GeoBlue
International Health Insurance for Higher Education

geobluestudents.com

GeoBlue Study Abroad Plan Renewal

Sarah Lawrence College

September 1, 2023

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued in the District of Columbia by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. This coverage is offered to the members of the Global Citizens Association, Washington, D.C.

GeoBlue, 933 First Avenue, King of Prussia, PA 19406
1.855.682.7965 | 1.610.254.5300 | fax 1.610.482.9953

GeoBlue

Schedule of Benefits: GeoBlue Study Abroad

Policy Year: 2023 - 2024

Medical Expense Benefits

Sarah Lawrence College
SCHEDULE OF BENEFITS
Metal Value: Platinum / Actuarial Value: 100.00%

Note: *Medically Necessary Treatment in the United States is only covered for medical emergencies while covered under the Plan. If covered, expenses are covered at 100% of the Allowed Amount*

Benefit Description	Cost Sharing Outside the U.S.	Notes/ Limits
Medical Limit	Unlimited	
Deductible	$0	
Out-of-Pocket Limit	n/a	
OFFICE VISITS		
Primary Care Office Visits (or Home Visits)	Covered in full	See benefit for description
Specialist Office Visits (or Home Visits)	Covered in full	See benefit for description
PREVENTIVE CARE – See benefit for description		
Well Child Visits and Immunizations	Covered in full	
Adult Annual Physical Examinations	Covered in full	
Adult Immunizations	Covered in full	
Routine Gynecological Services/Well Woman Exams	Covered in full	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	
Sterilization Procedures for Women	Covered in full	
Vasectomy	Covered in full	
Bone Density Testing	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
EMERGENCY CARE		
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	See benefit for description
Non-Emergency Ambulance Services	Covered in full	See benefit for description
Emergency Department	Covered in full	See benefit for description
Urgent Care Center	Covered in full	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Acupuncture	Covered in full	See benefit for description
Advanced Imaging Services	Covered in full	See benefit for description
Allergy Testing and Treatment	Covered in full	See benefit for description

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Benefit Description	Cost Sharing Outside the U.S.	Notes/ Limits
Ambulatory Surgical Center Facility Fee	Covered in full	See benefit for description
Anesthesia Services (all settings)	Covered in full	See benefit for description
Cardiac and Pulmonary Rehabilitation	Covered in full	See benefit for description
Chemotherapy and Immunotherapy	Covered in full	See benefit for description
Chiropractic Services	Covered in full	See benefit for description
Clinical Trials	Covered in full	See benefit for description
Diagnostic Testing	Covered in full	See benefit for description
Dialysis	Covered in full	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in full	60 visits per condition, per Plan Year combined therapies
Home Health Care	Covered in full	40 visits per Plan Year
Infertility Services	Covered in full	See benefit for description
Infusion Therapy	Covered in full	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	Covered in full	See benefit for description
Interruption of Pregnancy		
• Medically Necessary Abortions	Covered in full	Unlimited
• Elective Abortions	Covered in full	One (1) procedure per Plan Year
Laboratory Procedures	Covered in full	See benefit for description
Maternity and Newborn Care		
• Prenatal Care	Covered in full	See benefit for description
• Inpatient Hospital Services and Birthing Center	Covered in full	
• Physician and Midwife Services for Delivery	Covered in full	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	Covered for duration of breast feeding
• Postnatal Care	Covered in full	
Outpatient Hospital Surgery Facility Charge	Covered in full	See benefit for description
Preadmission Testing	Covered in full	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities	Covered in full	See benefit for description
Diagnostic Radiology Services	Covered in full	See benefit for description
Therapeutic Radiology Services	Covered in full	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in full	60 visits per condition, per Plan Year combined therapies
Retail Health Clinic Care	Covered in full	
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Covered in full	See benefit for description

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Benefit Description	Cost Sharing Outside the U.S.	Notes/ Limits
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)	Covered in full	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES		
Diabetic Equipment, Supplies and Self-Management Education		Cost -sharing for an insulin drug shall not exceed $100 per 30-day supply.
• Diabetic Equipment Supplies and Insulin (Up to a 90-day supply).	Covered in full	See benefit for description
• Diabetic Education	Covered in full	See benefit for description
Durable Medical Equipment and Braces	Covered in full	See benefit for description
External Hearing Aids	Covered in full	Single purchase once every three (3) years
Cochlear Implants	Covered in full	One (1) per year per time Covered
Hospice Care		
• Inpatient	Covered in full	210 days per Plan Year
• Outpatient	Covered in full	Five (5) visits for family bereavement counseling
Medical Supplies	Covered in full	See benefit for description
Prosthetic Devices		
• External	Covered in full	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements
• Internal	Covered in full	Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES		
Autologous Blood Banking	Covered in full	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	Covered in full	See benefit for description
Observation Stay	Covered in full	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	Covered in full	200 days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	Covered in full	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Covered in full	
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES (*All mental health and substance use benefits will be paid at the same level of coinsurance as any other illness/injury*)		
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	Covered in full	See benefit for description

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Benefit Description	Cost Sharing Outside the U.S.	Notes/ Limits
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	Covered in full	See benefit for description
ABA Treatment for Autism Spectrum Disorder	Covered in full	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	Covered in full	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	Covered in full	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS		**Limits**
*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy. A member’s out-of-pocket costs for prescription insulin drugs shall not exceed $100 per 30-day supply, regardless of the amount or type of insulin that is needed to fill such member’s prescription.		
Retail Pharmacy Tier 1- Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	 $0 Copayment per 30-day supply $0 Copayment per 30-day supply $0 Copayment per 30-day supply	See benefit for description
Up to a 90-day supply for Maintenance Drugs are available at retail level – copays apply for each 30-day supply		
Mail Order Pharmacy Up to a 90-day supply Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	 $0 Copayment per 30-day supply $0 Copayment per 30-day supply $0 Copayment per 30-day supply	See benefit for description
Enteral Formulas Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-Preferred Brand	 $0 Copayment per 30-day supply $0 Copayment per 30-day supply $0 Copayment per 30-day supply	See benefit for description
WELLNESS BENEFITS		
Gym Reimbursement	Up to $200 per six (6) month period	
PEDIATRIC DENTAL and VISION CARE		
Pediatric Dental Care Benefits are the same for Participating or Non-Participating Providers • Preventive Dental Care	 20% Coinsurance	One (1) dental exam and cleaning per six (6)-month period

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Benefit Description	Cost Sharing Outside the U.S.	Notes/ Limits
• Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics	20% Coinsurance 50% Coinsurance 50% Coinsurance	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care Benefits are the same for Participating or Non-Participating Providers • Exams • Lenses and Frames • Contact Lenses	0% Coinsurance 0% Coinsurance 0% Coinsurance	One (1) exam per Plan Year; One (1) prescribed lenses and frames per Plan Year or One-year supply of Contact lenses per Plan Year
OTHER ADDITIONAL BENEFITS		
Emergency Medical Transportation	Maximum Benefit up to $250,000	See benefit for description
Repatriation of Mortal Remains	Maximum Benefit up to $50,000	
Emergency Family Travel Arrangements	Maximum Benefit up to $5,000	
Accidental Death & Dismemberment Benefit	Maximum Benefit: Principal Sum up to $10,000 per insured Member	See benefit for description

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

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

C. **Conversion Therapy.** We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an 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 this 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 this Certificate unless medical information is submitted.

E. **Coverage Inside the United States**

We do not Cover care or treatment provided inside the United States or its possessions except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

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

G. **Experimental or Investigational Treatment:** We do not Cover any health care service, procedure, treatment, device or Prescription Drug that

is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this 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 this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

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

I. **Foot Care:** We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. **Government Facility:** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

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

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

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

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

O. **Services Not Listed:** We do not Cover services that are not listed in this Certificate as being Covered.

P. **Services Provided by a Family Member:** We do not Cover services performed by a covered person's immediate family. "Immediate family" member means a child, stepchild, spouse, parent stepparent, sibling stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

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

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

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

T. **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.

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This is only a summary of benefits. For more information about the benefits covered under this Plan, including benefit descriptions and other important information about the Plan, please see the full Certificate of Coverage. In the event of a discrepancy between this document and Certificate of Coverage, the Certificate controls.