Montefiore Medical Center: Empire MonteCare EPO Coverage Period: Beginning on or after 1/1/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs   **Coverage for:** Individual/Family | **Plan Type:** EPO

⚠️ **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.empireblue.com/montefiore** or by calling **1-866-236-6748** for medical and **www.express-scripts.com** or by calling **1-800-631-7780** for prescription.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network providers: $500 individual/$1,000 family Deductible not applicable for services provided at Montefiore facilities and by Montefiore providers and prescription drug expenses.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network Medical providers (including Montefiore facilities and providers): $5,350 individual /$10,700 family For prescription drugs $1,250 individual / $2,500 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.empireblue.com/montefiore or call 1-866-236-6748	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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> ⚠
> - **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
> - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
> - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
> - This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Montefiore Provider	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	20% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	$15 copay	20% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	$50 copay	20% coinsurance after deductible	Not covered	Applies to Chiropractic care, Allergy Testing($15 copay for MIPA). Chiropractic care limited to 10 visits per calendar year
	Preventive care/screening/immunization	No charge	No charge	Not covered	One preventive exam/calendar year; Well baby limited to 11 visits up to age 2
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use a Montefiore Provider	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	No charge	$15 copay for 30 day supply retail or mail; $30 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	Montefiore providers – All Montefiore Out Patient Pharamacies. In Network - All Express Script participating pharmacies. Out of Network cost is 25% of the cost if you use a non-participating pharmacy where there is a participating pharmacy available If you purchase a brand-name drug when a generic drug is available, you will pay the generic copay, plus the difference in cost between the brand and the generic. Some drugs may require prior authorization, in order to be covered and quantity limits may apply. You may be required to use a lower-cost drug(s) prior to benefits being available for certain drugs.
	Preferred brand drugs	$20 copay for 30 day supply; $40 copay for 90 day supply	$45 copay for 30 day supply retail or mail; $90 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	
	Non-preferred brand drugs	100% coinsurance of discounted cost	100% coinsurance of discounted cost	100% coinsurance of discounted cost	
	Specialty drugs	$20 copay for 30 day supply; $40 copay for 90 day supply	$100 copay for 30 day supply retail or mail; $150 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fees	No charge	20% coinsurance after deductible	Not covered	————————none————————

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Common Medical Event	Services You May Need	Your Cost If You Use a Montefiore Provider	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	$100 copay	Copay waived if admitted within 24 hours.
	Emergency medical transportation	20% coinsurance	20% coinsurance after deductible	Not covered	—————none—————
	Urgent care	Professional: $15 copay Facility: No charge	Professional: $30 copay Facility: $30 copay	Not covered	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	If pre-certified, 20% coinsurance after deductible If not pre-certified, 30% coinsurance after deductible	Not covered	Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Physician/surgeon fee	No charge	20% coinsurance after deductibe	Not covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay	20% coinsurance after deductible	Not covered	—————none—————
	Mental/Behavioral health inpatient services	No charge	If pre-certified, 20% coinsurance after deductible If not pre-certified, 30% coinsurance after deductible	Not covered	Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Substance use disorder outpatient services	$15 copay	20% coinsurance after deductible	Not covered	—————none—————
	Substance use disorder inpatient services	No charge	If pre-certified, 20% coinsurance after deductible If not pre-certified, 30% coinsurance after deductible	Not covered	Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.

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Common Medical Event	Services You May Need	Your Cost If You Use a Montefiore Provider	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance after deductible	Not covered	Your doctor's charges for delivery are part of prenatal and postnatal care. Pre-Certification required for Non-Montefiore In-Patient Admissions. Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Delivery and all inpatient services	No charge	If pre-certified, 20% coinsurance after deductible \n If not pre-certified, 30% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Limited to 200 days per calendar year.
	Rehabilitation services	No charge	20% coinsurance after deductible	Not covered	——————none——————
	Habilitation services	No charge	20% coinsurance after deductible	Not covered	——————none——————
	Skilled nursing care	No charge	No charge	Not covered	Limited to 120 days per calendar year.
	Durable medical equipment	Professional: 20% coinsurance Facility: No Charge	Professional: 20% coinsurance Facility: 20% coinsurance after deductible	Not covered	Hearing Aids limited to one per ear once every 36 months
	Hospice service	No charge	No charge	Not covered	Limited to 210 days per lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Not covered	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care	• Long-term care • Private-duty nursing • Non-emergency care when traveling outside the U.S.	• Routine eye care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Coverage provided outside the U.S. See www.bcbs.com/bluecardsworldwide • Hearing Aids	• Infertility treatment • Routine foot care • Nutritional Counseling

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan 914-378-6531. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Empire BlueCross BlueShield
P.O. Box 1407

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Church Street Station New York, NY 10008-1407
Attention: Member Services

Express Scripts
8111 Royal Ridge Pkwy
Irving TX, 75063-0000
Attention: Coverage Appeals

Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact:

Community Service Society of New York, Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
(888) 614-5400
http://www.communityhealthadvocates.org/

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niiłígíí bi'kéhgo bich'į hodiilní.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,375
- **Patient pays** $165

Assumes use of Montefiore facility, provider and pharmacy

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$15
Coinsurance	$0
Limits or exclusions	$150
Total	**$165**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,170
- **Patient pays** $230

Assumes use of Montefiore facility, provider and pharmacy

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$80
Total	**$230**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✻ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✻ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.