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: 2025-2026**

## 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 | |
| **Colon Cancer Screening** | Covered in full | |
| **Vasectomy** | Covered in full | |
| **Bone Density Testing** | Covered in full | |
| **Prostate Cancer Screening** | Covered in full | |
| **All other preventive services required by USPSTF and HRSA.** | Covered in full | |
| **EMERGENCY CARE** | | |
| **Emergency Ambulance Transportation** (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance | Covered in full | See benefit for description |
| **Non-Emergency Ambulance Services** (Ground and Air Ambulance) | Covered in full | See benefit for description |
| **Emergency Department** | Covered in full | Health care forensic examinations performed under Public Health Law §2805-l are not subject to Cost-Sharing |
| **Urgent Care Center** | Covered in full | See benefit for description |

| Benefit Description | Cost Sharing Outside the U.S. | Notes/ Limits |
|---|---|---|
| **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 |
| **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**<br>• Abortion Services | Covered in full | See benefit for description |
| **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 | Covered in full | 60 visits per condition, per Plan Year combined therapies |

| Benefit Description | Cost Sharing Outside the U.S. | Notes/ Limits |
|---|---|---|
| Therapy) | | |
| **Retail Health Clinic Care** | Covered in full | |
| **Second Opinions on the Diagnosis of Cancer, Surgery and Other** | Covered in full | See benefit for description |
| **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** | | |
| • Diabetic Equipment and Supplies | Covered in full | See benefit for description |
| • Diabetic Insulin (30-day supply) | Covered in full | |
| • Diabetic Education | Covered in full | |
| **Durable Medical Equipment and Braces** | Covered in full | See benefit for description |
| **External Hearing Aids/Prescription 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 | |

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| Benefit Description | Cost Sharing Outside the U.S. | Notes/ Limits |
|---|---|---|
| **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 or Residential Treatment** | Covered in full | See benefit for description |
| **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 |
| **Opioid Treatment Programs** | Covered in full | |
| **PRESCRIPTION DRUGS** | | **Limits** |
| *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. Insulin drugs shall be covered in full, regardless of the amount or type of insulin that is needed to fill such member's prescription. | | |
| **Retail Pharmacy** | | |
| Tier 1- Generic | $0 Copayment per 30-day supply | |
| Tier 2 – Preferred Brand | $0 Copayment per 30-day supply | See benefit for description |
| Tier 3 – Non-Preferred Brand | $0 Copayment per 30-day supply | |
| **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 | $0 Copayment per 30-day supply | |
| Tier 2 – Preferred Brand | $0 Copayment per 30-day supply | See benefit for description |
| Tier 3 – Non-Preferred Brand | $0 Copayment per 30-day supply | |
| **Enteral Formulas** | | |
| Tier 1 – Generic | $0 Copayment per 30-day supply | |
| Tier 2 – Preferred Brand | $0 Copayment per 30-day supply | See benefit for description |
| Tier 3 – Non-Preferred Brand | $0 Copayment per 30-day supply | |
| **WELLNESS BENEFITS** | | |
| **Gym Reimbursement** | Up to $200 per six (6) month period | |
| **PEDIATRIC DENTAL and VISION CARE** | | |

| Benefit Description | Cost Sharing Outside the U.S. | Notes/ Limits |
|---|---|---|
| **Pediatric Dental Care**<br>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 |
| • Routine Dental Care | 20% Coinsurance | |
| • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) | 50% Coinsurance | Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals |
| • Orthodontics | 50% Coinsurance | |
| **Pediatric Vision Care**<br>Benefits are the same for Participating or Non-Participating Providers | | |
| • Exams | 0% Coinsurance | One (1) exam per Plan Year; |
| • Lenses and Frames | 0% Coinsurance | One (1) prescribed lenses and frames per Plan Year or One-year supply of Contact lenses per Plan Year |
| • Contact Lenses | 0% Coinsurance | |
| **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 |