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.anthem.com/eocdps/aso. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (866) 236-6748 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/individual or **$0**/family for Montefiore Network Providers. **$625**/individual or **$1,250**/family for In-Network Providers. **$1,250**/individual or **$2,750**/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$0**/individual or **$0**/family for Montefiore Network Providers. **$5,350**/individual or **$10,700**/family for In-Network Providers. **$6,000**/individual or **$17,500**/family for Out-of-Network Providers. This plan has a separate Out of Pocket Maximum of **$1,500**/individual or **$3,000**/family for Prescription Drugs.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes, PPO. See www.anthem.com or call (866) 236-6748 for a list of network providers.	You pay the least if you use a provider in Preferred. You pay more if you use a provider in In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 Providers. (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 provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	20% coinsurance	40% coinsurance	--------none--------
	Specialist visit	$15/visit	20% coinsurance	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	One preventive exam/ benefit period; Well baby limited to 11 visits up to age 2. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	$250/visit	40% coinsurance	Non-Preferred Bronx, Westchester and Manhattan Facilities: $625/visit for In-Network Providers.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	No charge	$15/prescription (retail) and $30/prescription (home delivery)	25% of the cost if you use a non-participating.	Montefiore providers: All Montefiore Out Patient Pharmacies.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Providers. (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.expresscripts.com	Tier 2 - Typically Preferred / Brand	$20/prescription (retail) and $40/prescription (home delivery)	$45/prescription (retail) and $90/prescription (home delivery)	25% of the cost if you use a non-participating.	In Network: All Express Script participating pharmacies. Out of Network cost: 25% of the cost if you use a non-participating pharmacy where there is a participating pharmacy available If you purchase a brand-name drug when a generic drug is available, you will pay the generic copay, plus the difference in cost between the brand and the generic Some drugs may require prior authorization, in order to be covered and quantity limits may apply. You may be required to use a lower-cost drug(s) prior to benefits being available for certain drugs.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	100% coinsurance of discounted cost.	100% coinsurance of discounted cost.	100% coinsurance of discounted cost.	
	Tier 4 - Typically Specialty (brand and generic)	$20/prescription (retail) and $40/prescription (home delivery)	$100/prescription (retail) and $150/prescription (home delivery)	25% of the cost if you use a non-participating.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$500/visit	40% coinsurance	Non-Preferred Bronx, Westchester and Manhattan Facilities: $1,250/visit for In-Network Providers. Pre-Authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	Pre-Authorization required for certain services
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit deductible does not apply	Covered as In-Network	Copay waived if admitted within 24 hours.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Covered as In-Network	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Providers. (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$15/visit	$30/visit	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	**Preferred Facilities:** If pre-certified, $1,000 copay If not pre-certified, $1,500 copay	40% coinsurance	**Non-Preferred Bronx, Westchester and Manhattan Facilities:** If precertified, $2,500 copay If not precertified, $3,000 copay Pre-Certification by Conifer Value Based Care at 855-381-3441 required for Non-Montefiore In-Patient Admissions.
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $15/visit Other Outpatient $15/visit	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	No charge	**Preferred Facilities:** If pre-certified, $1,000 copay If not pre-certified, $1,500 copay	40% coinsurance	**Non-Preferred Bronx, Westchester and Manhattan Facilities:** If precertified, $2,500 copay If not precertified, $3,000 copay 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% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Non-Preferred Bronx, Westchester and Manhattan Facilities:** If precertified, $2,500 copay If not precertified, $3,000 copay Pre-Certification by Conifer Value Based Care at 855-381-3441
	Childbirth/delivery professional services	No charge	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No charge	**Preferred Facilities:** If pre-certified, $1,000 copay If not pre-certified, $1,500 copay	40% coinsurance	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Montefiore Network Providers. (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					required for Non-Montefiore In-Patient Admissions.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	0% coinsurance	200 days limit/benefit period.
	Rehabilitation services	No charge	20% coinsurance	40% coinsurance	*See Therapy Services section
	Habilitation services	No charge	20% coinsurance	40% coinsurance	
	Skilled nursing care	No charge	No charge	40% coinsurance	120 days limit/benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	No charge	40% coinsurance	210 days limit/lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (adult)
- Dental Check-up
- Eye exams for a child
- Glasses for a child
- Long- term care
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care 10 visits/benefit period.
- Hearing aids one/ear once every 36 months.
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

ATTN: Anthem Grievances and Appeals, NY-Administrative (Grievance) P.O. Box 1407, Church Street Station, New York, NY 10008-1407 OR NY – Clinical (Appeal) Mail Drop R/6-O, P.O. Box 11825 Albany, NY 12211

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

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

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 in-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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,770**

Managing Joe's Type 2 Diabetes
(a year of routine in-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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,530**

Mia's Simple Fracture
(in-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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

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

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

.(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 (Bàsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn (866) 236-6748.

(866) 236-6748

(866) 236-6748

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

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

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

Language Access Services:

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

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

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

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

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

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

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (866) 236-6748.

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

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

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

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

Language Access Services:

[illegible] (866) 236-6748

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (866) 236-6748.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (866) 236-6748 로 문의하십시오.

[illegible] (866) 236-6748.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bąąh íłínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodiilnih (866) 236-6748.

[illegible] (866) 236-6748

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (866) 236-6748 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (866) 236-6748 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (866) 236-6748.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (866) 236-6748.

[illegible] (866) 236-6748

Language Access Services:

[illegible] (866) 236-6748.

[illegible] (866) 236-6748.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (866) 236-6748.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (866) 236-6748.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (866) 236-6748.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (866) 236-6748.

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