

# Montefiore Medical Center: Empire MonteCare EPO

Summary of Benefits and Coverage: What this **Plan** Covers & What it Costs

Coverage Period: 01/01/2020– 12/31/2020


Coverage for: Individual/Family | Plan Type: EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.empireblue.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (866) 236-6748 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <b>deductible</b> ?	<b>\$0</b> /individual or <b>\$0</b> /family for Montefiore <a href="#">Network Providers</a> . <b>\$500</b> /individual or <b>\$1,000</b> /family for In- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <b>deductible</b> ?	Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .	You will have to meet the <a href="#">deductible</a> before the <b>plan</b> pays for any services.
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	<b>\$0</b> /individual or <b>\$0</b> /family for Montefiore <a href="#">Network Providers</a> . <b>\$5,350</b> /individual or <b>\$10,700</b> /family for In- <a href="#">Network Providers</a> . For prescription drugs \$1,500 individual / \$3,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <b>out-of-pocket limit</b> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <b>network provider</b> ?	Yes, EPO. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call (866) 236-6748 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in <a href="#">Preferred</a> . You pay more if you use a <a href="#">provider</a> in In- <a href="#">Network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <b>plan</b> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

**Questions:** Visit us at <https://eoc.empireblue.com/eocdps/aso> for medical and call 1-800-631-7780 or visit us at [www.express-scripts.com](http://www.express-scripts.com) for prescription.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15/visit	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$15/visit	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	No charge	Not covered	One preventive exam/benefit period; Well baby limited to 11 visits up to age 2. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	Not covered	Non-Preferred Bronx, Manhattan, Westchester Facilities: 40% <a href="#">coinsurance</a> for In- <a href="#">Network Providers</a> .

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></p>	Tier 1 - Typically Generic	No charge	\$15 copay for 30 day supply retail or mail; \$30 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	<p>Montefiore providers – All Montefiore Out Patient Pharmacies.</p> <p>In Network - All Express Script participating pharmacies.</p> <p>Out of Network cost is 25% of the cost if you use a non-participating pharmacy where there is a participating pharmacy available</p> <p>If you purchase a brand-name drug when a generic drug is available, you will pay the generic copay, plus the difference in cost between the brand and the generic.</p> <p>Some drugs may require prior authorization, in order to be covered and quantity limits may apply.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits being available for certain drugs.</p>
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$20 copay for 30 day supply; \$40 copay for 90 day supply	\$45 copay for 30 day supply retail or mail; \$90 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	100% coinsurance of discounted cost	100% coinsurance of discounted cost	100% coinsurance of discounted cost	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	\$20 copay for 30 day supply; \$40 copay for 90 day supply	\$100 copay for 30 day supply retail or mail; \$150 copay for 90 day supply mail	25% of the cost if you use a non-participating pharmacy	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	Not covered	Non-Preferred Bronx, Manhattan, Westchester Facilities: 40% <a href="#">coinsurance</a> for In- <a href="#">Network Providers</a> .
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100/visit	\$100/visit	Covered as In- <a href="#">Network</a>	Copay waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Urgent care</a>	\$15/visit	\$30/visit	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	<b>Preferred Facilities:</b> If precertified, 20% coinsurance after deductible, If not precertified, 30% coinsurance after deductible	Not covered	<b>Non-Preferred Bronx, Manhattan, Westchester Facilities:</b> If precertified, 40% coinsurance after deductible, If not precertified, 50% coinsurance after deductible Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	Not covered	-----none-----

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$15/visit Other Outpatient \$15/visit	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit Not covered Other Outpatient Not covered	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	No charge	<b>Preferred Facilities:</b> If precertified, 20% coinsurance after deductible, If not precertified, 30% coinsurance after deductible	Not covered	<b>Non-Preferred Bronx, Manhattan, Westchester Facilities:</b> If precertified, 40% coinsurance after deductible, If not precertified, 50% coinsurance after deductible Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
If you are pregnant	Office visits	\$15/visit first 1 visit	20% <a href="#">coinsurance</a>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <b>Non-Preferred Bronx, Manhattan, Westchester Facilities:</b> If precertified, 40% coinsurance after deductible, If not precertified, 50% coinsurance after deductible Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	No charge	<b>Preferred Facilities:</b> If precertified, 20% coinsurance after deductible, If not precertified, 30% coinsurance after deductible	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Not covered	200 days limit/benefit period for Montefiore <a href="#">Network Providers</a> and In- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	*See Therapy Services section
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	No charge	Not covered	120 days limit/benefit period for Montefiore <a href="#">Network Providers</a> and In- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section.
	<a href="#">Hospice services</a>	No charge	No charge	Not covered	210 days limit/lifetime for Montefiore <a href="#">Network Providers</a> and In- <a href="#">Network Providers</a> combined.
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Not covered	*See Vision Services section
	Children’s glasses	Not covered	Not covered	Not covered	
	Children’s dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

**Excluded Services & Other Covered Services:**

Services Your **Plan** Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Eye exams for a child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Glasses for a child</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Check-up</li> <li>• Long-term care</li> <li>• Routine eye care (adult)</li> </ul> |
|---|--|---|

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care 10 visits/benefit period.
• Hearing aids one/ear once every 36 months.	• Infertility treatment	• Routine foot care.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

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

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

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

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

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of Montefiore Provider Network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$90</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$410
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$465</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$45
<u>Coinsurance</u>	\$158
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$203</b>

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# Language Access Services:

(TTY/TDD: 711)

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

**Amharic (ሙርኛ):** ለዚህ ሰነድ ላይ ጥያቄዎች ለማግኘት ወይንም ለተጨማሪ መረጃ ለማግኘት፣ እኛን በስልክ ወይንም በጽሑፍ ወስኑ። (866) 236-6748 ስልክ ያድርጉ።

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

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

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò ni dyí-bédɛ̀in-dɛ̀ bɛ̀ m̀ ké gbo-kpá-kpá kè b́ǎ kpǎ́ dɛ̀ m̀ bídǐ-wùdù̀̀m̀ b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù̀ ke, d́á (866) 236-6748.

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

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

**Chinese ( )** (866) 236-6748.

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wër alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (866) 236-6748.

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

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

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

## Language Access Services:

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

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

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