

MonteCare Basic EPO
2017 SUMMARY PLAN DESCRIPTION

Montefiore

INTRODUCTION

This is a Summary Plan Description (SPD) of the MonteCare Basic EPO Plan. It is designed to meet your informational needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It explains when you become eligible, what benefits the Plan pays, any benefit limitations that apply, how to file claims and where to obtain additional information. The MonteCare Basic EPO Plan provides benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury. ***Only those services and supplies specifically listed as covered in this SPD are eligible for reimbursement.***

We suggest you read this SPD carefully, share it with your family and keep it in a safe place for future reference. If you have questions about your benefits, contact Montefiore's HR-Benefits Office.

Page

Glossary of Key Terms 3
Eligibility 9
Your Cost for Coverage 11
How to Enroll 12
HIPAA Special Enrollment Rights 13
When Coverage Begins 13
Coverage during Approved Leaves of Absence 14
MonteCare Basic EPO 15
Annual Out-Of-Pocket Maximum 16
Covered Expenses 17
Maximum Benefits 23
Exclusions 24
Non-Duplication of Benefits 28
If You Continue to Work after Age 65 30
Prescription Drug Benefits 30
Medicare Part D Notice 33
Other Important Information about Your Healthcare Benefits 36
Group Health Plan As Covered Entity 36
Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law 36
Section 1557 of the Affordable Care Act Grievance Procedure 38
Claiming Healthcare Benefits 40
For Urgent Care Claims 40
For Post Service Claims 41

Termination of Healthcare Coverage....42
General Notice of Cobra Continuation Coverage Rights....42
Important Notice Health Insurance Portability and Accountability Act of 1996 (HIPAA)....46
Genetic Information Non-discrimination Act of 2008 (GINA)....48
Surcharge....48
Subrogation....48
Qualified Medical Child Support Orders (QMCSO)....49
Occupational Health Services (OHS)....49
HealthCare Employee Assistance Program....49
Care Guidance....50
ERISA Additional Information....51
Plan Sponsor....51
Plan Administrator....51
Employer Identification Number....51
Claim Denials and Appeals....52
Legal Service....54
Administrative Information....55
Plan Type and Plan Year....55
Plan Documents....55
Plan Continuation....55
Your Rights Under ERISA (Employee Retirement Income Security Act of 1974)....56

Montefiore complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. See page 36 for more details.

If you (and/or your family members) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

Glossary of Key Terms

Ambulatory Surgical Center – A public or private facility, licensed and operated according to law, with an organized staff of physicians equipped to perform surgery. Both a physician and a registered nurse (RN) must be on the premises when surgery is performed. Ambulatory care centers do *not* provide services or accommodations for overnight stays.

Annual Out-of-pocket Maximum – The out-of-pocket maximum is the total dollar amount that you have to pay for eligible medical expenses in any calendar year. Once the annual out-of-pocket maximum is reached, MonteCare Basic EPO pays 100% of all remaining eligible covered expenses for that individual (or family) for the rest of that calendar year.

Birthing Center – A Birthing Center is a public or private facility, licensed and operated according to law, providing a home-like setting under a controlled environment for the purpose of childbirth.

Bona Fide Medical Emergency – A bona fide medical emergency is a sudden, unexpected and serious illness or injury requiring immediate medical care at the nearest hospital equipped to provide treatment. Examples include heart attack, loss of consciousness, poisoning, appendicitis and convulsions.

Brand Name Drug – A prescription drug with a proprietary name assigned to it by the manufacturer or distributor.

Chiropractic Services – The detection and correction, by manual or mechanical means, of the interference with nerve transmissions caused by the distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claims Administrator –the Company contracted by Montefiore to supervise the processing of claims and administration.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal legislation that provides participants who lose healthcare coverage with an opportunity to elect to continue healthcare coverage for a specified period of time by paying the full premium plus a 2% administrative charge.

Copayment – A flat-dollar amount you pay for certain medical services, such as in-network physicians' office visits or prescription drugs.

Custodial Care – Room and board and other institutional services provided mainly to aid an aged or physically impaired person in daily living. Activities of daily living include bathing, feeding, administration of oral medicines or other services, which can be provided by someone other than a trained healthcare provider.

Doctor (or physician) – An individual (other than yourself) holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatric Medicine (DPM) or Doctor of Chiropractic (DC), practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

Elective Medical Admission – Any non-emergency hospital admission, which may be scheduled at the patient's convenience.

Empire Behavioral Health Network – A network of providers who specialize in mental health, alcoholism and substance abuse counseling and treatment.

Empire BlueCross BlueShield (Empire) – The Claims Administrator for the MonteCare Basic EPO Plan.

Empire BlueCard PPO Network – A national network of doctors, hospitals, laboratories and ancillary healthcare providers who have agreed to charge negotiated rates for their services, which are typically lower than they would otherwise charge.

Experimental/Investigational – A service, supply, or treatment that meets one or more of these conditions:

- It is within the research or experimental/investigational stage, or
- It involves the use of a drug or substance that has not been approved by the United States Food and Drug Administration, by issuance of a New Drug Application or other formal approval, or
- It is not in general use by qualified physicians who are specialists in the field of the illness, or
- It is not of demonstrated value for the diagnosis or treatment of sickness or injury.

Formulary – A formulary is a list of medications approved by the U.S. Food and Drug Administration (FDA), including both brand name and generic drugs. Drugs on the formulary are selected by a panel of physicians and pharmacists because they can safely and effectively treat most medical conditions while helping to contain costs. The formulary is reviewed and revised regularly to reflect new prescription drugs and other changes in the market.

Generic Drug – A prescription drug, whether identified by its chemical proprietary or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent.

Healthcare Provider – A physician, nurse, psychologist, psychiatric social worker, psychiatric nurse practitioner, physical, speech or occupational therapist or any other individual providing healthcare services to whom a state has granted a license or certification and permits the billing of their services.

Home Healthcare Agency – A public or private agency or organization licensed and operated according to law, providing medical care and treatment in the patient's home. The agency must be supervised by at least one physician and registered nurse (RN), and be based on policies established by professionals in the field.

Home Hospice – A Hospice program of home care approved by a physician for a terminally ill patient with a life expectancy of no more than six months.

Hospice Facility – A public or private organization licensed and operated according to law, primarily engaged in providing palliative, supportive and other related care for terminally ill patients who are not expected to live more than six months. The facility must be staffed by at least one physician, one registered nurse, one social worker, one volunteer and have a volunteer program. A hospice is *not* a facility that is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital – A public or private facility licensed and operated according to law, which provides care and treatment by physicians and nurses to ill or injured people with facilities for diagnosis and major surgery. The facility must be under the supervision of physicians with registered nurses on duty at all times. A hospital does *not* include an institution, or part of one, which is mainly a place for rest, the aged or convalescent care. A hospital under this definition includes treatment facilities for tuberculosis, substance abuse and mental/nervous conditions.

Maintenance Care – Services and supplies provided primarily to maintain a level of physical or mental function.

Medically Necessary – Any generally accepted medical service or supply that is:

- Appropriate and necessary for the treatment or diagnosis of a medical condition
- Not primarily for the convenience of the patient or his/her healthcare provider
- Within medical standards or medical practice in the community where services are performed

  and

- The most appropriate treatment, which can safely be provided on an inpatient or outpatient basis.

For hospitalization, medically necessary also means that due to the patient's general health or the severity of the medical condition, treatment cannot be provided on an outpatient basis or in another, less intensive inpatient facility.

For ambulance service, medically necessary means the severity of the individual's medical condition precludes any other means of transportation.

Montefiore's HR-Benefits Office – Contact the HR-Benefits Office when you need assistance with benefits-related issues, by email at **montebenefits@montefiore.org** or by calling **914.349.8531**. The mailing address is:

HR-Benefits Office
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490

Montefiore Integrated Provider Association (MIPA) – The MIPA is a network of providers established by the Contract Management Organization (CMO) of Montefiore Medical Center. The HR-Benefits Office does not participate in selecting physicians who join the MIPA. The MIPA ensures physicians' credentials. MIPA physicians must be board-certified or board-eligible and must meet MIPA standards. Montefiore contracts with the MIPA under MonteCare Basic EPO for provider services only. You can call the Montefiore CMO Customer Service Department at **914.377.4400** to determine MIPA providers.

Morbid Obesity – A condition in which:

- An individual weighs at least 100 pounds more than his or her normal body weight or twice the normal weight of a person the same height

  and

- Conventional weight reduction measures have failed

  and

- The excess weight causes a medical condition – e.g., physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

Non-duplication of Benefits – A provision which limits payments from all sources to an amount that MonteCare would have paid had there been no other coverage available.

NYSNA – The New York State Nurses Association.

Nurse – A registered graduate nurse (RN), licensed vocational nurse (LVN), licensed practical nurse (LPN) or nurse practitioner – if licensed in the state where he or she practices for the services provided.

Ophthalmologist – A physician who specializes in eye care.

Optician – A person legally qualified to supply eyeglasses according to prescriptions written by an ophthalmologist or an optometrist.

Optometrist – A doctor of optometry who is trained and legally qualified to perform eye examinations and prescribe lenses.

Out-of-network Providers – Physicians and other healthcare providers who are not part of the MIPA or Empire BlueCard PPO Networks.

Separate Admission – Two or more hospital admissions for the same or a related condition that are separated by at least 90 days, *or* which are to treat entirely different illnesses or injuries.

Separate Surgical Procedure – Surgical procedures performed at different operative sessions. If two or more surgical procedures are performed during the same operative session through:

- The same incision, natural body orifice or operative field, Medical benefits will cover the R&C charge for the most expensive procedure only, or
- Different incisions, natural body orifice or operative field, Medical benefits will cover the R&C charge for the most expensive procedure plus 50% of the combined R&C charges for all other procedures performed.

Skilled Nursing Facility – A public or private facility, licensed and operated according to law, which maintains permanent and full-time accommodations for 10 or more resident patients. It must have a physician or registered nurse or licensed practical nurse on duty at all times. In addition, the facility must keep daily medical records, have transfer arrangements with one or more hospitals and a utilization review plan in effect. A skilled nursing facility must be primarily engaged in providing skilled nursing care for convalescence from an illness or injury and is not a rest home, for custodial care or for the aged.

Special Treatment Facility – A facility with a treatment program approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Spouse – The individual to whom you are legally married according to civil or common law in your state of residence.

Subrogation – The right of the MonteCare Basic EPO Plan to recover medical expenses paid to the participant for illness or injuries wrongfully caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party.

Subrogation Agreement – A written agreement in which a covered individual agrees to reimburse the MonteCare Basic EPO Plan for medical benefits resulting from illness or injuries caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party. The agreement must be signed by the associate and/or his or her family members, if applicable, before Plan payments are made to reimburse expenses incurred as a result of such illness or injury.

Substance Abuse Treatment Facility – A public or private facility, licensed and operated according to the law, which provides a program for the diagnosis, evaluation and effective treatment of substance abuse, including detoxification and infirmary-level medical services. The treatment must be provided by licensed nurses under the direction of a full-time registered nurse and the supervision of a staff of physicians. The facility must also prepare and maintain a written treatment plan for each patient based on the patient's medical, psychological and social needs.

Vision Examination – An examination by an ophthalmologist or an optometrist that includes, but is not limited to, history, external examination of the eye, examination to determine any refractive error, measurement of the ability to focus both eyes, examination of the interior of both eyes (by instrument), and a prescription for corrective lenses, if necessary.

Eligibility

The following associates are eligible to enroll in the plan.

- Part-time associates who are scheduled to work less than 50% of a normal work week but who actually worked an average of 30 or more hours per week (including hours on call, paid time off, vacation, sick and paid leave hours) during the eligibility measurement period.

  and

- Per diem associates who worked an average of 30 or more hours per week during the eligibility measurement period

You cannot enroll in the MonteCare Basic EPO, if you are eligible for any other Montefiore-sponsored medical plan or a medical plan provided under a collective bargaining agreement to which Montefiore makes contributions.

Eligibility Measurement Period

- ***Initial New Hire***
  - *Measurement Period* – 12 months from the first day of the month after your hire date
  - *Administrative Period* – the month following the Initial New Hire Measurement Period
  - *Stability Period* – 12 months from the first day of the month after the Administrative Period
- ***Annual***
  - *Measurement Period* – 12 months from October 12th through October 11th of the following year
  - *Administrative Period* – October 12th through December 31st
  - *Stability Period* –January 1st following the end of the Administrative Period through December 31st

Family Members

If you are eligible to enroll in the Plan, your family members are also eligible for coverage under the MonteCare Basic EPO Plan.

Eligible family members include your spouse (if legally married) or qualified same-sex domestic partner and children of you, your spouse, or qualified domestic partner whom you can cover through December 31 of the year they reach age 26.

Stepchildren, legally adopted children, and children for whom you are legal guardian are also eligible for coverage, as long as they meet the age requirement.

Coverage can be continued beyond the ages shown above for an eligible child who while covered as your dependent under the MonteCare Basic EPO Plan, becomes disabled – as determined by the Claims Administrator. You will initially be required to provide a physician's statement certifying the child's handicap and provide periodic proof thereafter, as requested by the Claims Administrator. Coverage will continue while you remain covered by Montefiore benefits for as long as the child remains disabled. To apply for this continuing coverage, you must notify Montefiore's HR-Benefits Office in writing on the appropriate forms at least 30 days before the child's coverage would otherwise end.

Your Cost for Coverage

You and Montefiore share the cost of coverage. Your MonteCare Basic EPO contributions are based on your salary, whether you use tobacco and whether you elect single or family coverage.

	2017 Monthly Premium Contributions (Non-tobacco User Rates) for Eligible Part-time and Per Diem Associates	
	You Only	You + Your Family
MonteCare Basic EPO Hourly Rate Bands		
<= $25.64	$137.24	$680.31
$25.64 – $41.66	$254.37	$712.18
$41.66 – $64.10	$265.74	$744.06
$64.10 – $96.15	$283.94	$795.06
$96.15 – $128.20	$293.04	$820.54
$128.20 – $160.25	$302.16	$846.04
$160.25+	$311.26	$871.54

Important Note: If you enroll, you will receive a bill from WageWorks each month. You must pay WageWorks' invoices within 30 days of the invoice date. Otherwise, your coverage will terminate and you will not be able to re-enroll until the next benefit election period, if you meet the eligibility requirements.

2017 Tobacco Use Surcharge

If you use tobacco, you will pay your regular medical premium contributions plus an additional ***20%***. You are considered a non-tobacco user if:

- You have not used tobacco products of any kind during the 6 months immediately before December 31, 2016

  or

- You indicate your intention to and arrange for a consultation with OHS to obtain counseling and a referral for Free Nicotine Replacement Therapy by December 31, 2016.

If you do not answer the tobacco use question during the Annual Benefits Election Period, you will pay the tobacco premium contribution surcharge for your medical coverage – even if you are not a tobacco user. Be sure to answer honestly. Failure to accurately respond to the tobacco use question is a violation of Montefiore policy that may subject you to disciplinary action.

How to Enroll

You enroll online at Montefiore's Enrollment Website – **www.montebenefits.com**. Or, you can call the Benefits Enrollment Call Center **888.860.6166** Monday through Friday between 8am and 8pm EST. An enrollment specialist will help you enroll.

If you have questions about:

- ***The enrollment process or the Enrollment Website***, click on the live Chat icon on the top, right toolbar after you log in (Monday through Friday between 8am and 8pm EST).
- ***Your benefits***, contact the HR-Benefits Office at **914.349.8531** or at **montebenefits@montefiore.org**.

Enroll Online

Log on to **www.montebenefits.com** using your Username and Password.

- **Verify Your Personal Information and Dependent Eligibility.**
  - You are required to enter a Primary Contact name and telephone number. It is important for Montefiore to know who to contact on your behalf in the event of an emergency.
  - Enter your family member information. You must include each dependent's name, date of birth and Social Security Number.

Important
Providing dependent information does not automatically enroll a dependent in coverage. That's accomplished through the benefits selection process.

If you need to make any changes to your personal information, please email the HR-Benefits Office at montebenefits@montefiore.org.

- **Select Your Benefits.**
  - When you enroll, indicate whether you use tobacco. If you have used tobacco products and answer "Yes" to the tobacco user question(s), you will be assessed a higher tobacco user premium. In 2017, this means your medical premium will be 20% higher than a non-tobacco user's premium rate. A non-tobacco user has not smoked, chewed or in any other manner used tobacco products of any kind during the 6 months immediately before December 31st or the individual(s) arranges for a consultation with OHS/Referral for Free Nicotine Replacement Therapy by December 31st.

    If you do not answer the tobacco use question, you will pay the higher tobacco user premium surcharge for medical coverage – even if you are not a tobacco user.
  - Enroll family members for healthcare coverage.

Dependent Verification

If you elect family healthcare coverage, you must submit verification of your family member's status with a copy of the following documentation:

- Marriage License, the first page of your most recent tax return (1040 form) or Affidavit of Domestic Partnership (if marriage between same sex partners is not recognized in your legal state of residence
- Birth Certificate, Affidavit of Dependency, final Adoption Decree or Court Order.

Please send the documents via email, fax or mail to:

- Email: **mmcdepverify@winstonbenefits.com**
- Fax: **732.903.1166**
- Mail: Winston Financial Services
  Montefiore Dependent Audit
  PO Box 430
  Manasquan, NJ 08736

You should notify Montefiore's HR-Benefits Office, in writing, within 30 days if a covered family member no longer qualifies for coverage. That way, you can, if you wish, arrange for COBRA coverage for Medical benefits. If you fail to notify Montefiore's HR-Benefits Office in writing, your contributions will continue to be based on the family rate even if you have no other covered dependents.

HIPAA Special Enrollment Rights

You may request a special enrollment under the following circumstances:

- Within 30-days of the date:
  - You or a family member loses other group health plan coverage (such as a spouse's plan)
  - You acquire a new family member through marriage, birth, adoption or legal guardianship
- Within 60-days of the date, you or a family member:
  - Are no longer eligible for coverage under the Children's Health Insurance Program (CHIP) or Medicaid
  - Becomes eligible for premium assistance under the State's Children's Health Insurance Program (CHIP) or Medicaid.

When Coverage Begins

Coverage for you and your family members begins after the **Administrative Period**, provided you enroll, supply dependent verification and make your first month's payment by the deadline.

If a family member (other than a newborn child) is hospitalized on the day coverage is to begin, coverage for that member won't begin until the confinement ends.

Coverage during Approved Leaves of Absence

If you request and are approved for a leave of absence under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be entitled to continue your healthcare coverage provided you satisfy certain requirements. Contact Montefiore's HR-Benefits Office for additional information.

Family and Medical Leave – If you go on an approved FMLA leave you can elect to:

- Continue healthcare coverage for yourself and any enrolled dependents and pay the required contributions

  or

- Suspend coverage during your leave. (If you suspend coverage, you and your dependents will be covered on the day you return to work. Evidence of insurability will not be required.)

If you elect to continue coverage, it will continue for the duration of your leave or until the earlier of the following:

- You fail to pay the required contribution within 30 days of its due date

  or

- The date you notify Montefiore that you will not return to work from your leave. (In this case, you will be required to reimburse Montefiore for the Montefiore-paid portion of the health insurance premium unless your termination of employment is from reasons beyond your control.)

Military Leave – Healthcare coverage continues for the first six-months of a military leave provided you continue to make the required contributions. If you remain absent for more than six-months, you may elect COBRA continuation coverage. Coverage for your family members remains in effect for six-months after which they may elect COBRA continuation coverage.

Personal Leave – Healthcare coverage continues through the end of the month in which your approved personal leave of absence begins provided you continue to make the required contributions. If you remain absent from work for more than 30 days, you may elect COBRA continuation coverage.

Sabbatical – You can elect to continue your healthcare coverage for up to six months of an approved sabbatical provided you continue to make the required contributions. If you suspend coverage during your leave, you and your dependents will be covered on the day you return to work – without having to provide evidence of insurability.

Paying For Coverage During a Leave

If you elect to continue coverage during an approved leave, you must continue to make the required contributions. You can:

- Pre-pay the entire amount before your leave begins, or
- Make contributions on a monthly basis after your leave begins.

MonteCare Basic EPO

MonteCare Basic EPO only pays benefits for in-network expenses. To receive benefits you must use in-network services provided by:

Physicians, Therapists, and Counseling for Mental Health and Substance Abuse	· Montefiore Integrated Provider Association (MIPA) · Empire BlueCard PPO Network · Montefiore Behavioral Care Integrated Provider Association (MBCIPA) · Empire Behavioral Health Network
Hospitals and other facilities	Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital, White Plains Hospital, Burke Rehabilitation Hospital, Montefiore Ambulatory Surgical Facilities, Montefiore Imaging Center, Montefiore Department of Radiology, Advanced Endoscopy Center and NY GI Center
Skilled nursing facility; hospice	Empire BlueCard PPO Network and Schaffer Extended Care Center
Laboratories	Quest Laboratories, LabCorp and Montefiore Network (including Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital laboratories)
Pharmacies	Montefiore outpatient pharmacies

No benefits are paid for out-of-network care except in a bona fide emergency.

It is your responsibility to confirm whether or not a physician is participating in the network when you call to make an appointment and at the time of each visit. For more information or if you would like to find a network provider you can contact the Montefiore CMO Customer Service Department at **914.377.4400**, Empire at **866.236.6748** or online at **www.empireblue.com/montefiore**.

Annual Out-Of-Pocket Maximum

The annual out-of-pocket maximum is the maximum total dollar amount you have to pay for eligible medical expenses including coinsurance and copayments (up to R&C limits) in any calendar year.

Once your share of eligible expenses reaches the out-of-pocket maximum, the plan pays 100% of covered services for the remainder of the calendar year. If you are enrolled for family coverage and one family member reaches the individual out-of-pocket maximum amount, the plan will pay 100% of that family member's eligible expenses for the rest of the calendar year. The expenses of any remaining family member or members would then be applied to the family maximum amount. No one individual is required to pay more than the individual out-of-pocket amount.

The maximum out-of-pocket limits are:

- $6,100 for an individual
- $12,200 for a family.

Covered Expenses

In-hospital Care

MonteCare Basic EPO covers semi-private hospital room, board and medical supplies for up to 365 days of treatment. If only private rooms are available, MonteCare Basic EPO covers those charges up to the prevailing semi-private room rate in the area in which treatment is received.

Inpatient expenses include:

- Anesthesia supplies and use of equipment
- Dressings and plaster casts
- Drugs and medicines for use in the hospital
- General nursing care (in-hospital private duty nursing care is not covered)
- Intensive care, coronary care or other special care units and equipment
- Medical services and supplies customarily provided by the hospital, other than personal convenience items
- Oxygen and use of equipment for its administration
- Use of blood transfusion equipment and administration of blood or blood derivatives if administered by a hospital employee
- Use of operating, cystoscopic and recovery rooms
- X-rays and laboratory examinations.

Coverage is also provided for:

- Cosmetic Surgery – if needed to repair damage caused by an accident or a birth defect
- Dental work or surgery if your physician certifies that hospitalization is necessary to safeguard your life
- Maternity care – a minimum of 48 hours following vaginal delivery; 96 hours following delivery by cesarean section; earlier release is possible after consultation between the attending physician and the mother
- Organ and tissue transplants – if the covered person is the recipient (benefits for the donor will also be covered if that person is not covered by any other group health insurance plan)
- Prosthetics and orthotics – when billed with another covered service such as minor/ambulatory surgery, cataract surgery or breast reconstructive mandates
- Treatment in a hospital emergency room or similar facility for a bona fide medical emergency
- Well baby nursery and physicians' charges during the initial confinement while the mother is confined in the same hospital – for up to the number of days medically necessary and appropriate for the type of delivery (well-baby nursery care will not be paid for any additional days the mother remains hospitalized due to an illness, injury or complications following delivery).

Inpatient Psychiatric Care/Substance Abuse

MonteCare Basic EPO provides benefits for inpatient psychiatric care and substance abuse – in either a general hospital or special treatment facility.

For purposes of this benefit, a general hospital means the following:

- In New York State
  - For alcoholism – a facility certified by the New York State Division of Alcoholism and Alcohol Abuse
  - For substance abuse – a facility certified by the New York State Division of Substance Abuse Services
- Outside of New York State – a facility with a treatment program approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Benefit Summary

The following table shows the benefits MonteCare Basic EPO provides for in-hospital services and supplies.

	MonteCare Basic EPO Your Cost If You Use:		
Benefits for In-hospital Care	**Montefiore Network**	**Empire BlueCard PPO Network**	**Out-of-network**
Hospital Inpatient Services and Ancillaries – semi-private room and board for up to 365 days · General Illness · Inpatient Surgery · Maternity · Medical Rehabilitation · Mental Healthcare · Organ Transplant · Sick Newborn · Substance Abuse Treatment · Accidental Injury · Medical Supplies · Well Newborn	$0	Not covered; except for an emergency admission	Not covered; except for an emergency admission
Emergency Room Care			
· Bona fide emergency – copayment waived if admitted	$100 copay	$100 copay	$100 copay
· Other than a bona fide emergency	Not covered	Not covered	Not covered
· Urgent Care Facility	$15 copay/visit	$50 copay/visit	Not covered
· Urgent Care Professional	$15 copay/visit	$50 copay/visit	Not covered

Alternatives to In-hospital Care

MonteCare Basic EPO provides benefits for services and supplies provided by the following alternatives to in-hospital care:

- ***Home Healthcare*** – up to a maximum of 200 visits in a calendar year. Each visit by a member of a home healthcare team counts as one home healthcare visit. Up to four hours of home health aide services count as one home healthcare visit. Home healthcare benefits are limited to 12 hours of care a day.

  Covered services must be provided by a certified home health agency and include:

  - Ambulance or ambulette to the hospital for needed care
  - Home infusion therapy
  - Medical social worker visits
  - Medical supplies, drugs and medicines prescribed by a physician
  - Necessary laboratory services
  - Part-time home health aide services
  - Part-time professional nursing
  - Physical, occupational or speech therapy.
  - X-ray and EKG services.
- **Ambulatory Surgical Facility**
- **Birthing Center**
- ***Hospice*** – for the medical care and treatment of a terminally ill patient for up to 210 days – provided the care is not primarily custodial. The care must be recommended by a physician and provided at any licensed facility or at home.
- **Skilled Nursing Facility** – up to 120 days each calendar year.

Benefit Summary

Benefits for Alternatives to In-hospital Care	MonteCare EPO Your Cost If You Use:	
	Montefiore Network	Empire BlueCard PPO Network
Ambulatory Surgical Facilities	$0	Not covered
Birthing Center	$0	Not covered
Home Healthcare – up to 200 visits in a calendar year	$0	$0
Home Infusion Therapy – (not in conjunction with Home Healthcare)	$0	$0
Hospice – up to 210 days	$0	$0
Skilled Nursing Facility – up to 120 days	$0	$0

Outpatient Medical/Surgical Services

MonteCare Basic EPO pays the following in-network benefits for services and supplies, if prescribed by a physician and medically necessary for the treatment or diagnosis of a covered condition.

Covered outpatient medical/surgical services and supplies include:	MonteCare Basic EPO Your Cost If You Use:	
	Montefiore Network	**Empire BlueCard PPO Network**
Preventive Care · Gynecological Exams (routine) · Immunizations – Hepatitis A, Annual Flu Shot, Tetanus, Pneumococcal · Nutrition Counseling – limited to 6 visits in a calendar year, if referred by a physician. · Physical Exams (routine) – once in a calendar year · Well Child Care – limited to 11 visits up to age 2. · Well Woman Care – Screening for gestational diabetes – HPV testing – Contraceptive methods and counseling – Breast feeding support, supplies and counseling – Counseling for sexually transmitted infections – Counseling and screening for HIV – Screening and counseling for interpersonal and domestic violence	$0	$0
Acupuncture – for the treatment of nausea and vomiting related to chemotherapy and pregnancy, osteoarthritis of the knee, post-operative dental pain, and post-operative nausea and vomiting in adults – limited to 12 treatments in a 12 month period	$0	$0
Alcohol/Substance Abuse Treatment	$15 copay/visit	$35 copay/visit
Allergy Care · Office Visit Testing · Treatment	 $0 $0 for treatment	 $50 copay $0 for treatment
Ambulance Service – in an emergency to the nearest medical facility equipped to treat that condition or if medically necessary	20% coinsurance	20%[1] coinsurance
Anesthesia Services – if performed by a licensed anesthesiologist in connection with a surgical procedure.	$0	$0
Birth Control – IUDs, diaphragm fittings, Norplant	$0	$0
Blood, Blood Plasma or Blood Derivatives	$0	$0
Cardiac Rehabilitation	$0	$0
Chemotherapy	$0	$0
Circumcision – if performed before the newborn leaves the hospital	$0	$0
Consultations and Surgical Opinions	$15 copay/visit	$35 copay/visit
Dental Services: · extractions of impacted wisdom teeth and other teeth impacted in bone which require oral surgery · treatment of an injury to sound natural teeth within 12 months of the date of injury	$0	Not covered
Durable Medical Equipment – purchase and rentals	20%[1] coinsurance	20%[1] coinsurance

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

Covered outpatient medical/surgical services and supplies include:	MonteCare Basic EPO Your Cost If You Use:	
	Montefiore Network	**Empire BlueCard PPO Network**
Genetic Testing (certified medically necessary by a physician)	$0	$0
Hemodialysis	$0	$0
Medical Supplies	$0	20%[1] coinsurance
Mental Healthcare	$15 copay/visit	$35 copay/visit
Nutrition Counseling – six visits each calendar year if referred by a physician. In-network providers are Registered Dieticians in the Empire BlueCard PPO Network, including Montefiore Registered Dieticians.	$0	$0
Obstetrical (Maternity) Care – including termination of pregnancy, certified nurse-midwife	$0	$0
Outpatient Diagnostic and Laboratory Tests	$0	Not covered
Physical, Occupational and Speech Therapy	$0	Not covered
Physicians' Visits		
· In-hospital by your attending physician	$0	$35 copay/visit
· Office visits including emergency care/first aid and medical evaluations	$15 copay/visit	$35 copay/visit
· Specialist office visits	$15 copay/visit	$50 copay/visit
Polysomnograms	$0	Not covered
Pre-surgical/Pre-admission tests – if performed within 14 days of a scheduled hospital admission	$0	Not covered
Prosthetics – including wigs and toupees	Not covered	Not covered
Radiation Therapy	$0	$0
Radiologist's Fees	$0	$0
Reconstructive Surgery Following a Mastectomy – while the person is covered by MonteCare Basic EPO– including: · reconstruction of the breast on which the mastectomy was performed · surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses · treatment of physical complications at all stages of the mastectomy, including lymphedemas	$0	$0
Respiratory Therapy	$0	Not covered
Shock Therapy	$0	Not covered
Sleep Disorders – treatment of sleep apnea and narcolepsy	$0	$0
Sterilization (but not reversals)	$0	$0
Surgeons' and Assistant Surgeons' Fees	$0	$0
Vision Therapy	Not covered	Not covered

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

Maximum Benefits

MonteCare Basic EPO generally provides *unlimited* in-network and out-of-network maximum lifetime benefits for you and each covered family member.

However, some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual and are:

- Acupuncture – limited to 12 treatments in a 12 month period
- Home healthcare – up to 200 visits each calendar year
- Hospice care – for up to 210 days
- Morbid Obesity – surgical treatment (limited to one procedure in a lifetime)
- Nutritional counseling – six visits in a calendar year
- Physical exams (routine) – once in a calendar year
- Travel and lodging expenses for a patient and one companion limited to $125/day for meals and lodging for transplants
- Skilled nursing facility – limited to 120 days each calendar year
- Well child care – limited to 11 visits up to age 2.

Exclusions

MonteCare Basic EPO does *not* pay benefits for all medical services and supplies – even if recommended by a physician. Expenses *not* covered include:

- Acupuncture – for anesthetic purposes in conjunction with surgery
- Advanced Reproductive Technologies
- Chiropractic services
- Complications arising from non-covered surgery
- Conditions, disabilities or expenses caused by:
  - commission of or participation in a crime
  - riot or war (declared or not)
  - serving in the armed forces
  - an illegal occupation
  - an occupational illness or injury
- Cosmetic surgery, except as specified under covered services
- Counseling – marital, family or sex counseling (unless provided by the staff counseling service under the Employee Assistance Program)
- Custodial, sanitarium or rest care
- Dental services for
  - X-ray examinations in conjunction with mouth conditions due to periodontal or periapical disease
  - any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure , the alveolar process or the gingival tissue
  - treatment of temporomandibular joint dysfunction (TMJ) when dental in nature
  - inpatient dental treatment unless certified by your physician to safeguard your life
- Donor search/Compatibility fee
- Drugs or medicines – prescription and non-prescription unless provided by a Hospital or dispensed from a doctor's office
- Eating disorders, except bulimia and anorexia nervosa
- Equipment that can be used by someone who is not ill or injured, such as air conditioners, air purifiers, heating pads, water beds, swimming pools, etc.
- Expenses:

- for broken appointments, telephone consultations, filling out medical reports, medical bills, and benefit request forms
- for care provided by any physician other than a network physician or any facility other than Montefiore – except in a bona fide emergency
- for care to correct learning or behavioral disorders
- for education, vocational counseling, and job training
- **in excess of reasonable and customary limits**
- incurred before coverage starts or after it ends
- related to the insertion or maintenance of an artificial heart
- to the extent they are reimbursable under another employer's plan or any other source of payment

- Eyeglasses and contact lenses except after Cataract Surgery
- Foot care
  - Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
  - Orthotics for treatment of routine foot care
- Hearing benefits
- Hearing aid insurance
- High Dose Chemotherapy with Autologous Bone Marrow Transplant ("HDCT-ABMT")
- Hospital confinement primarily for diagnostic studies
- Hypnosis (except for anesthetic purposes)
- Intentionally self-inflicted illness or injury
- Lamaze class
- Laser eye surgery
- Massage therapy and rolfing
- Medically necessary services that can be provided without the assistance of trained medical personnel – e.g., injections for diabetes, riding a bike as part of physical therapy, etc.
- Minoxidil (Rogaine)
- Penile prosthetic implant
- Personal comfort or service items while you are in the hospital, such as phones, radio, television, guest meals, etc.

- Private duty nursing
- Professional services provided by you, a family member or by someone who lives in your home
- Radial keratotomy and related procedures
- Services and/or supplies:
  - covered under the mandatory portion of a no-fault automobile insurance policy, if no-fault benefits are recovered or recoverable
  - for medical procedures or treatments
    - considered experimental, investigational or educational
    - provided primarily for research
    - not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness, injury or pregnancy
  - for recreational therapy
  - for smoking cessation programs including transdermal patches or Nicorette gum
  - for which there is no legal obligation to pay or charges that would not have been made except for the availability of benefits from Montefiore
  - not ordered by a physician
  - provided by a Health Maintenance Organization (HMO)
  - provided by the government, unless you are legally required to pay for the care you receive
  - **which are not specifically listed as covered expenses in this Summary Plan Description (SPD)**
  - which result from illness or injuries caused by a third party unless a subrogation agreement has been executed by you and/or the appropriate family member

- Sleeping disorders – treatment of sleeping disorders, including bruxism (grinding of teeth), drug dependency, dream anxiety attacks, shift work or schedule disturbances and migraine headaches (except as specified under covered services)
- Specialty Medications (However, they are covered under Montefiore's prescription drug benefits when filled through Montefiore's outpatient pharmacies)
- Sterilization – procedures to reverse voluntary sterilization
- Surrogate expenses
- Vaccinations, inoculations or immunizations, except as specified under covered services
- Vision perception training
- Vitamins, minerals and food supplements
- Weight reduction – treatment, instructions, activities or drugs for weight reduction or control, except for the diagnosed condition of morbid obesity.

Non-Duplication of Benefits

MonteCare Basic EPO contains a non-duplication of benefits feature. This feature applies when you or a family member is covered by more than one group medical plan. It limits payments from all sources combined to no more than MonteCare Basic EPO would pay if there had been no other coverage. The provision also applies to Medicare, Champus/Tricare and any other government programs with which MonteCare Basic EPO is allowed to coordinate by law. The non-duplication of benefits provision does not apply to any personal policy, except no-fault automobile insurance. This provision does not apply to Medicaid or any other government programs with which MonteCare Basic EPO is not allowed to coordinate by law.

Under the non-duplication of benefits provision, the plan that has primary responsibility always pays first. Briefly, non-duplication of benefits works like this.

- When the other plan does not have a non-duplication or coordination of benefits provision, it is considered primary.
- When both plans have a non-duplication or coordination of benefits provision:
  - The plan covering the person as an employee is primary and will pay benefits up to the limits of that plan; the plan covering the person as a dependent, retiree or COBRA participant (terminated employee who elected COBRA coverage) is secondary and pays any remaining eligible costs.
  - The plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay children's benefits first; the plan covering the other parent pays second and pays the remaining costs to the extent of coverage. This is called the "birthday" rule and is currently used by MonteCare Basic EPO.
  - In those plans which do not include the "birthday" rule, the father's plan is primary and will pay children's benefits first; the mother's plan pays second. This is called the "male-female" rule.
  - If one parent is covered by the "male-female" rule and the other by the "birthday" rule, the "male-female" rule applies.
  - If the parents of a dependent child are divorced or legally separated, the claims administrator will determine if there is a court decree which establishes financial responsibility for medical and dental care. If there is such a decree, the plan covering the parent who has that responsibility will be primary and pays first.

- If there is no decree, the plan which covers the child as a dependent of the parent with custody is primary and pays first; the other parent's plan is secondary.
- If there is no decree and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary; the non-custodial parent's plan is third.

· If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan and pays first.

Under non-duplication of benefits, if MonteCare Basic EPO pays benefits second, it will not duplicate any benefits that have already been paid. If the other plan pays as much or more than MonteCare Basic EPO, no payments will be made.

Claims should always be submitted to the primary plan first.

Coordination with an HMO

MonteCare Basic EPO also coordinates benefits with an HMO if:

· You are covered as a dependent under your spouse's (or qualified domestic partner's) HMO and are also enrolled in MonteCare Basic EPO

or

· Your spouse (or qualified domestic partner) is covered by an HMO and is also enrolled as your dependent in MonteCare Basic EPO.

In these instances, you may file a claim under Montefiore medical benefits for expenses not covered by the HMO. If the claim is for a covered expense, the option will pay its regular benefit.

Coordination with Medicare

Montefiore medical benefits provide primary coverage for the following covered Medicare-eligible individuals:

· Active associates and their spouses age 65 or older

· Individuals with End Stage Renal Disease for 30 months or less

· Covered disabled dependents of active associates.

If you are an active associate age 65 or over and eligible for Medicare, you can elect primary coverage under Medicare. However, if you do, no benefits will be payable under Montefiore medical benefits.

In addition, if you continue to work after age 65, you should notify the Social Security Administration. Otherwise, when you eventually enroll for Medicare, you will pay a higher premium.

If You Continue to Work after Age 65

You may be eligible for Medicare if you:

- are age 65 and older, or
- have received Social Security disability benefits for 24 months, have ALS (Amyotrophic Lateral Sclerosis) or have permanent kidney failure.

If you enroll in Medicare and continue to work, you and your family members are still eligible to be covered by Montefiore medical benefits.

If You Enroll in Medicare

If you choose to be covered by Medicare and Montefiore medical benefits, your Montefiore coverage will be primary to Medicare. Medicare will become your secondary plan and provide coverage for eligible expenses that your Montefiore coverage does not cover or if the plan pays less than Medicare would pay if Medicare had been primary.

If you are disabled as a result of End Stage Renal Disease ("ESRD") your Montefiore coverage will only be primary for a 30-month period beginning the first of the month in which you become eligible or enrolled in Medicare Part A.

If you waive Montefiore coverage, Medicare will be your primary insurance plan. You will not be eligible to receive medical benefits from Montefiore because federal law prohibits offering supplemental benefits for expenses covered under Medicare to active employees or their dependents.

If You Do Not Enroll in Medicare

If do not enroll in Medicare Part B when you first become eligible, you may be eligible to enroll (without a late penalty) during a Special Enrollment Period (SEP), if you are continuously covered by Montefiore until:

- you elect to waive coverage, or
- you are no longer eligible for coverage.

The Special Enrollment Period is open for eight months after Montefiore's coverage ends. For more information go to **www.medicare.gov**

Prescription Drug Benefits

Prescription drug benefits are provided by Montefiore Outpatient Pharmacies. There is no coverage for prescriptions obtained at retail pharmacies nor does it include a home delivery pharmacy service.

Benefit Summary

Copayments are based on the generic, preferred, non-preferred or specialty drug classification of each prescription.

	Your Cost If You Purchase:			
	Generic	**Preferred (Formulary)**	**Non-Preferred (Non-Formulary)**	**Specialty**
Montefiore Outpatient Pharmacies[1]				
• 30-day supply for new prescriptions for chronic medications and seasonal allergy medications	$0	$20 copay	You pay 100% of discounted cost	$20 copay
• 90-day supply for refills and all other medications	$0	$40 copay	You pay 100% of discounted cost	$40 copay

1. If you purchase a preferred formulary brand name medication when a generic equivalent is available, you are responsible for the generic copayment plus the difference in cost between the generic and preferred formulary brand name medication.

Prescription Drug Out-of-pocket Maximum

Your share of expenses for prescriptions obtained from Montefiore Outpatient Pharmacies is limited to $500 for any one covered person ($1,000 for a family) in a calendar year. Once that maximum is reached, the Plan pays 100% of any remaining prescription drug expenses from Montefiore Outpatient Pharmacies for that individual or family for the rest of the calendar year.

Utilization Management Features

The following plan features are designed to increase the quality and safety of the Prescription Drug Program. In addition, they can help keep prescription drug costs under control – for you and Montefiore.

- ***Drug Utilization Review*** – is designed to ensure that plan participants receive appropriate prescription medication. Express Scripts reviews your prescriptions and will contact your doctor if they identify potentially unsafe prescribing patterns. Express Scripts' determination is based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

  The review also regulates the timing between prescription refills. You must use at least 75% of a prescription before a refill will be approved. If you need a prescription refill sooner – for example, if you will be traveling – you can call Express Scripts for a waiver.

- ***Preferred Drug Step Therapy (PDST)*** – Before using a higher cost non-preferred drug, you are required to try a generic alternative or preferred brand name medication first. If your doctor prescribes a non-preferred drug, Express Scripts will work with your doctor to see if a generic alternative or preferred brand name medication would be equally effective. (In some cases, special circumstances may require you to use a non-preferred drug.) Note: If your prescription history shows that you have already tried preferred drugs, your prescription will be filled without a review.

- ***Drug Specific Prior Authorization*** – This feature insures that drugs are being used for their designed purpose. Express Scripts will review your prescriptions and contact your doctor to determine if your prescription qualifies for drug coverage based on nationally accepted clinical guidelines and standards. If you are taking drugs that require prior authorization, Express Scripts will notify you and provide you with instructions for beginning a coverage review.

- ***Quantity/Dose Limitations*** – Prescriptions for generic and brand name medications will only be filled in quantities and doses that are consistent with manufacturer and FDA clinical guidelines. If your doctor prescribes a drug in a quantity/dose that exceeds these guidelines your prescription will be filled according to the guidelines. If you are currently taking a drug in a quantity that is affected by these guidelines you will be pre-notified by Express Scripts – at which point you or your physician can initiate a coverage review process in order for greater quantities to be filled.

Medicare Part D Notice

Important Notice from Montefiore Medical Center about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Montefiore Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Montefiore Medical Center has determined that the prescription drug coverage offered by MonteCare Basic EPO is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, you will still be eligible to receive all of your current health and prescription drug benefits, provided you continue your Montefiore coverage.

If you do decide to join a Medicare drug plan and drop your current Montefiore coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Montefiore Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or Montefiore Prescription Drug Coverage

Call Montefiore's HR-Benefits Office at **914.349.8531**.

NOTE: You will receive this notice each year before the next period you can join a Medicare drug plan, and if Montefiore's coverage changes. You also may request a copy at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" Handbook.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" Handbook for their telephone number) for personalized help.
- Call 800-MEDICARE **(800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call **800.772.1213 (TTY 800.325.0778)**.

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2017
Name of Entity/Sender:	Montefiore Medical Center
Contact – Position/Office:	HR-Benefits Office
Address:	111 East 210th Street Bronx, NY 10467-2490
Phone Number:	**914.349.8531**

Other Important Information about Your Healthcare Benefits

GROUP HEALTH PLAN AS COVERED ENTITY

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

The Montefiore Medical Center Employee Health & Welfare Benefit Plan and the Montefiore Medical Center Retiree Benefit Plan (collectively, the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. The Plan does not exclude people or treat them differently because of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Plan Administrator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age, you may file a claim under the Plan. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the **Office for Civil Rights Complaint Portal**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800.868.1019**, **800.537.7697** (TDD).

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718-920-4943 (TTY: 1-718-920-5027).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-718-920-4943（TTY：1-718-920-5027）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718-920-4943 (телетайп: 1-718-920-5027).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718-920-4943 (TTY: 1-718-920-5027).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718-920-4943 (TTY: 1-718-920-5027) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718-920-4943 (TTY: 1-718-920-5027).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-718-920-4943 (TTY: 1-718-920-5027).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-718-920-4943 (TTY: ১-1-718-920-5027)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-718-920-4943 (TTY: 1-718-920-5027).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-718-920-4943 (رقم هاتف الصم والبكم: 1-718-920-5027).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718-920-4943 (ATS : 1-718-920-5027).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-718-920-4943 (TTY: 1-718-920-5027).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718-920-4943 (TTY: 1-718-920-5027).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-718-920-4943 (TTY: 1-718-920-5027).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-718-920-4943 (TTY: 1-718-920-5027).

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Montefiore not to discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. Montefiore has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (**42 U.S.C. 18116**) and its implementing regulations at **45 CFR part 92**, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Maria Trotta-Williams, Assistant Director, Customer Service, 111 East 210th Street, Bronx, NY 10467, **718.920.4943**, **718.231.4262**, **civcilrightscoordinator@montefiore.org**, who has been designated to coordinate the efforts of Montefiore to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Montefiore to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Montefiore relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the **Office for Civil Rights Complaint Portal**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: **www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Montefiore will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Claiming Healthcare Benefits

Claims should always be submitted to the primary plan first.

For Urgent Care Claims

If you file an urgent care claim, the Claims Administrator will make an initial benefit determination within 24 hours after they receive your properly completed claim form and all required documentation.

An urgent care claim is a claim filed before medical services are received and is for conditions in which receiving medical care quickly is a critical factor in:

- assuring the patient's life, health or ability to regain maximum function

  or

- in the opinion of a physician with knowledge of the patient's medical condition, avoiding severe pain.

If you file an incomplete urgent care claim, the following steps show the procedure and timing.

1. Within 24 hours after receiving your claim, the Claims Administrator will notify you that your claim is incomplete and tell you what information you need to provide.
2. You provide the requested information within the timeframe set by the Claims Administrator (but in no case less than 48 hours).
3. The Claims Administrator makes a final determination on the claim within 48 hours after:
   - You provide the requested information

     or

   - The end of the time period you have to provide the requested information

     . . . whichever is earlier.

If your claim is denied, you will receive notice of the denial as described in "**If Your Claim is Denied**". The initial denial of your urgent care claim may be provided orally. However, you will receive written notification of the denial within three days after the oral notification.

For Post Service Claims

If you file a post service claim, the Claims Administrator will send you written notification of their benefit determination within 30 days after receiving the claim. If matters beyond the control of the claims administrator require an extension of time, the Claims Administrator may extend the notification period by up to 15 days. If an extension is required, the Claims Administrator will notify you in writing before the end of the initial 30-day period. The notification will include the reasons the extension is required and the date by which the Claims Administrator expects to make its determination. If the extension is required because your claim was not complete, the notice of extension will describe the required information. You will have at least 45 days following receipt of the notice to provide the requested information.

A post service claim is a claim for benefits filed after the services are received.

Hospital Benefits

Generally, hospitals submit their bills directly to the Claims Administrator. If you do receive a hospital bill, make sure it is itemized and forward it to the Claims Administrator. If you or a covered family member is admitted to Montefiore, you should not receive a bill for the admission. If you do, do not pay it. Call the Montefiore billing department and identify yourself as covered under MonteCare Basic EPO benefits.

Laboratory Benefits

If you receive a bill for a covered expense directly from Quest Laboratories, LabCorp or any Montefiore hospital laboratory (including Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore Mount Vernon Hospital, Montefiore New Rochelle Hospital), do not pay the bill. Call the provider, identify yourself as an associate enrolled in MonteCare Basic EPO and instruct them to send the invoice to the Claims Administrator.

Other Benefits

Medical services you receive through in-network providers generally require no claim forms. Your network provider will handle all of the necessary paperwork.

Termination of Healthcare Coverage

Healthcare coverage ends on the last day of the month in which:

- The MonteCare Basic EPO Plan is terminated
- You no longer meet the eligibility requirements
- You terminate your employment
- You fail to pay any required contributions as described under Continuation Coverage (COBRA).

If a dependent no longer qualifies as an eligible family member, healthcare coverage ends:

- For your dependent children – on the last day of the calendar year
- For your spouse or domestic partner – on the last day of the calendar month.

Upon termination of coverage, you may be able to elect Continuation Coverage (COBRA) by paying the cost of coverage for a specified period of time.

General Notice of Cobra Continuation Coverage Rights

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive coverage.

If healthcare coverage stops as a result of:

- Layoff, leave of absence, disability or termination of employment for reasons other than gross misconduct
- Retirement before age 65 if you do not qualify for retiree medical benefits
- A reduction in your regularly scheduled hours
- Divorce or legal separation or termination of a qualified domestic partnership
- A child no longer qualifying as a family member
- Your death

. . . you and/or your qualified beneficiaries can individually elect to continue MonteCare Basic EPO coverage you had in effect at the time of the qualifying event. Depending on the type of qualifying event, your spouse or qualified domestic partner, and eligible dependent children may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries.

You will have the opportunity to change your coverage during the next fall annual election period. At that time, you will receive all the materials you need to make your elections. The decisions you make during the election period will take effect the following January 1.

Notifying the COBRA Administrator of Qualifying Events

You or your family members must notify Montefiore's HR-Benefits Office in writing if healthcare coverage will stop due to any of the following events:

- you and your spouse are divorced or legally separated,
- your qualified domestic partnership terminates

  or

- a child no longer qualifies as a dependent.

You must send this written notification within 60 days after the date of the event or the date coverage would stop – whichever is later.

To elect continuation coverage, you must return the COBRA Election Form to the COBRA Administrator within 60 days after:

- You receive notice of your right to continue healthcare coverage

  or

- The date healthcare coverage stops, if later.

If you or a dependent initially waives COBRA continuation coverage, that individual may revoke that waiver during the 60-day COBRA election period. In that case, COBRA coverage will begin on the date you first became eligible provided you pay the required retroactive contributions on a timely basis.

Paying for COBRA Coverage

If you (or your family members) elect continuation coverage, you must pay 102% of the cost of coverage, as determined by the COBRA Administrator. If a disability occurs within the first 60 days of COBRA continuation coverage, the 18 month period for medical coverage may be extended up to 29 months as a result of the disability. The premium for the family may increase to 150% of the cost of coverage for the additional 11 months. While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

You have 45 days after you elect COBRA coverage to pay the premium for the period beginning on the date COBRA coverage begins until the end of the month in which you return the COBRA election form. Claims under COBRA coverage will not be processed for this initial period until payment is received by the COBRA Administrator. After the initial payment, you must pay your monthly COBRA premium on the first day of the month. If not paid within 30 days of the date payment is due, coverage will automatically terminate without further notice. Claims under COBRA coverage will not be processed for any period until full payment is received by the COBRA Administrator.

Duration of COBRA Coverage

The following table shows the longest period of time coverage can be continued.

If you are:	And lose healthcare coverage due to one of the qualifying events shown below:	You can choose continuation of healthcare coverage for up to:
an MMC associate	· layoff, leave of absence (including military leave), or termination of employment (for reasons other than your gross misconduct) · a reduction in your regularly scheduled hours	18 months
	· disability (at the time of termination of coverage or within the first 60 days of continuation coverage)	29 months
a covered spouse or qualified domestic partner of an MMC associate	· your spouse or domestic partner is on layoff, leave of absence, or terminates employment (for reasons other than gross misconduct) · a reduction in your spouse or domestic partner's regularly scheduled hours	18 months
	· your spouse or domestic partner is disabled at termination of employment or within the first 60 days of continuation coverage	29 months
	· the death of your spouse or domestic partner · your spouse or domestic partner is disabled · divorce, legal separation, annulment or termination of a qualified domestic partnership	36 months
a covered dependent child of an MMC associate	· your parent is on layoff, leave of absence or terminates employment (for reasons other than gross misconduct) · a reduction in your parent's regularly scheduled hours	18 months
	· your parent is disabled at termination of employment or within the first 60 days of continuation coverage	29 months
	· the death of your parent · your parents' divorce, legal separation, annulment or termination of a qualified domestic partnership · you no longer qualify as a dependent for medical and dental coverage	36 months
Note: In no case can COBRA coverage continue for more than 36 months, even if you experience multiple qualifying events.		

When the continuation period ends, healthcare benefits stop.

Continuation of healthcare coverage may be cut short if:

- You or your family members do not make all the required contributions on a timely basis

  or

- Montefiore terminates all health plans.

Continuation of your Medical coverage will also stop if you or your family members become entitled to Medicare (coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible).

If You Have Questions

For more information about your rights and obligations under the Plans and under federal law, you should contact the COBRA Administrator who is responsible for administering COBRA continuation coverage. The COBRA Administrator is:

WageWorks
PO Box 14053
Lexington, KY 40511
877.924.3967
ATTN: COBRA Department

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Program Informed of Address Changes

To protect your family's rights, you must notify the COBRA Administrator in writing of any changes in the addresses of family members. You should also keep a copy of any notices you send to the COBRA Administrator for your records.

Important Notice
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal privacy regulations to protect personal medical information went into effect on April 14, 2003 and were amended effective September 23, 2013 by the Health Information Technology for Economic and Clinical Health Act (HITECH). These privacy rules set limits on how health plans, pharmacies, hospitals, clinics, nursing homes and other direct-care providers (called covered providers) use individually identifiable health information.

This overview of HIPAA is intended to help you understand your rights and protection of personal information related to your health. Please review it carefully.

Key provisions of these privacy standards include:

- Access To Medical Records – HIPAA gives you the ability to review and obtain copies of your medical records. If your medical records are maintained electronically, you may request access to your electronic medical records, if that format is readily producible. Otherwise, the covered provider must provide the requested information in an electronic format that you can read on your computer (e.g., Word, Excel, etc.) You may also request corrections if you have identified any errors. Covered providers generally should provide access to your records within 30 days of your request and may charge for the cost of copying and sending the records to you.
- Notice of Privacy Practices – Covered providers will provide you with a HIPAA notice advising you of your rights. You may be asked to sign, initial or otherwise acknowledge that you have received this notice. You may also ask to restrict the use or disclosure of your information beyond the practices included in the notice, but the covered providers would not have to agree to the changes.
- Limits on Use of Personal Medical Information – The privacy rule sets limits on how covered providers may use your identifiable health information. These limits do not restrict the ability of health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care. Covered providers may use or share only the minimum amount of protected information needed for a particular purpose. In no case will a covered provider use or disclose your personal medical information which is genetic information for underwriting purposes. You must provide written authorization for the following medical information to be disclosed:
  - Psychotherapy notes if maintained by the plan.
  - Personal medical information for marketing purposes. For example, your written authorization will be required for the covered provider to share your medical information to promote health care products or services, alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.

- Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide service, such as research or for the services provided by the health information exchange.
- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care.

- Stronger State Laws – The federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; any state law providing additional protections would continue to apply. When a state law requires a certain disclosure – such as reporting an infectious disease outbreak to the public health authorities – the federal privacy regulations would not preempt the state law.
- Confidential communications – Under the privacy rule, you can request that your doctors, health plans and other covered providers take reasonable steps to ensure that their communications with you are confidential. For example, you could ask your doctor to call you at work rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.
- Complaints – You may file a formal complaint regarding Montefiore Medical Center privacy practices to:

  Health Plan Privacy Officer
  HR – Benefits Office
  Montefiore Medical Center
  111 East 210th Street
  Bronx, NY 10467-2490
  Telephone: **1-914-378-6531**

  Complaints may also be made in writing to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation.

If there is a breach of your unsecured personal medical information, you will be notified promptly.

For More Information – You can find additional HIPAA information on the Internet at **www.hhs.gov/ocr/hipaa** or by calling **1-866-627-7748**. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **1-866-444-3272** (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at **1-800-633-4227** (ask for Protecting Your Health Insurance Coverage). These publications and other useful information are also available on the Internet at: **www.dol.gov/ebsa** the DOL's interactive Web pages – **Health Elaws**.

Genetic Information Non-discrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of the Health Insurance Portability and Accountability Act (HIPAA), generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

Surcharge

New York State has imposed an 8.18% surcharge on certain medical expenses. Montefiore has made arrangements to pay this surcharge directly to the State. If you receive a bill that itemizes the surcharge, do not pay this charge. Notify the provider that Montefiore participates in the New York State Department of Health Public Goods Pool.

It is important for you not to make this payment since Montefiore has already made this payment for you. The Claims Administrator will not reimburse you for this charge. If you have paid this surcharge, you should contact the provider for a refund. You can ask the Claims Administrator to send a letter to the provider confirming that the Claims Administrator has paid the surcharge to the State.

Subrogation

This provision applies if you and/or your covered family members become ill or are injured as a result of the intentional action or negligence of a third party or any illness or injury for which you and/or your dependents are eligible to receive reimbursement from a third party. In that case, you must sign an agreement known as a Subrogation Agreement, to reimburse MonteCare Basic EPO from whatever moneys are recovered from the third party (whether an individual or insurance company is liable) as a result of a court judgment, settlement or otherwise. Here is an example of how subrogation works.

If you were hurt as a result of another person’s negligence, the individual – or his or her insurance company – might compensate you for your injury. In that case, you would be required to repay any amounts the Plan had advanced to you and/or your covered family members for medical and/or dental expenses resulting from such illness or injuries. The repayment must equal the benefits you received from the Plan less reasonable expenses to make the recovery.

You must take whatever actions are required by the Plan Administrator and/or the Subrogation Agreement to enforce the subrogation right of the plan. Failure to cooperate in the enforcement of this Agreement, including the failure to repay the Plan from the judgment or settlement proceeds, may lead to the suspension of any further benefits you and any of your family members may receive under the plan.

Qualified Medical Child Support Orders (QMCSO)

Federal law requires group health plans to honor qualified medical child support orders (QMCSOs).

In general, a QMCSO is a state order or directive requiring a parent to provide medical support to a child in case of separation or divorce and under certain statutory conditions. Upon receipt of a medical child support order (MCSO), the Plan Administrator will notify you and the affected child that it is reviewing the order to determine if it is qualified and the procedures used to determine whether the order is qualified. If the Plan Administrator determines that the order is qualified, MonteCare Basic EPO is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. However, the child must be enrolled and the associate must be making any required contributions. For further information, contact Montefiore's HR-Benefits Office.

Occupational Health Services (OHS)

You also have access to Occupational Health Services (OHS). Montefiore's Occupational Health Services Department offers the following services:

- Free annual assessments including tuberculosis and diabetes screening (A1C testing – fasting is not required) and influenza vaccinations
- Nutrition Counseling Service – One-on-one, confidential counseling to help you manage your weight, lower your health risks, enhance your life and eat wisely
- Smoking Cessation Programs – Provides information on nicotine replacement therapy and offers a no-cost nicotine replacement therapy starter kit through Montefiore's outpatient pharmacies
- Montefiore provides a lactation-friendly environment and supports mothers who continue to breastfeed after returning to work from maternity leave. Associate Lactation Suites are located at the Moses, Wakefield and Einstein Campuses.

HealthCare Employee Assistance Program

The HealthCare EAP provides assistance to you or members of your immediate family if you have a personal problem, such as marital, parent-child, legal or financial difficulties, stress, depression, anxiety, grief reactions, substance abuse, or any other emotional or behavioral problem. Assistance is provided on a strictly confidential basis, through a staff of experienced counselors from various disciplines. These include sociologists, substance abuse counselors, social workers, and a session psychiatrist.

The HealthCare EAP is provided at no cost to you through ESI/Longview Associates **800.666.5EAP (5327)** **www.MyHealthCareEAP.com.** .

Care Guidance

The Care Guidance Program provides you with a Personal Health Nurse (PHN) who will work one-on-one with you for as long and as often as you need. This is a voluntary program that can provide support and resources to help you, or a member of your family, manage your or their health. Montefiore provides this program at no cost to you. All services are completely confidential.

Working as a team, your physician and your PHN will set health goals, create an action plan and identify ways to help you maintain healthy habits. Your PHN's goal is to efficiently guide you through the different aspects of the healthcare system, making your care manageable and more successful.

Your PHN will help you:

- Find a physician or other healthcare provider; schedule appointments and navigate other healthcare services
- Communicate with care providers and coordinate healthcare related services from multiple doctors and facilities
- Understand your medications. Your PHN may arrange a consultation with the Care Guidance Program's pharmacist to ensure that you are being treated with the most effective medication regimen.
- Prepare a Living Will, identify a Healthcare Proxy and discuss these important Life Planning decisions with family members and healthcare providers.

Voluntary Pre-Certification

You are requested to voluntarily pre-certify Care Guidance if you or a covered family member is admitted to the hospital for any reason (e.g. medical, surgical, behavioral health, substance abuse, maternity, skilled nursing and rehabilitation services). This will allow Care Guidance to work with you at critical points in your care, help answer questions and help you follow your doctor's course of treatment.

You should notify Care Guidance:

- 14 days before a non-emergency inpatient admission
- Within 48 hours or as soon as reasonably possible after an emergency admission.

Call **855.MMC.WELL (855.662.9355)** or email **mmccareguidance@montefiore.org**

ERISA Additional Information

This section contains information about how the plans are administered and your rights as a participant as defined under the Employee Retirement Income Security Act of 1974 (ERISA). Under the provisions of ERISA, the U.S. Department of Labor requires that Montefiore provide you with this additional information.

This Summary Plan Description (SPD) is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). If there are any discrepancies between the information contained in this SPD and the official written Plan documents, the Plan documents will govern.

Plan Sponsor

The sponsor of MonteCare Basic EPO is:

Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490

Plan Administrator

The Plan Administrator for MonteCare Basic EPO is:

Vice President, Human Resources
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490
914.349.8531

Employer Identification Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service (IRS) to Montefiore Medical Center is 13-1740114.

Claim Denials and Appeals

You must file a claim to receive benefits from the plans. A claim for benefits should be submitted to and will be approved or denied by the appropriate fiduciary, Claims Administrator, insurance company or Plan Administrator, as designated in each plan.

The claims review fiduciary has the discretionary authority to interpret the coverages and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties. The fiduciary for each Plan is shown in the following table.

For These Covered Expenses	Claim Denials Are Received From And Appeals Should Be Directed To The Appropriate Fiduciary
MonteCare Basic EPO	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748 **www.empireblue.com/montefiore**
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780 **www.medco.com**

If Your Claim Is Denied

If your claim for benefits is denied, in whole or in part, you will receive a written notice. This notice will include the following:

1. the specific reasons for the denial of your claim
2. the specific references in the Plan document that support those reasons
3. a description of the information you must provide to perfect your claim and the reasons why that information is necessary
4. a discussion of the procedure available for further review of your claim, including your right to file a civil action following an adverse benefit determination on review
5. if the denial relies on an internal rule, protocol or guideline, such rule, protocol or guideline, or a statement that it will be provided free of charge to you upon request
6. if the denial is based on a medical necessity or an experimental treatment, an explanation of the clinical or scientific reasoning for denial of the claim, or a statement that it will be provided to you free of charge upon request.

In the case of a denial of an urgent care claim, the notice also will set forth a description of the expedited review process for an urgent care claim.

Your Right To Appeal

You have the right to appeal a denial of your claim. You must submit a written appeal to the insurance company within 180 days after you receive the claim denial notice. In preparing your appeal, you shall be entitled to request and receive, free of charge, copies of any documents, records or other pertinent information associated with your claim. This pertinent information includes any information in the initial benefit determination that was considered or generated (even if not relied on) and the identity of any medical expert who was consulted (even if not relied on). Any of this information may be submitted for determination, even if it was not considered in the initial benefit determination.

The insurance company will conduct a full and fair review of your appeal and it will not give deference to the initial benefit determination. The appeal shall be heard by an appropriate individual (or individuals), who is not the person having made the initial benefit determination or a subordinate of that person. This reviewer on appeal also may consult with a medical professional, who was not consulted or a subordinate of any person consulted in the initial benefit determination.

If your appeal involves an urgent care claim, the insurance company shall notify you of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your appeal. You may request an expedited appeal, which may be made either orally or in writing and allows all necessary communication between you and the administrator to take place via telephone, facsimile or other equally expeditious method.

If your appeal involves a pre-service claim, the insurance company will notify you of the decision within 30 days after receipt of your appeal.

If your appeal involves a post-service claim, the insurance company will notify you of the decision within 60 days after receipt of your appeal.

If your appeal is denied, in whole or in part, the insurance company will provide you with a notice with the following:

1. the specific reasons for the denial including the specific Plan provisions on which the denial relies
2. a statement informing you of the availability of any documents, records or other relevant information free of charge upon request
3. a description of any internal rule or protocol relied upon or a statement that any such rule or protocol will be provided free of charge upon request
4. an explanation of any voluntary appeals procedures that may be available and a statement of your right to bring a civil action
5. if the denial of an appeal is based on a medical necessity or experimental treatment, an explanation of the scientific or clinical judgment exercised or a statement that the explanation will be provided free of charge and upon request
6. the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what might be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Throughout the claims review procedure, you may have a personal representative act on your behalf.

Any failure on your part to comply with the request for information by the Plan Administrator or insurance company may result in delay or a denial of your claim.

The insurance company has the authority to make final decisions with respect to paying claims under the Medical Plan.

If you believe that you have been improperly denied a benefit from the Plan after making full use of the claims and appeals procedure, you may serve legal process on the Plan Administrator.

Legal Service

Legal process for MonteCare Basic EPO may be served on the Plan Administrator, who is Vice President, Human Resources, Montefiore Medical Center, 111 East 210th Street, Bronx, New York 10467-2490 and, in addition, on the insurance company.

Administrative Information

Official Plan Name	Claims Administrator/Insurance Company	Plan Number	Plan Funding
The Montefiore Medical Center Montefiore Associate Benefits Program	*For MonteCare Basic EPO* Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 **866.236.6748** *For Prescription Drug Program:* Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 **800.631.7780**	501	Associate and Montefiore contributions

Plan Type and Plan Year

The following table shows the Plan year on which Plan records are maintained and the Plan type.

	Plan Type	Plan Year
Medical	Welfare providing healthcare benefits	January 1 to December 31
Prescription Drug	Welfare providing prescription drug benefits	January 1 to December 31

Plan Documents

This Summary Plan Description describes only the highlights of the MonteCare Basic EPO and does not attempt to cover all details. These are contained in the Plan documents and/or insurance company contracts, which legally govern the Plan and which are controlling in the event of a conflict with this Summary Plan Description. These documents, as well as the annual report of each Plan's operation and each Plan's description (which are filed with the U.S. Department of Labor) are available for review through Montefiore's HR-Benefits Office during normal working hours. Upon written request to the Plan Administrator, copies of any of these documents will be furnished to a Program member or beneficiary within 30 days at a nominal cost.

Plan Continuation

Montefiore expects and intends to continue the MonteCare Basic EPO indefinitely, but reserves the right to change, modify or terminate the Plan, in whole or in part, at any time and for any reason. If Medical benefits are terminated, you will not have the right to any benefits or have any further rights – other than the payment of covered expenses you had incurred before the coverage terminated.

YOUR RIGHTS UNDER ERISA
(EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)

The benefits provided by MonteCare Basic EPO are covered by ERISA. The law does not require Montefiore to provide benefits. However, it does set standards for any benefits Montefiore offers – and it requires that you be given an opportunity to learn what those benefits are and your rights to them under the law. ERISA provides that all Plan participants, with appropriate notice, shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plans, including the Trust agreement and administrative service contracts, Plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA) – formerly the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plans, including the Trust agreement and administrative service contracts, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

HIPAA also requires that you be provided with a certificate of creditable coverage free of charge if you leave Montefiore. You can request a certificate of creditable coverage:

- when you lose health coverage
- when you become entitled to elect COBRA continuation coverage
- when your COBRA continuation coverage ends
- at any time before losing healthcare coverage

  or

- up to 24 months after losing healthcare coverage.

You can use a certificate of creditable coverage to eliminate or reduce any pre-existing condition limitation period under another group healthcare plan.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. Although these rights are in no way a guarantee or contract of employment, no one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from a plan or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the appropriate fiduciary review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the appropriate fiduciary and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the appropriate fiduciary to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the appropriate fiduciary.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning a medical child support order or the status of a qualified domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse a Plan's money, or, if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about these plans, you should contact the appropriate fiduciary. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of EBSA, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at **800.998.7542**.