# Mount Sinai Health System

## Traditional Plan


January 1, 2023

| | Medical Benefits | | | |
|---|---|---|---|---|
| **Covered Services** | **Top Tier Mount Sinai** | **Enhanced In-Network Tier** | **In-Network Providers** | **Out-of-Network Providers** |
| Calendar Year Deductible<br>Per Person<br>Family | <br>$0<br>$0 | <br>$350<br>$1000 | <br>$1000<br>$3000 | <br>$4,000<br>$11,000 |
| Maximum Out-of-Pocket Expense Per Calendar Year<br>Per Person<br>Family | <br>$1,500<br>$3,000 | <br>$2,250<br>$7,000 | <br>$5,000<br>$12,000 | <br>$12,500<br>$37,500 |
| Primary Care Physician Office Visits | $30 copay | $40 copay | $50copay | 50% after deductible |
| Specialist Office Visits | $40 copay | $50 copay | $75 copay | 50% after deductible |
| Dependent Child (up to age 26) | $30 copay | $25 copay | $35 copay | 50% after deductible |
| Urgent Care Visit | $100 copay | $100 copay | $100 copay | 50% after deductible |
| Urgent Care Visit – Dependent Child | $50 copay | $50 copay | $50 copay | 50% after deductible |
| Emergency Room | 100% after $200 copay | | | |
| Ambulance | 100% | | | |
| Durable Medical Equipment | 100% | 100% after deductible | 30% after deductible | 50% after deductible |
| Inpatient Hospital Services | 100% after $200 copay | $200 copay then 100% after deductible | $400 copay then 30% after deductible | $600 copay then 50% after deductible |
| Outpatient **Facility** | 100% after $50 copay | 100% after deductible | 30% after deductible | 50% after deductible |
| Outpatient Hospital **Facility Charges** | 100% after $50 copay | 100% after deductible | 30% after deductible | 50% after deductible |
| Outpatient Hospital **Facility** Diagnostic Lab | 100% after $50 copay | 100% after deducible | 30% after deductible | 50% after deductible |
| Outpatient Hospital **Facility** Diagnostic Radiology | 100% after $65 copay | 100% after deducible | 30% after deductible | 50% after deductible |
| Outpatient Hospital **Physician** Charges (per visit) Diagnostic Lab | 100% after $50 copay | 100% after $60 copay | 100% after $85 copay | 50% after deductible |
| Outpatient Hospital **Physician** Diagnostic Radiology | 100% after $65 copay | 100% after $75 copay | 100% after $85 copay | 50% after deductible |

| | | | | |
|---|---|---|---|---|
| Outpatient Hospital Physician Charges – Dependent Child (per visit) | 100% after $30 copay for Lab, and $30 copay for radiology | 100% after $25 copay for Lab, and $25 copay for radiology | 100% after $35 copay for Lab, and $35 copay for radiology | 50% after deductible |
| Bariatric, Hip & Knee Surgery | 100% | $1,000 copay<br>100% after deductible | $1,000 copay<br>30% after deductible | $1,000 copay<br>50% after deductible |
| Outpatient Hospital Surgery | 100% after $50 copay | 100% after deductible | 30% after deductible | 50% after deductible |
| Physical, Occupational, Speech Therapy | $30 (PCP) or<br>$40 (specialist) copay | $40 (PCP) or<br>$50 (specialist) copay | $50 (PCP) or<br>$75 (specialist) copay | 50% after deductible |
| Physical, Occupational, Speech Therapy – Dependent Child | 100% after $30 copay | 100% after $25 copay | 100% after $35 copay | 50% after deductible |
| Preventive/Routine Exams | 100% | 100% | 100% | 50% after deductible |
| Preventive/Routine Services | 100% | 100% | 100% | 50% after deductible |
| Women's Preventive Health Care | 100% | 100% | 100% | 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 (30-day supply) | |
| For Generic Drugs | $5 |
| For Preferred Brand Drugs | $15 |
| For Non-Preferred Brand Drugs | $20 |
| **Retail Pharmacy – In-House Pharmacy** | |
| Coinsurance (90-day supply) | |
| For Generic Drugs | $12.50 |
| For Preferred Brand Drugs | $37.50 |
| For Non-Preferred Brand Drugs | $50 |
| **Retail Pharmacy – In-Network Pharmacies** | |
| Coinsurance (30-day supply at In-Network) | |
| For Generic Drugs | $10 |
| For Preferred Brand Drugs | 25% ($40 min / $80 max) |
| For Non-Preferred Brand Drug | 25% ($60 min / $120 max) |
| **Mail Order or Maintenance Medications through In-Network Pharmacies** | |
| Coinsurance (90-day supply) | |
| For Generic Drugs | $25 |
| For Preferred Brand Drugs | 25% ($100 min / $150 max) |
| For Non-Preferred Drugs | 25% ($150 min / $300 max) |

| | |
|---|---|
| **Specialty** | |
| Coinsurance (30-day supply) | |
| MSHS Specialty Pharmacy* | |
| For Generic Specialty Drugs | $20 |
| For Preferred Brand Specialty | $50 |
| For Non-Preferred Brand Specialty | $75 |

* All specialty medications must be filled at the MSHS Specialty Pharmacy. Exceptions include: HIV, Transplant, Anti-Coagulation, Fertility, Limited Distribution Medications, etc.

** Prescribers or patients requesting a brand name medication when an equivalent generic is available will pay the brand copay plus the cost difference between the brand and generic cost.

**MedImpact Member Services:** 1-888-807-5963

UMR

A UnitedHealthcare Company

**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?** | **$0** person / **$0** family Top Tier (Tier 1)<br>**$350** person / **$1,000** family Enhanced In-network (Tier 2)<br>**$1,000** person / **$3,000** family In-network all other UHC (Tier 3)<br>**$4,000** person / **$11,000** 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, 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 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?** | **$1,500** person / **$3,000** family Top Tier (Tier 1)<br>**$2,250** person / **$7,000** family Enhanced In-network (Tier 2)<br>**$5,000** person / **$12,000** family In-network all other UHC (Tier 3)<br>**$12,500** person / **$37,500** 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, 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?** | 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 | $30 Copay per visit | $25 Copay per visit to age 26;<br>$40 Copay per visit from age 26;<br>Deductible Waived | $35 Copay per visit to age 26;<br>$50 Copay per visit from age 26;<br>Deductible Waived | 50% Coinsurance | None |
| | Specialist visit | $30 Copay per visit to age 26;<br>$40 Copay per visit from age 26 | $25 Copay per visit to age 26;<br>$50 Copay per visit from age 26;<br>Deductible Waived | $35 Copay per visit to age 26;<br>$75 Copay per visit from age 26;<br>Deductible Waived | 50% Coinsurance | None |
| | Preventive care / screening / immunization | No charge | No charge;<br>Deductible Waived | No charge;<br>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. |

| 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 a test** | Diagnostic test (x-ray, blood work) | $10 Copay per visit labs; $25 Copay per visit x-ray Lab Corp; $30 Copay per visit PCP; $40 Copay per visit from age 26 Specialist office setting; $50 Copay per visit labs; $65 Copay per visit x-ray outpatient setting | $25 Copay per visit to age 26; $40 Copay per visit from age 26 PCP; $25 Copay per visit to age 26; $50 Copay per visit from age 26 Specialist; office setting; $60 Copay per visit labs; $75 Copay per visit x-ray outpatient setting; Deductible Waived | $35 Copay per visit to age 26; $50 Copay per visit from age 26 PCP; $35 Copay per visit to age 26; $75 Copay per visit from age 26 Specialist office setting; $85 Copay per visit labs; $100 Copay per visit x-ray outpatient setting; Deductible Waived | 50% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $30 Copay per visit PCP; $40 Copay per visit from age 26 Specialist office setting; $50 Copay per visit lab; No charge x-ray outpatient setting | No charge | 30% 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.**<br><br>More information about prescription drug coverage is available at www.MedImpact.com | Generic drugs (Tier 1) | In-House Pharmacy (30 days) $5 | In-Network Pharmacies (30 days) $10 | In-House Pharmacy (90 days) $12.50 | MedImpact Mail Order and In-Network Pharmacies (90 days) $25 | All specialty medications must be filled at the MSHS Specialty Pharmacy. Exceptions include: HIV, Transplant, Anti-Coagulation, Fertility. Limited Distribution Medications, etc. |
| | Preferred brand drugs (Tier 2) | In-House Pharmacy (30 days) $15 | In-Network Pharmacies (30 days) 25% ($40 min / $80 max) | In-House Pharmacy (90 days) $37.50 | MedImpact Mail Order and In-Network Pharmacies (90 days) 25% ($100 min / $150 max) | |
| | Non-preferred brand drugs (Tier 3) | In-House Pharmacy (30 days) $20 | In-Network Pharmacies (30 days) 25% ($60 min / $120 max) | In-House Pharmacy (90 days) $50 | MedImpact Mail Order and In-Network Pharmacies (90 days) 25% ($150 min / $300 max) | |
| | Specialty drugs (Tier 4) | $20 | N/A | N/A | N/A | |
| | Preferred brand Specialty drugs (Tier 5)* | $50 | N/A | N/A | N/A | |
| | Non-preferred brand Specialty drugs (Tier 6)* | $75 | N/A | N/A | N/A | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50 Copay per visit | No charge | 30% 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 | |
| | Physician/surgeon fees | No charge | No charge | 30% Coinsurance | 50% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $200 Copay per visit | $200 Copay per visit; Deductible Waived | $200 Copay per visit; Deductible Waived | $200 Copay per visit; Deductible Waived | Copay may be waived if admitted |
| | Emergency medical transportation | No charge | No charge | No charge | No charge | Tier 2 deductible applies to Tiers 3 & 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 | $50 Copay per visit to age 26; $100 Copay per visit from age 26 | $50 Copay per visit to age 26; $100 Copay per visit from age 26; Deductible Waived | $50 Copay per visit to age 26; $100 Copay per visit from age 26; Deductible Waived | 50% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 Copay per admission | $200 Copay per admission | $400 Copay per admission; 30% Coinsurance | $600 Copay per admission; 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 | No charge | 30% 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 | $30 Copay per office visit; $50 Copay per visit other outpatient services | $25 Copay per visit to age 26;<br>$40 Copay per visit from age 26;<br>Deductible Waived office visits;<br>No charge other outpatient services | $35 Copay per visit to age 26;<br>$50 Copay per visit from age 26;<br>Deductible Waived office visits;<br>30% Coinsurance other outpatient services | 50% Coinsurance | None |
| | Inpatient services | $200 Copay per admission | $200 Copay per admission | $400 Copay per admission;<br>30% Coinsurance | $600 Copay per admission;<br>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;<br>Deductible Waived | No charge;<br>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 | No charge | 30% Coinsurance | 50% Coinsurance | |
| | Childbirth/delivery facility services | $200 Copay per admission | $200 Copay per admission | $400 Copay per admission;<br>30% Coinsurance | $600 Copay per admission;<br>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 | No charge | 30% 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 | $30 Copay per visit PCP; $40 Copay per visit Specialist | $25 Copay per visit to age 26; $40 Copay per visit PCP; $50 Copay per visit Specialist; Deductible Waived office therapy & ST | $35 Copay per visit to age 26; $50 Copay per visit PCP; $75 Copay per visit Specialist; Deductible Waived office therapy & ST | 50% Coinsurance | Habilitation services for Learning disabilities are not covered. |
| | Habilitation services | | | | | |
| | Skilled nursing care | No charge | No charge | 30% 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 | No charge | 30% Coinsurance | 50% Coinsurance | None |
| | Hospice service | No charge | No charge | 30% 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 | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • 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 | • Hearing aids | • Infertility treatment (Tiers 1, 2 & 3 only) |
| • Chiropractic 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: 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 | $0 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $200 |
| 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 | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$270** |

### 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 | $40 |
| Hospital (facility) copayment | $200 |
| 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* | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$4,500** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $40 |
| Hospital (facility) copayment | $200 |
| 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* | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$410** |

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.