The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, The Office of Human Resources. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.hofstra.edu/pdf/about/hr/hr_sbc_uniformglossary.pdf or call 1-516-463-6956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. **$50** Individual /**$100** Family for dental services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services
What is the out-of-pocket limit for this plan?	**$3,000** individual/**$6,000** family for network providers. For Pharmacy/Prescription Expenses: $2,000 individual / $4,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.empireblue.com/** or call 1-800-435-1385 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. The claim will be denied if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	Not Covered	None
	Specialist visit	$30 copayment/visit	Not Covered	None
	Preventive care/screening/ immunization	$0 copayment/visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 preventive/$20 copayment/visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$0 preventive/$30 copayment/visit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.hofstra.edu/pdf/about/hr/hr_sumplan_expressscripts.pdf	Generic drugs	$10 retail/$20 mail order copayment	Retail out-of-network provider claims are reimbursed based on copayment; member pays any difference between pharmacy charge and allowed-amount.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$30 retail/$60 mail order copayment		
	Non-preferred brand drugs	$50 retail/$100 mail order copayment		
	Specialty drugs	$10 generic/$30 preferred/$50 non-preferred		Covers up to a 30-day supply retail subscription or mail order prescription
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copayment	Not Covered	None
	Physician/surgeon fees	$0 copayment	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 copayment	$100 copayment	Copayment is waived if admitted to the same hospital within 24 hours.
	Emergency medical transportation	$30 copayment	$30 copayment	None
	Urgent care	$30 copayment	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment per admission	Not Covered	None
	Physician/surgeon fees	$0 copayment	Not Covered	None

[* For more information about limitations and exceptions, see the plan or policy document at http://www.hofstra.edu/about/hr/hr-benefits.html]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment per visit office and/or facility	Not Covered	None
	Inpatient services	$250 copayment per admission	Not Covered	None
If you are pregnant	Office visits	$20 copayment	Not Covered	No copayment applies to Physician office visits for routine prenatal care after the first visit in which a $20 copayment applies.
	Childbirth/delivery professional services	$250 copayment per admission	Not Covered	None
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	$0 copayment	Not Covered	Up to 40 visits per calendar year, in-network and out-of-network combined (a visit equals 4 hours of care)
	Rehabilitation services	$30 copayment		Up to 30 visits combined in home, office or outpatient facility per calendar year. $0 co-pay for in-patient
	Habilitation services	$30 copayment		
	Skilled nursing care	$0 copayment		Up to 60 days per calendar year.
	Durable medical equipment	$0 copayment		$0 copayment applies if getting the supplies through Empire BlueCross BlueShield
	Hospice services	$0 copayment		Up to 210 days per lifetime, in-network & out-of-network combined
If your child needs dental or eye care	Children's eye exam	$0 copayment	Up to $30 reimbursement	Once every 24 months
	Children's glasses	$0 copayment ; $75 allowance; 20% discount	Up to $40 reimbursement	
	Children's dental check-up	100% covered	100% covered up to allowed amount	Once every 6 months/2 times per calendar year. If an out-of-network dentist charges more than the allowed amount, you may have to pay the difference

[* For more information about limitations and exceptions, see the plan or policy document at http://www.hofstra.edu/about/hr/hr-benefits.html]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Hearings aid
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental Care (Adult)
- Private-duty nursing
- Routine eye care(Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa , or https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ or Office of Personnel Management Multi State Plan program: https://www.opm.gov/healthcare-insurance/multi-state-plan-program. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

The address for filing a Level 1 appeal or grievance is:

Empire BlueCross BlueShield
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

The address for filing a Level 2 appeal or grievance is:

Hofstra University
Human Resources
205 Hofstra University

Hempstead, NY 11549-2050

If your grievance or appeal concerns behavioral healthcare, call 1-800-435-1385 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 0647

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at http://www.hofstra.edu/about/hr/hr-benefits.html]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital copayment	$250
Other prescriptions	$200

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$480**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$480**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	%
Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	%
Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$**

The plan would be responsible for the other costs of these EXAMPLE covered services.