

Your Summary of Benefits

(Eff 10/01/10, Pending NYS Dept. of Insurance Approval)



POS

HOFSTRA UNIVERSITY – POS PLAN – TR, OF EFFECTIVE 1/01/2011

Benefit	In-Network ³	Out-of-Network ⁴
Deductible	N/A	\$250/\$500
Coinsurance	N/A	30%
Out-Of-Pocket Maximum	N/A	\$3,000/\$6,000 (excludes deductible)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care¹	Member Pays In-Network	Member Pays Out-of-Network
Covered Adult Preventive Care	\$0	Deductible and coinsurance
Annual Physical Exam	\$0	Covered in-network only
Well-Child Care (Up to age 19; including covered immunizations)	\$0	Deductible and coinsurance
Preventive Well-Woman Care	\$0	Deductible and coinsurance
Home/Office/Outpatient Care	Member Pays In-Network	Member Pays Out-of-Network
Home/Office/Outpatient Visits Copayment ²	\$15 (Non-Specialist) / \$25 (Specialist) copay	Deductible and coinsurance
Emergency Room/Facility (initial visit per occurrence)	\$25 copay (Waived if admitted within 24 hours)	\$25 copay (Waived if admitted within 24 hours)
Ambulatory/Outpatient Surgery ^{5,6}	\$0	Deductible and coinsurance
Presurgical Testing, Anesthesia	\$0	Deductible and coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and coinsurance
Routine Maternity Care	\$0 (after initial office visit)	Deductible and coinsurance
Laboratory Tests, X-rays, MRI ⁵ /MRA ⁵ , CAT Scan, PET and Nuclear Cardiology	\$0 (Non-Preventive Lab & X-Rays subject to \$25 copay)	Deductible and coinsurance
Allergy Testing & Treatment	\$15 (Non-Specialist) / \$25 (Specialist) copay (Waived for treatment)	Deductible and coinsurance
Chiropractic Care (Up to 20 visits per calendar year) (In-Network & Out-of-Network combined)	\$25 (Specialist) copay	Deductible and coinsurance
Home Healthcare (Up to 40 visits per calendar year) (In-Network & Out-of-Network combined)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Deductible and coinsurance
Hospice Care (Up to 210 days per lifetime) (In-Network & Out-of-Network combined)	\$0	Deductible and coinsurance
Physical Therapy ^{2,5} (Up to 30 visits per calendar year combined in home, office or outpatient facility) (In-Network & Out-of-Network combined)	\$0	Deductible and coinsurance
Speech/Language ^{2,5} , Occupational ^{2,5} , Vision Therapies ² (Up to 30 visits per calendar year combined in home, office or outpatient facility) (In-Network & Out-of-Network combined)	\$0	Deductible and coinsurance
Outpatient Cardiac Rehabilitation ²	\$0	Deductible and coinsurance
Second Surgical Opinion	\$15 (Non-Specialist) / \$25 (Specialist) copay (no copay applies if arranged through the Medical Management Program)	Deductible and coinsurance
Kidney Dialysis	\$0	Deductible and coinsurance

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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Benefit	In-Network ³	Out-of-Network ⁴
Inpatient Care⁵	Member Pays In-Network	Member Pays Out-of-Network
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Surgery, Surgical Assistant, Anesthesia	\$0	Deductible and coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year) (In-Network & Out-of-Network combined)	\$0	Deductible and coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year) (In-Network & Out-of-Network combined)	\$0	Deductible and coinsurance
Mental Health	Member Pays In-Network	Member Pays Out-of-Network
Outpatient Visits in Office	\$15 (Non-Specialist) copay	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Care ⁷ (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Alcohol/Substance Abuse⁷	Member Pays In-Network	Member Pays Out-of-Network
Outpatient Visits in Office	\$15 (Non-Specialist) copay	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Inpatient Rehabilitation	\$0	Deductible and coinsurance
Other	Member Pays In-Network	Member Pays Out-of-Network
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	Deductible and coinsurance
Durable Medical Equipment ⁵	\$0	Deductible and coinsurance
Prosthetics & Orthotics ⁵	\$0	Deductible and coinsurance
Ambulance (air ambulance)	\$0	Deductible and coinsurance
Private Duty Nursing (covered only at home – unlimited visits)	\$0	Deductible and coinsurance
Organ Transplants –Travel & Lodging (\$10,000 Lifetime Maximum)	\$0	Deductible and coinsurance

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- (1) The following benefits, if provided in-network for preventive care, are not subject to copayment; mammography screenings, cervical cancer screening, colorectal cancer screenings, prostate cancer screenings, hypercholesterol screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations.
- (2) The following practitioners receive the lower (primary) copay for services provided in an office: patient's PCP, obstetricians, gynecologists, certified nurse midwives, and physical therapists. The higher (specialist) copay will apply for all other specialists when a copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational and vision therapies.
- (3) In-network provider delivers care. In-network providers are in Empire's POS network, and in our affiliate POS network in Connecticut, Anthem Blue Cross and Blue Shield.
- (4) Out-of-network providers are providers who are not in Empire's POS network or our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Out-of-network services rendered by providers who do not participate with Empire or with another Blue Cross Blue Shield plan through the BlueCard Program are subject to balance billing over the allowed amount. (This does not apply to emergency benefits.)
- (5) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond INN copayment (if applicable) for covered services. You are responsible for obtaining precertification for out-of-network services. Your provider may call for you.
- (6) For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for proposed cosmetic surgery, an excluded benefit except when medically necessary.
- (7) Precertification must be obtained from the Behavioral Healthcare Manager.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

POS REV Sept 2010

Prepared on 10/08/10 jl