APPENDIX A

TARGET DATES FOR PERSONNEL ACTION

	Faculty Credentials Submitted	Recommendation of DPC or Ad Hoc Tenure Committee and Chairperson to Dean	Recommendation of FPB to Dean (if necessary)	Recommendation of Dean to Provost	Recommendation of UAB to Provost (if necessary)	Recommendation of Provost to President	Recommendation of President to Board of Trustees	Decision by Board of Trustees
Reappointments								
A. December 31 Notification: (Initial reappointment to rank of regular Instructor commencing September 1)	4/30 (Of First Year)	5/15	9/15	10/10	11/1	11/22	12/15	12/30
B. June 30 Notification: (Initial reappointment to rank of regular Instructor commencing Spring semester)	12/1	2/1	2/25	3/20	4/10	5/1	5/25	6/29
C. August 31 Notification (Initial reappointment; rank of regular Assistant Professor and higher)	2/15	3/15	4/15	5/15	6/15	6/30	7/15	8/30
D. August 31 Notification (other than initial reappointment; rank of regular Assistant Professor and higher)	9/1	10/15	11/22	1/10	2/25	4/1	5/8	6/29
Tenure and Promotion:								
August 31 Notification	9/1	12/15	2/22	3/30	5/7	6/15	7/15	8/30
Annual Evaluations	11/1	12/15 (Chair recommendation only)		2/15	3/15	4/30 (Provost's review completes process)		

Notes:

(1) This schedule shall become effective as of September 1, 2011.

(2) Refer to Article 6.1 to determine contract periods and expiration dates for each rank as well as the tenure probationary period.

(3) For special appointments, notice of reappointment/non-reappointment shall be as specified in Article 24; for appointments where the reappointment schedules above do not allow adequate notice, and/or adequate time for review, the Dean of the affected unit shall work with the department to develop an appropriate schedule for review. In no case, however, may the date by which notice must be received be postponed.

(4) Course and Teacher Ratings for all prior semesters shall be available prior to the Faculty Credentials submission date.

HU Doc# 10903

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Lifetime Maximum	Unlimited	Unlimited
Medical Deductible	No deductible	$1,000/$2,000
Prescription Drug Deductible	No deductible	Covered in-network only
Medical Out-of-Pocket Maximum	$3,500/$7,000 for in-network claims	$3,500/$7,000 for out-of-network claims
Prescription Drug Out-of-Pocket Maximum	$2,000/$4,000 for all pharmacy claims	Covered in-network only
Dependent Children (covered to the end of the month	Dependents to Age 26	Dependents to Age 26
Covered Adult Preventive Care	$0	35% after deductible
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	35% after deductible
Preventive Well-Woman Care	$0	35% after deductible
Home/Office Visits[2]	$25 (Non-Specialist) / $35 (Specialist) copay	35% after deductible
Emergency Room/Facility (initial visit per occurrence)	$125 (Waived if admitted within 24 hours)	$125 (Waived if admitted within 24 hours)
Urgent Care Facility	$35 (Specialist) copay	35% after deductible
Ambulatory/Outpatient Surgery[5,6]	$100	35% after deductible
Presurgical Testing, Anesthesia	$35	35% after deductible
Chemotherapy, Radiation Therapy	$0	35% after deductible
Routine Maternity Care	$25 for initial visit, $0 for subsequent maternity visits	35% after deductible
Laboratory Tests, X-rays	$0 (Non-Preventive subject to $25 copay)	35% after deductible
MRI/MRA[5], CAT Scan, PET & Nuclear Cardiology	$0 (Non-Preventive subject to $35 copay)	35% after deductible
Allergy Testing & Treatment	$25 (Non-Specialist) / $35 (Specialist) copay (Waived for treatment)	35% after deductible
Chiropractic Care (Up to 20 visits per calendar year)(In-Network & Out-of-Network combined)	$35 (Specialist) copay	35% after deductible
Home Healthcare (Up to 40 visits per calendar year)(In-Network & Out-of-Network combined)	$0	35% (no deductible)
Home Infusion Therapy	$0	35% after deductible
Hospice Care (Up to 210 days per lifetime)(In-Network & Out-of-Network combined)	$0	35% after deductible
Physical Therapy[2,5] (Up to 30 visits per calendar year combined in home, office or outpatient facility)(In-Network & Out-of-Network combined)	$35	35% after deductible
Other Short-Term Rehabilitative Therapies[2,5] (Speech/Language/Occupational/Vision) (Up to 30 visits per calendar year combined in home, office or outpatient facility)(In-Network & Out-of-Network combined)	$35	35% after deductible
Cardiac Rehabilitation	$0	35% after deductible
Second Surgical Opinion	$25 (Non-Specialist) / $35 (Specialist) copay (no copay applied if arranged through the Medical Management Program)	35% after deductible
Kidney Dialysis	$0	35% after deductible
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$275 per admission	35% after deductible
Surgery, Surgical Assistant, Anesthesia	$0	35% after deductible
Physical Therapy, Physicial Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year)	$0	35% after deductible
Skilled Nursing Facility (Up to 60 days per calendar year,	$0	35% after deductible

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[redacted]	[redacted]	[redacted]
Outpatient Visits in Office	$25	35% after deductible
Outpatient Visits in Facility	$25	35% after deductible
Inpatient Care[7] (As many days as is medically necessary; semiprivate room and board)	$275 per admission	35% after deductible
[redacted]	[redacted]	[redacted]
Outpatient Visits in Office	$25	35% after deductible
Outpatient Visits in Facility	$25	35% after deductible
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$275 per admission	35% after deductible
Inpatient Rehabilitation	$275 per admission	35% after deductible
[redacted]	[redacted]	[redacted]
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	35% after deductible
Durable Medical Equipment[5]	$0	35% after deductible
Prosthetics & Orthotics[5]	$0	35% after deductible
Ambulance (air ambulance)	$35	35% after deductible
Private Duty Nursing (covered at home only – unlimited visits)	$0	35% after deductible
Organ Transplants – Travel & Lodging ($10,000 Lifetime Maximum)	$0	35% after deductible
[redacted]	[redacted]	[redacted]
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	$20	Covered in-network only
Mail Preferred Brand	$60	Covered in-network only
Mail Non-Preferred Brand	$100	Covered in-network only
[redacted]	[redacted]	[redacted]
Select Home Delivery - Active Choice	Allows members to choose between filling maintenance medications at retail and home delivery. They can choose to remain at retail without penalty as long as they notify Express Scripts of their decision.	

(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.

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Benefit	In-Network	Out-of-Network

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.

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Lifetime Maximum	Unlimited	Unlimited
Medical Deductible	No deductible	$2,000/$4,000
Prescription Drug Deductible	No deductible	Covered in-network only
Medical Out-of-Pocket Maximum	$3,500/$7,000 for in-network claims	$5,000/$10,000
Prescription Drug Out-of-Pocket Maximum	$2,000/$4,000 for all pharmacy claims	Covered in-network only
Dependent Children (covered to the end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Adult Preventive Care	$0	35% after deductible
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	35% after deductible
Preventive Well-Woman Care	$0	35% after deductible
Home/Office Visits[2]	$35 (Non-Specialist) / $50 (Specialist) copay	35% after deductible
Emergency Room/Facility (initial visit per occurrence)	$250 (Waived if admitted within 24 hours)	$250 (Waived if admitted within 24 hours)
Urgent Care Facility	$50 (Specialist) copay	35% after deductible
Ambulatory/Outpatient Surgery[5,6]	$125	35% after deductible
Presurgical Testing, Anesthesia	$50	35% after deductible
Chemotherapy, Radiation Therapy	$0	35% after deductible
Routine Maternity Care	$35 for initial visit, $0 for subsequent maternity visits	35% after deductible
Laboratory Tests, X-rays	$0 (Non-Preventive subject to $35 copay)	35% after deductible
MRI/MRA[5], CAT Scan, PET & Nuclear Cardiology	$0 (Non-Preventive subject to $50 copay)	35% after deductible
Allergy Testing & Treatment	$35 (Non-Specialist) / $50 (Specialist) copay (Waived for treatment)	35% after deductible
Chiropractic Care (Up to 20 visits per calendar year)(In-Network & Out-of-Network combined)	$50 (Specialist) copay	35% after deductible
Home Healthcare (Up to 40 visits per calendar year)(In-Network & Out-of-Network combined)	$0	35% (no deductible)
Home Infusion Therapy	$0	35% after deductible
Hospice Care (Up to 210 days per lifetime)(In-Network & Out-of-Network combined)	$0	35% after deductible
Physical Therapy[2,5] (Up to 30 visits per calendar year combined in home, office or outpatient facility)(In-Network & Out-of-Network combined)	$50	35% after deductible
Other Short-Term Rehabilitative Therapies[2,5] (Speech/Language/Occupational/Vision) (Up to 30 visits per calendar year combined in home, office or outpatient facility)(In-Network & Out-of-Network combined)	$50	35% after deductible
Cardiac Rehabilitation	$0	35% after deductible
Second Surgical Opinion	$35 (Non-Specialist) / $50 (Specialist) copay (no copay applied if arranged through the Medical Management Program)	35% after deductible
Kidney Dialysis	$0	35% after deductible
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$550 per admission	35% after deductible
Surgery, Surgical Assistant, Anesthesia	$0	35% after deductible
Physical Therapy, Physicial Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year)	$0	35% after deductible
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	35% after deductible

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Benefit	In-Network[3]	Out-of-Network[4]
Outpatient Visits in Office	$35	35% after deductible
Outpatient Visits in Facility	$35	35% after deductible
Inpatient Care[7] (As many days as is medically necessary; semiprivate room and board)	$550 per admission	35% after deductible
Behavioral Health Services	**In-Network Only**	**Out-of-Network Only**
Outpatient Visits in Office	$35	35% after deductible
Outpatient Visits in Facility	$35	35% after deductible
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$550 per admission	35% after deductible
Inpatient Rehabilitation	$550 per admission	35% after deductible
Outpatient Services	**In-Network Only**	**Out-of-Network Only**
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	35% after deductible
Durable Medical Equipment[5]	$0	35% after deductible
Prosthetics & Orthotics[5]	$0	35% after deductible
Ambulance (air ambulance)	$50	35% after deductible
Private Duty Nursing (covered at home only – unlimited visits)	$0	35% after deductible
Organ Transplants – Travel & Lodging ($10,000 Lifetime	$0	35% after deductible
Prescription Drugs	**Covered Rx In-Network**	**Out-of-Network Coverage**
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
Out-of-Network Drug Coverage		
Exclusive Home Delivery (replaces Select Home Delivery - Active Choice)	Members with maintenance medications must fill the prescription through home delivery	

(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.

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[redacted]	[redacted]	[redacted]

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

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Lifetime Maximum	Unlimited	Covered in-network only
Medical Deductible	No deductible	Covered in-network only
Prescription Drug Deductible	No deductible	Covered in-network only
Medical Out-of-Pocket Maximum	$3,000/$6,000	Covered in-network only
Prescription Drug Out-of-Pocket Maximum	$2,000/$4,000	Covered in-network only
Dependent Children (covered to the end of the month[1])	Dependents to Age 26	Covered in-network only
Covered Adult Preventive Care	$0	Covered in-network only
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Covered in-network only
Preventive Well-Woman Care	$0	Covered in-network only
Home/Office Visits	$20 (Non-Specialist) / $30 (Specialist) copay	Covered in-network only
Emergency Room/Facility (initial visit per occurrence[2])	$100 (Waived if admitted within 24 hours)	Covered in-network only
Urgent Care Facility	$30 (Specialist) copay	Covered in-network only
Ambulatory/Outpatient Surgery[3]	$75	Covered in-network only
Presurgical Testing, Anesthesia	$30	Covered in-network only
Chemotherapy, Radiation Therapy	$0	Covered in-network only
Routine Maternity Care	$20 for initial visit, $0 for subsequent maternity visits	Covered in-network only
Laboratory Tests, X-rays	$0 (Non-Preventive subject to $20 copay)	Covered in-network only
MRI/MRA, CAT Scan, PET & Nuclear Cardiology	$0 (Non-Preventive subject to $30 copay)	Covered in-network only
Allergy Testing & Treatment	$20 (Non-Specialist) / $30 (Specialist) copay (Waived for treatment)	Covered in-network only
Chiropractic Care (Up to 20 visits per calendar year)	$30 (Specialist) copay	Covered in-network only
Home Healthcare (Up to 40 visits per calendar year[4])	$0	Covered in-network only
Home Infusion Therapy	$0	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	$0	Covered in-network only
Physical Therapy (Up to 30 visits per calendar year combined in home, office or outpatient facility[5])	$30	Covered in-network only
Other Short-Term Rehabilitative Therapies (Speech/Language/Occupational/Vision) (Up to 30 visits per calendar year combined in home, office or outpatient facility[5])	$30	Covered in-network only
Cardiac Rehabilitation	$0	Covered in-network only
Second Surgical Opinion	$20 (Non-Specialist) / $30 (Specialist) copay (no copay applied if arranged through the Medical Management Program)	Covered in-network only
Kidney Dialysis	$0	Covered in-network only
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$250 per admission	Covered in-network only
Surgery, Surgical Assistant, Anesthesia	$0	Covered in-network only
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year)	$0	Covered in-network only
Skilled Nursing Facility (Up to 60 days per calendar year[4])	$0	Covered in-network only
Outpatient Visits in Office	$20	Covered in-network only
Outpatient Visits in Facility	$20	Covered in-network only
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	$250 per admission	Covered in-network only
Outpatient Visits in Office	$20	Covered in-network only
Outpatient Visits in Facility	$20	Covered in-network only

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Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$250 per admission	Covered in-network only
Inpatient Rehabilitation	$250 per admission	Covered in-network only
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Covered in-network only
Durable Medical Equipment[5]	$0	Covered in-network only
Prosthetics & Orthotics[5]	$0	Covered in-network only
Ambulance (air ambulance)	$30	Covered in-network only
Private Duty Nursing (covered at home only – unlimited visits)	$0	Covered in-network only
Organ Transplants – Travel & Lodging ($10,000 Lifetime	$0	Covered in-network only
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	$20	Covered in-network only
Mail Preferred Brand	$60	Covered in-network only
Mail Non-Preferred Brand	$100	Covered in-network only
Select Home Delivery - Active Choice	Allows members to choose between filling maintenance medications at retail and home delivery. They can choose to remain at retail without penalty as long as they notify Express Scripts of their decision.	

(1) A network provider must deliver all care. There is no out-of-network option for this product, except for emergency care (and Private Duty Nursing). The following practitioners receive the lower (Non-Specialist) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, nurse practitioners, Preventive Medicine, Geriatrics, Internal Medicine, Pediatrics, General Practitioner, Family Practitioner. The higher (Specialist) copay will apply for all other specialists when a Copay is required.

(2) The following benefits, if provided in-network for preventive care, are not subject to copayment: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations.

(3) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(4) Precertification is required by Empire's Behavioral Healthcare Management Program.

(5) For services received from an Empire network provider, the provider must precertify in-network services; Empire's network providers cannot bill members for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area). The BlueCard® PPO provider may call for you for services that do require precertification.

(6) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network copayment for covered services. Authorization is not required for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.

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

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Effective 1/1/2019

Lifetime Maximum	Unlimited	Covered in-network only
Medical Deductible	No deductible	Covered in-network only
Prescription Drug Deductible	No deductible	Covered in-network only
Medical Out-of-Pocket Maximum	$3,000/$6,000	Covered in-network only
Prescription Drug Out-of-Pocket Maximum	$2,000/$4,000	Covered in-network only
Dependent Children (covered to the end of the month	Dependents to Age 26	Covered in-network only
Covered Adult Preventive Care	$0	Covered in-network only
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Covered in-network only
Preventive Well-Woman Care	$0	Covered in-network only
Home/Office Visits	$25 (Non-Specialist) / $40 (Specialist) copay	Covered in-network only
Emergency Room/Facility (initial visit per occurrence	$200 (Waived if admitted within 24 hours)	Covered in-network only
Urgent Care Facility	$40 (Specialist) copay	Covered in-network only
Ambulatory/Outpatient Surgery[2]	$100	Covered in-network only
Presurgical Testing, Anesthesia	$40	Covered in-network only
Chemotherapy, Radiation Therapy	$0	Covered in-network only
Routine Maternity Care	$25 for initial visit, $0 for subsequent maternity visits	Covered in-network only
Laboratory Tests, X-rays	$0 (Non-Preventive subject to $25 copay)	Covered in-network only
MRI/MRA, CAT Scan, PET & Nuclear Cardiology	$0 (Non-Preventive subject to $40 copay)	Covered in-network only
Allergy Testing & Treatment	$25 (Non-Specialist) / $40 (Specialist) copay (Waived for treatment)	Covered in-network only
Chiropractic Care (Up to 20 visits per calendar year)	$40 (Specialist) copay	Covered in-network only
Home Healthcare (Up to 40 visits per calendar year)	$0	Covered in-network only
Home Infusion Therapy	$0	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	$0	Covered in-network only
Physical Therapy (Up to 30 visits per calendar year combined in home, office or outpatient facility)	$40	Covered in-network only
Other Short-Term Rehabilitative Therapies (Speech/Language/Occupational/Vision) (Up to 30 visits per calendar year combined in home, office or outpatient facility)	$40	Covered in-network only
Cardiac Rehabilitation	$0	Covered in-network only
Second Surgical Opinion	$25 (Non-Specialist) / $40 (Specialist) copay (no copay applied if arranged through the Medical Management Program)	Covered in-network only
Kidney Dialysis	$0	Covered in-network only
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$500 per admission	Covered in-network only
Surgery, Surgical Assistant, Anesthesia	$0	Covered in-network only
Physical Therapy, Physicial Medicine, or Rehabilitation (Up to 30 inpatient days per calendar year)	$0	Covered in-network only
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Covered in-network only
Outpatient Visits in Office	$25	Covered in-network only
Outpatient Visits in Facility	$25	Covered in-network only
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	$500 per admission	Covered in-network only

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Benefit	In-Network	Out-of-Network
Outpatient Visits in Office	$25	Covered in-network only
Outpatient Visits in Facility	$25	Covered in-network only
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$500 per admission	Covered in-network only
Inpatient Rehabilitation	$500 per admission	Covered in-network only
Other Services	Members pay In-Network	Members pay Out-of-Network
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Covered in-network only
Durable Medical Equipment[5]	$0	Covered in-network only
Prosthetics & Orthotics[5]	$0	Covered in-network only
Ambulance (air ambulance)	$40	Covered in-network only
Private Duty Nursing (covered at home only – unlimited visits	$0	Covered in-network only
Organ Transplants – Travel & Lodging ($10,000 Lifetime	$0	Covered in-network only
Prescription Drugs	Members pay In-Network	Members pay 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 Features		
Exclusive Home Delivery (replaces Select Home Delivery - Active Choice)	Members with maintenance medications must fill the prescription through home delivery	

(1) A network provider must deliver all care. There is no out-of-network option for this product, except for emergency care (and Private Duty Nursing). The following practitioners receive the lower (Non-Specialist) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, nurse practitioners, Preventive Medicine, Geriatrics, Internal Medicine, Pediatrics, General Practitioner, Family Practitioner. The higher (Specialist) copay will apply for all other specialists when a Copay is required.

(2) The following benefits, if provided in-network for preventive care, are not subject to copayment; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations.

(3) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(4) Precertification is required by Empire's Behavioral Healthcare Management Program.

(5) For services received from an Empire network provider, the provider must precertify in-network services; Empire's network providers cannot bill members for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area). The BlueCard® PPO provider may call for you for services that do require precertification.

(6) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network copayment for covered services. Authorization is not required for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.

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.

Hofstra University - Post-65 Retiree Plan APPENDIX D-1

Effective 1/1/2017 through 12/31/2018

Benefit	Participating & Non-Participating Providers
Lifetime Maximum	Unlimited
Medical Deductible	$500/$1,000
Prescription Drug Deductible	No deductible
Medical Out-of-Pocket Maximum	$3,500 per person
Prescription Drug Out-of-Pocket Maximum	No out-of-pocket maximum
Dependent Children (covered to the end of the month)	Dependents to Age 26
Hospital Benefits	**Member Pays**
Inpatient (180 days-semiprivate room and board)	$0
Inpatient Mental Health	$0
Inpatient Substance Abust and Detoxification	$0
Outpatient Pre-Surgical Testing	$0
Emergency Room/Facility	20% (not subject to deductible)
Extended Benefits	**Member Pays**
Home Health Care (up to 240 visits per year)	20% after deductible
Hospice (up to 210 days per calendar year)	$0
Skilled Nursing Facility (up to 100 day visits per year)	$0
Medical Benefits	**Member Pays**
Home/Office Visits	20% after deductible
Diagnostic Screening & Mammography	20% after deductible
Anesthesiology	20% after deductible
Lab and X-Ray (Non-Preventive)	20% after deductible
Outpatient Mental Health	20% after deductible
Physical Therapy (up to 30 visits per year)	20% after deductible
Occupational and Speech Therapy (up to 30 visits per year)	20% after deductible
Durable Medical Equipment	20% after deductible
Ambulance	20% after deductible
Chiropractic Care (up to 20 visits per year)	20% after deductible
Prescription Drugs	**Member Pays**
Retail Generic	$10
Retail Preferred Brand	$30
Retail Non-Preferred Brand	$50
Mail Generic	$20
Mail Preferred Brand	$60
Mail Non-Preferred Brand	$100

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. 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.

Hofstra University - Post-65 Retiree Plan APPENDIX D-2

Effective 1/1/2019

Benefit	Post-65 Retiree Plan Benefits
Lifetime Maximum	Unlimited
Medical Deductible	$500/$1,000
Prescription Drug Deductible	No deductible
Medical Out-of-Pocket Maximum	$3,500 per person
Prescription Drug Out-of-Pocket Maximum	No out-of-pocket maximum
Dependent Children (covered to the end of the month)	Dependents to Age 26
[illegible]	[illegible]
Inpatient (180 days-semiprivate room and board)	$0
Inpatient Mental Health	$0
Inpatient Substance Abust and Detoxification	$0
Outpatient Pre-Surgical Testing	$0
Emergency Room/Facility	20% (not subject to deductible)
[illegible]	[illegible]
Home Health Care (up to 240 visits per year)	20% after deductible
Hospice (up to 210 days per calendar year)	$0
Skilled Nursing Facility (up to 100 day visits per year)	$0
[illegible]	[illegible]
Home/Office Visits	20% after deductible
Diagnostic Screening & Mammography	20% after deductible
Anesthesiology	20% after deductible
Lab and X-Ray (Non-Preventive)	20% after deductible
Outpatient Mental Health	20% after deductible
Physical Therapy (up to 30 visits per year)	20% after deductible
Occupational and Speech Therapy (up to 30 visits per year)	20% after deductible
Durable Medical Equipment	20% after deductible
Ambulance	20% after deductible
Chiropractic Care (up to 20 visits per year)	20% after deductible
[illegible]	[illegible]
Retail Generic	$10
Retail Preferred Brand	$30
Retail Non-Preferred Brand	$50
Mail Generic	$25
Mail Preferred Brand	$75
Mail Non-Preferred Brand	$125

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. 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.

APPENDIX E

EPO/POS Plan Design

Plan	EPO	POS
Deductible		**$750/$1,500**
Coinsurance		**Ded then 20%**
Medical OOP		**$4,000/$8,000**
Home/Office Visits		**Ded then 20%**
Specialist		**Ded then 20%**
Emergency Room		**Ded then 20%**
Urgent Care		**Ded then 20%**
OP Surgery		**Ded then 20%**
IP Hospital		**Ded then 20%**
IP Coinsurance		**Ded then 20%**
Retail Drug		**$15/$40/$60**
Mail Order Drug		**$35/$100/$150**