Mount Sinai Health System

Traditional Plan

January 1, 2024

	Medical Benefits			
Covered Services	**Top Tier Mount Sinai**	**Enhanced In-Network Tier**	**In-Network Providers**	**Out-of-Network Providers**
Calendar Year Deductible Per Person Family	 $0 $0	 $350 $1000	 $1000 $3000	 $4,000 $11,000
Maximum Out-of-Pocket Expense Per Calendar Year Per Person Family	 $1,500 $3,000	 $2,250 $7,000	 $5,000 $12,000	 $12,500 $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	70% after deductible	50% after deductible
Inpatient Hospital Services	100% after $200 copay	$200 copay then 100% after deductible	$400 copay then 70% after deductible	$600 copay then 50% after deductible
Outpatient **Facility**	100% after $50 copay	100% after deductible	70% after deductible	50% after deductible
Outpatient Hospital **Facility Charges**	100% after $50 copay	100% after deductible	70% after deductible	50% after deductible
Outpatient Hospital **Facility** Diagnostic Lab	100% after $50 copay	100% after deducible	70% after deductible	50% after deductible
Outpatient Hospital **Facility** Diagnostic Radiology	100% after $65 copay	100% after deducible	70% 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 100% after deductible	$1,000 copay 70% after deductible	$1,000 copay 50% after deductible
Outpatient Hospital Surgery	100% after $50 copay	100% after deductible	70% after deductible	50% after deductible
Physical, Occupational, Speech Therapy	$30 (PCP) or $40 (specialist) copay	$40 (PCP) or $50 (specialist) copay	$50 (PCP) or $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.

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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)

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For Non-Preferred Drugs	25% ($150 min / $300 max)
Specialty	
Coinsurance (30-day supply)	
For Generic Specialty Drugs	$20
For Preferred Brand Specialty	$50
For Non-Preferred Brand Specialty	$75

MedImpact Member Services: 1-888-807-5963

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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) $350 person / $1,000 family Enhanced In-network (Tier 2) $1,000 person / $3,000 family In-network all other UHC (Tier 3) $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) $2,250 person / $7,000 family Enhanced In-network (Tier 2) $5,000 person / $12,000 family In-network all other UHC (Tier 3) $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; $40 Copay per visit from age 26; Deductible Waived	$35 Copay per visit to age 26; $50 Copay per visit from age 26; Deductible Waived	50% Coinsurance	None
	Specialist visit	$30 Copay per visit to age 26; $40 Copay per visit from age 26	$25 Copay per visit to age 26; $50 Copay per visit from age 26; Deductible Waived	$35 Copay per visit to age 26; $75 Copay per visit from age 26; Deductible Waived	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 needed 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
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 (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. Select diabetes and weight loss medications are
	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)	In-House Pharmacy (90 days) $50	MedImpact Mail Order and In-Network Pharmacies (90 days)	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
			25% ($60 min / $120 max)		$25% ($150 min / $300 max)	required to fill at Mount Sinai pharmacy. If you or your doctor request a brand name medication when there is a generic equivalent available, you will be required to pay the brand copay, plus the difference in cost between the brand name and the generic medication.
	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 5)*	$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
	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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
						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 fees	No charge	No charge	30% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per office visit; $50 Copay per visit other outpatient services	$25 Copay per visit to age 26; $40 Copay per visit from age 26; Deductible Waived office visits; No charge other outpatient services	$35 Copay per visit to age 26; $50 Copay per visit from age 26; Deductible Waived office visits; 30% Coinsurance other outpatient services	50% Coinsurance	None
	Inpatient services	$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.

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 are pregnant	Office visits	No charge	No charge; Deductible Waived	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for 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; 30% Coinsurance	$600 Copay per admission; 50% Coinsurance	
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					

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
	Skilled nursing care	No charge	No charge	30% Coinsurance	50% Coinsurance	200 Maximum days 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
- 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 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.