	MONTECARE EPO – YOUR COST IF YOU USE:			
	MONTEFIORE NETWORK	ANTHEM NETWORK		OUT-OF-NETWORK
Financial				
Individual/Family Deductible	None	$550/$1,000		Not covered
Individual/Family Out-of-pocket Maximum (Deductible + Copayment + Coinsurance)	$5,350/$10,700	$5,350/$10,700		Not covered
		PREFERRED FACILITIES	NON-PREFERRED FACILITIES	
Inpatient Care • Illness or Injury • Mental Health/Substance Abuse Care • Physical/Occupational Therapy or Rehab	$0	20%[1] coinsurance after deductible if pre-certified by Montefiore's Care Management Company[2]; an additional 10% after deductible if the inpatient care is not pre-certified by Montefiore's Care Management Company	40%[1] coinsurance after deductible if pre-certified by Montefiore's Care Management Company[2]; an additional 10% after deductible if the inpatient care is not pre-certified by Montefiore's Care Management Company	Not covered except in the case of an emergency admission
High-Tech Radiology Services (including diagnostic MRI, MRA, CAT Scan, PET, Nuclear Cardiology)	$0	20%[1] coinsurance after deductible	40%[1] coinsurance after deductible	Not covered
Outpatient Surgery	$0	20%[1] coinsurance after deductible	40%[1] coinsurance after deductible	Not covered
Hospice – 210 days	$0	$0		Not covered
Skilled Nursing Facility – 120 days	$0	$0		Not covered
Emergency Room Care				
• Bona Fide Emergency	$100 copay; waived if admitted	$150 copay; waived if admitted		$150 copay; waived if admitted
• Other than Bona Fide Emergency	20% coinsurance	20%[1] coinsurance after deductible		Not covered
• Urgent Care Facility	$0	$50 copay/visit		Not covered
• Urgent Care Professional	$15 copay per visit	$30 copay/visit		Not covered
Preventive Care – Routine Physical Exam with PCP including OB/GYN; Routine Child Exam/ Immunizations; Routine Mammography	$0	$0		Not covered
Outpatient Diagnostic and Laboratory Tests X-rays, Bone Density, Blood, Urine, etc.	$0	20%[1] coinsurance after deductible		Not covered
Physician Services (office visits)				
• Primary Care Physician including OB/GYN and Mental Health/Substance Abuse Care	$15 copay/visit	20%[1] coinsurance after deductible		Not covered
• Specialists	$15 copay/visit	20%[1] coinsurance after deductible		Not covered
• Chiropractic Care – 10 visits	$50 copay/visit	20%[1] coinsurance after deductible		Not covered
• Surgery	$0	20%[1] coinsurance after deductible		Not covered
Home Health Care – 200 visits	$0	$0		Not covered
Maternity	$0	20%[1] coinsurance after deductible		Not covered
Allergy Testing and Treatment	$15 copay/visit; $0 for treatment	20%[1] coinsurance after deductible		Not covered
Physical, Occupational and Speech Therapy	$0	20%[1] coinsurance after deductible		Not covered

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

[2] Pre-certification will ensure that services are medically necessary and provided in an appropriate treatment setting.

	MONTECARE PPO – YOUR COST IF YOU USE:			
	MONTEFIORE NETWORK	ANTHEM NETWORK		OUT-OF-NETWORK
Financial				
Individual/Family Deductible	None	$675/$1,250		$1,250/$2,750
Individual/Family Out-of-pocket Maximum (Deductible + Copayment + Coinsurance)	$5,350/$10,700	$5,350/$10,700		$6,000/$17,500
		PREFERRED FACILITIES	NON-PREFERRED FACILITIES	
Inpatient Care • Illness or Injury • Mental Health/Substance Abuse Care • Physical/Occupational Therapy or Rehab	$0	$1,000 copay if pre-certified by Montefiore's Care Management Company[1]; an additional $500 copay if the inpatient care is not pre-certified by Montefiore's Care Management Company	$2,500 copay if pre-certified by Montefiore's Care Management Company[1]; an additional $500 copay if the inpatient care is not pre-certified by Montefiore's Care Management Company	40%[2] coinsurance after $1,000 copay if pre-certified by Montefiore's Care Management Company[1]; an additional $500 copay if the inpatient care is not pre-certified by Montefiore's Care Management Company
High-Tech Radiology Services (including diagnostic MRI, MRA, CAT Scan, PET, Nuclear Cardiology)	$0	$250 copay	$625 copay	40%[2] coinsurance after deductible
Outpatient Surgery	$0	$500 copay	$1,250 copay	40%[2] coinsurance after deductible
Hospice – 210 days	$0	$0		40%[2] coinsurance after deductible
Skilled Nursing Facility – 120 days	$0	$0		40%[2] coinsurance after deductible
Emergency Room Care				
• Bona Fide Emergency	$100 copay; waived if admitted	$150 copay; waived if admitted		$150 copay; waived if admitted
• Other than Bona Fide Emergency	30% coinsurance	30%[3] coinsurance after deductible		40%[2] coinsurance after deductible
• Urgent Care Facility	$0	$50 copay/visit		40%[2] coinsurance after deductible
• Urgent Care Professional	$15 copay/visit	$30 copay/visit		40%[2] coinsurance after deductible
Preventive Care – Routine Physical Exam with PCP including OB/GYN; Routine Child Exam/ Immunizations; Routine Mammography	$0	$0		40%[2] coinsurance after deductible
Outpatient Diagnostic and Laboratory Tests X-rays, Bone Density, Blood, Urine, etc.	$0	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
Physician Services (office visits)				
• Primary Care Physician including OB/GYN and Mental Health/Substance Abuse Care	$15 copay/visit	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
• Specialists	$15 copay/visit	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
• Chiropractic Care – 10 visits	$35 copay/visit	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
• Surgery	$0	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
Home Health Care – 200 visits	$0	$0		40%[2] coinsurance after deductible
Maternity	$0	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
Allergy Testing and Treatment	$15 copay/visit; $0 for treatment	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible
Physical, Occupational and Speech Therapy	$0	20%[3] coinsurance after deductible		40%[2] coinsurance after deductible

[1] Pre-certification will ensure that services are medically necessary and provided in an appropriate treatment setting.

[2] Reasonable and Customary charges are based on 150% of the National Medicare Physician Fee Schedule. The Plan benefit is then determined by applying the cost-sharing percentage to this amount; you are responsible for paying the balance of the bill to the provider.

[3] If services are billed by a facility, then percentages are applied to covered charges which are based on the rate paid to like-kind Anthem in-network facilities if the facility is within the Anthem area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Anthem area.