Customer Legal Name	Hofstra University	
Control Number	286535	
Effective date	1/1/2027	
BENEFIT PROVISIONS	**POS Medical**	
Product Type: (Aetna Product Name)	Aetna Choice POS II	
Dependent Children (covered to end of month)	Dependents to age 26	
MEMBER COST SHARING	**In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited	Unlimited
Medical Individual Deductible	$0	$2,000
Medical Family Deductible	$0	$4,000
Prescription Individual Deductible	$0	N/A
Prescription Family Deductible	$0	N/A
Plan Coinsurance (plan pays %)*	100%	65%
Medical Individual Payment Limit	$3,500	$5,000
Medical Family Payment Limit	$7,000	$10,000
Prescription Individual Payment Limit	$2,000	N/A
Prescription Family Payment Limit	$4,000	N/A
Physician's Office Visit	100% no deductible after $35 copay	65% after deductible
Specialist Office Visit	100% no deductible after $50 copay	65% after deductible
Office Based Surgery	Covered at applicable PCP or Specialist Office Visit cost	65% after deductible
PREVENTIVE CARE	**In-Network**	**Out-of-Network**
Well Child Care (WCC) Cost Sharing	100% no deductible no copay	65% after deductible
Adult Routine Physical Exam (RPE) Cost Sharing	100% no deductible no copay	65% after deductible
Immunizations	100% no deductible no copay	65% after deductible
Preventive Well Woman Care	100% no deductible no copay	65% after deductible
MATERNITY BENEFITS	**In-Network**	**Out-of-Network**
Maternity / Obstetrics: Hospital/Facility delivery charges are covered under the hospital benefit.	Covered same as any other expense	Covered same as any other expense
Maternity / Newborn Inpatient Hospital Copay	Separate cost sharing applies for Mother and Newborn including separate inpatient hospital copays if applicable	
Pre-Natal Maternity	100% no deductible no copay	65% after deductible
OTHER PHYSICIAN /PROVIDER SERVICES	**In-Network**	**Out-of-Network**
Acupuncture	100% no deductible no copay	65% after deductible

BENEFIT PROVISIONS	POS Medical	
Physician Allergy Testing and Treatment	PCP: 100% no deductible after $35 copay Specialist: 100% no deductible after $50 copay	65% after deductible
Allergy Injections	100% no deductible no copay	65% after deductible
SURGERY	**In-Network**	**Out-of-Network**
Second Surgical Opinion	Same as any other office visit	Same as any other office visit
Outpatient Surgery Facility Charges: Performed in outpatient dept. of hospital or ambulatory surgery center setting	100% no deductible after $125 copay	65% after deductible
Transplants - Travel & Lodging limited to $10,000 for any one procedure treatment or type.	100% no deductible after $550 copay	No coverage for services rendered at a non-IOE
DIAGNOSTIC PROCEDURES	**In-Network**	**Out-of-Network**
Outpatient Diagnostic X-ray and Lab	100% no deductible after $35 copay	65% after deductible
Complex Imaging Services: MRIs, CAT Scans, etc.	100% no deductible after $50 copay	65% after deductible
EMERGENCY MEDICAL CARE	**In-Network**	**Out-of-Network**
Urgent Care Facility	100% no deductible after $50 copay	65% after deductible
Emergency Room **Copay waived if admitted**	100% no deductible after $250 copay	100% no deductible after $250 copay
Ambulance	100% no deductible after $50 copay	100% no deductible after $50 copay
HOSPITAL CARE	**In-Network**	**Out-of-Network**
Inpatient Hospital	100% no deductible after $550 copay	65% after deductible
Inpatient Per Confinement Copay	$550 copay	None
Outpatient Hospital Expenses	100% no deductible no copay	65% after deductible
MENTAL HEALTH & SUBSTANCE ABUSE	**In-Network**	**Out-of-Network**
Inpatient Mental Disorders	100% no deductible after $550 copay	65% after deductible
Inpatient Substance Abuse Disorder	100% no deductible after $550 copay	65% after deductible
Outpatient Mental Disorders: Therapy visits	100% no deductible after $35 copay	65% after deductible
Outpatient Substance Abuse Disorder: Therapy visits	100% no deductible after $35 copay	65% after deductible
Residential Treatment Facility	100% no deductible after $550 copay	65% after deductible
OTHER COVERED SERVICES	**In-Network**	**Out-of-Network**
Skilled Nursing Facility / Short-Term Rehab Facility	100% no deductible	65% after deductible
SNF /STRF Maximum	60 days per year	
Home Health Care	100% no deductible no copay	65% no deductible
HHC Maximum	40 visits maximum per year	
Private Duty Nursing	100% no deductible no copay	65% after deductible

BENEFIT PROVISIONS	POS Medical	
PDN Maximum	Unlimited	
Hospice Care Inpatient	100% no deductible no copay	65% after deductible
Inpatient Hospice Lifetime Maximum	Unlimited	
Hospice Care Outpatient	100% no deductible no copay	65% after deductible
Inpatient Hospice Lifetime Maximum	Unlimited	Unlimited
Durable Medical Equipment	100% no deductible	65% after deductible
Prosthetics Devices	100% no deductible	65% after deductible
Orthotics	100% no deductible	65% after deductible
THERAPY SERVICES	**In-Network**	**Out-of-Network**
Chiropractic	100% no deductible after $50 copay	65% after deductible
Chiropractic Maximum	20 visits per year	
Outpatient Short-Term Rehabilitation	100% no deductible after $50 copay	65% after deductible
STR Maximum	30 visits per year for physical therapy, 30 visits per year for occupational and speech therapy combined	
PRESCRIPTION DRUGS	**In-Network**	**Out-of-Network**
Retail Generic	$10	Covered in-network only
Retail Preferred Brand	$30	Covered in-network only
Retail Non-Preferred Brand	$50	Covered in-network only
Mail Generic	$25	Covered in-network only
Mail Preferred Brand	$75	Covered in-network only
Mail Non-Preferred Brand	$125	Covered in-network only
OTHER PRESCRIPTION DRUG PROGRAM		
Exclusive Home Delivery (replaces Select Hom Delivery - Active Choice)	Members with maintenance medications must fill the prescription through home delivery	

*Plan Coinsurance shows the % of benefits that the plan (Hofstra) pays.

Note: The above is a high level overview of the benefits offered by Hofstra University. Additional detailed information is available in the Summary of Benefits and Coverage (SBC) document.