Farmingdale State College
2018-2019 Student Health Plan
Group No: ST0840SH
Policy No: AIIC1819NYSHIP42

Dear Students:
We are pleased to provide you with this summary of the Student Health Plan for Farmingdale State College. This plan is fully compliant with the Affordable Care Act.

Who Is Eligible To Enroll?
All registered students residing in campus housing and registered commuter students taking at least 1 credit are eligible to enroll in this insurance plan. Dependents of the student are also eligible to enroll.
Students must attend classes for at least 30 consecutive days to remain eligible for coverage.

How Do I Enroll?
Registered students residing in campus housing are automatically enrolled in this insurance plan and the premium is added to the student's tuition and fees, unless the student waives coverage.
Full-time and part-time commuter students may enroll by completing a form request to the College. The premium will be added to student's tuition and fees.
Students may enroll eligible dependents on a voluntary basis by completing an enrollment form on the CHP website.

How Do I Waive Coverage?
Resident students may waive coverage by completing a waiver form and returning it to Health and Wellness by the waiver deadline date.

Waiver/Enrollment Period Deadline Dates	
Annual	September 14, 2018
Spring	February 15, 2019

Cost and Periods of Coverage*		
	Annual 8/16/18 to 8/15/19	Spring 1/26/19 to 8/15/19
Student	$2,575	$1,425
Spouse	$2,575	$1,425
Each Child	$2,575	$1,425
3 or More Children	$7,725	$4,275
*The above rates include an administrative broker fee and College administrative fee. Dependent rates are in addition to the student rate.		

HEALTH INSURANCE BENEFIT SUMMARY*		
BENEFIT	**NETWORK Member Responsibility**	**NON-NETWORK Member Responsibility**
Benefit Maximum	Unlimited	
Annual Deductible	$150	$600
Out-of- Pocket Maximum	$5,000 Individual $12,700 Family	$20,000 Individual $20,000 Family
Coinsurance	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care	Covered in Full	40% coinsurance after deductible

HEALTH INSURANCE BENEFIT SUMMARY*		
BENEFIT	**NETWORK Member Responsibility**	**NON-NETWORK Member Responsibility**
Inpatient Hospital Room & Board**	$500 copay then 20% coinsurance after deductible	$500 copay then 40% coinsurance after deductible
Surgery (Inpatient or Outpatient)	20% coinsurance after deductible	40% coinsurance after deductible
In Office Physician Visit or Consultant or Specialist	$25 copay then 20% coinsurance after deductible	$25 copay then 40% coinsurance after deductible
Emergency Department	$150 copay then 20% coinsurance after deductible	$150 copay then 20% coinsurance after deductible
Urgent Care Center	$100 copay then 20% coinsurance after deductible	$100 copay then 20% coinsurance after deductible
Diagnostic Testing*** or Radiology**** or Laboratory*****	$25 copay then 20% coinsurance after deductible	$25 copay then 40% coinsurance after deductible
Advanced Imaging Services in Freestanding Radiology facility	$100 copay then 20% coinsurance after deductible	$100 copay then 40% coinsurance after deductible
Cardiac/Pulmonary****** or Chemotherapy*** or Dialysis***** or Infusion Therapy***	$25 copay then 20% coinsurance after deductible	$25 copay then 40% coinsurance after deductible
Mental Health or Substance Use Disorder Services	20% coinsurance after deductible	40% coinsurance after deductible
Medications administered In Office***	$25 copay then 20% coinsurance after deductible	$25 copay then 40% coinsurance after deductible
Prescription Drugs Retail Pharmacy (benefits provided on a reimbursement basis)	20% coinsurance after deductible: $25 copay per Generic Drug $50 copay per Preferred Brand $75 copay per non-Preferred Brand $75 copay per Specialty Drug (Copay waived for Contraceptives and wellness drugs)	
*This is only a brief description of the coverage(s) available under Certificate form NY SHIP CERT (2018). The Certificate will contain the reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.		
**All inpatient confinements require pre-certification. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible		
***copay applies when performed in PCP or specialist office		
****Diagnostic Radiology copay applies when performed in PCP or specialist office or freestanding radiology facility. Therapeutic Radiology copay applies to specialist office or freestanding facility.		
*****copay applies when performed in PCP or specialist office or freestanding facility		
******copay applies when performed in specialist office		

Underwritten By:
Atlanta International Insurance Company

Plan Administrator:
Consolidated Health Plans, Inc.
2077 Roosevelt Ave.
Springfield, MA 01104
chpstudenthealth.com
(877) 657-5030

Servicing Agent:
Student Healthcare Solutions
5001 Genesee Street
Buffalo, NY 14225
(800) 444-5530

FlyST0840SH

Where Can I Obtain More Information About The Plan?	
Enroll Dependents - complete an online enrollment form)	Consolidated Health Plans (CHP) www.chpstudenthealth.com
Resident Students - Waive Coverage	Complete waiver form and return to Health and Wellness
Insurance Benefits Claim Processing ID Cards	Consolidated Health Plans (CHP) www.chpstudenthealth.com
Find Network Provider	CHP or Cigna www.cigna.com

The following Value-Added Services are not part of the Policy and are not underwritten by Atlanta International Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision
- Medical travel assistance through Scholastic Emergency Services
- 24-hour nurse line through Ask Mayo Clinic

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 the 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 the certificate unless medical information is submitted

E. Coverage Outside of the United State, Canada or Mexico.
We do not cover care or treatment provided outside the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. 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 the certificate.

G. 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 the certificate, or 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 the certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the certificate for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due 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).

I. 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 Your legs or feet.

J. 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

K. 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 the certificate

L. 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)

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

N. No-Fault Automobile Insurance.
We do not Cover any Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This Exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
We do not Cover services that are not listed in the certificate as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by You or a member of Your immediate. Immediate family shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. 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.

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

U. 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.