Student Health Insurance Program

Designed for the Students of

SARAH • LAWRENCE • COLLEGE

2012-2013
Nationwide Life Insurance Company
Columbus, Ohio
Policy Number: 302-075-3110

Effective September 1, 2012 to September 1, 2013

NOTICE: Your Student Health Insurance coverage, offered by Nationwide Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits for health insurance plans other than Student Health Insurance coverage for the 2012/2013 policy year. Minimum restrictions for policy year dollar limits for Student Health Insurance coverage are $100,000 for the 2012/2013 policy year. Your Student Health Insurance coverage has a limit of $100,000 per policy year. Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Consolidated Health Plans at 800-633-7867.

Preferred Provider Networks

By enrolling in this Insurance Program, you have access to Preferred Provider Networks, available to You and Your Dependents, if any, providing access to quality health care at discounted fees.

MagnaCare

In the New York and New Jersey areas and by enrolling in this Insurance Program, you have access to the MagnaCare Preferred Provider Network, available to You and Your Dependents, if any. A complete listing is available at www.magnacare.com.

MultiPlan

On a national level, you have access to the MultiPlan Preferred Provider Network. A complete listing is available at www.multiplan.com.

THE PROGRAM DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER, but if an eligible Expense is incurred through a Preferred Provider, You will receive the maximum coverage when you visit doctors, hospitals and other providers who belong to the MagnaCare Preferred Provider Network:

Payments are subject to:

- An aggregate maximum benefit;
- Limits as stated in the Policy Schedule of Benefits; and
- Terms and conditions of the Policy and any Exclusions and Other Insurance and Recovery Limits.

Dear Students and Parents:

Sarah Lawrence College is committed to promoting good health and meeting the medical needs of its students. A health insurance plan is critical in providing peace of mind, knowing that students can receive the services they need in the event of a sickness or injury.

The College requires all students to carry adequate medical insurance to help cover the extra expenses of medical treatment that are not covered by our Health Services. The Student Health Insurance Plan provides coverage to students for a 12-month period, September 1, 2012 to September 1, 2013. The Plan includes a local and national network of Preferred Providers, and is designed to be an affordable option. I urge you to enroll in this Plan for several reasons.

Although many families have some form of insurance, it's important to ensure that students are adequately covered while attending school. All too often situations arise where a student requires medical or mental health care beyond what is available at the SLC Health Center, only to discover that their insurance covers them only in the event of an emergency or in their home geographic region. This frequently results in students having to take an otherwise unnecessary leave of absence from college to return home in order to get the treatment they need. In other situations, the student's insurance plan may provide coverage in New York, but the lists of providers they must choose from is extremely limited and often are not close to campus, making access a significant problem. SLC Health Center staff members are rarely familiar with these providers and therefore cannot assist the student with any recommendations. Further, coverage that is provided is often insufficient in meeting the student's need. The result is an added out-of-pocket expense for parents who must pay privately for adequate care.

To assist you in making an informed decision regarding your student's health insurance needs, here are some general questions to ask your current health plan to ensure that it provides adequate coverage:

- Does your current health plan provide coverage while in the area of the Sarah Lawrence campus? Many HMO plans provide coverage for Emergency Treatment only, while out of area of the local HMO.
- Does your current health plan cover your daughter/son as long as they are a registered student at Sarah Lawrence College? Most employer plans drop dependents at a certain age or if a parent has a job change.

- Does your current health plan cover mental health services? Many employer-sponsored plans provide very limited coverage for mental health services.
- Does your current health plan provide coverage anywhere in the world, including medical evacuation and repatriation benefits, while the student is away from campus for academics, research, work, or vacation? Many employer-sponsored plans will only provide coverage while in the United States, and most do not include any medical evacuation or repatriation benefits.
- Does your current health plan include a nationwide network of Preferred Providers, guaranteeing acceptance of your insurance plan, and reducing the student's out-of-pocket expenses? Many employer-sponsored plans are managed-care type plans, with a regionally-based preferred provider network.
- Does your current health plan include Prescription Drug coverage, and a nationwide network of member pharmacies? Many employer sponsored plans do not provide prescription drug coverage, or only very limited benefits available at certain local pharmacies.
- Does your current health plan include coverage for Intercollegiate Sports? It is standard practice for employer-sponsored health plans to exclude coverage for all Intercollegiate Sports related injuries.

While the majority of students' health issues can be met by Health Services, there are times when outside specialists or additional consultation is warranted. At such times, the Student Health Insurance Plan sponsored by Sarah Lawrence College provides coverage worldwide and allows students to seek care from any licensed provider, once the referral from Sarah Lawrence Health Services is made. Students also have access to a nationwide Preferred Provider Network, as well as a national network of member pharmacies.

When students use a preferred provider, their out-of-pocket expenses can be limited as students' coinsurance expenses are based on negotiated Preferred Provider fees. The Plan provides coverage for expenses relating to injury or sickness including diagnostic testing, lab and x-ray services, doctor visits, and prescription drugs.

Students who determine that they have existing comparable coverage will need to complete and submit the online Waiver Form by August 15, 2012 for the Fall Term. It is your responsibility to carefully compare your current insurance plan

with that offered by SLC to ensure that the coverage is truly comparable. By signing the waiver, you are attesting to the fact that you are familiar with both plans and will be responsible for providing for your student's medical and/or mental health needs should your own insurance prove insufficient. If you do not have comparable health insurance, or do not submit the online Waiver Form by August 15, 2012, you will be required to purchase the Student Health Insurance Plan, and will automatically be enrolled.

We encourage you to read the Brochure and take the time to make an informed decision regarding your health coverage. If you have questions regarding the Student Health Insurance Plan, please contact Consolidated Health Plans at (800) 633-7867 or www.chpstudent.com.

Yours truly,

Nance Roy, Ed. D.
Director of Health Services

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WHERE TO FIND HELP

For questions about:

- Insurance Benefits (ext 191)
- Claims Processing (ext 191)
- Lost ID Cards (ext 137)

Please contact:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(800) 633-7867
Fax: (413) 733-4612
www.chpstudent.com

For questions about:

- Enrollment Process
- Waiver Process

Please contact:

University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
(800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.com
Email: info@univhealthplans.com

If you need medical attention before you receive your ID card, inform your healthcare provider that your insurance coverage is provided by Nationwide Life Insurance Company. Benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the health care provider to facilitate prompt payment of your claims.

For questions about:

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs

Please contact:

Express Scripts
(800) 451-6245
www.express-scripts.com

For Provider Listings

A complete list of Providers can be found by logging on to www.chpstudent.com or www.magnacare.com or www.multiplan.com.

Worldwide Web Access:

Consolidated Health Plans
www.chpstudent.com
University Health Plans, Inc.
www.universityhealthplans.com
Student Health Services
www.slc.edu/offices-services/healthservices

Sarah Lawrence College Student Health Services

Lyles House	Monday through Friday
914-395-2350	9 a.m. to 5 p.m.

Sarah Lawrence Health Services provides compassionate, informative and confidential care for our students' medical and mental health concerns. Regular services on campus for routine care, particular health problems and for short-term, outpatient treatment are provided at no cost.

Services Include:

- ✓ Medical and mental health coverage during the school year for routine, preventive and urgent care for the Sarah Lawrence undergraduate and graduate student population.
- ✓ Educational programs on a variety of medical and mental health issues relevant to college students.
- ✓ Referrals for long-term medical and psychological treatment with off-campus specialists, whenever warranted.

Physical Health

Our staff is specially trained to understand and treat problems that relate to college-age students and their lifestyles. Health Services is staffed primarily by Family Nurse Practitioners (FNPs) and Nurses while the College is in session. A local physician who is affiliated with Lawrence Hospital provides consultation to the Nurses and Nurse Practitioners, and is available to see students by appointment.

The Nurse Practitioners can:

- ✓ Diagnose and treat short-term physical illnesses and minor injuries.
- ✓ Prescribe common medications for acute illness.

- ✓ Give vaccinations or regular allergy injections and perform routine lab work.
- ✓ Test and treat sexually transmitted diseases including HIV testing.
- ✓ Perform annual gynecological exams and PAP tests and address routine gynecological problems and concerns.
- ✓ Provide birth control and sexual protection to both men and women, including emergency contraception (morning-after pill) for women, depot (DMPA) contraceptive injections and prescriptions for oral contraceptives.

Mental Health

Sarah Lawrence College Mental Health Services is staffed by licensed psychiatrists, psychologists, clinical social workers and post-doctoral fellows in clinical psychology who work under the supervision of the professional staff.

Common student concerns treated by our staff include depression, anxiety, eating disorders, substance abuse and relationship and family issues. Counseling services are available in three distinct treatment modalities: Brief Individual Psychotherapy, Group Psychotherapy and Dialectical Behavioral Therapy (DBT). All treatment, regardless of modality, begins with a comprehensive mental health evaluation by a staff clinician who then recommends a course of treatment for each student. In conjunction with psychotherapy, the staff psychiatrist is available for psychiatric medication evaluation, prescriptions and medication management. Appointments for evaluations and treatment are available Monday- Friday, 9 a.m. - 5 p.m.

Appointments

Health Services is located in Lyles House, near the Westlands Gate, at Mead Way and Boulder Trail. Our Offices are open for appointments Monday through Friday from 9 a.m. to 5 p.m. when the College is in session. Appointments for medical and mental health services can be made by calling the Health Services receptionist at (914) 395-2350.

Same-Day Appointments for Medical and Mental Health Services are available weekdays when the College is in session.

After Hours

When Health Services is closed, students can call Westlands desk at (914) 395-2222 for urgent medical and mental health needs. The desk will contact the on-call doctor as well as the College's on-call staff. If hospitalization is required, students will be transported to Lawrence Hospital in Bronxville, N.Y., or St. Joseph's Hospital in Yonkers, N.Y.

Health Education

One of the primary missions of Health Services is health education and outreach. By being well informed, students can make more educated and responsible choices for healthy living. A variety of educational programs and workshops are held throughout the year. Topics include dealing with depression and anxiety, substance abuse, relationship issues, managing stress and adjusting to college, to name a few.

Confidentiality

The Health Services professional staff conforms to standard professional, ethical and state-mandated procedures of confidentiality. Maintenance of records is in accordance with professional and legal guidelines. The student may authorize the release of confidential information to others by signing a standard release form available at Health Services.

Exceptions to the standard procedures of confidentiality occur when a student is assessed to be a danger to him/herself or others, when records are subpoenaed, or in reporting abuse (e.g., abuse or neglect of a minor) as required by law. In such cases, the student would be informed, if possible, and only the necessary information would be released.

Fees for Service

There are no fees for any of the regular services provided by the Health Services staff. Allergy injections, vaccinations and some medications are provided for a fee to cover costs. Any medications not available at Health Services may be purchased at a local pharmacy and might be covered by insurance, depending on students' insurance plans. Special diagnostic services such as laboratory tests, X-rays and diagnostic procedures are provided off campus. **Consultations with specialists in the community, as well as off-campus diagnostic procedures, are covered according to the Sarah Lawrence College Student Health Insurance Plan only after a referral is made by Sarah Lawrence Health Services staff.** (See the Referral Section of this Brochure for additional details regarding referral requirements.) Students who waive participation in the Sarah Lawrence Student Health Insurance Plan should check with their own insurance companies regarding coverage.

Sarah Lawrence College Student Health Insurance Plan

The Sarah Lawrence College Health Insurance Plan has been developed especially for Sarah Lawrence College students. The Plan provides coverage for Illnesses and Injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. Sarah Lawrence

College is pleased to offer the Plan as described in this Brochure.

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Policy Period

Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on September 1, 2012, and will terminate at 12:01 a.m. on September 1, 2013.

Coverage for all newly enrolled insured students for the Spring Semester will become effective at 12:01 a.m. on January 21, 2013 and will terminate at 12:01 a.m. on September 1, 2013.

Premium Rates

	Annual	Spring Semester
Student Only:	$2,491	$1,702
Spouse or Domestic Partner:	$6,320	$4,236
Child(ren):	$3,018	$2,035

Student Coverage Eligibility

All registered students of Sarah Lawrence College are automatically enrolled in the Student Health Insurance Plan.

Students who do not want to be enrolled must submit a completed Waiver Form and provide proof of comparable coverage (i.e., copy of current medical insurance ID Card) by **August 15, 2012** for the Fall Semester, or by **January 14, 2013** for students newly enrolled for Spring Semester. If you do not submit a completed Waiver Form by the waiver deadline date for the term you are enrolling in at Sarah Lawrence College, you will be responsible for the insurance premium posted to your student account.

Dependent Coverage Eligibility

Covered students may also enroll their lawful spouse or domestic partner, and dependent children under age twenty-six (26) for the same coverage.

Enrollment

To enroll the dependent(s) of a covered student, please complete a Dependent Enrollment Form, and return it to University Health Plans, Inc., together with your check, money order, or MasterCard/Visa payment. The dependent enrollment deadline date for the Fall Semester is **August 15, 2012**. The

enrollment deadline date for the Spring Semester is **January 14, 2013**. If the dependent Enrollment Form and premium are received after the semester start date of coverage, then coverage becomes effective the day after the postmarked date of the Enrollment Form.

Dependent Enrollment Forms are available:

- ✓ By contacting University Health Plans at: (800) 437-6448
- ✓ At Student Health Services

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for thirty-one (31) days from the date of birth or adoption. At the end of this thirty-one (31) day period, coverage will cease under the Sarah Lawrence College Student Health Insurance Plan. To extend coverage for a newborn past the thirty-one (31) days, the Covered Person must 1) enroll the child within thirty-one (31) days of birth and 2) pay the additional premium starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Person for thirty-one (31) days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the thirty-one (31) days, the Covered Person must 1) enroll the child within thirty-one (31) days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

For further assistance and premium information, please contact University Health Plans.

Handicapped Children

If You have Dependent coverage and that Dependent ceases to be eligible for coverage because of age, he or she will continue to be an Insured Person so long as the child is and continues to be both: 1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and 2) chiefly dependent upon You for support and maintenance. Proof of such incapacity and dependency must be furnished to Us within thirty-one (31) days of the child's attainment of the specified age and subsequently as may be required, but not more frequently than annually after the two-year (2) period following the child's attainment of the specified age.

Late Enrollment

Under certain circumstances, coverage for late enrollees may be possible. For the Fall Semester, any enrollment occurring after August 15, 2012 will be considered a late enrollment. For the Spring Semester, any enrollment occurring after January 14, 2013 will be considered a late enrollment. Contact University Health Plans, or refer to the Master Policy for details. Please refer to the Pre-Existing Conditions/Continuously Insured Provisions section of the online Brochure for information on Pre-Existing Conditions, which applies to all late enrollees under this Plan.

Pre-Existing Conditions / Continuously Insured Provisions

Pre-Existing Condition: Any Condition for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) months immediately prior to an Insured's Effective Date of Coverage; or (b) a pregnancy existing on the Insured's Effective Date of Coverage. **Limitation:** There is no Coverage for Pre-existing Conditions unless the Covered Person has had twelve (12) months of Continuous Coverage.

This limitation will not apply if, during the period immediately preceding the Covered Person's Effective Date of Coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for six (6) consecutive months. Prior Creditable Coverage of less than six (6) months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for Coverage within sixty-three (63) days of termination of his or her prior Coverage.

This limitation does not apply to Dependents under nineteen (19) years of age.

Continuous Coverage: The period of time that a Covered Person is continuously Insured under this Policy and/or any prior Creditable Coverage with no greater than a sixty-three (63) day lapse between the Effective Date of Coverage under this Policy and the termination of prior Creditable Coverage.

Previously insured students and dependents must re-enroll for coverage by **August 15, 2012**, for the Fall Semester and by **January 14, 2013**, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in Continuous Coverage occurs, the definition of a Pre-Existing Condition will apply in determining coverage of any condition which existed during the break.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student who has not incurred any claims and who withdraws from school during the first thirty (30) days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of premium will be made. Students withdrawing after such waiver deadline date will remain covered under this Plan for the full period for which premium has been paid. **No refund will be allowed.**

A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by Consolidated Health Plans within ninety (90) days of withdrawal from school.

Preferred Provider Network

Consolidated Health Plans has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the Sarah Lawrence College campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of Sarah Lawrence College, Consolidated Health Plans or Nationwide Insurance Company. A complete listing of participating providers is available at Student Health Services. You may also contact Consolidated Health Plans at (800) 633-7867 or for coverage in the New York and New Jersey areas, MagnaCare at (800) 235-7267 or for national coverage, MultiPlan at (800) 546-3887. Additionally, you can obtain information regarding Preferred Providers through the Internet by accessing www.magnacare.com or www.multiplan.com.

Referral Requirement

Student Health Services (SHS)

When the College is in full-session, and the Student Health Services is open, Insured Students must first visit the Student Health Services before seeking treatment and receive a referral in order to have treatment covered under the Health Insurance Plan.

Exceptions to the Referral Requirement for Insured Students:

- ✓ Medical Emergency (the student must return to Student Health Services for necessary follow-up care).
- ✓ When the Student Health Services is closed.
- ✓ Medical care received when the student is no longer eligible to use Student Health Services due to a change in student status.
- ✓ Gynecological care.
- ✓ When having a prescription filled under the pharmacy benefit.
- ✓ Insured dependents.

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred while covered under the Plan, not to exceed an Aggregate Maximum Benefit while continuously insured of $100,000 per Policy Year.

The payment of any Co-pays, Deductibles, the balance above any Coinsurance Amount, and any medical expenses not covered are the responsibility of the Covered Person.

To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximum. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

Summary of Benefits
HEALTH INSURANCE PLAN

The following benefits are subject to the Policy limitations and exclusions. All coverage is based on the Reasonable Charge allowance unless otherwise specified.

This Plan always pays benefits in accordance with any applicable New York Insurance Law(s).

AGGREGATE POLICY YEAR MAXIMUM

$100,000

ANNUAL DEDUCTIBLE

$150

ANNUAL OUT-OF-POCKET MAXIMUM

$1,500 (Deductible, non-covered services and prescription drug co-pays do not apply towards meeting the out-of-pocket maximum).

INPATIENT HOSPITALIZATION BENEFITS

Hospital Room and Board Expense

Covered Medical Expenses are payable as follows:

Preferred Care: 90% of the Negotiated Charge for an overnight stay.

Non-Preferred Care: 60% of the Reasonable Charge for the semi-private room rate for an overnight stay.

Intensive Care Unit Expense

Covered Medical Expenses are payable as follows:

Preferred Care: 90% of the Negotiated Charge for an overnight stay.

Non-Preferred Care: 60% of the intensive care room rate for an overnight stay.

MISCELLANEOUS HOSPITAL EXPENSE

Covered Medical Expenses include, but are not limited to: laboratory tests, x-rays, anesthesia, use of special equipment, medicines and use of operating room.

Covered Medical Expenses are payable as follows:

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Doctor Hospital Visit Expenses

Covered Medical Expenses for charges for the non-surgical services of the attending Doctor or a consulting Doctor are payable as follows:

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

SURGICAL BENEFITS (INPATIENT AND OUTPATIENT)

Surgical Expense

Covered Medical Expenses for charges for surgical services performed by a Doctor are payable as follows:

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Anesthetist Expense and Assistant Surgeon Expense

Covered Medical Expenses for the charges of an anesthetist and an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows:

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred: 60% of the Reasonable Charge.

OUTPATIENT BENEFITS

Covered Medical Expenses include, but are not limited to: Doctor's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, physical therapy, clinical lab, radiological facility or other similar facility licensed by the state.

Doctor's Office Visits

Covered Medical Expenses are payable as follows:

Preferred Care: 80% of the Negotiated Charge after a $15 co-pay per visit.

Non-Preferred Care: 60% of the Reasonable Charge after a $15 co-pay per visit.

Preventive/Wellness/Immunizations

Covered Medical Expenses are payable as follows:

Preferred Care: 100% of the Negotiated Charge; deductible does not apply.

Non-Preferred Care: Not Covered.

Hospital Emergency Care

Covered Medical Expenses for treatment of an Emergency Medical Condition in a hospital emergency room are payable as follows:

Preferred Care: 80% of the Negotiated Charge after a $100 co-pay per visit.

Non-Preferred Care: 80% of the Reasonable Charge after a $100 co-pay per visit.

Lab and X-Ray (Non-Hospital)

Covered Medical Expenses are payable as follows:

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Durable Medical Equipment

Covered Medical Expenses are payable as follows:

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

MENTAL HEALTH AND CHEMICAL ABUSE BENEFITS

Coverage for Adults and Children with Biologically Based Mental Illnesses and for Children with Serious Emotional Disturbances

Covered Medical Expenses are payable as any other Sickness.

Inpatient Expense—Mental Health

Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness, limited to a maximum of sixty (60) days per Policy Year.

Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Benefits will be payable in place of an inpatient admission, whereby two (2) days of partial hospitalization may be exchanged for one (1) day of full hospitalization.

Outpatient Expense—Mental Health

Covered Medical Expenses for the outpatient care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable up to a maximum of thirty (30) visits per Policy Year, as follows:

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 80% of the Reasonable Charge.

Inpatient Expense— Chemical Abuse

Covered Medical Expenses for the treatment of chemical abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness.

Covered Medical Expenses for detoxification are payable on the same basis as any other Sickness, up to a maximum of seven (7) days per Policy Year. Covered Medical Expenses for inpatient treatment is limited to a maximum of sixty (60) days per Policy Year.

Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Benefits will be payable in place of an inpatient admission, whereby two (2) days of partial hospitalization may be exchanged for one (1) day of full hospitalization.

Outpatient Expense— Chemical Abuse

Covered Medical Expenses for outpatient treatment of chemical abuse are payable up to a maximum of sixty (60) visits per Policy Year for outpatient treatment and to a maximum of twenty (20) visits per Policy Year for counseling.

Covered Medical Expenses for the care and treatment of chemical abuse by a licensed or accredited health service organization or hospital or by a fully-licensed practitioner are payable as follows:

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 80% of the Reasonable Charge.

ADDITIONAL BENEFITS

Women's Health Benefit (no referral required)

Covered Medical Expenses will include one (1) baseline mammogram for women between the ages of 35 and 40. Women age 40 and older have coverage for one (1) annual mammogram per Policy Year thereafter. Coverage will be provided more frequently if recommended by a Physician for a Covered Person who has a prior history of breast cancer or who has a first-degree relative with a prior history of breast cancer. Covered Medical Expenses are payable on the same basis as any Wellness/Preventive Care expense.

The Plan will pay for one (1) routine annual Pap smear screening, including the office visit, for women age 18 and older. Covered Medical Expenses are payable on the same basis as any Wellness/Preventive Care expense.

Prescription Contraceptive Medical Expenses

Covered Medical Expenses are payable and include any expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive.

Coverage of oral contraceptives, Lunelle, Depo-Provera, Patch or Ring is provided under the separate Prescription Drug portion of the Plan.

Prescription Drug Coverage Expense

Covered Medical Expenses for outpatient Prescription Drugs are payable as follows:

Preferred Care: 80% of the Negotiated Charge after a $10 Co-pay for each Generic Prescription Drug and a $25 Co-pay for each Brand-Name Prescription Drug. 100% of the Negotiated Charge for Generic Contraceptives; Co-pays do not apply.

Non-Preferred Care: 80% of the Reasonable Charge after a $10 Deductible for each Generic Prescription Drug and a $25 Deductible for each Brand-Name Prescription Drug.

Medications not covered by this benefit include, but are not limited to, drugs whose sole purpose is to promote or stimulate hair growth, appetite suppressants, and non-self injectibles.

Covered medications include oral contraceptives, Lunelle, Depo-Provera, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive is provided under the Medical portion of the Plan. Prior authorization is required for growth hormones and drugs which are used for the treatment of Malaria. For assistance, or for a complete list of excluded medications and drugs available with prior authorization, please contact (800) 451-6245.

Express Scripts: Eligible prescriptions must be filled at an Express Scripts participating pharmacy. Covered Persons will be given an ID card to show the pharmacy as proof of coverage. No claim forms need to be completed once this ID card is received. Until the card is received, eligible prescriptions may be filled, and claims will be paid on a reimbursement basis. Submit a completed Express Scripts claim form to the address provided on the form. Express Scripts claim forms and a list of participating pharmacies can be obtained by calling Express Scripts at (800) 451-6245 or by visiting their website at: www.express-scripts.com.

Non-Express Script: You may obtain your Prescription from a Non-Express Scripts Pharmacy and be reimbursed by submitting a completed Express Scripts Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge allowance, less any applicable Deductible, directly by Express Scripts. You will be responsible for any amount in excess of the Reasonable Charge.

Please note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. (Please refer to the Prescription Drug Claim Procedure section of this Brochure for information regarding the claim submission and reimbursement process.) Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Express Scripts at (800) 451-6245.

When submitting a claim, please include all Prescription receipts; indicate that you attend Sarah Lawrence College and include your name, address, and student identification number.

Ambulance Expense

Covered Medical Expenses are payable at 100% of the Reasonable Charge for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.

Maternity Care

Coverage for maternity care, including Complications of Pregnancy, starts with the date the Covered Person's Coverage becomes effective under the Policy. This Coverage will be provided for pregnancies that commence while the Covered Person is covered under this Policy, even after all other coverage under this Policy is terminated. We will pay Benefits for maternity care, including Hospital, surgical or medical care, to the same extent that coverage is provided for any other Sickness covered under the Policy. Such care other than coverage for Complications of Pregnancy, will include:

- Not less than two (2) payments, at reasonable intervals and for services rendered, for prenatal care, and a separate payment for delivery and postnatal care;
- Inpatient Hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section. If the mother should elect to be discharged earlier than the time frame in item 1 of this provision, the inpatient benefit will include at least one home care visit that will be in addition to any Home Health Care coverage available under this Policy. Such a visit may be requested at any time within 48 or 96 hours of the time of delivery and will be delivered within 24 hours of either the mother's discharge or of the time of the mother's request, whichever is later. This visit will not be subject to Deductibles, Coinsurance or Co-payments.

- The services of a licensed midwife who is affiliated or practicing in conjunction with a facility licensed according to public health law. We will NOT pay for duplicative routine services actually provided by both a licensed midwife and a Physician;
- Parent education, assistance and training in breast or bottle feeding; and
- The performance of any necessary maternal and newborn clinical assessments.

Voluntary Termination of Pregnancy

Covered Medical Expenses for voluntary termination of pregnancy are payable at 100% of Reasonable Charge up to a maximum of $500 per Policy Year.

Home Health Care Expenses

Covered Medical Expenses are payable as follows for charge incurred within twelve (12) months from the date of the first home health care visit. The maximum number of covered visits is limited to 40 visits per Policy Year. Four (4) hours of home health aide service shall be considered as one (1) home care visit.

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Second Medical Opinion

We will pay the Covered Medical Expenses incurred for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Pre-admission Testing

This Policy includes coverage for Pre-Admission Testing ordered by a Doctor performed in the outpatient facilities of a hospital as a planned preliminary to admission of the patient as an inpatient for surgery in the same hospital provided that:

1. The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
2. Reservations for a hospital bed and for an operating room were made prior to the performance of the tests;

3. The surgery actually takes place within seven (7) days of the tests; and
4. The patient is physically present at the hospital for the tests.

Treatment of Correctable Medical Conditions that Cause Infertility

This Policy does not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under this Policy solely because the medical condition results in infertility.

SUPPLEMENTAL MEDICAL COVERAGE

The Sarah Lawrence College Student Health Insurance Plan provides a maximum benefit $100,000 per Policy Year. Though this limit is sufficient to meet most students' insurance needs, some students may prefer a higher Plan maximum. An Optional Supplemental Major Medical Plan is available to students and their eligible dependents. If you purchase this Supplemental Plan and incur Covered Medical Expenses beyond $100,000 (the Plan maximum of the Sarah Lawrence College Student Health Insurance Plan and the Deductible for the Plan), the Company will pay 100% of the Reasonable Charge allowance incurred up to a combined maximum (of the Basic and Supplemental Plans) of $300,000 per Policy Year for students and dependents. Enrollment in the Supplemental Plan must take place at the same time as enrollment under the Basic Sarah Lawrence College Student Health Insurance Plan, and is subject to enrollment deadline dates. The Supplemental Plan will not provide coverage for any conditions excluded under the Basic Student Health Insurance Plan, and does not cover any Pre-Existing Conditions (a condition that first manifests itself prior to the effective date of coverage under the Supplemental Major Medical Plan), Sports-related Injuries, Prescription Drugs in excess of the $100,000 Basic Policy Year Maximum, or does not pay the Coinsurance not covered by the Basic Plan.

Please contact University Health Plans for additional information and an application if you are interested in purchasing this optional coverage.

GENERAL PROVISIONS

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable New York State Insurance Law(s).

Note: Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the Schedule of Benefits for coverage details.

Autism Spectrum Disorder

This Policy does not exclude coverage for diagnosis and treatment of medical conditions otherwise covered under the Policy because the treatment is provided to diagnose or treat Autism Spectrum Disorder.

Bone Mineral Density Tests

We shall pay Covered Medical Expenses for bone mineral density measurements, tests, drugs and devices approved by the Federal Food and Drug Administration or generic equivalents as approved substitutes. These benefits will be paid according to the criteria of the Federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy x-ray absorptiometry.

Covered Medical Expenses will be paid according to the criteria of the Federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Covered Persons qualifying for Benefits shall at a minimum, include Covered Persons:

1. previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
2. with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
3. on a prescribed drug regimen posing a significant risk of osteoporosis; or
4. with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
5. with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Cancer Screening Tests

We will pay the Covered Medical Expenses for the following cancer screening tests:

1. **Mammography Screening** for occult breast cancer as follows:
   a. Upon the recommendation of a Doctor, a mammogram at any age, a mammogram at any age for Insured Persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;
   b. A single baseline mammogram for Covered Persons age 35 to 39 inclusive;
   c. An annual mammogram for covered persons age 40 and older.
2. **Annual Cervical Cytology Screening (PAP tests)** for an annual cervical cytology screening (PAP tests) for cervical cancer and its precursor states for women as recommended by a Doctor. Such annual screening includes an annual pelvic exam, collection and preparation of the Pap smear and laboratory and diagnostic services provided in conjunction with examining and evaluating the Pap smear.
3. **Prostate Cancer Screening**, for standard diagnostic testing for prostate cancer, including but not limited to:
   a. a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and
   b. an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer factors.

Chiropractic Care Benefit

We will pay the Covered Medical Expenses incurred for chiropractic care, performed by a doctor of chiropractic, to the same extent as would be payable for Doctor's services in a Doctor's office. Chiropractic care must be in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Diabetic Education, Equipment, Supplies and Service

Equipment and supplies that may be Medically Necessary for the treatment of diabetes include, but are not limited to the following:

- Lancets and automatic lancing devices;
- Glucose test strips;
- Blood glucose monitors;
- Blood glucose monitors for visually impaired;
- Control solutions used in blood glucose monitors;
- Diabetes data management systems for management of blood glucose;
- Urine testing products for glucose and ketones
- Oral anti-diabetic agents used to reduce blood sugar levels;
- Alcohol swabs;
- Syringes;
- Injection aids including insulin drawing up devices for the visually impaired;
- Cartridges for the visually impaired;
- Disposable insulin cartridges and pen cartridges;
- All insulin preparations;
- Insulin pumps and equipment for the use of the pump including batteries;
- Insulin infusion devices;
- Oral agents for treating hypoglycemia such as glucose tablets and gels; and
- Glucagon for injection to increase blood glucose concentration.

We will also pay the Reasonable and Customary Expense for diabetes self management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. This Benefit will be limited to visits Medically Necessary upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Covered Person's symptoms or conditions that necessitate changes in a Covered Person's self-management or where reeducation or refresher education is necessary. Coverage also includes home visits when Medically Necessary. Such education may be provided by:

- The Doctor or other licensed health care provider legally authorized to prescribe under Title 8 of the education law,

  or their staff as part of an office visit for diabetes diagnosis or treatment; or
- A certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider.

Education provided by the certified diabetes nurse educator, certified nutritionist or registered dietitian is limited to group settings wherever practicable.

Covered Medical Expenses are payable as follows:

Inpatient

Preferred Care: 90% of the Negotiated Charge.

Non-Preferred Care: 60% of the Reasonable Charge.

Outpatient

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred : 60% of the Reasonable Charge.

Note: Coverage of diabetic test strips, lancets, insulin and syringes are a covered expense under the Prescription Drug Plan.

End of Life Care Expenses

Covered Medical Expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.

Enteral Formula Benefit

When an issued policy covers prescription drugs, as part of that benefit, We will pay the expenses incurred for the cost of Enteral Formulas for home use when prescribed by a Doctor or other licensed health care provider. Any prescription from the Doctor or licensed health care provider must state the use of such formulas is clearly Medically Necessary and has been proven effective as a disease-specific treatment for an Insured Person who is or who will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death.

Enteral formulas which are Medically Necessary and taken under written prescription from a Doctor for the treatment of specific diseases will be distinguished from nutritional supplements taken electively. Specific diseases for which enteral formulas have been proven effective include, but are not

limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation and death.

Coverage for certain inherited diseases of amino acid and organic acid metabolism will include modified solid food products that are low protein or which contain modified protein which are Medically Necessary.

Experimental Cancer Drugs

Coverage for prescribed drugs, approved by the Food and Drug Administration of the United States government for the treatment of certain types of cancer, will not exclude coverage of any such drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Coverage will not be provided for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. The provisions of this paragraph apply to cancer drugs only and nothing should be construed to create, impair, alter, limit, modify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

Experimental or Investigational Services Recommended by an External Appeal Agent

We will not exclude Benefits for health care services rendered or proposed to be rendered to a Covered Person on the basis that such service is Experimental or Investigational, is rendered as part of a clinical trial or is a pharmaceutical product prescribed by the Covered Person's attending Doctor for a use other than those uses for which the pharmaceutical product has

been approved for marketing by the U.S. Federal Food and Drug Administration, if the services have been recommended by an External Appeals Agent in response to an appeal filed by an Covered Person or his or her attending Doctor. Such an External Appeal recommendation is binding upon the Covered Person, the Doctor and Us. Any Benefits provided will be subject to the terms and conditions applicable to other Benefits provided under the Policy.

Pre-hospital Medical Emergency Services

We will pay the Covered Expenses incurred for pre-hospital medical emergency services for the treatment of an emergency condition when such services are provided by a certified ambulance service.

As used above: "Pre-hospital Emergency Medical Services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a Hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

"Emergency Condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Breast Cancer Benefit

Hospital facility services will be payable for such period of time as determined by the doctor, in consultation with you, to be medically

appropriate when you are undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy. Covered expenses for a mastectomy include prosthesis and physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the doctor and the patient. Such treatment will be subject to any deductible and coinsurance amounts shown in the schedule of benefits.

Eating Disorders

This Policy does not exclude Coverage for diagnosis and treatment of eating disorders when provided by a comprehensive care center.

Second Surgical Opinion

We will provide coverage for a second surgical opinion by a qualified physician on the need for surgery, subject to the following:

1. A qualified physician must be a board-certified specialist who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed;
2. Obtaining the second surgical opinion will be at the insured's option;
3. The benefit is applicable to all in-patient surgical procedures of a non-emergency nature covered under this Policy;
4. The benefit is payable only if the insured is examined in person by the physician rendering the second surgical opinion and a written report is provided to Us; and
5. If the Board-certified specialist who renders the second surgical opinion also performs the surgery, no second surgical opinion benefit is payable.

Coordination of Benefits

Benefits received from this Policy are coordinated with benefits, which the Covered Person may receive from certain other Plans. The Covered Person is urged to file any claims as early as possible with all insurance companies under which he or she has health coverage. This will help Us to provide the maximum Benefit due as soon as possible.

The total benefit received from all Plans may not exceed 100% of Allowable Expenses.

The Plan pays in accordance with the rules set forth in the Policy.

DEFINITIONS

Accident: An occurrence, which (a) is unforeseen, (b) is not due to or contributed to by Sickness or disease of any kind, and (c) causes Injury.

Actual Charge: The Actual Charge made for a covered service by the provider that furnishes it.

Aggregate Maximum: The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person.

Autism Spectrum Disorder: A neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.

Biologically-Based Mental Illness: A mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

Brand-Name Prescription Drug or Medicine: A prescription drug, which is protected by trademark registration.

Coinsurance: The percentage of the expense for which the Company is responsible for a covered service. The Coinsurance is separate and not a part of the Deductible and Copayment.

Co-payment/Co-pay: A specified dollar amount a Covered Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance or out-of-pocket maximum.

Covered Medical Expenses: As used herein means those charges for any treatment, services or supplies: (a) for Network Providers not in excess of the Preferred Allowance; (b) for Non-Network Providers not in excess of the charges of the Reasonable and Customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Covered Person except with respect to any covered expense payable under the Extension of Benefits Provision.

Covered Person: A covered student whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Creditable Coverage:

- Any individual or group Policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, and that arranges or provides medical, Hospital, and surgical Coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion Coverage but does not include accident only, credit, Coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, Coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which Benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
- The Federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

Deductible: A specific amount of Covered Medical Expenses that must be incurred by, and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Doctor: Any of the following to the extent they are authorized by law and duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy: Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage**.**

Elective Treatment: Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's Effective Date of Coverage. Elective treatment includes, but is not limited to:

Vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; and treatment of infertility.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate, medical attention to result in (a) placing the health of the person afflicted with such condition in severe jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious dysfunction of any bodily organ or part of such person, or (d) serious disfigurement of such person. It does not include elective care, routine care, or care for non-emergency Sickness.

Generic Prescription Drug or Medicine: A Prescription Drug, which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Injury: Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider; if, as determined by Nationwide Life Insurance Company (a) the service or supply could have been provided by a Preferred Care Provider and (b) the provider is of a type that falls into one (1) or more of the categories of providers listed in the Directory.

Non-Preferred Care Provider (or Non-Preferred Provider): A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Out-of-Pocket Maximum Expense: The maximum dollar amount an Insured is required to pay out during a Policy Year subject to the limitations listed below: Once an Insured individual has reached the applicable Out-of-Pocket Maximum

(as stated above) within a Policy Year for Covered Medical Expenses (not including Prescription Drugs), the Policy will pay 100% up to the overall Policy Maximum benefit. Any applicable In-Network Co-pays, Out-of-Network Deductibles, or expenses in excess of the Reasonable & Customary Charges do not apply towards meeting the Out-of-Pocket Maximum. Charges in excess of any specified maximum and non-covered services are not applied toward meeting the Out-of-Pocket Maximum and are the responsibility of the Insured.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

Pre-Existing Condition: Any Injury, Sickness, or condition for which medical advice, diagnosis, or treatment was recommended or received within six (6) months prior to the Covered Person's effective date of insurance.

Prescription: An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Reasonable and Customary Expense (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The charge which would have been made by the Provider of medical services for a comparable service or supply made by other Providers in the same geographic area, as reasonably determined by Us for the same service or supply.

No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Reasonable and Customary expense.

Serious Emotional Disturbance of a Child: Persons under the age of eighteen (18) years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

(i) serious suicidal symptoms or other life-threatening self-destructive behaviors;
(ii) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
(iii) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or

(iv) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

EXCLUSIONS

The Policy does not cover loss nor provide Benefits for:

1. International Students Only - Covered Medical Expenses incurred while in the student's home country, however coverage will be provided in the possessions of the United States, Canada and Mexico;
2. Dental care or treatment, except for such care and treatment due to Accidental Injury to sound, natural teeth within twelve (12) months of the accident and except for care and treatment due to congenital disease or anomaly;
3. Professional services rendered by a Family Member;
4. Eyeglasses, hearing aids, and examination for the prescription or fitting thereof;
5. Foot care in connection with corns, calluses, flat feet, fallen arches, week feet, chronic foot strain or symptomatic complaints of the foot;
6. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
7. Covered Medical Expenses provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable;
8. Services for which no charge is normally made;
9. Loss incurred as the result of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
10. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces or units auxiliary thereto;

11. Treatment provided in a government hospital, except for a non-service related Injury or Sickness rendered at a Veterans' Hospital;
12. Accident resulting from the Insured Person participating in a felony, riot or insurrection;
13. Coverage for custodial care as defined in 11 NYCRR 52.16(1) and for transportation;
14. Coverage for rest cures.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

EXTENSION OF BENEFITS

The coverage provided under this Policy ceases on the termination date. However, if an Insured is Hospital confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date or totally disabled on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of twelve (12) months or until date of discharge, whichever is earlier.

TERMINATION OF STUDENT COVERAGE

Insurance for a covered student will end on the first of these to occur:

1. the date the Policy terminates;
2. the last day for which any required premium has been paid;
3. the date on which the covered student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within ninety (90) days from withdrawal.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term for which they are enrolled and for which premium has been paid.

MEDICAL EVACUATION EXPENSE

(International Students and/or Dependents Only) – If an Insured Person is unable to continue their academic program as the result of a Covered Injury or Sickness occurring while he or she is covered under this Policy, We will pay the necessary

reasonable and customary charges, not to exceed the specified benefit shown in the Schedule of Benefits, for evacuation to another medical facility of the Insured Person's home country. A medical evacuation would be considered only if medically necessary, and after a Hospitalization of at least five (5) days. Any expenses payable under this benefit require approval of the attending Doctor as well as Ours.

REPATRIATION EXPENSE

(International Students and/or Dependents Only) – In the event of the death of an Insured Person, while he or she is covered under this Policy, We will pay the necessary Reasonable and Customary charges, not to exceed the specified benefit shown in the Schedule of Benefits, for preparation and transportation of the remains to the Insured Person's place of residence in his or her home country. Any benefits payable under this provision require Our prior approval.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

This benefit provides Accidental Death and Dismemberment coverage of up to $10,000.

Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of $10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech or hearing, please refer to your Master Policy available at your school.)

To file a claim for Accidental Death and Dismemberment, please contact Consolidated Health Plans at (800) 633-7867 for the appropriate claim forms.

IMPORTANT NOTE

Please keep this Brochure as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This student plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

This insurance Policy provides limited benefits for Student Health Insurance ONLY. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare Supplement, long-term care insurance, nursing home insurance only, home health care insurance only, a nursing home and home health care insurance as defined by the New York State Insurance Department. This insurance coverage is being offered on a primary basis. The insurance Policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore important to read this brochure carefully.

This above disclosure is included as required by New York Insurance Regulation Section 52.10 and 52.59. Sarah Lawrence College Student Health Insurance benefits are described in this Brochure.

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.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.

For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.

If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 *or* if you are in a foreign country, call collect at: 1-410-453-6330**.**

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

CLAIM PROCEDURES

In the event of Covered Accident or Sickness:

1. **Contact your Student Health Services, if available.** They will provide primary care and, if necessary, refer You to a MagnaCare or MultiPlan Preferred Provider located nearby for treatment at reduced cost. A referral from Health Services is required for coverage of treatment provided off campus (exceptions are listed in the Referral Requirement section).
2. **Itemized billings:** Written Proof of Loss must be submitted by You or Your health care provider to Consolidated Health Plans within ninety (90) days of treatment, or as soon as reasonably possible.

To appeal a claim: send a letter stating the issues of the appeal to Consolidated Health Plans' Appeal Department at the address below. Include your name, phone number, address, school attended and email address, if available.

Claims will be reviewed and responded to within sixty (60) days by Consolidated Health Plans.

Managed Care Grievance Procedure

Please refer to the policy for complete details on the Managed Care Grievance Procedure, Medical Review and External Appeal Procedure which is on file at Student Health Services.

Legal Action

No action at law or in equity should be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is to be furnished.

Claims Administrator:

CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540
Toll Free (800) 633-7867
www.chpstudent.com

For a copy of the Company's privacy notice, go to:
www.consolidatedhealthplan.com/about/hipaa

2012-2013

STUDENT HEALTH INSURANCE PLAN

The Plan is underwritten and offered by:

Nationwide Life Insurance Company

Columbus, Ohio

Policy Number: 302-075-3110

Vision Benefits

For Vision Discount Benefits please go to:

www.chpstudent.com

(DETACH AND RETAIN IF YOU ARE INSURED)

TEMPORARY INSURANCE IDENTIFICATION CARD

SARAH LAWRENCE COLLEGE

2012-2013

STUDENT HEALTH INSURANCE PLAN

For Claim Information Contact:

Consolidated Health Plans - 800-633-7867

2077 Roosevelt Avenue, Springfield, MA 01104

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(Insured Student – Print Name)

Policy Number: 302-075-3110

Underwritten by

NATIONWIDE LIFE INSURANCE COMPANY

SARAH LAWRENCE COLLEGE 2012-2013 SUMMARY OF BASIC INSURANCE BENEFITS
UP TO $100,000 MAXIMUM BENEFIT PAID AS SPECIFIED BELOW

The chart below shows how the plan pays benefits for the major types of health plan expenses. Please note the difference in cost if you seek the services of a Preferred Provider. By using a Preferred Provider, you will lower your out-of-pocket expenses, and extend the overall benefits available to you under the plan.

PLEASE NOTE THE FOLLOWING:

- In-Network Charges are covered at the Negotiated Rate. Out-of-Network Charges are covered at the Reasonable and Customary Rate (R&C).
- Referral from Student Health Services (SHS) is required before any benefits will be paid under the Health Insurance Plan. The Referral Requirement is waived under the following circumstances:
    - Medical Emergency (the student must return to SHS for necessary follow-up care).
    - When the SHS is closed.
    - Medical Care received when the student is no longer eligible to use SHS due to a change in student status.
    - Gynecological Care, including Maternity Care.
    - When having a prescription filled under the pharmacy benefit.
    - Insured Dependents.

Aggregate Policy Year Maximum:	$100,000
Plan Deductible:	$150 per policy year
Annual Out-of-Pocket Maximum:	$1,500 (deductible, non-covered services and prescription drug co-pays do not apply towards meeting the Out-of-Pocket Maximum).
Referral Requirement:	Except as outlined in this flyer, all non-emergency services require a referral from the Student Health Services in order to be eligible for coverage.

The following summary is intended as an overview of the benefits provided under the 2012-2013 Sarah Lawrence College Student Health Insurance Plan. To view the full plan brochure, including plan limitations and exclusions, please visit www.universityhealthplans.com, and click on "Sarah Lawrence College".

RATES	Annual	Spring
Student:	$2,491	$1,702
Spouse or Domestic Partner:	$6,320	$4,236
Child(ren):	$3,018	$2,035

Benefit	**In-Network** **NY/NJ area - MagnaCare – Preferred Providers can be found on-line at www.magnacare.com** **Nationally – MultiPlan – Preferred Providers can be found on-line at www.multiplan.com**	**Out-of-Network**
Hospital Inpatient: including Room & Board, Intensive Care Unit, Miscellaneous charges and nonsurgical services of the attending Physician or a consulting Physician.	90% of the Negotiated Rate	60% of the R&C
Surgical Benefits (Inpatient and Outpatient) including Surgeon, Assistant Surgeon and Anesthetist.	90% of the Negotiated Rate	60% of the R&C
Outpatient Benefits: Including Physician Office Visit, Lab and X-Ray.	80% of the Negotiated Rate after a $15 co-pay per visit	60% of the R&C after a $15 co-pay per visit
Emergency Room: for treatment of an Emergency Medical Condition	80% of the Negotiated Rate after a $100 co-pay per visit	80% of the R&C after a $100 co-pay per visit
Preventive/Wellness & Immunizations:	100% of the Negotiated Rate; Deductible does not apply.	Not Covered
Ambulance Expense:	100% of the Negotiated Rate	100% of the R&C
Maternity Expense:	Covered on the same basis as any other Sickness.	
Voluntary Termination of Pregnancy:	100% up to $500 per policy year	100% up to $500 per policy year
Biologically-Based Mental Illness: (Inpatient and Outpatient)	Covered on the same basis as any other Sickness.	
Inpatient Mental Health - Non-Biologically-Based: Maximum of sixty (60) days per policy year	Covered on the same basis as any other condition	
Outpatient Mental Health- Non-Biologically-Based: Maximum of thirty (30) visits per year	80% of the Negotiated Rate	80% of the R&C
Inpatient Chemical Abuse: Maximum of sixty (60) days per policy year; seven (7) days for detoxification	Covered on the same basis as any other condition	
Outpatient Chemical Abuse: Maximum sixty (60) visits for treatment and twenty (20) visits for counseling per policy year	80% of the Negotiated Rate	80% of the R&C
Medical Evacuation Expense: (International Students Only)	100% of R&C, not to exceed $10,000	
Repatriation Expense: (International Students Only)	100% of R&C, not to exceed $7,500	
Prescription Drugs: Deductible does not apply.	Plan pays 80% of the Negotiated Rate after a $10 co-pay per generic and a $25 co-pay per brand name prescription. Plan pays 100% of the Negotiated Rate for generic contraceptives; Co-pays do not apply. Participating Pharmacies can be found on-line at www.express-scripts.com.	Plan pays 80% of the R&C after a $10 co-pay per generic and a $25 co-pay per brand name prescription. Please Note – if you fill a prescription at an out-of-network pharmacy, you will be required to pay for the prescription up front, and submit the receipt to the claims administrator for reimbursement, less the applicable co-pay.