

Montefiore Medical Center: Registered Nurses Health Plan

Coverage Period: 01/01/2019– 12/31/2019

Summary of Benefits and Coverage: What this [Plan](#) Covers & What it Costs

Coverage for: Individual/Family | Plan Type: Indemnity



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, <https://eoc.empireblue.com/eocdps/aso>. 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 www.healthcare.gov/sbc-glossary/ or call (866) 236-6748 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$50 /individual or \$150 /family for Empire Tier Providers . Deductible not applicable for services provided at Montefiore facilities and by Montefiore providers and prescription drug expenses	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care for Any Providers .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,600 /individual or \$11,200 /family for Any Providers . For prescription drugs: \$1,250 individual / \$2,500 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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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 ?	Not Applicable.	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .


Questions: Visit us at <https://eoc.anthem.com/eocdps/aso> for medical and call 1-800-631-7780 or visit us at www.express-scripts.com for prescription.

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 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
		Montefiore Provider Network (You will pay the least)	Empire Indemnity Network Providers (You will pay more)	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	No charge	20% coinsurance	20% coinsurance	-----none-----
	Specialist visit	No charge	20% coinsurance	20% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge	No charge	20% coinsurance	One preventive exam/benefit period; Well baby limited to 11 visits up to age 2. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	20% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	20% coinsurance	-----none-----

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<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com.</p>	Tier 1 - Typically Generic	\$0 copay	\$7 copay for 30 day supply at participating retail pharmacy; \$7 copay for 90 day supply through mail order;	25% of the cost if you use a non-participating pharmacy	<p>Montefiore providers – All Montefiore Out Patient Pharmacies.</p> <p>In Network All Express Script participating pharmacies.</p> <p>Out of Network cost 25% of the cost if you use a non-participating pharmacy where there is a participating pharmacy available.</p> <p>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.</p> <p>Some drugs may require prior authorization, in order to be covered and quantity limits may apply.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits being available for certain drugs.</p>
	Tier 2 - Typically Preferred / Brand	\$0 copay	\$10 copay for 30 day supply at participating retail pharmacy; \$10 copay for 90 day supply through mail order;	25% of the cost if you use a non-participating pharmacy	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$0 copay	\$20 copay for 30 day supply at participating retail pharmacy; \$20 copay for 90 day supply through mail order	25% of the cost if you use a non-participating pharmacy	
	Tier 4 - Typically Specialty (brand and generic)	\$0 copay	\$7 copay for 30 day supply at participating retail pharmacy; \$7 copay for 90 day supply through mail order;	25% of the cost if you use a non-participating pharmacy	

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge	-----none-----
	Physician/surgeon fees	No charge	No charge up to \$2,000 then 20% coinsurance	No charge up to \$2,000 then 20% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	-----none-----
	Emergency medical transportation	20% coinsurance deductible does not apply	20% coinsurance	20% coinsurance	-----none-----
	Urgent care	No charge	20% coinsurance	20% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	-----none-----
	Physician/surgeon fees	No charge	No charge up to \$2,000 then 20% coinsurance	No charge up to \$2,000 then 20% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	No charge	No charge	No charge	-----none-----
If you are pregnant	Office visits	No charge	No charge up to \$2,000 then 20% coinsurance	No charge up to \$2,000 then 20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge up to \$2,000 then 20% coinsurance	No charge up to \$2,000 then 20% coinsurance	
	Childbirth/delivery facility services	No charge	No charge	No charge	

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		Montefiore Provider Network (You will pay the least)	Empire Indemnity Network Providers (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	100 visits/benefit period.
	Rehabilitation services	No charge	20% coinsurance	20% coinsurance	*See Therapy Services section
	Habilitation services	No charge	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge	No charge	No charge	-----none-----
	Durable medical equipment	Not covered	20% coinsurance	20% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	No charge	No charge	210 days limit/lifetime.
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Not covered	*See Vision Services section
	Children’s glasses	Not covered	Not covered	Not covered	
	Children’s dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

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
- Private-duty nursing
- Dental care (adult)
- Routine eye care (adult)
- Long- term 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
- Hearing aids
- Routine foot care
- Bariatric surgery
- Infertility treatment
- Chiropractic care 10 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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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, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. 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:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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

Express Scripts

8111 Royal Ridge Pkwy

Irving TX, 75063-0000

Attention: Coverage Appeals

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 [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

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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 Montefiore Provider Network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$50
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's type 2 Diabetes (a year of routine Montefiore Provider Network care of a well- controlled condition)

- The [plan's](#) overall [deductible](#) \$50
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$55

Mia's Simple Fracture (Montefiore Provider Network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$50
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$7
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$7

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Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (866) 236-6748

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (866) 236-6748 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (866) 236-6748.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (866) 236-6748:

Bassa (Bàsɔ́ Wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò nì dyí-bɛ̀dɛ̀in-dɛ̀ bɛ̀ é̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídǐ-wùdù̀ùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù̀ ke, d́á (866) 236-6748.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (866) 236-6748 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (866) 236-6748 သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (866) 236-6748。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wɛr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin cɔl (866) 236-6748.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (866) 236-6748.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (866) 236-6748 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (866) 236-6748.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (866) 236-6748.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (866) 236-6748.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (866) 236-6748.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (866) 236-6748.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (866) 236-6748 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (866) 236-6748.

Igbo (Igbo): O bụr u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (866) 236-6748.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (866) 236-6748.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (866) 236-6748.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (866) 236-6748

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(866) 236-6748 にお電話ください。

Language Access Services:

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