SARAH · LAWRENCE · COLLEGE

Sarah Lawrence College
Underwritten by: Wellfleet New York Insurance Company
2020-2021 Student Health Plan
Group No: ST0778SH
Policy No: WNY2021NYSHIP07

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

Who Is Eligible To Enroll?

If You are a registered student, You are eligible for coverage and will be automatically enrolled in and charged for coverage under the Plan unless You provide proof of comparable coverage and complete an online waiver form at https://www.universityhealthplans.com by the applicable waiver deadline date listed below.

Important Dates and Deadlines:

Waiver Deadline: July 8, 2020

How Do I Enroll/Waive Coverage?

New and returning students for the 2020 - 2021 Academic Year who determine that they have existing comparable coverage will need to complete and submit the online Waiver Form by July 8, 2020. If you do not have comparable health insurance, or do not submit the online Waiver Form by July 8, 2020, you will be automatically enrolled in the Student Health Plan and charged for the coverage.

Cost and Periods of Coverage*

	Annual 8/15/20 to 8/14/21	Fall (Graduating students only) 8/15/20 to 12/31/20	Spring (New Students in the Spring only) 1/1/21 to 8/14/21
Student Only	$2,757	$1,050	$1,707

*The above rates include an administrative fee.

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

- Vision discount program through Davis Vision
- Medical Travel Assistance Through Travel Guard
- 24-hour nurse line
- 24/7 Behavioral Health Hotline/CareConnect.

Where Can I Obtain More Information About The Plan?

Waive off the insurance plan:	www.universityhealthplans.com
Insurance Benefits Claim Processing ID Cards	www.wellfleetstudent.com
Find Network Provider:	Cigna www.cigna.com
Find Prescription Drug Provider:	www.wellfleetstudent.com

HEALTH INSURANCE BENEFIT SUMMARY*

BENEFIT	IN-NETWORK	NON-NETWORK
Deductible	$150	$150
Out-of-Pocket Expense Limit	$6,350 Individual	None
BENEFIT	IN-NETWORK	NON-NETWORK
Coinsurance Amount	20%	40%
Preventive Care	Covered in full	30% Not subject to Deductible
Hospital Room & Board (Inpatient)**	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Primary Care Office Visits (or Home Visits)	$15 Copayment 20% Coinsurance After Deductible	$15 Copay 40% Coinsurance After Deductible
Outpatient Mental Health and Substance Abuse	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Emergency Services Expense (Copay waived if admitted)	$100 Copay 20% Coinsurance Not subject to Deductible	$100 Copay 20% Coinsurance Not subject to Dductible
Chiropractic Services**	$15 Copay 20% Coinsurance After deductible	$15 Copay 40% Coinsurance After deductible
Diagnostic X-ray & Laboratory	20% Coinsurance After deductible	40% Coinsurance After deductible
Outpatient Prescription Drugs (Not subject to deductible)	Tier 1 $20 copay 20% Coinsurance Tier 2 $30 copay 20% Coinsurance Tier 3 $30 copay 20% Coinsurance	Tier 1 $20 copay 20% Coinsurance Tier 2 $30 copay 20% Coinsurance Tier 3 $30 copay 20% Coinsurance

*This is only a brief description of the coverage(s) available under Certificate form NY SHIP Cert (2020). The Certificate will contain reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

**Preauthorization is required for inpatient hospital, surgery and selected outpatient services. For inpatient hospital, preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a hospital certified pursuant to Article 28 of the Public Health Law.

Underwritten By:
Wellfleet New York Insurance Company

Plan Administrator:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
www.wellfleetstudent.com
(877) 657-5030

Exclusions and Limitations
No coverage is available under the Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in the Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of the Certificate unless medical information is submitted.

E. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of the Certificate.

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of the Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.
We do not Cover any illness, treatment or medical condition due Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when a Member has a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in the Member's legs or feet.

I. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

J. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Policy.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

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

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

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

O. Services Provided by a Family Member.
We do not Cover services performed by a member of the Member's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of the Member or the Member's Spouse.

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

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

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Policy.

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

T. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.