



## Out of Area Premium 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 [www.oraclebenefits.com](http://www.oraclebenefits.com) or call 1-888-404-2494. 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](http://www.healthcare.gov/sbc-glossary) or call 1-866-672-2511 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | <u>Network</u> : \$100.00 Individual / \$300.00 Family<br><u>Non-Network</u> : \$100.00 Individual / \$300.00 Family per calendar year.                                      | 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive Care</u> and primary care services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | 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.                                                                                                                                                                                                                                                                                                                                                      |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network provider</u> : \$1,100.00 Individual / \$2,300.00 Family<br>For <u>out-of-network providers</u> : \$1,100.00 Individual / \$2,300.00 Family per calendar year | 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.                                                                                                                                                                                                                                        |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover.                                                                                | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Not Applicable                                                                                                                                                               | This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .                                                                                                                                                                                                                                                                                                                                                                                            |

| Important Questions                                        | Answers | Why This Matters:                                                        |
|------------------------------------------------------------|---------|--------------------------------------------------------------------------|
| Do you need a <b>referral</b> to see a <b>specialist</b> ? | No      | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                          |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | *Virtual visit – in- <u>network</u> \$5.00 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visits, additional copays, <u>deductibles</u> , or <u>coinsurance</u> may apply. |
|                                                               | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                     |
|                                                               | <u>Preventive care/screening/immunization</u>    | No charge                                           | No charge                                                 | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                  |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                     |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                                                                                                                                            | Services You May Need                          | What You Will Pay                                                                                                                          |                                                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                 |                                                | <u>Network Provider</u><br>(You will pay the least)                                                                                        | <u>Out-of-Network Provider</u><br>(You will pay the most)                                    |                                                                                                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.myuhc.com">www.myuhc.com</a></b> | Generic Drugs (Tier 1)                         | Retail: \$5.00 <u>copay</u><br>Mail Order: \$10.00 <u>copay</u>                                                                            | Retail: 50% <u>coinsurance</u> , <u>deductible</u> does not apply<br>Mail Order: Not Covered | Certain preventive medications (including certain contraceptives) are covered at No Charge.                                                                                                                                                 |
|                                                                                                                                                                                                 | Preferred brand drugs (Tier 2)                 | Retail: 20% <u>coinsurance</u> , <u>deductible</u> does not apply<br>Mail Order: 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Retail: 50% <u>coinsurance</u> , <u>deductible</u> does not apply<br>Mail Order: Not Covered | Retail-\$30.00 min-\$60.00.00 max / Mail Order-\$60.00 min-\$120.00 max<br>Certain preventive medications (including certain contraceptives) are covered at No Charge.                                                                      |
|                                                                                                                                                                                                 | Non-preferred brand drugs (Tier 3)             | Retail: 20% <u>coinsurance</u> , <u>deductible</u> does not apply<br>Mail Order: 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Retail: 50% <u>coinsurance</u> , <u>deductible</u> does not apply<br>Mail Order: Not Covered | Retail-\$50.00 min-\$100.00.00 max / Mail Order \$100.00 min-\$200.00 max<br>Certain preventive medications (including certain contraceptives) are covered at No Charge.                                                                    |
|                                                                                                                                                                                                 | <u>Specialty drugs</u> (Tier 4)                | Specialty copays and co-insurance based on mail order tiers                                                                                | Not covered                                                                                  | Specialty drugs must be filled through mail order by a designated OptumRx Specialty Pharmacy, Optum Specialty Pharmacy or another designated Specialty Pharmacy in the OptumRx Specialty Network, and can only be filled in 31-day supplies |
| <b>If you have outpatient surgery</b>                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                     | 20% <u>coinsurance</u>                                                                       | None                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                 | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                                     | 20% <u>coinsurance</u>                                                                       | None                                                                                                                                                                                                                                        |
| <b>If you need immediate medical attention</b>                                                                                                                                                  | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>                                                                                                                     | 20% <u>coinsurance</u>                                                                       | None                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                 | <u>Emergency medical transportation</u>        | No charge                                                                                                                                  | No charge                                                                                    | None                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                 | <u>Urgent care</u>                             | 20% <u>coinsurance</u>                                                                                                                     | 20% <u>coinsurance</u>                                                                       | None                                                                                                                                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                    | Partial <u>Hospitalization</u> /Intensive Outpatient treatment and Intensive Behavioral Therapy (ABA) 20% after in- <u>network plan deductible</u> and non-network 20% after plan <u>deductible</u> .<br><br>EAP is limited to 10 visits per issue per Calendar Year.                                                                                                                                      |
|                                                                           | Inpatient services                        | 10% <u>coinsurance</u>                              | 10% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean. <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 professional services | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Limited to 100 visits per Calendar Year for <u>Home Health Care</u> .                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Pulmonary and Cardiac Rehabilitation therapy is unlimited. Occupational, Speech and Physical Therapy is limited to 60 combined visits per Calendar Year.                                                                                                                                                                                                                                                   |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                     |
|----------------------------------------|----------------------------------|-----------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------|
|                                        |                                  | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                            |
|                                        | <u>Habilitation services</u>     | Not covered                                         | Not covered                                               | <u>Habilitation Services</u> are not covered.                                              |
|                                        | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Limited to 100 days per Calendar Year                                                      |
|                                        | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required for any <u>durable medical equipment</u> over \$1,000. |
|                                        | <u>Hospice services</u>          | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Limited to Lifetime max of 6 months.                                                       |
| 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> .) |                                                                                                                             |                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Adult routine vision care (i.e. refraction)</li> <li>Cosmetic Surgery</li> </ul>                                                | <ul style="list-style-type: none"> <li>Dental Care</li> <li><u>Habilitation Services</u></li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>                                  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                                                                                                                             |                                                                                                                                    |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care – 20 per calendar year</li> </ul>                                                        | <ul style="list-style-type: none"> <li>Hearing aids – 1 per ear every 3 years</li> <li>Infertility treatment</li> </ul>     | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul> |

**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/](http://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: 1-866-672-2511 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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For more information about limitations and exceptions, see plan or policy document at [Oracle Welcome Page](#)

**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 1-866-672-2511.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-672-2511.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo holne' 1-866-672-2511.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-672-2511 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-672-2511.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-672-2511.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-672-2511.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-866-672-2511.

*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 deductible   | \$100.00 |
| ■ <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 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>        |            |
|----------------------------|------------|
| <u>Deductibles</u>         | \$100.00   |
| <u>Copayments</u>          | \$0.00     |
| <u>Coinsurance</u>         | \$1,000.00 |
| <u>What isn't covered</u>  |            |
| Limits or exclusions       | \$60.00    |
| The total Peg would pay is | \$1,160.00 |

### Managing Joe's type 2 Diabetes

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

|                                          |          |
|------------------------------------------|----------|
| ■ The <u>plan's</u> overall deductible   | \$100.00 |
| ■ <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 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>        |            |
|----------------------------|------------|
| <u>Deductibles</u>         | \$100.00   |
| <u>Copayments</u>          | \$200.00   |
| <u>Coinsurance</u>         | \$800.00   |
| <u>What isn't covered</u>  |            |
| Limits or exclusions       | \$20.00    |
| The total Joe would pay is | \$1,120.00 |

### Mia's Simple Fracture

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

|                                          |          |
|------------------------------------------|----------|
| ■ The <u>plan's</u> overall deductible   | \$100.00 |
| ■ <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 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>        |          |
|----------------------------|----------|
| <u>Deductibles</u>         | \$100.00 |
| <u>Copayments</u>          | \$10.00  |
| <u>Coinsurance</u>         | \$400.00 |
| <u>What isn't covered</u>  |          |
| Limits or exclusions       | \$0.00   |
| The total Mia would pay is | \$510.00 |