



HI Choice 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 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 or call 1-866-672-2511 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : \$0 <u>Non-Network</u> : \$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No	See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers.
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> : \$1,000.00 Individual / \$2,000.00 Family per calendar year For <u>out-of-network providers</u> : Not Covered	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> , the overall family <u>out-of-pocket limits</u> must be 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.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.myuhc.com or call 1-866-672-2511 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$15.00 <u>copay</u> /visit	Not covered	*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 co-insurance may apply.
	<u>Specialist</u> visit	\$25.00 <u>copay</u> /visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

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.myuhc.com	Generic Drugs (Tier 1)	Retail: \$5.00 <u>copay</u> Mail Order: \$10.00 <u>copay</u>	Retail: Not covered	Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Preferred brand drugs (Tier 2)	Retail: \$15.00 <u>copay</u> Mail Order: \$30.00 <u>copay</u>	Retail: Not covered	Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Non-preferred brand drugs (Tier 3)	Retail: \$25.00 <u>copay</u> Mail Order: \$50.00 <u>copay</u>	Retail: Not covered	Certain preventive medications (including certain contraceptives) are covered at No Charge.
	<u>Specialty drugs</u> (Tier 4)	Specialty copays and coinsurance based on mail order tiers	Retail: 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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100.00 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50.00 <u>copay</u> /visit	\$50.00 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$15.00 <u>copay</u> /visit	Not covered	None

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 hospital stay	Facility fee (e.g., hospital room)	\$250.00 <u>copay</u> /visit, medical <u>deductible</u> does apply	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15.00 <u>copay</u> /visit	Not covered	Partial <u>Hospitalization</u> /Intensive Outpatient treatment and Intensive Behavioral Therapy (ABA) 20% after in- <u>network plan deductible</u> . EAP is limited to 10 visits per issue per calendar year.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	\$15.00 <u>copay</u> /initial visit only	Not covered	<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) Routine Pre-natal care covered at no charge.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250.00 <u>copay</u> /visit	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	Limited to 100 visits per Calendar Year for <u>Home Health Care</u> .
	<u>Rehabilitation services</u>	\$25.00 <u>copay</u> /visit	Not covered	Pulmonary and Cardiac Rehabilitation therapy is unlimited. Occupational, Speech and Physical Therapy is limited to 60 combined visits per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation Services</u> are not covered

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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>Skilled nursing care</u>	\$250.00 <u>copay</u> /visit	Not covered	Limited to 100 days per calendar year.
	<u>Durable medical equipment</u>	No charge	Not covered	None
	<u>Hospice services</u>	No charge	Not covered	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> .)			
- 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 - Chiropractic care - Bariatric Surgery	- Hearing aids – 1 per ear every 3 years - 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: 1-866-672-2511 or visit www.myuhc.com 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 1-866-672-2511.

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, kwiiijigo 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.

Samoan (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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall deductible	\$0.00	■ The <u>plan's</u> overall deductible	\$0.00	■ The <u>plan's</u> overall deductible	\$0.00
■ <u>Specialist copayment</u>	\$25.00	■ <u>Specialist copayment</u>	\$25.00	■ <u>Specialist copayment</u>	\$25.00
■ <u>Hospital (facility) copayment</u>	\$250.00	■ <u>Hospital (facility) copayment</u>	\$250.00	■ <u>Hospital (facility) copayment</u>	\$250.00
■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0.00	<u>Deductibles</u>	\$0.00	<u>Deductibles</u>	\$0.00
<u>Copayments</u>	\$300.00	<u>Copayments</u>	\$600.00	<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$0.00	<u>Coinsurance</u>	\$0.00	<u>Coinsurance</u>	\$0.00
<u>What isn't covered</u>		<u>What isn't covered</u>		<u>What isn't covered</u>	
Limits or exclusions	\$60.00	Limits or exclusions	\$20.00	Limits or exclusions	\$0.00
The total Peg would pay is	\$360.00	The total Joe would pay is	\$620.00	The total Mia would pay is	\$200.00