SCHEDULE OF BENEFITS
Sarah Lawrence College

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual	$250	$250	
Prescription Drug Deductible • Individual • Family	None None	None None	
Out-of-Pocket Limit • Individual	$6,350	Unlimited	
Accidental Death and Dismemberment Annual Maximum	N/A	N/A	$10,000
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$15 Copayment 20% Coinsurance with Referral; 30% Coinsurance without Referral after Deductible	$15 Copayment 40% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$15 Copayment 20% Coinsurance with Referral; 30% Coinsurance without Referral after Deductible	$15 Copayment 40% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations	Covered in full	40% Coinsurance After Deductible	See benefit for description
• Adult Annual Physical Examinations	Covered in full	40% Coinsurance After Deductible	
• Adult Immunizations	Covered in full	40% Coinsurance After Deductible	
• Routine Gynecological	Covered in full	40% Coinsurance After Deductible	

Services/Well Woman Exams • Mammograms Screening and Diagnostic Imaging for the Detection of breast Cancer • Sterilization Procedures for Women • Vasectomy • Bone Density Testing • Screening for Prostate Cancer • All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in full Covered in full Covered in full Covered in full Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	40% Coinsurance After Deductible 40% Coinsurance After Deductible 40% Coinsurance After Deductible 40% Coinsurance After Deductible 40% Coinsurance After Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	See benefit for description
Emergency Department Copayment / Coinsurance waived if	$100 Copayment 20% Coinsurance not subject to Deductible	$100 Copayment 20% Coinsurance not subject to Deductible	See benefit for description

Hospital admission			
Urgent Care Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	40% Coinsurance after Deductible 40% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

• Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	
Chiropractic Services	$15 Copayment 20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Home Health Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible	40 visits per Plan Year
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic	See benefit for description

		Procedures)	
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Medications administrated in Office • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	

Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 20% Coinsurance after Deductible 20% Coinsurance after Deductible Covered in full 20% Coinsurance after Deductible	20% Coinsurance after Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology			See benefit for

Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other	0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit description

Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (up to a 90day supply) • Diabetic Education	 See the Prescription Drug Cost-Sharing 20% Coinsurance after Deductible	 See the Prescription Drug Cost-Sharing 40% Coinsurance after Deductible	See benefit for description
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Cochlear Implants	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	 0% Coinsurance after Deductible 0% Coinsurance after Deductible	 0% Coinsurance after Deductible 0% Coinsurance after Deductible	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime Unlimited; See benefit for description
Shoe Inserts	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *****Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

by the HRSA or if the item or service has an "A" or "B" rating from the USPSTF			
Retail Pharmacy			
30-day supply Tier 1 Tier 2	 $20 Copayment 20% Coinsurance not subject to Deductible $30 Copayment 20% Coinsurance not subject to Deductible	 $20 Copayment 20% Coinsurance not subject to Deductible $30 Copayment 20% Coinsurance not subject to Deductible	See benefit for description
Enteral Formulas Tier 1 Tier 2	 $20 Copayment 20% Coinsurance not subject to Deductible $30 Copayment 20% Coinsurance not subject to Deductible	 $20 Copayment 20% Coinsurance not subject to Deductible $30 Copayment 20% Coinsurance not subject to Deductible	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics and Prosthodontics) • Orthodontic **Orthodontics and Major Dental Require Preauthorization**	 0% Coinsurance after Deductible 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible **Orthodontics and Major Dental Require Preauthorization**	 0% Coinsurance after Deductible 30% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One (1) dental exam and cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care • Exams	 20% Coinsurance after Deductible	 20% Coinsurance after Deductible	One (1) exam per Plan Year

• Lenses and Frames • Contact Lenses	20% Coinsurance after Deductible 20% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	One (1) prescribed lenses and frames per Plan Year
Emergency Medical Evacuation	0% coinsurance of Actual Cost	0% coinsurance of Actual Cost	Unlimited
Repatriation of Remains	0% coinsurance of Actual Cost	0% coinsurance of Actual Cost	Unlimited
Accidental Death and Dismemberment Benefits	N/A	N/A	$10,000 See Benefit for Description