



Base CDHP Savings Plan



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 <https://intranet.corp.fin/wps/myportal/int/employee/benefitnotices> or call 1-800-804-8502. 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 1-800-804-8502 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$3,000 Individual / \$6,000 Family <u>Non-Network</u> *: \$6,000 Individual / \$12,000 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$6,000 Individual / \$12,000 Family For out-of- <u>network providers</u> *: \$10,000 Individual / \$20,000 Family per calendar year * <u>Out-of-pockets</u> cross-apply	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myuhc.com or call 1-877-370-0823 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
		Network Provider (You will pay the least)	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	20% coinsurance	40% coinsurance	Virtual Visit - in- network 20% coinsurance after deductible by a Designated Virtual Network Provider . No virtual visit coverage for out of network . If you receive services in addition to office visit, additional deductibles or coinsurance may apply.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge	40% 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> OneImaging Provider (x-ray, ultrasound): No charge after <u>deductible</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for Sleep Studies or benefit reduced to 40% of allowed. For more information on how to use OneImaging, visit join.oneimaging.com/onemain or call (833) 619-0837.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> OneImaging Provider: No charge after <u>deductible</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or benefit reduced to 40% of allowed. For more information on how to use OneImaging, visit join.oneimaging.com/onemain or call (833) 619-0837.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com	Generic Drugs (Tier 1)	30-day: \$10 <u>copay</u> 90-day: \$25 <u>copay</u>	\$10 <u>copay</u>	Prescription drug costs are subject to the annual <u>deductible</u> .
	Preferred brand drugs (Tier 2)	30-day: 30% <u>coinsurance</u> ; \$35 min/\$125 max 90-day: 30% <u>coinsurance</u> ; \$70 min/\$250 max	30% <u>coinsurance</u> ; \$35 min/\$125 max	Retail: Up to a 90-day supply Mail Order: Up to a 90-day supply (excluding <u>Specialty Drugs</u> , which are allowed only up to a 30-day supply.) Certain drugs may have <u>preauthorization</u> , <u>step therapy</u> and/or <u>quantity limit</u> requirements or may result in a higher cost. The <u>deductible</u> is waived for medications that are classified as preventive treatments for specified chronic diseases included on the Optum Rx Preventive Medication List. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Pharmacy Member Services: 1-855-597-7599
	Non-preferred brand drugs (Tier 3)	30-day: 50% <u>coinsurance</u> ; \$50 min/\$150 max 90-day: 50% <u>coinsurance</u> ; \$100 min/\$300 max	50% <u>coinsurance</u> ; \$50 min/\$150 max	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u> (Tier 4)	20% <u>coinsurance</u>	Not covered	Optum Specialty Pharmacy must be used to fill Specialty Drug prescription orders, subject to a 30-day supply. For more information or to order specialty medications, call 1-877-838-2907 or visit <u>specialty.optumrx.com</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or reduced to 40% of allowed.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain treatments, partial <u>hospitalization</u> /intensive outpatient treatment and Intensive Behavioral Therapy (ABA) or benefit reduced to 40% of allowed. EAP through ComPsych is limited to 5 sessions per calendar year.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient facility or benefit reduced to 40% of allowed.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or benefit reduced to 40% of allowed. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 visits per calendar year combined for <u>Home Health Care</u> and Outpatient Private Duty Nursing. <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or benefit reduced to 40% of allowed.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 30 visits each per calendar year for Physical Therapy, Speech Therapy & Occupational Therapy. Visit Limit does not apply to members with a behavioral diagnosis.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation Services</u> are not covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 days per calendar year. <u>Prior Authorization</u> required out-of- <u>network</u> or benefit reduced to 40% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Wigs limited to \$500 per calendar year. <u>Prior Authorization</u> required out-of-network for DME over \$1,000 or reduced to 40% of allowed.
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network before admission for an inpatient stay in a hospice facility or benefit reduced to 80% of allowed.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
- Adult routine vision exam (i.e. refraction) - Cosmetic Surgery - Dental Care (Adult)	<u>Habilitation Services</u> - Long-term care	- Routine foot care - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
- Acupuncture - Bariatric Surgery - Chiropractic care	- Hearing aids - Infertility treatment	- Non-emergency care when traveling outside the U.S. - Private-duty nursing

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. 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: 1-800-804-8502 or visit <https://intranet.corp.fin/wps/myportal/int/employee/hr-benefits/benefitnotices> or the Employee Benefits Security Administration at 1-866-444-3272 or 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-804-8502.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-804-8502.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-804-8502.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-804-8502 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-804-8502.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-804-8502.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-804-8502.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-804-8502.

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 <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,970

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,320

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800