Mount Sinai Health System

HDHP Plan

January 1, 2022

	Medical Benefits			
Covered Services	**Top Tier Mount Sinai**	**Enhanced In Network Tier**	**In-Network Providers**	**Out-of-Network Providers**
Calendar Year Deductible Single Family ***Note: If Family Coverage is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.***	 $2,000 $4,000	 $2,000 $4,000	 $2,000 $4,000	 $4,000 $7,500
Maximum Out-of-Pocket Expense Per Calendar Year Single Family ***Note: If Family Coverage is Elected, The Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.***	 $3,000 $6,000	 $3,500 $7,000	 $3,500 $7,000	 $12,500 $25,000
Primary Care Physician Office Visits	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Specialist Office Visits	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Dependent Child (up to age 26)	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Urgent Care Visit	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Urgent Care Visit – Dependent Child	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Emergency Room	100% covered after deductible	5% after deductible	20% after deductible	20% after deductible
Ambulance	100% covered after deductible	5% after deductible	20% after deductible	20% after deductible
Durable Medical Equipment	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Inpatient Hospital Services	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Outpatient Facility	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible

Outpatient Hospital Facility Charges (Includes Diagnostic X-ray and Lab)	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Outpatient Hospital Physician Charges (per visit) (Includes Diagnostic X-ray and Lab)	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Outpatient Hospital Physician Charges – Dependent Child (per visit)	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Outpatient Hospital Surgery	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Physical, Occupational, Speech Therapy	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Physical, Occupational, Speech Therapy – Dependent Child	100% covered after deductible	5% after deductible	20% after deductible	50% after deductible
Preventive/Routine Exams	100%; deductible waived	100%; deductible waived	100%; deductible waived	50% after deductible
Preventive/Routine Services	100%; deductible waived	100%; deductible waived	100%; deductible waived	50% after deductible
Women's Preventive Health Care	100%; deductible waived	100%; deductible waived	100%; deductible waived	50% after deductible

Submit Claims to: UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

Prescription Drug Benefits

Maximum Out-of-Pocket Expense

Per Calendar Year	
Per Person	Combined with Medical
Family	Combined with Medical

Retail Pharmacy – In-House Pharmacy

Coinsurance (34-day supply)	
For Generic Drugs	20% ($5 min / $10 max)
For Preferred Brand Drugs	20% ($10 min / $20 max)
For Non-Preferred Brand Drugs	20% ($15 min / $30 max)

Retail Pharmacy – In-House Pharmacy	
Coinsurance (90-day supply)	
For Generic Drugs	20% ($12.50 min / $25 max)
For Preferred Brand Drugs	20% ($25 min / $50 max)
For Non-Preferred Brand Drugs	20% ($37.50 min / $75 max)
Retail Pharmacy – MedImpact Member Services and In-Network Pharmacies	
Coinsurance (34-day supply at In-Network)	
For Generic Drugs	20% ($10 min / $20 max)
For Preferred Brand Drugs	20% ($30 min / $60 max)
For Non-Preferred Brand Drug	20% ($45 min / $135 max)
Mail Order	
Coinsurance (90-day supply)	
For Generic Drugs	20% ($25 min / $55 max)
For Preferred Brand Drugs	20% ($75 min / $150 max)
For Non-Preferred Drugs	20% ($110 min / $335 max)
Specialty	
Coinsurance (34-day supply)	
At In-House Pharmacy	
For Generic Specialty Drugs	20% ($20 min / $40 max)
For Preferred Brand Specialty	20% ($40 min/ $80 max)
For Non-Preferred Brand Specialty	20% ($70 min / $140 max)
At Retail Pharmacy – MedImpact Specialty and In-Network Specialty Pharmacies	
For Generic Specialty Drugs	20% ($35 min / $70 max)
For Preferred Brand Specialty	20% ($75 min / $150 max)
For Non-Preferred Brand Specialty	20% ($100 min / $200 max)

MedImpact Member Services:

Commercial 1-888-807-5963

UMR: MOUNT SINAI HEALTH SYSTEM: 7670-00-413549 007, 008

Coverage for: Individual + Family | **Plan Type:** HDHP

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, visit www.umr.com or by calling 1-844-287-3868. 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.umr.com or call 1-844-287-3868 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family Top Tier (Tier 1) **$2,000** person / **$4,000** family Enhanced In-network (Tier 2) **$2,000** person / **$4,000** family In-network all other UHC (Tier 3) **$4,000** person / **$7,500** family Out-of-network (Tier 4)	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$3,000** person / **$6,000** family Top Tier (Tier 1) **$3,500** person / **$7,000** family Enhanced In-network (Tier 2) **$3,500** person / **$7,000** family In-network all other UHC (Tier 3) **$12,500** person / **$25,000** family Out-of-network (Tier 4)	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, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Penalties, 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. See www.umr.com or call 1-844-287-3868 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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
		Tier 1	Tier 2	Tier 3	Tier 4	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Specialist visit	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Preventive care / screening / immunization	No charge	No charge; Deductible Waived	No charge; Deductible Waived	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.MedImpact.com	Generic drugs (Tier 1)	In-House Pharmacy 20% ($5 min / $10 max)	MedImpact and other In-Network Pharmacies 20% ($10 min / $20 max)	In-House Mail Order 20% ($12.50 min / $25 max)	MedImpact Mail Order 20% ($25 min / $55 max)	None
	Preferred brand drugs (Tier 2)	In-House Pharmacy 20% ($10 min / $20 max)	MedImpact and other In-Network Pharmacies 20% ($30 min / $60 max)	In-House Mail Order 20% ($25 min / $50 max)	MedImpact Mail Order 20% ($75 min / $150 max)	
	Non-preferred brand drugs (Tier 3)	In-House Pharmacy 20% ($15 min / $30 max)	MedImpact and other In-Network Pharmacies 20% ($45 min / $135 max)	In-House Mail Order 20% ($37.50 min / $75 max)	MedImpact Mail Order 20% ($110 min / $335 max)	
	Specialty drugs (Tier 4)	In-House Pharmacy 20% ($20 min / $40 max)	MedImpact Specialty 20% ($35 min / $70 max)	N/A	N/A	
	Preferred brand Specialty drugs (Tier 5)	In-House Pharmacy 20% ($40 min/ $80 max)	MedImpact Specialty 20% ($75 min / $150 max)	N/A	N/A	
	Non-preferred brand Specialty drugs (Tier 6)	In-House Pharmacy 20% ($70 min / $140 max)	MedImpact Specialty 20% ($100 min / $200 max)	N/A	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
If you need	Emergency room care	No charge	5% Coinsurance	20% Coinsurance	20% Coinsurance	Tier 3 deductible applies to Tier 4 benefits

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
immediate medical attention	Emergency medical transportation	No charge	5% Coinsurance	20% Coinsurance	20% Coinsurance	Tier 3 deductible applies to Tier 4 benefits; Preauthorization is required for Non-emergent air ambulance & medical evacuation from outside the U.S. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service.
	Urgent care	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service.
	Physician/surgeon fee	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Inpatient services	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service.
If you are pregnant	Office visits	No charge	No charge; Deductible Waived	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you need help recovering or have other special health needs	Home health care	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	200 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service.
	Rehabilitation services	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Habilitation services	Not covered	Not covered	Not covered	Not covered	None
	Skilled nursing care	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	200 Maximum visits per calendar year Tiers 2, 3 & 4; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service.
	Durable medical equipment	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
	Hospice service	No charge	5% Coinsurance	20% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care	• Hearing aids	• Infertility treatment (Tiers 1, 2 & 3 only)

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? 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.

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**	**$2,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,070**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$2,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$2,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,010**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-844-287-3868.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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