Are you ready?

US Benefits 2019 Enrollment Guide

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This Enrollment Guide ("guide") contains a summary (not complete details) of the primary benefit programs available to eligible Oracle US employees. The intent of this Enrollment Guide is to provide information that will help you make informed and thoughtful enrollment decisions and provide enrollment instructions for New Hire, Qualified Family Status Change (FSC), and Open Enrollment events.

Oracle reserves the right to terminate, suspend, withdraw, amend, or modify the benefits described in this Enrollment Guide, in whole or in part at any time.

We make every effort to ensure the information in this Enrollment Guide is current and accurate. However, if there is a conflict between this Enrollment Guide and official Plan Documents, the official Plan Documents will govern. You can find the official Plan Documents on the Oracle US Benefits Website.

Oracle network access required

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Introduction

This Enrollment Guide ("guide") provides general information for eligible employees enrolling in Oracle US Benefits as a New Hire, making changes due to a Qualified Family Status Change, and/or making new elections during Open Enrollment.

US Benefits Website

Located at **www.oraclebenefits.com**, the Oracle US Benefits Website is your best source of benefits and enrollment information. Listed below are links to website content to help you make your benefit decisions and successfully complete the enrollment process.

- Frequently Asked Questions (FAQs)
- Health Plan Comparison Charts
- Plan Costs
- What's New
- HSA Medical Plan Resource Center
- Webcast Access & Replays
- Vendor Contacts
- Summary Plan Description (SPD)

This Enrollment Guide provides a summary of the following programs:

- Medical
- Dental
- Vision
- Employee Assistance Program (EAP)
- Mental Health & Substance Abuse
- Long Term Disability (LTD) Insurance
- Life/Accidental Death & Dismemberment (AD&D) Insurance
- Health (General and Limited Purpose) & Dependent Care Flexible Spending Accounts (FSAs)
- Personal Financial Planning Services
- Legal Insurance

When Benefits Begin and End

WHEN YOUR BENEFITS BEGIN

- **Newly Eligible (New Hire):** Coverage for you and eligible dependent(s) begin on your initial eligibility date (e.g., your new hire date)
- **New Hire Through Acquisition:** Coverage for you and eligible dependent(s) begin on the date of Legal Entity Combination (LEC)
- **US Benefits Open Enrollment:** The effective date of elections you make during Open Enrollment is January 1 of the following calendar year.

WHEN YOUR BENEFITS END

Benefits for you and your eligible dependent(s) become inactive at 11:59 PM on the day you become ineligible (e.g. resignation date). If you and/or your dependent(s) do not have alternate coverage – you can consider the following options:

- **COBRA:** Continue your Oracle US Benefits (medical, dental, vision) for a period of 18 or 36 months. Click here for more information.
- **Health Care Insurance Marketplace:** Purchasing medical coverage from a Health Care Insurance Marketplace is another option to obtain medical insurance. Click for more information: **Marketplace Notice** | **Healthcare.gov**

Cost of Oracle's US Benefits

New Hires

Your per pay period premium deductions and any applicable flex credits provided by Oracle are retroactive to your New Hire date.

Oracle subsidizes approximately 80% of the aggregate cost of your health care coverage across all plans and election levels.

Oracle's United Healthcare medical, MetLife dental, and Vision Service Plan (VSP) vision plans are self-insured -- meaning that all plan member benefit claims along with administrative fees are funded from Oracle's general assets.

The Kaiser Permanente HMO Plans, Employee Assistance Program (EAP), life insurance, accidental death and dismemberment, and long-term disability insurance are fully insured plans – meaning that Oracle pays a set premium each month – and the vendors pay for administration and all claims.

Oracle has offered a flex Cafeteria style benefits plan for many years. A flex plan provides Flex Credits to offset the cost of benefits, however, flex plans are no longer commonly offered by employers and also complicate reporting and compliance under the Affordable Care Act. Oracle's flex plan and Flex Credits are being phased out over the next few years, however, Oracle's underlying financial support for the benefit plans remains the same -- even though no longer illustrated through Flex Credits -- along with commitment to choice for plan members.

The following chart shows the Oracle Flex Credits applied each pay period to the benefit plans that still have corresponding credits. You may review the costs of your benefits in the **Oracle US Benefits Enrollment System** or on the **Oracle US Benefits Website**.

Benefit Type	Oracle's Subsidy - Credits (Per Pay Period)			
Medical – phased out in 2018	N/A	N/A	N/A	N/A
Dental – phased out in 2017	N/A	N/A	N/A	N/A
Vision	Employee Only (EE) $7	EE + Spouse/DP $7	EE + Child(ren) $7	EE + Family $7
Waive Coverage – phased out in 2018	Medical N/A	Dental N/A	Vision $7	
Long Term Disability (LTD)	66 2/3% coverage level is fully subsidized by Oracle[1]			

[1]The amount of subsidy is not the same for all employees. Subsidy is based on your age and your annual benefits compensation.

Life and (AD&D)	2 x annual benefits compensation coverage level is fully subsidized by Oracle[1]

ANNUAL BENEFITS COMPENSATION

Annual Benefits Compensation is used to determine your Life/AD&D and Long-Term Disability Insurance, and Oracle's contribution (seed) to the Health Savings Account (HSA) Medical Plan.

Your Annual Benefits Compensation effective January 1, 2019 includes your base salary as of October 1, 2018, plus any Oracle performance based bonuses, Oracle commissions, shift differentials and overtime paid to you from October 1, 2017 through September 30, 2018. Compensation paid outside of the specified period due to payment timing, errors, and/or omissions will NOT be counted in your current Annual Benefits Compensation - it will be included in your following year's Annual Benefits Compensation.

» **Hourly Employee:** If you are an hourly paid employee, base salary will be based upon your hourly rate of compensation multiplied by the average number of hours you are expected to work for that calendar year. If you worked for another Oracle entity outside the U.S. prior to joining Oracle America, Inc., those bonuses, commissions, shift differentials, and overtime will not be included in your Annual Benefits Compensation.

» **New Hire:** If you are a new hire with a start date on or after October 1, 2018, your Annual Benefits Compensation for the 2019 Plan Year will be based on your annual base salary in effect on your hire date.

» **Rehire Employee:** If you are a rehire, only bonuses, commissions, shift differentials and overtime paid to you during the look back period will be included.

» **New Acquired Employee:** If you are a new employee of Oracle through an acquisition, any compensation paid to you prior to legal entity combination (LEC) or under a bonus or commission plan of the acquired company will not be included in your Annual Benefits Compensation.

Core and Default Coverage

There are certain minimum benefits in which you are required to enroll in. These minimum benefits are referred to as "core coverage" and are listed below:

Core Coverage (Minimum Required)

» Medical coverage for yourself (unless you have alternate coverage)[1]

» Life Insurance: $10,000 pre-tax or 1 x annual compensation after-tax

» Accidental Death & Dismemberment (AD&D) Insurance: $10,000

» Long Term Disability (LTD) Insurance: 50% pre-tax Coverage Level

1. You may elect any of the Oracle medical plans you are eligible for. Additionally, if you are covered by an alternate medical plan (e.g. your spouse or domestic partner's medical plan) you may waive medical coverage altogether. Refer to "Declining Coverage".

DEFAULT COVERAGE

If you are a newly eligible employee (e.g., new hire) and **DO NOT** complete your enrollment during the designated enrollment period, you will **AUTOMATICALLY** be enrolled in the default plans listed below. Newly eligible employees have 31 days following eligibility date (e.g. new hire date) to complete elections.

Default coverage INCLUDES:

- UHC HSA Medical Plan (Employee Only)
- Life Insurance: $10,000 pre-tax
- Accidental Death & Dismemberment (AD&D) Insurance: $10,000
- Long Term Disability (LTD) Insurance: 50% pre-tax Coverage Level

Default coverage does NOT INCLUDE:

- Coverage for eligible dependents (spouse/domestic partner and children)
- Dental Insurance
- Vision Insurance
- Health/Dependent Care Flexible Spending Accounts (FSA)
- Legal Insurance
- Personal Financial Planning Services

DECLINING COVERAGE

You may decline medical coverage provided you can verify coverage from another source, such as your spouse or domestic partner's medical plan.

Eligibility

EMPLOYEES

All regular full-time employees on the Oracle US payroll scheduled to work 30 hours or more per week and regular part-time employees scheduled to work an average of 20–29 hours per week are eligible to enroll in Oracle US Benefits. Independent contractors and/or "leased employees" engaged by a staff leasing company are NOT eligible for Oracle US Benefits.

LONG TERM ASSIGNMENTS (OUTSIDE OF YOUR HOME COUNTRY)

If you are assigned to work outside of your home country – you may be eligible for alternative US benefits that better meet the needs of you and your eligible dependents. Click **HERE** for more information.

DEPENDENTS

Your spouse/domestic partner and children are eligible to enroll in certain benefits. The list below provides general eligibility information. Review the **Summary Plan Description** for more information.

Your spouse includes:

- Your spouse recognized under federal law
- Your domestic partner includes:
- Your qualified same or opposite sex domestic partner
- Same sex partners who have entered into a valid civil union under state law are treated as an eligible domestic partner

Your child(ren) includes:

- natural, adopted, foster, and step children
- children of your qualified domestic partner
- children for whom you are the legal guardian
- children for whom you are required to provide coverage as the result of a Qualified Medical Child Support Order (QMCSO)
- "Adult" Children

By law, "adult children" are eligible for medical coverage to the limiting age regardless of financial dependence, place of residence, and student, employment, or marital status. Furthermore – coverage will be extended through the last day of the month of your child's 26th birthday. For example – if your child's 26th birthday is on December 2 – his/her coverage will remain in-force through December 31. In addition to medical coverage, Oracle offers coverage for your adult children on your dental and vision plans. Expanded coverage for adult children" does NOT apply to life insurance. See **"Life Insurance Coverage for Your Children"** for more information.

DEPENDENT ELIGIBILITY

The following table provides a summary of the benefit plan(s) your dependents are eligible for.

Plan Type	Spouse/DP	Children
Medical	YES	YES[1]
Dental	YES	YES[1]
Vision	YES	YES[1]
Employee Assistance Program (EAP)	YES[2]	YES
Life Insurance	YES	YES[3]
Accidental Death & Dismemberment (AD&D)	NO	NO
Long Term Disability (LTD)	NO	NO

1. Children to age 26 (age 26+ if child meets disability requirements) are eligible for medical coverage. Effective January 1, 2015, coverage will be extended through the last day of the month of the child's 26th birthday. *See "Adult" Children above*
2. In addition to an eligible spouse/domestic partner and children, other residents of your household are eligible for EAP services
3. Student status is required upon submission of a benefit claim only. Unlike medical, dental, and vision coverage – your child(ren) are eligible for life insurance to age 21, to age 23 if a full-time student, or to age 25 if you are a resident of Texas.

» Domestic Partnership and Same-Sex Marriage - Visit the **Oracle US Benefits Website**

For More Information

Same and Opposite Sex Domestic Partners

You may choose to enroll your eligible same or opposite sex domestic partner and their children in the medical, dental, vision and dependent life insurance plan.

Employees Who Enroll a Domestic Partner

In accordance with the Internal Revenue Service (IRS) Defense of Marriage Act (DOMA) ruling, individuals in domestic partnerships, civil unions, or other relationships that are not denominated "marriage" under state law will NOT be treated as married for federal tax purposes. Qualified benefits and state law protections may be offered in the same manner as an opposite sex spouse. Any special tax treatment remains the responsibility of the employee and should be addressed when filing your state income tax return.

Oracle Couples

If both you and your spouse/domestic partner are employed by Oracle, you may not have "double coverage" under Oracle's medical, dental and vision plans. This means you may not be covered as both an Oracle employee and as a dependent of another Oracle employee for these plans. In addition, you and your spouse/domestic partner may not cover the same child as a dependent for any benefit. However, you may both elect spouse/domestic partner after-tax life insurance for one another. If one or both of you choose to "double cover" under the employee and spouse/domestic partner life insurance options, the combined maximum amount of life insurance coverage you may purchase is $2,550,000.

Rehired Employees
If you leave Oracle and are rehired within 30 days, the benefits in-force on your termination date will automatically be reinstated. If you are rehired after 30 days, you must re-enroll for benefits.

How to Enroll

Oracle US Benefits Enrollment System
Enrolling in Oracle US Benefits is simple. In addition to enrolling in benefits you may also add or update dependent information and designate or modify your life insurance/AD&D.

If you enroll in the HSA Medical Plan you must make your Health Savings Account (HSA) beneficiary designation directly with **Optum Bank**.

Oracle US Benefits Enrollment System

Login from inside and outside of the Oracle firewall using your Oracle Single-Sign-On (SSO) user name and password

New Hires/Newly Eligible
There is a slight delay in your ability to access the enrollment system. If your hire date is a Monday or Tuesday you will generally be able to access the system and make your elections on Wednesday or Thursday. If your hire date is Wednesday, Thursday, or Friday you will generally be able to access the system and make your elections on the following Monday or Tuesday. You will be notified via email when you are able to make your elections.

Enrollment Email and Letter
An email will be sent to your Oracle email address and you will receive a letter via US mail to your home address following your eligibility date (e.g. new hire date). The enrollment letter provides you with important enrollment information and instructions - including your enrollment deadline. Upon receipt of either one of these communications, you can make your elections by accessing the **Oracle US Benefits Enrollment System**. You can make changes to your enrollment up to your deadline. If you don't enroll by the specified deadline, you will automatically be enrolled in the required minimum core benefits. *Refer to the "Core Coverage" section of this document.*

Enrollment Instructions
To make your US Benefits elections, visit the **Oracle US Benefits Enrollment System** and follow the online instructions to make your benefit elections. You may access the enrollment application as many times as needed, up until your election deadline. After that, your elections are binding. When you have completed your elections, please review your summary of elections for accuracy and keep a copy for your records. The benefits shown on your election summary will remain in effect for the plan year unless you experience a qualified family status change.

Benefits Confirmation Statement
After you submit your election, you will receive an e-mail confirming your elections have been recorded. Upon receipt of this email you can view your Confirmation Statement online. **Please review this statement carefully for accuracy and make any corrections prior to the enrollment date deadline listed in your e-mail.** If you do not make your corrections prior to your deadline, the benefits and enrolled dependent(s) reflected on your Confirmation Statement will remain active through the calendar year unless you have a qualified family status change event. Refer to the **Oracle US Benefits Website** to learn more about qualified family status change events.

Enrollment Deadline
If you do not enroll by your specified deadline you will automatically receive the default coverage. The default coverage does **NOT** cover your eligible dependents - nor does it include dental and vision. **Newly eligible employees have 31 days following eligibility date (e.g. new hire date) to complete elections.**

Annual US Benefits Open Enrollment

Open Enrollment Period: October 29 – November 16, 2018

Take advantage of your annual opportunity to review your benefits and make changes for the new year

Frequently Asked Questions (FAQs)
Health Plan Comparison Charts
Plan Costs
What's New
HSA Medical Plan Resource Center
Information - Webcast Sessions
Summary Plan Description (SPD)

- Review your benefits
- Modify benefit plan elections
- Add/drop coverage for yourself and dependents
- Enroll or make changes to your Health/Dependent Care FSAs
- Reaffirm your HSA contribution election if applicable
- Update your dependent and beneficiary information

Make Your Open Enrollment Elections

Access the **Oracle US Benefits Enrollment System** inside or outside of the Oracle firewall using your Oracle Single-Sign-On (SSO) Username and Password. All plan and cost changes become effective January 1, 2019 and remain in effect for the entire year. Your next opportunity to make changes to your benefits is the next annual Open Enrollment period or if you make changes because of a qualified family status change event. Refer to the **Oracle US Benefits Website** to learn more about qualified family status changes.

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Open Enrollment is NOT a Qualified COBRA Event

Eligible dependents removed from coverage during Open Enrollment period is not an IRS qualified COBRA event. If you drop an eligible dependent, he/she will not be eligible for COBRA benefits continuation.

Qualified Family Status Change Events

You may be eligible to make certain changes to your benefits during the year as a result of a qualified family status change event. A few of the most common events are:

- Marriage
- Birth or adoption
- Child Becomes Ineligible For Coverage
- Change of Spouse Coverage

For a complete list of qualified family status change events – visit the **Oracle US Benefits Website**.

Effective Date

The effective date of coverage and the date of your qualified family status change event are not always the same. For coverage to be effective on the date of your qualified family status change, you must submit the change on the event date. If you would like to submit your election prior to the event date, you must contact **Oracle US Benefits** for assistance. A few qualified event changes are retroactive to the event date provided you make your benefit changes within 62 days of the change. The most common events include:

- Marriage or divorce
- Birth or adoption
- Ineligible dependents

Qualified Family Status Change – Making Benefit Elections

Submit your benefit elections by accessing the **Oracle US Benefits Enrollment System**. You may access the enrollment system in or outside of the Oracle firewall using your Oracle Single-Sign-On (SSO) Username and Password. You must make your changes within 62 days of the status change. You can make benefit changes that are directly related to your qualified family status change event. For example, if you adopt a child, you may add your child to your current medical plan, but you may not drop your spouse's medical coverage at that time. Visit the **Oracle US Benefits Website** for more information regarding allowable changes.

Beneficiary Designation

Access the **Oracle US Benefits Enrollment System** at anytime to designate, review, or update your life insurance and accidental death & dismemberment insurance beneficiary information. If you enrolled in the UHC HSA Medical Plan you must make your Health Savings Account beneficiary designation directly with **Optum Bank**.

- **Add Your New Children: New children such as a newborn must be added to your coverage within 62 days of the event. Your new children are not automatically enrolled for you.**

Medical Plans

Quick Links: Medical Comparison Tool | Summary Plan Description | Summary of Benefits Coverage (SBCs) | HSA Med Plan

Medical Plan Eligibility – Geographic Service Area

Your place of residence determines which medical plans you are eligible for. You can enroll in a plan if your home address zip code falls within the plan's service area. The chart below identifies each of the medical plan offerings and provides general geographic availability. You may also use the online **Medical Plan Eligibility** tool to determine which medical plan(s) you are eligible to elect. Additionally, when you access the **Oracle US Benefits Enrollment System**, only the medical plans you are eligible for will be displayed.

Medical Plan	Geographic Availability
United Healthcare (UHC) Plans	
Medium PPO	Nationwide
Premium PPO	Nationwide
EPO Choice	Nationwide
HSA Medical Plan	Nationwide
HPHC Passport	Massachusetts
EPO Choice (HI)	Hawaii[1]
Medium & Premium Out-of-Area PPO	Areas where UHC networks are not available[2]
Kaiser Permanente HMO Plans	
Kaiser Atlanta	Georgia
Kaiser California (Northern)	Northern California
Kaiser California (Southern)	Southern California
Kaiser Colorado	Colorado
Kaiser Mid-Atlantic	Washington DC
Kaiser Northwest	Oregon and Washington
Kaiser Washington	Washington

1 Residents of Hawaii are required to select this state mandated/approved plan. No other medical plan is available.

The United Healthcare (UHC) network of physicians, providers, and facilities extends across the entire US and most employees have access to an extensive network of providers. In a few rural areas the network is limited and you are eligible to enroll in the Premium or Medium Out-of-Area Plans – which offer non-network coverage equitable to other plans where the network is accessible.

United Healthcare (UHC) Plans

Oracle offers you a choice of United Healthcare (UHC) medical plans including Preferred Provider Options (PPOs), a Choice Exclusive Provider Organization (EPO) plan and a High Deductible Health Plan (HDHP). Eligible services are the same in all UHC plans – however the amount you pay for services and per pay period premium costs vary by plan.

Premium Choice Plus PPO Plan

The rich coverage of the UHC Premium PPO Plan makes this plan attractive. However, due to the high plan value it is also has the highest per pay period premium of the UHC plans. Network physician's office visits are covered at 100% after you pay the applicable co-pay and most other network services are covered at 100% after you meet the annual deductible. If you receive care from non-network providers, the plan pays 80% of UCR charges after you meet the annual deductible. This plan has the richest non-network coverage.

Medium Choice Plus PPO Plan

The UHC Medium PPO Plan is the most popular UHC option. Its' comprehensive coverage and moderate per pay period premium meets the healthcare needs for most employees. This plan is most cost effective when care is received by network providers. However – it provides a moderate level of non-network coverage. The plan covers network physician's office visits at 100% after you pay the applicable co-pay. Most other network provider services are covered at 90% after you meet the annual deductible. If you receive care from non-network providers, the plan pays 70% of UCR charges after you meet the annual deductible. This plan maximizes its' value when network providers are used – however it does provide you moderate non-network coverage.

EPO Choice Plan

The EPO Plan is a network ONLY plan and requires you to use UHC EPO Choice physicians and facilities to receive benefits. Network physician's office visits are covered at 100% after you pay the applicable co-pay and most other network services are also covered at 100% after you meet the annual deductible. The plan does **NOT** cover care from non-network providers except in an emergency, acupuncture services, or Applied Behavioral Analysis (ABA) Therapy for autism. This plan has rich network coverage. Other than a few exceptions, you must receive care from network providers.

HPHC Passport Plan

United Healthcare's Harvard Pilgrim Passport Plan (HPHC) network is available to most employees who live in Massachusetts, Maine, New Hampshire, and the cities in Vermont and New York that border Massachusetts or New Hampshire. The HPHC Passport Plan requires you to use HPHC physicians and facilities to receive benefits. When you (or eligible dependents) are outside of the designated HPHC network area you have the flexibility to access the broader UHC Choice network. The majority of services are covered at 100% after you pay the applicable co-pay, and most other network services are also covered at 100% after you meet the annual deductible. The plan does NOT cover care from non-network providers except in an emergency, acupuncture services, or Applied Behavioral Analysis (ABA) Therapy for autism. Aside from the exceptions described above, services obtained outside the HPHC network or UHC Choice network are NOT covered. You may also use the online **Medical Plan Eligibility** tool to determine if you are eligible to elect this plan. Additionally, when you access the **Oracle US Benefits Enrollment System**, only the medical plans you are eligible for will be displayed. HPHC Passport Plan members have the flexibility to use the broader UHC Choice network if traveling -- or have dependents -- that do not live in the HPHC service area.

HSA Medical Plan

The UHC HSA Medical Plan consists of three components: a qualified High Deductible Health Plan (HDHP), a Health Savings Account (HSA), and an optional Limited Purpose Health Care Flexible Spending Account (FSA); which are designed to work together.

Key Benefits of an HSA

- An HSA offers TRIPLE tax savings
- The money in the account is always yours, even if you leave Oracle
- You can use it now or save it for the future
- You can decide if you'd like to invest it

The UHC HSA Medical plan is an IRS qualified High Deductible Health Plan (HDHP). All services (except for eligible preventive care services, which are covered at 100% no deductible) are subject to the plan deductible and coinsurance. If you receive care from a network provider, the plan pays 90% of UCR charges after you meet the annual deductible. If you receive care from non-network providers, the plan pays 70% of UCR charges after you meet the annual deductible. In this plan, all prescriptions are subject to the plan deductible and coinsurance. For more information about the HSA Medical Plan visit the **HSA Medical Plan Resource Center**.

ARE YOU ELIGIBLE TO CONTRIBUTE TO AN HSA?

There are specific eligibility requirements to open and contribute to a Health Savings Account (HSA).

Be sure you validate your eligibility by reviewing the criteria available on the **HSA Medical Plan Resource Center**

HSA Medical Plan - Aggregate Deductible

Unlike the previous UHC plans summarized above, the annual deductible and out of pocket maximum rules are different in the HSA Medical Plan. In other UHC plans an individual within a family is subject to coinsurance once he/she satisfies the individual deductible. Likewise, an individual within a family isn't responsible for additional eligible expenses in the plan year once he/she satisfies the individual out of pocket maximum. In the UHC HSA Medical Plan, the plan deductible is aggregated. This means the family deductible must be met before coinsurance applies even if one family member meets the individual deductible.

Network Providers

All UHC plans utilize the same large nationwide network and you are encouraged to use network providers whenever possible. For the most part the provider attrition rate is low and the network continues to grow. You are encouraged to verify the network status of your provider before seeking care. UHC negotiates contract agreements with all network providers which results in discounts for you and for Oracle. Network providers are also required to submit patient claims and fulfill notification and authorization requirements.

Non-Network Providers

If you obtain care from a non-network provider you will be responsible for the plan deductible. Once the deductible is met the plan pays a percentage of UCR charges. UCR charges usually exceed negotiated UHC contract rates. And, amounts exceeding UCR are generally your responsibility. When you use non-network providers, you are responsible to submit claims and fulfill notification and authorizations requirements. Improper notification and authorization can result in a financial penalty.

Usual, Customary, and Reasonable (UCR)

UCR is the amount paid for a medical service in a geographic area and is based on a review of the prevailing charges made by peer physicians for a particular health service within a specific community or geographical area. Non-network expenses that exceed UCR are generally not covered by the plan and you are responsible for any amount above UCR. Amounts that exceed UCR generally do not apply to your annual deductible or out-of-pocket maximum. You are not responsible for charges in excess of UCR when services are obtained from a network provider.

Out of Pocket Maximum

An "out of pocket maximum" is a safety net that protects you from the high expenses associated with catastrophic injury or illness. The plans' calendar year out of pocket maximum varies between plans; however, each has a maximum amount you will be required to pay each year. Should you reach your annual out of pocket maximum the plans will pay 100% of eligible expenses for the rest of the year. Amounts above UCR generally remain your responsibility even if you reach the out of pocket maximum.

100% Covered – FREE!

ALL Oracle medical plans cover eligible **Preventive Care Services** at 100%

When network providers are used

Managing Your Prescription Costs

Prescription drugs are the fastest-growing segment of health care expenses. Drug costs are increasing at double-digit rates and are outpacing costs for hospital and physician services.

UHC's Preferred Prescription Drug List (PDL): Medicines prescribed in the UHC plans fall into one of three drug tiers. You will pay more or less depending on which tier your medication falls in. A Preferred Drug List (PDL) is a formal list that classifies prescribed medications into different tiers. The list includes generic, brand name, and compound prescription medications approved by the FDA. When you choose a medication you and your physician should consult the PDL to help you obtain the most out value from your benefit. **You may obtain the most current UHC PDL on the Oracle US Benefits Website, www.myuhc.com** or by calling the UHC member phone number noted on the back of your ID card. Tier changes generally occur each January and July.

UHC's Prescription Drug Tiers: UHC medical plan prescription drugs are categorized into three individual tiers. Each tier has an associated cost (co-pay or coinsurance). This is the amount you will pay when you fill a prescription. There are three tiers – tier 1 is the lowest cost option, tier 2 is mid-range, and tier 3 is the highest cost option. Generally you will find that most generic medications are classified in tier 1 however that may not always be the case. If you are currently taking a medication that falls in tier 2 or 3 – you may want to ask your physician if there is an appropriate medication classified in a lower cost tier. Compound medications are those with one or more ingredients that are prepared at the pharmacy location. These types of medications are almost always classified as tier 3 and a lower tier option is not available. Certain compound medications will require authorization prior to fill to ensure the medication is FDA approved.
Drug tiers are identified on the **UHC PDL.**

Classification Decisions: The UHC PDL Management Committee is responsible for making tier placement decisions. This committee is made up of senior level UHC physicians and business leaders. The goal of this committee is to help ensure access to a wide range of medications and at the same time help control costs. Decisions are made based as new drugs are released and clinical guidelines are updated. Tier changes can be made during the year. If your current medication(s) move to a different tier (up or down) it may result in you paying a lower or higher amount for your medication.

****Mail Order Program (Maintenance Medications):** The mail order program is required if you or a covered dependent require maintenance medications – such as medicines for cholesterol and high blood pressure. Using the mail order program saves you money and is also convenient. You receive a higher quantity of medications at a lower cost and prescriptions are mailed directly to your home which saves you a trip to the retail pharmacy. There is an "opt out" option for employees if mail order is not your preference.

Specialty Medications: Specialty medications are critical to improving the health and lives of individuals with complex, serious, or rare conditions. They are the most expensive medications being used today - usually costing more than $250 per prescription. These types of prescriptions are typically not available at retail pharmacies and require additional clinical support for better health outcomes. The majority of medications are not classified in this special category.
For the small percentage of employees and family members who require specialty medications, the program is designed to make them accessible, affordable, and provide additional customer service and clinical support. Therefore, UHC medical plan members are **required** to use a participating specialty pharmacy to receive network coverage for all specialty medications. Specialty medications are dispensed in a 30-day supply only and are available through mail order only.
To locate a participating specialty pharmacy visit **www.uhcspecialtyrx.com** or call the Specialty Pharmacy Referral Line at 866-429-8177. Representatives are available 24/7 and will answer any questions you may have about the program and transfer you directly to a participating network specialty pharmacy based on your medication(s). If you choose to fill your prescription at a non-network pharmacy, you will be required to pay a higher amount.

» **UHC SPECIALTY MEDICATIONS**

www.uhcspecialtyrx.com
1-866-429-8177

Kaiser Permanente HMOs
(Available in California, Colorado, Georgia, Washington DC, Oregon, and Washington)
Kaiser Permanente (Kaiser) is available to Oracle employees in certain geographic regions across the country. When enrolled in Kaiser, you receive your care by Kaiser Physicians and facilities. Services are covered at 100% after you pay the applicable co-pay and there are no deductibles or claim forms to file. The plan does NOT cover care from non-network providers except in an emergency.

When you enroll in a Kaiser plan, prescription drugs are included and you fill your prescription drugs through a Kaiser pharmacy. There are two categories of prescription drugs – generic, and brand name. Each drug category is covered at 100% after you pay the applicable co-pay. For cost savings and convenience, the HMOs offer a mail-order program for maintenance prescriptions.

Each of the Kaiser plans includes an "out of pocket maximum" which acts as a safety net against catastrophic injury or illness that may result in high cost claims. The plans' calendar year out of pocket maximum varies between plans - however each limit the amount you will be required to pay each year. Should you reach your annual out of pocket maximum the plans will pay 100% of eligible expenses for the rest of the year.
Each Kaiser plan offers similar benefits (including prescription drugs) – but services and coverage levels vary by plan. To review and compare plan features including eligible services and co-pays, you are encouraged to review the **Medical Comparison Tool**, **Kaiser Certificates of Coverage** 🔒, and **Summary of Benefits Coverage (SBC) documents** 🔒.
For more information about service areas – refer to the "Eligibility – Geographic Service Area" section of this document. You may also use the online **Medical Plan Eligibility** tool to determine if you are eligible for Kaiser coverage. Additionally, when you access the **Oracle US Benefits Enrollment System**, only the medical plans you are eligible for will be displayed.

Medical Plan Selection Considerations

- Are your doctors, facilities, and hospitals in or out of the network?
- Do you want flexibility to see non-network providers?
- Are there chronic conditions that may need recurring medical care?
- Are you anticipating hospital stays (e.g. pregnancy) for yourself or family members?
- What is your financial risk tolerance?
- Would you prefer to pay more in per pay period premiums for richer coverage?
- Have you historically met the annual deductible and reached the out of pocket maximum?
- Where do your dependents live?
- Will you have children going to college in another state? Or studying abroad?
- Do you travel out of state or country?

Mental Health and Substance Abuse

Quick Links: Medical Comparison Tool | Summary Plan Description | www.liveandworkwell.com | Summary of Benefits Coverage (SBCs)

Employee Assistance Program (EAP)
Confidential, personal assessment and referral services for you and household members. Enrollment is automatic and free of charge to you, your eligible dependents and other members living in your household. You do not need to be enrolled in an Oracle medical plan to access services. United Behavioral Health (UBH) administers the EAP.

United Behavioral Health (UBH)
866.728.8413
www.liveandworkwell.com
(access code 228485)

The EAP is available 24 hours a day, 7 days a week to help you with:

- Stress & Depression
- Job Worries
- Legal & Financial Concerns
- Family & Marital Problems
- Alcohol & Chemical Dependency

When you call UBH, an intake specialist will work with you to find the appropriate clinician based on the nature of your issue and any gender, language, and cultural preferences you may have. The EAP provides 100% coverage for up to six (6) in person visits per concern per year with an EAP counselor. Mental health outpatient care beyond six (6) visits is managed through Mental Health and Substance Abuse benefits described in this document.

6 Free EAP Counseling Sessions (Per Concern) Each Calendar Year United Behavioral Health (UBH)	Available 24 x 7 866.728.8413

Mental Health and Substance Abuse Benefits
Care beyond the six free EAP visits
If you enroll in a UHC medical plan, your mental health and substance abuse coverage will be provided through UHC and its subsidiary United Behavioral Health (UBH). If you enroll in an HMO, mental health outpatient care is managed through the HMO – contact your HMO for more information. UHC medical plan participants are required to pre-authorize any mental health and substance abuse outpatient and inpatient treatment.

The UBH network includes a wide range of professionals — psychiatrists, psychologists, masters-level social workers, and marriage and family counselors — as well as hospitals and alcohol and substance abuse treatment centers. This applies to both network and non-network facilities. Please call UBH to pre-authorize services. When you access care through the UBH mental health network you receive a higher level of benefits than if you obtain care outside the network. Your benefits vary depending on which plan you're in and whether you obtain authorization from UBH.

Live and Work Well
Live and Work Well provides website access to benefits and tools to help enhance your work, health, and life. You may access this online resource center at **www.liveandworkwell.com** (use Oracle's access code 228485).

Dental Plans

Quick Links: Dental Plan Comparison Tool | Summary Plan Description | www.metlife.com/mybenefits

Oracle offers you a choice of two dental plans administered by MetLife, Dental Plan I and Dental Plan II. Dental Plan I covers nearly all of the same things covered by Dental Plan II with just a couple of exceptions:

- No orthodontia coverage under Dental Plan I
- Major care covered at 50% (versus 80% under Dental Plan II)
- Otherwise, Dental Plan I is exactly like Dental Plan II and it's **FREE** (employees make no monthly contribution for this plan, so there will not be a payslip deduction).

The chart below identifies the key differences between the two plans.

Dental Plan Provisions	Dental Plan I	Dental Plan II
Annual Deductible		
- Individual	$50	$50
- Family	$150	$150
Annual Maximum	$1,500	$1,500
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	80%
Orthodontia	Not Covered	50%
Ortho Lifetime Maximum	NA	$2,000

This chart is for comparison purposes only and does not include all plan provisions including limits and exclusions.

NETWORK AND NON-NETWORK DENTISTS

Both plans allow you to use any licensed dentist. You can choose a dentist from MetLife's PDP Plus network or any dentist outside of the network. When you obtain services from a network or non-network dentist, the plan applies the same deductible and coinsurance. However, because network providers have agreed to accept negotiated fees that are 15% - 45% less than average dental fees in the same community, your out-of-pocket costs are usually lower. This helps to reduce your out of pocket costs and stretch your annual dental benefit maximum.

To illustrate potential cost savings – review the example below.

Cost Saving Example	Network	Non-Network
Implant – UCR	$2,500	
Negotiated Contracted Rate	$1,868	Not Applicable
Plan Pays	$1,494 (80% of contracted rate)	$2,000 (80% of UCR)
You Pay	$374	$500 **Note:** If the non-network dentist charges above UCR – you are also responsible for the additional fees exceeding UCR.
Savings Using Network Dentist	$126 out of pocket cost $506 less applied to your calendar year benefit maximum	

This example assumes the non-network dentist charges UCR amount of $2,500.

MetLife Dental Cards

MetLife does not require or issue ID cards for the dental plans. You simply notify your dentist that you are a MetLife dental participant and provide the MetLife group number (#300569). The dental office will verify your eligibility with MetLife.

Dental Plan Pre-Treatment Estimates

If your dentist recommends treatment with an expected cost of more than $300 it is suggested that a pre-treatment estimate is obtained. Your dentist will provide MetLife with details about your dental needs including the proposed course of treatment, expected charges, and copies of applicable charts and x-rays. MetLife will then determine which services are covered and estimate how much the plan will pay, and the amount you will pay.

Vision Plans

Quick Links: Vision Plan Comparison Tool | Summary Plan Description 🔒 | www.vsp.com | VSP Discounts/Special Offers

Oracle offers you a choice of two vision plans administered by Vision Service Plan (VSP). The chart below identifies the key differences between the two plans.

Benefits	Vision Plan I	Vision Plan II
Annual Eye Exam	X	X
Pair of Frames and Lenses	X	X
Elective Contact Lenses (in lieu of frames/lenses)	$250 Allowance	$300 Allowance
Additional Pair of Frames/Lenses **OR** Contact Lenses	None	X
Non-VSP Provider Coverage	X	X
VSP Discounts and Special Offers **(Learn)**	X	X

Note: This chart is for comparison purposes only and does not include all plan provisions including limits and exclusions.

Network and Non-Network Eye Care Professionals

You may choose a provider from VSP's network or any non-network provider. Benefits for services performed by VSP network providers are covered at a higher rate and you will incur less out of pocket cost for services performed. The plan pays up to specified dollar amounts for non-network services.

HOW TO USE VSP

Network VSP Providers: Select a VSP provider and schedule an appointment. Inform your VSP provider that you are a VSP participant through Oracle. VSP providers will verify your eligibility, your benefit allowances, and process any necessary forms. Be sure that your provider receives approval from VSP **prior** to receiving services.

Non-Network Providers: If you receive services from a non-VSP provider, you must first pay the bill in full and then submit an itemized receipt of payment to VSP for reimbursement. Access the **Vision Plan Comparison Tool** to view the non-network allowances.

Calendar Year Benefits Eligibility

Your eligibility for vision benefits is based the plan in which you are enrolled. Additionally, your benefits and allowances are based on a calendar year and refreshed each January 1.

VSP ID Cards

VSP does not require or issue ID cards for the vision plans. See “How to Use VSP” above.

Vision Plan Selection Considerations

- How often do you need to replace your glasses or contact lenses?
- Do you or your dependents wear glasses or contact lenses?
- Have you noticed any changes in your vision?
- Do you expect you or any of your dependents will need glasses or contact lenses for the first time?
- Even if you do not require corrective lenses – an annual eye examination is a good preventive measure. Medical conditions, such as certain cancers and diabetes, can be identified through a non-invasive eye exam.
- Most vision services are eligible Health Care FSA and Health Savings Account (HSA) expenses.

Disability Insurance

Financial Coverage for Short and Long Term Disabilities

Short Term Disability (STD) Insurance

Eligible employees are automatically enrolled in short-term disability insurance at no cost. Employees who work in California are automatically enrolled in Oracle's Voluntary Plan - Voluntary Disability Insurance (VDI), which is a self insured plan as part of a legal alternative in lieu of applying for State Disability Insurance. Employees will contribute into the Voluntary Plan through payroll deductions. Employees may receive VDI benefits up to 52 weeks of an approved disability. Employees who work outside of California may receive Short-Term Disability benefits of up to 12 weeks for an approved disability, integrated with statutory benefits where applicable. Employees that remain disabled greater than 90 days are eligible to apply for Long Term Disability benefits.

STD - More Information: STD - Statement of Coverage (CA) 🔒 | STD Summary Plan Description (Non-CA) 🔒

Long Term Disability (LTD) Insurance

Long-Term Disability (LTD) insurance provides income protection if you become totally disabled and cannot work. You may be eligible for monthly LTD benefits after three months of continuous disability. LTD begins on the 91st calendar day and is integrated with your Voluntary Disability Insurance benefits (for California workers) and picks up where STD ends (for non-California workers) such that you do not have a gap in your income stream. LTD is a core benefit — you are required to purchase a minimum amount of LTD insurance coverage for yourself.

LTD - More Information: LTD – Certificate of Coverage (All States) 🔒 | Summary Plan Description 🔒

Generally, you are considered totally disabled if, as a result of injury or illness, you cannot perform the material duties of your occupation in the first 24 months. After the first 24 months, you are considered totally disabled if you cannot perform the duties of any occupation for which you are reasonably qualified by education, training or experience, due to the same injury or illness. Your dependent spouse/domestic partner or children are not eligible for LTD coverage.

Oracle offers you two levels of LTD overage

50% of your annual benefits compensation, up to a maximum benefit of $12,000 per month[1]

66 2/3% of your annual benefits compensation, up to a maximum benefit of $18,500 per month

Long Term Disability is a core benefit. For more information - refer to the "Core Coverage" section of this document.

The amount of your LTD benefit will be based on the level of coverage you choose and your annual benefits compensation at the time you initially become disabled. Your monthly benefit will never be less than the minimum monthly benefit of $50. If you receive benefits for less than a month, you will receive 1/30 of the monthly benefit for each day you were disabled. However, your LTD benefits will be reduced by any income you receive from other sources, such as Social Security, Workers' Compensation, State Disability Insurance (SDI), and Voluntary Disability Insurance (VDI). Your LTD premiums are based on the coverage level you choose, your age as of January 1 and your annual benefits compensation.

Long Term Disability (LTD): Pre-Tax vs. After-Tax Coverage

You may enroll in either pre-tax or after-tax LTD coverage. If you enroll in pre-tax LTD, your payroll deductions are not taxed. However, if you become eligible to receive LTD benefits, the compensation paid to you will be fully taxable. If you enroll in after-tax LTD, your benefits will generally not be taxed in the future because you've already paid taxes on your payroll contributions. Enrolling in after-tax LTD maximizes the net benefit amount you receive in the event of a long-term disability. The premium for coverage is based on a monthly rate set by the insurance company. This rate is applied to your benefit coverage level.

An IRS rule known as the "three-year look back" will be used to determine the tax treatment of your LTD Benefits. This provision applies if you switch your election from pre-tax to after-tax, or vice versa, within a three-year period.

PRE TAX OR POST TAX PREMIUMS?
Paying for LTD premiums pre-tax will result in taxable LTD benefits.
Your LTD benefits will NOT be taxed if you pay your premium after-tax.

Long Term Disability (LTD) Selection Considerations

- How much income would you and your family need if you were to become disabled and unable to work?
- What are your current short/longer term financial resources? Do you have other insurance outside of Oracle?
- Are you prepared to pay income taxes on disability compensation you receive?
- Choosing pre-tax coverage may reduce the amount of your LTD benefit because they will be taxed.

Life Insurance

Quick Links: Certificate of Coverage | Summary Plan Description | US Benefits Website – Life/AD&D

Oracle offers you pre-tax and supplemental after-tax life insurance coverage that pays benefits to help meet your financial obligations in the event of your death.

Life insurance is a core benefit and you are required to purchase a minimum amount of coverage for yourself. For more information - refer to the "Core Coverage" section of this document. You also have the option to purchase after-tax life insurance coverage for your spouse/domestic partner, your children, and your domestic partner's children.

Premiums for children are based on a flat rate and the coverage level you choose. Plan premiums for you and your spouse/domestic partner are based on the insured's age and the coverage level you choose. Rates will increase as you age and move from one insurance age band to another (See Insurance Age Bracket Table). It is recommended that you review your insurance cost each year during the annual Open Enrollment period.

In the event of death, benefits will be paid to your designated beneficiary. You are automatically the beneficiary for your dependents. If your dependent dies while covered by the plan, benefits will be paid to you.

Employee Pre-Tax Life Insurance

Oracle offers you the choice of two levels of pre-tax life insurance coverage:

- $10,000 (minimum required - core coverage)
- $50,000

» SELECT & MAINTAIN YOUR BENEFICIARIES

It is important that you select and keep your beneficiary information current. You may submit or update your Life/AD&D insurance beneficiary information in the Oracle US Benefits Enrollment System. Health Savings Account (HSA) beneficiary designation can be made directly with Optum Bank.

INSURANCE AGE BRACKETS

< 30 years old	50-54 years old
30-34 years old	55-59 years old
35-39 years old	60-64 years old
40-44 years old	65-69 years old
45-49 years old	70+ years old

» **Important Note About Your Cost**: Your premium costs will increase when your annual benefits compensation increases and/or when you move to a new insurance age bracket. Be sure to access the **Oracle US Benefits Enrollment System** each year to view costs specific to you.

After-Tax Life Insurance
You may elect coverage for yourself and your eligible dependents, including your spouse/domestic partner and children.

After-Tax Life Insurance Coverage for You
Upon initial eligibility (e.g., new hire), you may choose from 1 times to 6 times your annual benefits compensation of after-tax life insurance coverage for yourself. The maximum combined pre-tax and after-tax life insurance you may purchase for yourself is $2,550,000. Upon initial eligibility (e.g. new hire) evidence of insurability is not required for any level of life insurance. You may also increase your coverage by one level during the annual Open Enrollment Period and as a result of certain qualified family status change events.

Life Insurance Coverage for Your Spouse/Domestic Partner
Upon initial eligibility (e.g., new hire), you may choose from the following levels of after-tax life insurance coverage for your spouse or domestic partner:

- $5,000
- $25,000
- 50% of 1 times to 6 times your annual benefits compensation

Life insurance coverage for your spouse/domestic partner is limited to 50% of your after-tax employee life insurance (or pre-tax employee life insurance if you do not elect after-tax) coverage or $500,000; whichever is less. Upon initial eligibility (e.g. new hire) evidence of insurability is not required for any level of life insurance. You may also increase your coverage by one level during the annual Open Enrollment Period and because of certain qualified family status change events.

DOUBLE COVERAGE	**If your spouse/domestic partner is an Oracle employee covered under his or her own employee life insurance coverage, you may choose to "double cover" him or her. The combined maximum amount of coverage is $2,550,000 collectively.**

LIFE INSURANCE COVERAGE FOR YOUR CHILDREN
Upon initial eligibility (e.g., new hire or the birth of your first and only child), you may choose from the following levels of after-tax life insurance coverage for your eligible child(ren):

- $2,500
- $10,000
- 25% of 1 times to 6 times your annual benefits compensation

The election you choose covers all of your eligible children. Life insurance coverage for your children is limited to 25% of your after-tax employee life insurance (or pre-tax employee life insurance if you do not elect after-tax) coverage or $250,000; whichever is less. You may elect coverage for your, and/or your domestic partner's children from birth to 21 years or to 23 years if they are full-time students (to age 25 in Texas). Expanded coverage for adult children (age 26) applicable to health coverage does not apply to life insurance. It is your responsibility to remove ineligible dependents from coverage. Upon initial eligibility (e.g. new hire, gain of your first (and only) child) evidence of insurability is not required for any level of life insurance. After initial eligibility – you may also increase your coverage by one level during the annual Open Enrollment Period and as a result of certain qualified family status change events – without evidence of insurability.

Life Insurance and AD&D Selection Considerations

- What expenses would your family or other beneficiary have if you were to die or become seriously injured in an accident?
- What financial resources would they need on a short- and long-term basis?
- What level of protection do you want to provide through your insurance?
- What expenses would you or your family incur if your spouse/domestic partner or child(ren) were to die?
- What other insurance do you have outside of the Oracle life insurance plan?

Accidental Death and Dismemberment (AD&D) Insurance

Quick Links: Certificate of Coverage | Summary Plan Description | US Benefits Website – Life/AD&D

Oracle offers you Accidental Death and Dismemberment (AD&D) coverage that pays benefits to you or your beneficiaries if you die or sustain certain serious injuries in an accident. AD&D insurance is a core benefit and you are required to purchase a minimum amount of AD&D coverage for yourself. For more information - refer to the "Core Coverage" section of this document. AD&D Plan premiums are based on the dollar amount of the coverage level you choose. Your spouse/domestic partner or child(ren) are not eligible for AD&D insurance coverage. The plan pays benefits to you or your beneficiaries as shown below.

IF YOU ...	AD&D PLAN PAYS
Die	100% of your coverage amount
Lose both hands, both feet, sight in both eyes, or any combination of the above	100% of your coverage amount
Lose one hand, foot, or sight in one eye	50% of your coverage amount

Upon initial eligibility (e.g. new hire), you may choose from the following AD&D coverage levels for yourself:

- $10,000 (core coverage)
- $50,000
- 1 times to 6 times your annual benefits compensation

The maximum AD&D coverage you may purchase for yourself is $2,550,000. Upon initial eligibility (e.g. new hire) evidence of insurability is **NOT** required for any level of AD&D insurance. You may also increase your coverage by one level during the annual Open Enrollment Period and as a result of certain qualified family status change events without evidence of insurability.

Additional Benefits: Coverage includes additional benefits at no extra charge including the following.
Review the **Certificate of Coverage** for details.

Child Care Benefit: Additional amount to attend a licensed Child Care Center

Child Education Benefit: Additional benefit equal to the tuition charges for each eligible dependent child to attend college or another accredited institution

Spouse Education Benefit: Tuition charges for 1 academic year

Travel Assistance and Identify Theft Solutions: Medical assistance while traveling, emergency medical evacuation, help with lost documents and credit cards, identity theft guidance

Health & Dependent Care Flexible Spending Accounts (FSA)

Quick Links: Summary Plan Description | www.myuhc.com | FAQs | IRS Publication 502 | Benefits US Website – FSA

Oracle offers three pre-tax FSA options administered by United Healthcare:

- General Purpose Health Care Flexible Spending Account (FSA)
- Limited Purpose Health Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)

Separate Accounts

Eligible healthcare expenses for you and your dependents are covered under the Health Care FSA. The Dependent Care FSA covers qualified childcare or elder care expenses. The accounts are separate— you cannot transfer money from one reimbursement account to the other.

Eligible Expenses

Only expenses incurred during the plan year and while you are an active participant under the plan are eligible for reimbursement. This means you may not submit expenses that were incurred for the current plan year while not actively participating, even if you enroll at a later time during the year.

Effective Date

Your benefits begin on your enrollment effective date (e.g. new hire date or January 1 if enrolled during Open Enrollment). This means that your "annual" reimbursement account contribution covers expenses incurred on your effective date through December 31. Should you become ineligible prior to the end of the year (e.g. termination) expenses must be incurred prior to your ineligibility date.

Use It or Lose It (Dependent Care FSA)

According to the IRS's "Use it or Lose it" rule, if your eligible dependent care expenses for the calendar year (January 1 – December 31) is less than your account balance you will forfeit the unused balance. Your unused balance cannot be paid back to you or carryover into the next year. Plan your expenses carefully! All funds left in your Dependent Care FSA at the end of the plan year will be forfeited. You may not carry over balances from year to year or receive a refund of unused amounts. You may submit claims until March 31st of the following year for expenses incurred during the preceding plan year ending December 31st.

Carryover Provision (General and Limited Purpose Health Care FSAs)

In October 2013, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) modified the "Use It or Lose It" rule which has historically required any leftover balance in a General or Limited Purpose Health Care FSA to be forfeited at the end of each plan year. Under the new rule you may carryover up to $500 of your unused money to the following year. This change does not apply to Dependent Care FSA.

You may carryover up to $500 of your unused Health Care FSA money into the next plan year. This means that any unused balance (up to $500) can be used to pay for eligible expenses incurred in subsequent years. The carryover applies to the General Purpose and Limited Purpose Health Care FSA only. It does not apply to Dependent Care FSA.

Taxes

You may not claim a tax deduction for any expenses reimbursed from your Health Care FSA. You may use the General Purpose Health Care FSA to pay for any health care expenses considered tax-deductible by the IRS, except for health insurance premiums in certain circumstances. If you pay for expenses through the General Purpose Health Care FSA, you may not take a tax deduction for those expenses. Please consult with your tax advisor for details.

Flexible Spending Account Elections Do Not Carry Over Each Year

You must make an active election during Open Enrollment in order to participate in a Flexible Spending Account for the following year.

Payment & Reimbursement Options

You have several ways to access your account(s) to pay for or obtain reimbursement for your eligible expenses.
MasterCard Debit Card: Pay for eligible expenses at the point of service/sale. Due to IRS rules, some purchases may require you to submit receipts to UHC
Online Claim Submission: Access www.myuhc.com and submit reimbursement claim(s) online
Printed Claim Form: Forms are available on www.myuhc.com or on the Oracle US Benefits Website

General Purpose Health Care FSA

The General Purpose Health Care FSA allows you to use pre-tax dollars to pay for eligible health care expenses incurred by you or any person whom you claim as a dependent on your federal tax return and who receives more than 50% of financial support from you during the plan year. You may contribute up to $2,650 each plan year to a General Purpose Health Care FSA.

General Purpose Health Care FSA - Eligible Expenses

You may use the Health Care FSA to pay for any eligible health care expenses as defined by the IRS. The following is a partial list of expenses eligible for reimbursement. A more comprehensive list of eligible expenses are contained in **IRS Publication 502** entitled Medical and Dental Expenses.

Partial list of eligible expenses	» Acupuncture » Alcoholism treatment » Ambulance » Artificial limbs » Braille books/magazines » Car controls for the disabled » Chiropractors » Coinsurance » Crutches » Deductibles » Dental » Dentures » Drug/Medical Supplies	» Eyeglasses & Exams » Hearing devices and batteries » Hospital » Insulin » Laboratory » Nurse » Obstetrics » Orthodontia » Orthopedic care » OTC drugs (prescribed by MD) » Physicians » Psychiatric care » Psychologist care	» Radial keratotomy surgery » Non-diagnostic services » Seeing-eye dog & maintenance » Special education for the blind » Surgical fees » Phone equipment for the deaf » Therapy for alcohol/drug addiction » Therapy Treatments » Tuition for special schools Wheelchair » Wigs (medically necessary) » X-rays

Health Care FSA Expenses NOT eligible for reimbursement include:

- Childcare or elder care expenses
- Cosmetic treatment, surgery or supplies (unless to correct a congenital deformity or injury)
- Health Club/Gym Membership Fees
- Health plan insurance premiums (including COBRA premiums)
- Over-the-counter drugs (unless prescribed by a physician)
- Social activities, such as dance lessons (even if recommended by physician)
- Vitamins
- Weight-loss and stop-smoking programs (unless medical necessary as determined by physician and health plan)

Limited Purpose Health Care FSA

The Limited Purpose Health Care FSA works similarly to the general purpose account, however, reimbursements are restricted to eligible dental and vision expenses. It allows you to use pre-tax dollars to pay for these eligible expenses incurred by you or any person whom you claim as a dependent on your federal tax return and who receives more than 50% of financial support from you during the plan year. You may contribute up to $2,650 each plan year to a Limited Purpose Health Care FSA. You are eligible to contribute to the Limited Purpose Health Care FSA ONLY if you enroll in the UHC HSA Medical plan which consists of a qualified High Deductible Health Plan (HDHP) and Health Savings Account (HSA).

HEALTH CARE FSA - AUTOMATIC REIMBURSEMENT

If you enroll in a UHC medical plan, dental plan, or vision plan and you are also participating in the Health Care FSA, all eligible expenses not paid by the medical, dental, or vision plans will automatically be processed as a claim and reimbursed to you. If you do not want automatic reimbursement under the Health Care FSA, you must access www.myuhc.com and "opt out" of this feature.

HEALTH CARE FSA ENROLLMENT CONSIDERATIONS

- How much will you spend in eligible health care expenses?
- If you're already participating, will the goal amount you've elected this year make sense for the next year? If not, be sure to make a change to your election during Open Enrollment because your elections will automatically continue each year unless you choose otherwise
- Remember the carryover rule – any unused monies not to exceed $500 can be used in subsequent years.
- HSA Medical Plan enrollees may consider the Limited Purpose Health Care FSA. It allows you to save more on a pre-tax basis. Also, you can use the account for planned dental and vision expenses and reserve your Health Savings Account (HSA) for medical expenses only.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to use pre-tax dollars to pay for eligible dependent care expenses (childcare or elder care) you incur during the plan year if you (or you and your spouse) need these services to allow you to work. You are eligible to enroll if you have an eligible dependent and if you fall into one of the following categories:

- You are a working single parent
- You and your spouse both work
- Your spouse is a full-time student for at least five months of the plan year
- Your spouse is mentally or physically disabled and unable to care for himself or herself or your dependent

The IRS maximum contribution each plan year is $5,000. The actual amount you can contribute to a Dependent Care FSA depends on your family situation and tax filing status.

Dependent Care FSA Contributions

if you are…	you may contribute up to…
A working single parent	$5,000 per year
Married and filing a joint tax return and spouse does not have access to a Dependent Care FSA	$5,000 per year
Married and filing a joint tax return and spouse is a student or disabled	$3,000 per year for one dependent or $5,000 per year for two or more dependents
Married and filing separate tax returns	$2,500 per year
Married and your spouse earns less than $5,000 per year	The amount of your spouse's annual income
Married to another Oracle employee	$5,000 per year combined

You also have the option to take a federal tax credit for dependent care expenses instead of using a Dependent Care FSA. You should consult with a tax advisor to determine which method is best for you.

Eligible dependents for the purposes of this account must be claimed as dependents on your federal tax return and be:

- Under age 13
- Mentally or physically unable to care for himself or herself, regardless of age, which may include children over the age of 13, Disabled spouse, or older relative
- Incapacitated elderly adult who lives with you at least eight hours per day

ELIGIBLE Dependent Care FSA Expenses Include:

- Care at a day care facility
- In-home baby-sitting services
- Day camp (e.g., summer camp)
- Before-school and after-school care
- Practical nursing care for an adult

INELIGIBLE Dependent Care FSA Expenses Include:

- Medical or healthcare expenses
- Any amounts paid to provide food, clothing or education
- Services outside your home at a camp where your child or disabled spouse or dependent stays overnight
- Transportation to and from the place where care is provided
- Training and travel expenses for childcare provider

If the dependent care provider is your own child or relative, your expenses are eligible for reimbursement only if the provider is at least age 19 before the end of the plan year in which claims are incurred. The provider also cannot be claimed as a dependent on your income tax return. You are also required to report the name, address and Social Security Number or Tax Identification Number of your dependent care providers on your federal tax return. Otherwise, the amount of your reimbursements will become taxable income and will be reported on your W-2.

Dependent Care FSA Enrollment Considerations

- How much will you spend in the plan year for dependent care expenses? Don't forget day care, nursery school, after-school programs, and summer care that are likely to come up during the year.
- Will your dependent child turn 13?
- Compare the advantages of the Dependent Care FSA with the federal dependent care tax credit and similar tax credits to see which approach provides the greatest tax advantage.
- If you're already participating, will the goal amount you elected this year make sense for the new plan year? If not, be sure to make a change to your election during the annual US Benefits Open Enrollment period
- Should the cost of your care change over the course of the year – you may report a **qualified status change event** and modify your election. Keep in mind that changes made are done so on a prospective basis.

PLAN YOUR FSA ELECTIONS CAREFULLY

No Automatic Re-Enrollment: Healthcare and Dependent Care Flexible Spending Account (FSA) elections will not automatically roll-over into the new year. You must enroll during Open Enrollment of each year if you want to continue your elections.

"Use it or Lose it": Plan your expenses carefully! All funds left in your Dependent Care FSA at the end of the plan year will be forfeited. You may not carry over balances from year to year or receive a refund of unused amounts. You may submit claims until March 31st of the following year for expenses incurred during the preceding plan year ending December 31st.

Carryover Provision: On October 31, 2013, the U.S. Department of the Treasury modified the "Use It or Lose It" rule which has historically required any leftover balance in a **General or Limited Purpose Health Care FSA** to be forfeited at the end of each plan year. Under the new rule you will now be able to carryover up to $500 of your unused money to the following year. This change does **NOT** apply to Dependent Care FSA.

Verify Expenses: Before enrolling in the Health or Dependent Care FSA, confirm the expenses you plan to incur are eligible for reimbursement. Certain information in IRS Publication 502 may not be applicable, since some of the laws governing health care FSA plans are different from the laws governing medical expense deductibility.
For example, insurance premiums and certain long term care expenses are not eligible for reimbursement from the General and Limited Purpose Health Care FSA even though these expenses may qualify as deductible medical expenses as explained in IRS Publication 502. If you have any questions regarding what qualifies as an eligible expense, contact United Healthcare at 1.866.672.2511.

Legal Insurance

At Oracle, we want you to embrace life's opportunities with fewer worries. That's why we're excited to provide you with UltimateAdvisor® legal insurance from ARAG®. It's affordable and reliable legal counsel for everyday life matters – like a dispute with a contractor, buying or selling a home or the need for estate planning. The plan also includes Identify theft protection, revocable trusts, family law and tax services. The plan provides you with the peace of mind knowing that attorney fees for most covered legal matters are 100% paid in full when you work with a Network Attorney. You and your eligible dependent(s) may use this plan to protect yourselves from everyday legal issues – and the high cost of attorney fees. This voluntary program is a 100% employee paid benefit with premiums deducted from your paycheck on an after tax basis. Your per pay period cost is reflected on the **Oracle US Benefits Enrollment System**.

Resolve Your Legal Issues with a Network Attorney In-Office

ARAG will be there for you, backed by a nationwide network of more than 9,300 credentialed attorneys. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court. For any legal matters not covered and not excluded, you can still receive at least 25% off the normal Network Attorney's normal rates (including Immigration Assistance). Contact ARAG for more details.

Call a Network Attorney for Legal Assistance

Get assistance from Network Attorneys and an award-winning Customer Care Center over the phone. You'll also benefit from Financial Education and Counseling Services for a wide range of financial topics – cash and debt management, budgeting, retirement planning, federal tax information and more – from a certified Financial Counselor.

Visit the ARAG Legal Insurance Website and Learn More About Your Everyday Legal Issues

Your path to legal protection starts with easy-to-use online resources at to help you handle legal issues on your own, including DIY Docs®, Online Financial Tools, Guidebooks and hundreds of articles to help you learn more about everyday legal issues.

Identity Theft Protection provides an even stronger front line of defense against identity theft with:

- **Identity Theft Insurance:** Coverage up to $1 million for expenses associated with restoring your identity**
- **Full-Service Identity Restoration:** Specialists will guide you to clear your name and restore your identity.
- **Lost Wallet Services:** Specialists will help you cancel and reissue credit cards, driver's license, etc.
- **Credit Monitoring**: Monitors and informs members of changes to their credit report.
- **Internet Surveillance:** Monitors websites and other data points to alert you if personal information is being traded
- **Child Monitoring:** Monitors your minor's identity to alert you if their personal information is being traded and/or sold.

Exclusions

Most personal and consumer related legal matters are covered by the Legal Plan. However, any legal matter that occurs or is initiated before the effective date of your coverage will be excluded and no benefits will apply. ARAG excludes matters against ARAG and/or Oracle.

Additional Information and Questions

Visit the **ARAG Legal Insurance Website** to learn more about what these plans offer, research specific legal topics and more. You may also call 800-247-4184 to speak with an ARAG Customer Care Specialist.

Personal Financial Planning Services

Oracle is pleased to offer an extensive financial planning benefit to help you with the complexities of personal financial planning. This voluntary program is a 100% employee paid benefit with premiums deducted from your paycheck on an after tax basis. Your per pay period cost is reflected on the **Oracle US Benefits Enrollment System**.

The *Money in Motion*® Personal Finance Program, provided by The Ayco Company, L.P., a Goldman Sachs Company, provides both personalized telephonic and digital planning resources and includes:

- Unlimited access to the *Ayco AnswerLine*® service
- Online planning tools via the Ayco Financial Network website
- Personalized reports for retirement, investments and college funding
- E-subscriptions to the *Updates* newsletter and Monthly Money Map action series

The Ayco AnswerLine® service

Toll-free and provides direct and confidential access to a professional financial counselor. It is not an automated response system. One-on-one counseling helps you establish financial goals and take informed action to reach them. Ayco's financial counselors provide you with unbiased information. They do not represent financial products or investments, and are not paid by commission. Ayco's counselors are also knowledgeable about Oracle's benefit plans and can assist you with understanding your benefits and integrating them into your overall financial plan.

The Ayco Financial Network – Interactive Financial Planning Website

Access the ***Aycofn*® website** where you'll find tools and resources to help you take control of your financial planning, including:

Ayco360 – Easy-to-use tools to link your accounts, organize your finances, and track your spending patterns.
5 Minute Financial Checkup – answer a short series of questions to identify your financial strengths and weaknesses
MyLearning Center – improve your financial health at your own pace with a collection of multimedia content
Helpful easy-to-use calculators for financial modeling and projections
Educational materials on cash flow, debt management, investments, estate planning, insurance, education funding, tax planning, and more

http://www.aycofn.com/oracle.mim
1-800-348-2093

Health Care Reform

Quick Links: Oracle's Health Care Reform Website | Marketplace Notice | FAQs | HealthCare.Gov

Understanding the health care landscape is the key to understanding how Oracle manages your benefits. Health Care Reform impacts all of us on some level and we understand the importance for all of you to be informed.

Visit the **Oracle US Benefits Website** and check general information regarding Health Care Reform. The information provided does not include every provision of the law and focuses on key events that directly impact Oracle sponsored health benefits. The information will change as the Health Care Reform law develops and policies are established so please check back regularly to obtain the most recent information.

DID YOU KNOW?
Oracle's medical plans meet Health Care Reform's minimum standards with respect to comprehensive coverage and affordable cost. If you and your eligible dependent(s) enroll in one of Oracle's medical plans, you meet the requirements of the Individual Mandate Law.

Maximize Your Benefits

Taking time to learn, make informed selections, and using your benefits wisely are ways you can stay healthy and manage costs for yourself and for Oracle.

Take care of yourself: The best way to keep your healthcare costs down is to stay as healthy as possible. You can't control heredity, but you can control what you do about your individual risk factors.

Learn what is treatable without a physician: Did you know that the majority of health problems are cared for in the home? Know how to recognize common health problems, what to do when they occur, when and where to seek help, and how to prevent them in the first place.

Use provider websites to find answers to your questions: Oracle's health program vendors host websites that contains a wealth of health information. Click here to access a list of Oracle's program contacts and websites.

Access 24/7 Nurseline services: Utilize the 24/7 Nurseline services available as a starting point for health care information rather than visiting your physician or the emergency room.

Leverage Telemedicine: Use the power of technology and mobile devices as a convenient and less costly way to access care. While telehealth services are not a complete replacement for all of your health care needs, this approach addresses most common ailments. Using online devices such as your lap top, mobile phone, or tablet, your physician can review your history, answer your questions and at their discretion diagnose, treat, and in most states prescribe medication and electronically submit a prescription fill to the pharmacy of your choice. Go to - **https://oracle.amwell.com/home.htm** for more information.

Visit emergency rooms only in true medical/life threatening emergencies: Unless you have a life/limb threatening condition think about using Urgent Care Centers or your general physician if acute treatment is not required. Calling the 24/7 Nurseline services is another option to help you determine suitable treatment options.

Save time and money by using mail order: Buy ongoing maintenance prescription drugs by mail. Using mail order programs can reduce your cost and provides the convenience of having medications delivered to your home - saving you a trip to the retail pharmacy.

Consider Tier 1/Generic medications: Instead of automatically purchasing a brand-name medication, ask your physician if a generic equivalent is available. Generic equivalent medications contain the same active ingredients and are subject to the same rigid Federal Drug Administration standards for quality, strength and purity as their brand-name counterparts. Choosing lower cost Tier 1 or generic medications (if available and appropriate for your condition) can effectively treat your condition and save you money.

Select network physicians and service providers: Remember, you pay less when you use network providers. When you and your family use these providers, you save money because network providers have agreed to accept negotiated rates for their services and you pay a lower portion of coinsurance.

Take advantage of preventive screenings, check-ups and online wellness resources information: All of Oracle's medical plan offerings provide coverage for preventive care. Eligible network preventive care services are covered at 100%.

Get to know your plan: Become familiar with your plan and use the features that help you prevent illness or manage your current condition.

Follow through on your physician's prescribed course of treatment: Compliance with your physician's treatment can help you experience better medical outcomes.

Take advantage of tax savings opportunities: Pay for eligible expenses using pre-tax dollars. Enroll in the General Purpose Health Care FSA (or Limited Purpose Health Care FSA if you elect the UHC HSA Medical Plan).

Notice of Privacy Practices

Oracle is committed to protecting the privacy and security of your personal information. The **Oracle Benefits Health Insurance Portability and Accountability Act Notice** (HIPAA Notice) satisfies HIPAA's requirement that a group health plan, such as the Oracle America, Inc. Flexible Benefit Plan, provide notice to individuals whose protected health information (PHI) will be used or maintained by the group health plan.