Important Annual Mandatory Insurance Information

Attention Students:

After collecting student feedback and review of the student health insurance plan, the college has decided to offer a 90/10 preferred provider co-insurance and prescription co-payment. This replaces the current 80/20 plan where students paid 20% of the allowed amount for covered health care services to providers who contract with their health insurance. Preferred provider (in-network) co-insurance usually costs less than non-preferred provider (out-of-network) co-insurance. Also, the out of pocket expense limit has been decreased from $6,350.00 to $3,000.00

PLEASE SHARE THIS INFORMATION WITH YOUR PARENTS TO AVOID ANY UNNECESSARY CHARGES TO YOUR STUDENT ACCOUNT.

Annually, all incoming and returning students are required to provide the Student Health and Wellness Center with proof of health insurance coverage. This applies even if your insurance remains the same from last year. It is the student’s or parent’s responsibility to contact their health insurance provider to find out how the coverage works while a student is attending school.

- If you have health insurance coverage, choose Option 1 (on the form provided), fill out the requested information & return it to the Student Health and Wellness Center by June 15, 2016.
- If you would like to enroll in the college health insurance plan, choose Option 2 (on the form provided), fill out the bottom portion of the form & return it to the Student Health and Wellness Center by June 15, 2016.
- Students may opt to update their insurance information on-line through mySwarthmore.
- Parents can update this insurance information on-line by logging into their E-Bill account (and selecting the “Student Health Insurance” tab). If a parent is not currently enrolled in E-Bill, they may find out how to enroll by visiting the following link www.swarthmore.edu/e-bill (and selecting Parent/Authorized User Set Up).

COLLEGE INSURANCE PLAN DESCRIPTION:


- No overall annual limit per contract year
- Out-of-pocket-expense limit of $3,000 for preferred providers per contract year
- 90% coverage with preferred providers; see limitations & exceptions for non-preferred providers
- Mental Health, behavioral health, or substance abuse needs: refer to the schedule of benefits
- Accidental death and dismemberment, Medical Evacuation & Repatriation benefits through Arch insurance group
- Hormone therapy for transgender students, see limitations
- Prescription Benefit: including hormone therapy for transgendered students, see schedule of benefits for limitations & exceptions
- Refer to Swarthmore College Student Health and Wellness website to view the College Health Insurance Brochure http://www.swarthmore.edu/student-health
- The college health plan is compliant with the Affordable Care Act and applicable state mandates
- Enrollment for the full academic year in fall or ½ year spring semester only - no prorated enrollment or refunds

The 2016-2017 student health insurance policy is effective August 17, 2016 through August 16, 2017. The $1,387 premium is billed in one installment on the fall semester E-Bill (issued in early July 2016). Any student with a question regarding eligibility for financial assistance with the insurance premium to meet Swarthmore’s health insurance requirement can email health@swarthmore.edu by June 15, 2016.

DEADLINE: June 15, 2016. If your information is not received by the deadline, you will be enrolled in the college health plan and charged the full premium of $1,387 on your fall semester tuition E-Bill (issued in early July 2016).

REQUIREMENTS: All enrolled students must be insured.

In order to waive coverage, your current plan must meet the following requirements:

- Be effective through the academic year (notify student health immediately if you should have a change or loss of coverage)
- Provide for emergency and urgent care locally
- Cover hospital admissions locally
- Provide coverage while studying abroad

The information must be received by the Student Health and Wellness Center no later than the deadline of June 15, 2016 (even if your insurance remains the same as last year).

Contact Mary Jane Palma at 610-328-8062 or email the Student Health and Wellness Center at <health@swarthmore.edu> if you have questions.

Sincerely,

Alice Holland
Director, Student Health and Wellness Center
ANNUAL MANDATORY INSURANCE ENROLLMENT FORM 2016-2017

You may email this completed form to health@swarthmore.edu
or mail to: Swarthmore College, Attn: Student Health and Wellness Center, 500 College Avenue, Swarthmore, PA 19081

Students (in lieu of completing this form) may opt to update this insurance information on-line through mySwarthmore or Parents can update this insurance information on-line by logging into their E-Bill account (and selecting the “Student Health Insurance” tab). If a parent is not currently enrolled in E-Bill, they may find out how to enroll by visiting the following link www.swarthmore.edu/e-bill (and selecting Parent/Authorized User Set Up).

Print Student Name: ____________________________________ Class Year _______________________
Date of Birth__________________________________________ Student id#_________________________

___ OPTION (1): My insurance listed below meets the College requirements listed on the back of this form and I wish to WAIVE the Swarthmore College Health Plan.

Signature (Student or Parent): _____________________________________________________________

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (front and back) TO THIS FORM
**Also include a copy of any separate prescription card**

Insurance Company Name:_________________________________________________________________

Insurance Company Address:_________________________________________________________________

_____________________________________________________________________________________

ID#_________________________________GROUP#_____________________________________________

Insurance Company Phone Number:___________________________________________________________

Name of policy holder:_____________________________________________________________________

Address of policy holder:_____________________________________________________________________

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Phone number of policy holder:_______________________________________________________________

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PLEASE COMPLETE THIS SECTION TO ENROLL IN THE COLLEGE HEALTH INSURANCE PLAN

___ OPTION (2): I would like to enroll in the College Health Insurance Plan at the rate of $1,387 for the year beginning August 17, 2016 and ending August 16, 2017.

___ Due to economic hardship, I would like to be considered for a discounted rate. I do not have other health insurance that meets the college minimum requirements.

Signature: _____________________________________________________________________________