This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://resources.hewitt.com/siemens or by calling **1-800-392-7495**. Additionally, you can contact Anthem Blue Cross and Blue Shield at **1-855-869-8137** or UnitedHealthcare at **1-866-221-5901**, as applicable.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,400** individual/**$3,500** family in-network; **$2,100** individual/**$5,250** family out-of-network (includes Mental Health and Substance Abuse). **$450** individual or **$900** individual plus spouse or domestic partner is contributed to your HRA by Siemens. Additional funding is available via earned Healthy Rewards.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. In-network and out-of-network deductibles are separate. Expenses applied to the in-network deductible are not applied to the out-of-network deductible. Expenses applied to the out-of-network deductible are not applied to the in-network deductible. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,700** individual/**$10,000** family in-network; **$4,700** individual/**$14,000** family out-of-network (includes deductible, copays, Mental Health and Substance Abuse).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. In-network and out-of-network out-of-pocket limits are separate. Expenses applied to the in-network limit are not applied to the out-of-network limit. Expenses applied to the out-of-network limit are not applied to the in-network limit.
What is not included in the out–of–pocket limit?	**Premiums**, prescription drugs (separate limit applies), services deemed not **medically necessary**, penalties for non-compliance, charges over the maximum **allowed amount**, balance-billed charges, and health care this plan option doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.anthem.com** or call **1-855-869-8137**, or **www.myuhc.com** or call **1-866-221-5901**, as applicable.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay; 15% coinsurance for other medical expenses	35% coinsurance	Coinsurance applied to deductibles and annual out-of-pocket limits. No cross-application of deductibles and out-of-pocket maximum between in-network and out-of-network benefits.
If you visit a health care provider's office or clinic	Specialist visit	$40 copay; 15% coinsurance for other medical expenses	35% coinsurance	Coinsurance applied to deductibles and annual out-of-pocket limits. No cross-application of deductibles and out-of-pocket maximum between in-network and out-of-network benefits.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	15% coinsurance for chiropractor and acupuncture	35% coinsurance for chiropractor and acupuncture	Combined in-network and out-of-network limit per calendar year: chiropractor (25 days); acupuncture (18 visits); subject to medical review.
	Preventive care/screening/ immunization	No charge	35% coinsurance	Subject to federal health care reform guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance if independent lab or outpatient hospital; no charge in physician office	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance if independent lab or outpatient hospital; No charge in physician office	35% coinsurance	Preauthorization may be required; limitations may apply.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**	Generic drugs	10% coinsurance	100%. You are reimbursed in-network cost after your submitted claim is approved.	Up to 30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,000 individual/$3,000 family out-of-pocket maximum.
	Preferred brand drugs	30% coinsurance (minimum $20 at retail or $40 for mail order)	100%. You are reimbursed in-network cost after your submitted claim is approved.	30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,000 individual/$3,000 family out-of-pocket maximum.
	Non-preferred brand drugs	45% coinsurance (minimum $35 at retail or $70 for mail order)	100%. You are reimbursed in-network cost after your submitted claim is approved.	30-day supply at retail (limit one refill, then mandatory mail order); 90-day supply for mail order. $2,000 individual/$3,000 family out-of-pocket maximum.
	Specialty drugs	10% coinsurance	100%. You are reimbursed in-network cost after your submitted claim is approved.	30-day supply limit. For eligible drugs only. $2,000 individual/$3,000 family out-of-pocket maximum.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	None
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	Must be true medical emergency. If not, you are charged 100%.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Must be true medical emergency.
	Urgent care	$35 copay	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Preauthorization required.
	Physician/surgeon fee	15% coinsurance	35% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay for individual therapy; $10 copay for group therapy; all other services 15% coinsurance	35% coinsurance	None
	Mental/Behavioral health inpatient services	15% coinsurance	35% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	$25 copay for individual therapy; $10 copay for group therapy; all other services 15% coinsurance	35% coinsurance	None
	Substance use disorder inpatient services	15% coinsurance	35% coinsurance	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	$40 copay initial visit only, then 15% coinsurance for subsequent visits	35% coinsurance	None
	Delivery and all inpatient services	15% coinsurance	35% coinsurance	Hospital notification required; newborns must be enrolled in coverage within 30 days of their date of birth.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 90 visits per calendar year; no prior hospitalization is required.
	Rehabilitation services	15% coinsurance	35% coinsurance	Physical and occupational therapy combined in-network and out-of-network limit of 60 visits per calendar year. Speech therapy combined in-network and out-of-network limit of 60 visits per calendar year. Subject to medical necessity and ongoing improvement.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 60 days per calendar year; must be precertified.
	Durable medical equipment	15% coinsurance	35% coinsurance	Limitations apply. Preauthorization may be required.
	Hospice service	15% coinsurance	35% coinsurance	Preauthorization required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental and eye care (Child)
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (except nutritional counseling)

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (limitations apply)
- Bariatric surgery (if determined to be medically appropriate by claims administrator)
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if determined to be medically appropriate by claims administrator; limitations apply)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-392-7495. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross and Blue Shield at P.O. Box 105568, Atlanta, GA 30348 or UnitedHealthcare at P.O. Box 740800, Atlanta, GA 30374.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-392-7495.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-392-7495.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,298
- **Patient pays** $3,242

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles (mother + baby)	$2,300
Copays	$40
Coinsurance	$752
Limits or exclusions	$150
Total	**$3,242**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,090
- **Patient pays** $2,310

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,100
Copays	$ 130
Coinsurance	$1,000
Limits or exclusions	$80
Total	**$2,310**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs assume Individual only coverage. Newborn is enrolled in coverage within 30 days of birth.
- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.