowance for Preventive Services	See Benefit for Limitations 70% of the Usual and Reasonable Charge for Preventive Services
Emergency Dental Routine Dental Endodontic Services Prosthodontic Services Medically Necessary Orthodontic Care	50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable	50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable
Pediatric Vision Care Benefit Limited to 1 visit per Benefit Period and 1 pair of prescribed lenses and frames per Benefit Period	100% of PPO Allowance for Covered Medical Expenses for Preventive Services Deductible Waived	The Usual and Reasonable Charge stated above
Interpreter Expenses for the Hearing Impaired	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Sleep Studies	No Benefit	No Benefit
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Breast Reconstructive Surgical Services	Same as any other Covered Surgical Procedure	
Organ, Tissue and Bone Marrow Transplant Benefits	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Allergy Testing	The PPO Allowance stated above	The Usual and Reasonable Charge stated above

MANDATED BENEFITS	
Hearing Aids	Same as any other Preventive Service
Autism Spectrum Disorder	Same as any other Covered Sickness
Bone Mass Measurement	Same as any other Covered Sickness
Cancer Screening	Same as any other Preventive Service
Attention Deficit Disorder	Same as any other Covered Sickness
Clinical Trials (Cancer)	Same as any other Covered Sickness
Dental Anesthesia	Same as any other Covered Condition
Diabetes Care and Management	Same as any other Covered Sickness
Inherited Metabolic Diseases	Same as any other Covered Sickness

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life $5,000.00
½ Principal Sum for Single Dismemberment.....$2,500.00

Loss must occur with 365 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy.