

Sarah Lawrence College - 2014-2015 SCHEDULE OF BENEFITS

	In-Network	Out-of-Network
Policy Year Maximum Benefit (includes Medical Evacuation & Repatriation)	Unlimited	
Deductible	\$150 Per Policy Year	
Out-of-Pocket Maximum (includes Coinsurance and Copayments; does not include non-covered medical expenses or elective treatment)	\$6,350 per Individual//\$12,700 Family	No Maximum
Referral Requirement	Referral from Student Health Services (SHS) is required before any benefits will be paid under the Health Insurance Plan.	
Coinsurance	Preferred Allowance (PA)	Reasonable & Customary (R&C)
Preventive/Wellness & Immunization Services deductible does not apply	100% of PA	60% of R&C
Outpatient Services (other than Surgery, Maternity, Mental Health/Drug or Alcohol)		
Office Visits (includes Specialists/Consultants), benefits are limited to one (1) visit per day and do not apply when related to surgery or physiotherapy.	80% of PA after a \$15 co-pay	60% of R&C after a \$15 co-pay
Diagnostic Imaging, X-ray and Laboratory Services	80% of PA	60% of R&C
Inpatient Services – (other than Surgery, Maternity, Mental Health/Drug or Alcohol, except as specified)		
Miscellaneous Hospital Services	90% of PA	60% of R&C
Room and Board expense, at the semi-private room, general nursing care, and ICU	90% of PA	60% of R&C
Physician visits (includes Specialists/Consultants), benefits are limited to one (1) visit per day and do not apply when related to surgery.	90% of PA	60% of R&C
Skilled Nursing and Sub-Acute Care Facilities	90% of PA	60% of R&C
Surgical Services (Inpatient & Outpatient) -		
Surgeon's Fee / Assistant Surgeon/ Anesthetist Services	90% of PA	60% of R&C
Hospital Miscellaneous includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	90% of PA	60% of R&C
Obesity surgery(Treatment of Morbid Obesity)	90% of PA up to \$5,000, 50% thereafter	60% of R&C
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.		
Maternity care and pre-natal services	Paid the same as any other Sickness	
Voluntary Sterilization Surgery (such as vasectomy) (Note: Sterilization procedures for women are covered under preventive.)	Paid the same as any other Sickness	
Mental Conditions & Substance Abuse		
Inpatient Services	Paid the same as any other Sickness	
Biologically Based Mental Illness & Substance Abuse outpatient office visits	80% of PA	80% of R&C
Non-Biologically Based Mental Illness Outpatient Office Visits	80% of PA	80% of R&C
Urgent Care and Emergency Services		
Urgent Care	90% of PA	60% of R&C
Emergency services. Co-pay waived if admitted (In-network Out-of-Pocket Maximum applies to Out-of-Network services)	80% of PA after \$100 co-pay per visit	80% of R&C after \$100 co-pay per visit
Emergency Medical Transportation services	100% of PA	100% of R&C
Other Services		
Allergy Services (testing/injections/treatment)	90% of PA	60% of R&C
Habilitative and Rehabilitative therapy – including Physical, Speech and Occupational Therapy	90% of PA	60% of R&C
Chiropractic	80% of PA after a \$15 co-pay per visit	60% of R&C after a \$15 co-pay per visit
Home Health Care – forty (40) visit maximum per Policy Year	90% of PA	60% of R&C
Hospice	100% of PA	100% of R&C
Diabetic treatment and Education	Paid the same as any other Sickness	
Durable Medical Equipment (DME) – includes Prosthetic and Orthotic Devices	90% of PA	60% of R&C
Prescription Drug Expense <ul style="list-style-type: none"> • Only a thirty (30) day supply can be dispensed at any time • One (1) copayment per thirty (30) day supply • Copayments apply to the out-of-pocket • Prescriptions must be filled at an "Express Scripts" participating pharmacy. • 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 CHP for reimbursement, less the applicable co-pay. 	80% of PA after: \$15 co-pay per generic drug \$25 co-pay per brand name drug 100% of PA for generic contraceptives; Co-pays do not apply.	80% of R&C after: \$15 co-pay per generic drug \$25 co-pay per brand name drug
Routine Vision Exam for Covered Persons under nineteen (19) – limited to one (1) exam per Policy Year. Includes prescription eye glasses (lenses & frames), or contact lenses in lieu of eyeglasses, limited to once per Policy Year.	100% of R&C up to \$150, 50% thereafter.	
Hearing aids	Up to \$1,500 PPY every 3 years	
Intercollegiate and Club Sports, up to \$90,000 Policy Year maximum.	Paid the same as any other Injury	
Home Country Coverage (Only for International Students/Dependents who have purchased the Supplemental Home Country Coverage Plan), for medical treatment provided in the Covered Person's Home Country, if not covered by any other coverage.	Paid the same as any other Condition	
Services not covered under this plan: TMJ; Gender reassignment surgery; adult vision exams (eye glasses/contacts); adult dental services, for age 19 and older; advanced infertility treatment; acupuncture; non-emergency treatment outside of the United States (except as specified) and private duty nursing.		