SUMMARY OF BENEFITS

HIP *POS*

HIP Prime Network for NY CT and NJ Residents

HOFSTRA UNIVERSITY

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MAJOR COST SHARING PROVISIONS	Participating Provider	Non - Participating Provider
Benefit Period	Plan Year	Plan Year
Maximum Out-of-Pocket Limit	$6,600 Individual / $13,200 Family	Individual $5,250 / Family $10,500
Medical Deductible	$0 Individual / $0 Family	Individual $250 / Family $500
Medical Coinsurance	0%	30%
Medical Coinsurance Maximum	Not Applicable	Individual $5,000 / Family $10,000
Annual Maximum	Unlimited	Unlimited
PCP Office Visits	$15 Copayment	Subject to Deductible and Coinsurance
Specialist Office Visits	$15 Copayment	Subject to Deductible and Coinsurance
Hospital Admission	No Copayment	Subject to Deductible and Coinsurance
Emergency Room Copay(waived if Hospital admission)	$50 Copayment	$50 Copayment
Prescription Drugs	$10 generic / $15 brand (Subject to Drug Formulary) Contraceptives Included; $30 Non-Formulary(Formulary copays are reduced by 50% when utilizing the Mail Order Pharmacy Service. Up to a 90 day supply may be obtained.)	Not Applicable
INPATIENT HOSPITAL SERVICES	**Participating Provider**	**Non - Participating Provider**
• Hospital and physician services	Included in Hospital Admission Copayment	Subject to Deductible and Coinsurance
• Semi-private room and board	Included in Hospital Admission Copayment	Subject to Deductible and Coinsurance
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs,anesthesia, X-rays, lab tests, mastectomy care, cardiac and pulmonary rehabilitation and end of life care	Included in Hospital Admission Copayment	Subject to Deductible and Coinsurance
• Inpatient Habilitation Services (Physical,Speech and Occupational Therapy), 30 days of combined therapies	Covered in full	Subject to Deductible and Coinsurance
• Inpatient Rehabilitation Services (Physical,Speech and Occupational Therapy), 30 days of combined therapies	Covered in full	Subject to Deductible and Coinsurance
• Radiation therapy and Chemotherapy	Included in Hospital Admission Copayment	Subject to Deductible and Coinsurance
• Human organ transplants	Included in Hospital Admission Copayment	Subject to Deductible and Coinsurance

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➢ MATERNITY AND NEW BORN CARE	Participating Provider	Non - Participating Provider
• Prenatal care	Covered in full	Subject to Deductible and Coinsurance
• Inpatient Hospital Services and Birthing Center	Covered in full	Subject to Deductible and Coinsurance
• Physician and Midwife Services for Delivery	Covered In Full	Subject to Deductible and Coinsurance
• Breast Pump	Covered in full	Subject to Deductible and Coinsurance
• Postnatal care	Covered in full	Subject to Deductible and Coinsurance
➢ PROFESSIONAL SURGICAL SERVICES	Participating Provider	Non - Participating Provider
• Inpatient Hospital Surgery	Covered in full	Subject to Deductible and Coinsurance
• Outpatient Hospital Surgery	Covered in full	Subject to Deductible and Coinsurance
• Surgery performed in a PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Surgery performed in a Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Surgery performed at an Ambulatory Surgical Center	Covered in full	Subject to Deductible and Coinsurance
➢ **CARDIAC REHABILITATION,** 32 visits, combined with Outpatient Hospital and Specialist Office limits	**Participating Provider**	**Non - Participating Provider**
• Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost-Sharing	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in a Specialist Office	$15 Copayment	Subject to Deductible and Coinsurance
➢ OUTPATIENT MEDICAL CARE	Participating Provider	Non - Participating Provider
• PCP office visits	Subject to PCP office visit copay	Subject to Deductible and Coinsurance
• Specialists office visits	Subject to Specialist office visit copay	Subject to Deductible and Coinsurance
• Preventive care, including well-child visits and immunizations, adult annual physical examinations, adult immunizations, routine gynecological services/well woman exams, mammograms, screening and diagnostic imaging for the detection of breast cancer, sterilization procedures for women, and bone density testing	Covered in full	Subject to Deductible and Coinsurance
• Laboratory Procedures,		
• Performed in a PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in a Free Standing Laboratory	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance

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➢ OUTPATIENT MEDICAL CARE	Participating Provider	Non - Participating Provider
• Diagnostic Radiology		
• Performed in a PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in a Free Standing Radiology Facility	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance
• Diagnostic Testing		
• Performed in a PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance
• Advanced Imaging Services (PET scans, MRI, nuclear medicine, CAT scans)		
• Performed in a Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in a Freestanding Center	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance
• Infusion Therapy		
• Performed in PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance
• Home Infusion Therapy	Covered in full	Subject to Deductible and Coinsurance
• Ambulatory surgery center facility fee	Covered in full	Subject to Deductible and Coinsurance
• Outpatient hospital surgery facility charge	Covered in full	Subject to Deductible and Coinsurance
• Preadmission testing	Covered in full	Subject to Deductible and Coinsurance
• Second opinions on the diagnosis of cancer, surgery and other	No Copay, not subject to deductible	Subject to Deductible and Coinsurance
• Routine foot care	Not covered	Not Covered

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➢ OUTPATIENT MEDICAL CARE	Participating Provider	Non - Participating Provider
• Outpatient Habilitation Services (physical therapy, occupational therapy, speech therapy)	120 visits, combined therapies	
• Performed in a PCP Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in a Specialist Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in an Outpatient Facility	$15 Copayment	Subject to Deductible and Coinsurance
• Outpatient Rehabilitation Services(physical therapy,occupational therapy, speech therapy, pulmonary rehabilitation)	120 visits, combined therapies	
• Performed in a PCP Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in a Specialist Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in an Outpatient Facility	$15 Copayment	Subject to Deductible and Coinsurance
• Allergy Testing and Treatment		
• Performed in a PCP Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in a Specialist Office	$15 Copayment	Subject to Deductible and Coinsurance
• Acupuncture	Not Covered	Not Covered
• Therapeutic Radiology Services		
• Performed in Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in a Free Standing Radiology Facility	Covered in full	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	Covered in full	Subject to Deductible and Coinsurance
• Chemotherapy		
• Performed in a PCP Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in a Specialist Office	Covered in full	Subject to Deductible and Coinsurance
• Performed in an Outpatient Facility	Covered in full	Subject to Deductible and Coinsurance
• Telemedicine Program		
• Provided by a Telemedicine Physician	Not Covered	Not Covered

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➢ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES	Participating Provider	Non - Participating Provider
• **Mental Health Care**		
• Inpatient	Covered in full, Unlimited Days	Subject to Deductible and Coinsurance
• Outpatient	$15 Copayment, Unlimited Visits	Subject to Deductible and Coinsurance
• **Substance Use Services**		
• Inpatient	Covered in full, Unlimited Days	Subject to Deductible and Coinsurance
• Outpatient	$15 Copayment	Subject to Deductible and Coinsurance
➢ **SPECIAL KINDS OF CARE**	**Participating Provider**	**Non - Participating Provider**
Urgent Care Center	$15 Copayment	Subject to Deductible and Coinsurance
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	Covered in full
Non-Emergency Ambulance Services	Covered in full	Subject to Deductible and Coinsurance
Home Health Care, 40 visits	$15 Copayment	Subject to Deductible and Coinsurance
Hospice Care	No copay. Limit of 210 days per year.	Not Covered
Skilled Nursing Facility (including cardiac and pulmonary rehabilitation)	Covered in full, 45 Day Limit	Not Covered
Dialysis Treatment		
• Performed in PCP Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in Specialist Office	$15 Copayment	Subject to Deductible and Coinsurance
• Performed in a Freestanding Center	$15 Copayment	Subject to Deductible and Coinsurance
• Performed as Outpatient Hospital Services	$15 Copayment	Subject to Deductible and Coinsurance
Diabetes equipment, supplies, Insulin and education	$15 Copayment/ Insulin $0 Copayment	Subject to Deductible and Coinsurance
Chiropractic Services	$15 Copayment	Subject to Deductible and Coinsurance
Family Planning Services	Covered in full	Subject to Deductible and Coinsurance
Vasectomy	$15 Copayment	Subject to Deductible and Coinsurance
Infertility Diagnosis and Treatment	3 Cycles IVF, Per Lifetime, Subject To Applicable Copayment	Subject to Deductible and Coinsurance
Dental Care • Preventive Dental	Preventive Not Included	Not Covered
Durable Medical Equipment and Braces	No Deductible, Covered In Full	Not Covered
Prosthetics	Covered In Full	Not Covered
Orthotics	Covered In Full	Not Covered

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➢ SPECIAL KINDS OF CARE	Participating Provider	Non - Participating Provider
Medical Supplies	Covered in full	Subject to Deductible and Coinsurance
External Hearing Aids	Not Covered	Not Covered
Cochlear Implants	No Copayment - One (1) per ear per time Covered	Not Covered
Optical Care		
• Refractive Eye Exams	$15 Copayment / Once per covered period	Not Covered
• Eyeglasses	Eyeglasses $35 Every 24 Months	Not Covered
ABA Treatment for Autism Spectrum Disorder	$15 Copayment	Subject to Deductible and Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment	Subject to Deductible and Coinsurance
➢ ADDITIONAL BENEFITS	Participating Provider	Non - Participating Provider
Nurse Advice Line	Covered	Not Covered
WellSpark	Health Risk Assessment	Not Covered
Gym Reimbursement	Not Covered	Not Covered

FOOTNOTES

Drugs are dispensed in accordance with EmblemHealth's Drug Formulary. Please refer to your Prescription Drug Rider for details.

The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. Some Covered Services, such as Acupuncture, Urgent Care, Telemedicine, and Prescription Drugs are only Covered when received from Participating Providers and are not Covered as out-of-network benefits.

We determine the allowed amount paid for Covered services received from health care providers not in our network of participating providers. Please refer to your plan documents for out of network reimbursement information. Member is responsible for any difference between the plan payment and the out of network provider's bill charged.

EmblemHealth Participating Physicians and Providers have contracted with EmblemHealth Insurance Company to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.

POS is underwritten by EmblemHealth Insurance Company, an EmblemHealth Company.