

Graduate and Professional Student Council
Duke University
Student Medical Insurance Plan
Request for Proposals
Released: January 7, 2008

The Duke University Student Health Insurance Advisory Committee (SHIAC) in conjunction with Larry Moneta, Vice President of Student Affairs has released a request for proposals (RFP) for the student health insurance plan. This is part of a routine process that ensures that Duke Students get the best value in health insurance.

What follows is taken from the RFP and outlines the specific benefits that we are requesting. In addition to this benefits table, we are requesting that prospective insurers also include prices for:

1. An identical prescription drug plan that we have this year, which is a \$100 deductible, you (the member) pays 20% (coinsurance) up to the maximum coinsurance level of \$1000.
2. A revised co-payment schedule with
 - a. Per hospital admission copayment: \$300 (Emergency room copayment is waived if hospital admission copayment is applied)
 - b. Diagnostic imaging and scans: \$200 (per scan or image)
 - c. Surgical procedures: \$100 (per procedure)
 - d. Ambulance transportation: \$100 per trip
3. Inclusion of the \$100 glasses or contact lens benefit.
4. Benefits for services through Duke Integrative Health
5. Continuation of Medical Evacuation/Repatriation/Travel Assistance coverage through our current provider, Medex.

SHIAC will be evaluating the proposals, the insurer provider network, and customer service. This will occur in mid-March. If members have any input they should contact the GPSC Subcommittee on Health Insurance at DukeStudentInsurance@gmail.com.

	In-Network Coverage	Out-of-Network Coverage
Plan Year Deductible	\$0	\$300 per person \$900 per family
Plan Year Out-of-Pocket Maximum	\$1,500 per person \$4,500 per family <i>In-network copayments do not count toward satisfaction of the Plan Year out-of-pocket maximum.</i>	\$3,000 per person \$9,000 per family <i>Out-of-network deductibles do not count toward satisfaction of the Plan Year out-of-pocket maximum.</i>
Coinsurance SMIP/Covered Person Coinsurance will be 80% SMIP/20% covered person for in-network care (or 70%/30% for out-of-network care) unless otherwise specified.	80%/20% Based on participating facility/provider allowed fee schedule.	70%/30% Based on the usual and customary, or reasonable charge determination.
Emergency Room	Illness or Injury Per Visit Copayment: \$150 (waived for life-threatening conditions) Mental Health Care Per Visit Copayment: \$0 (does not require life-threatening condition - refer to special medical necessity criteria for mental health use of emergency room) Coinsurance: 100% coverage for all medically necessary services and supplies, including any expenses incurred for physician charges, surgery charges, and charges from other hospital departments (other than images and scans) if they are ordered by the emergency department and provided on the same day as the emergency	70%/30%

	room visit.	
Hospital Services (including North Carolina required benefits for mental health care services and substance abuse/chemical dependency)	80%/20%	70%/30%
Physician/Provider Visits (including North Carolina required benefits for mental health care services and substance abuse/chemical dependency) This provision also applies to inpatient hospital visits.	Per Visit Copayment: \$25 100% coverage for visit charges Coinsurance: 80%/20% for ancillary services	70%/30%
Outpatient PDC Facility Physician/Provider Visits Only provided at Private Diagnostic Clinic, PLCC, at Duke University Medical Center	Per Visit Copayment: \$25 100% coverage for visit charges after copayment Coinsurance: 80%/20% for ancillary services	Not Applicable
Urgent Care	Per Visit Copayment: \$45 100% coverage for visit charges after copayment Coinsurance: 80%/20% for ancillary services	70%/30%
Physician Charges for Surgery or Anesthesia	80%/20%	70%/30%
Diagnostic X-ray and Laboratory (including imaging and scans)	80%/20%	70%/30%
North Carolina Required Mental Health, Substance Abuse, and Chemical Dependency Care <i>Examples of required mental health care services include: Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoia and Other Psychotic Disorder, Schizoaffective Disorder, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia.</i>	Benefits are provided on the same basis as any other medical condition.	Benefits are provided on the same basis as any other medical condition.
Other Mental Health Care Services These benefits are separate from the required mental health care services and treatment for	Per Visit Copayment: \$25 100% coverage for visit charges after copayment	70%/30%

<p>substance abuse/chemical dependency. Plan Year maximum number of 60 visits and 60 days of hospital confinement</p>	<p>Coinsurance: 80%/20% for ancillary services</p>	
<p>Prescription Drug Coverage</p>	<ul style="list-style-type: none"> ➤ Tier one: \$10 co-payment for generic medications. ➤ Tier two: \$20 co-payment for brand medications (the generic copayment is used if the brand prescription medication costs less than the equivalent generic). ➤ Tier three: copayment doubles for 90-day mail order prescription medications. ➤ There is no internal plan year limit for prescription medications. ➤ Covered medical expenses include coverage for oral contraceptives and contraceptive devices/medications. 	<ul style="list-style-type: none"> ➤ Tier one: \$20 co-payment for generic medications. ➤ Tier two: \$40 co-payment for brand medications (the generic copayment is used if the brand prescription medication costs less than the equivalent generic). <p>Covered persons must submit claims directly to the claims administrator.</p> <p>Copayments may not be used to satisfy the out-of-network deductible or Plan Year annual Out-of-Pocket expense limit.</p>
<p>Pregnancy</p>	<p>Pregnancy benefits, including voluntary termination of pregnancy, are provided on the same basis as any other temporary disability.</p>	
<p>Short-Term Therapies</p> <p>Coverage includes: physical/occupational therapy, including chiropractic services, up to a maximum of 30 visits per plan year for both in-network and out-of-network services.</p>	<p>80%/20%</p>	<p>70%/30%</p>
<p>Other Therapies</p>	<p>80%/20%</p>	<p>70%/30%</p>

<p>Includes chemotherapy, dialysis, and cardiac rehabilitation.</p>		
<p>Preventive Care – Routine Physical Exams</p> <p>Subject to allowed annual or lifetime exams. Includes gynecological exams, cervical cancer screening, ovarian cancer screening, mammograms, colorectal screening, and prostate screening.</p>	<p>Per Visit Copayment: \$25 100% coverage for visit charges after copayment</p> <p>Coinsurance: 80%/20% for ancillary services</p>	<p>70%/30%</p>
<p>Preventive Care – Well Baby/Child Care</p> <p>Covered for up to age six, including periodic assessments and immunizations. Benefits are limited to six well baby visits up to 12 months old and three well child visits per up to age six.</p>	<p>Per Visit Copayment: \$25 100% coverage for visit charges after copayment</p> <p>Coinsurance: 80%/20% for ancillary services</p>	<p>70%/30%</p>
<p>Preventive Care -- Immunizations</p> <p>Includes the full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) covered up to age six.</p> <p>Immunizations are covered up to a Plan Year maximum benefit of \$500 for both in- and out-network care. Covered immunizations include the following: Diphtheria Pertussis, Tetanus Toxoid (DPT), Pneumococcal vaccine, Polio, HiB, Measles/Mumps Rubella (MMR), Hepatitis A and B, Human Papilloma Virus vaccine, Influenza, Meningococcal vaccine, Chicken pox, and Rotavirus.</p> <p>Allergy injections and sera are covered under medical benefits and are not considered preventive.</p>	<p>80%/20%</p>	<p>70%/30%</p>
<p>ADHD Testing</p>	<p>80%/20%</p> <p>Lifetime maximum benefit of \$1,000 when authorized by Duke designated providers.</p>	<p>Not Covered</p>

<p>Infertility and Sexual Dysfunction Services</p> <p>Covered up to a combined lifetime maximum benefit of \$5,000 for in- and out-of-network benefits.</p>	<p>80%/20%</p>	<p>70%/30%</p>
<p>Skilled Nursing Facility</p> <p>Covered up to a combined Plan Year maximum benefit of 60 days for in- and out-of-network benefits.</p>	<p>80%/20%</p>	<p>70%/30%</p>
<p>Other Services</p> <p>Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and home health care.</p> <p>Orthotic devices for correction of positional plagiocephaly limited to a lifetime maximum of \$600.</p> <p>Home health care is limited to a combined in and out-of-network maximum of 60 days per Plan Year.</p>	<p>80%/20%</p>	<p>70%/30%</p>
<p>Certification Penalty</p> <p>All current pre-certification requirements will be maintained unless otherwise specified by the Proposer (refer to Inquiry E of Section 4.4).</p>	<p>Certain services, regardless of location, require prior review and certification in order to receive benefits. Failure to request prior review and receive certification may result in allowed charges being reduced by 25% or full denial of benefits.</p>	
<p>Dental Benefits</p> <p>Only for injury to sound, natural teeth, limited to a combined in-and out-of-network maximum benefit of \$2,500.</p>	<p>80%/20%</p>	<p>70%/30%</p>

3.5 MEDICAL COVERED EXPENSES AND EXCLUSIONS

Unless otherwise specified in this Section 3.5, the Proposers must replicate covered expenses as shown in the 2007-2008 SMIP brochure and policy. This requirement for replication of existing coverage provisions includes all plan definitions, special provisions, and other attendant plan provisions required to interpret the covered expenses and services provision. The following exclusions is hereby removed from the 2008-2009 benefit design (refer to page 27 of Section VI, Attachment B-4): For injury resulting from participation in a prearranged vehicle race or speed contest.