




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to [mySiemensBenefits.com](http://mySiemensBenefits.com) or call 1-800-392-7495. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/SBC-GLOSSARY/> or call 1-800-392-7495 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$1,500</b> individual / <b>\$3,700</b> family in-network; <b>\$2,250</b> individual / <b>\$5,550</b> family out-of-network. <b>\$400</b> individual or <b>\$800</b> individual plus spouse or domestic partner is contributed to your HRA by Siemens. Additional funding is available via earned Healthy Rewards. The maximum HRA balance that can roll over from year to year is \$4,000.</p>	<p>You must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services you use. In-network and out-of-network <a href="#">deductibles</a> are separate. Expenses applied to the in-network <a href="#">deductible</a> are not applied to the out-of-network <a href="#">deductible</a>. Expenses applied to the out-of-network <a href="#">deductible</a> are not applied to the in-network <a href="#">deductible</a>. Check your policy or plan document to see when the <a href="#">deductible</a> 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 <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes, in-network preventive care.</p>	<p>This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No. There are no other specific deductibles.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>\$3,700</b> individual / <b>\$10,000</b> family in-network; <b>\$4,700</b> individual / <b>\$14,000</b> family out-of-network (includes deductible).</p>	<p>The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> 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.</p>

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of preferred providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-855-869-8137, or <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-221-5901, as applicable.	If you use an in-network doctor or other health care <a href="#">provider</a> , 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 <a href="#">provider</a> for some services. <a href="#">Plans</a> use the term in-network, <a href="#">preferred</a> , or participating for <a href="#">providers</a> in their <a href="#">network</a> . See the chart starting on page 2 for how this <a href="#">plan</a> pays different kinds of <a href="#">providers</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a specialist.	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	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.
	<a href="#">Specialist</a> visit	15% coinsurance	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.
	<a href="#">Preventive care/screening/immunization</a>	No charge	35% coinsurance	Subject to federal health care reform guidelines.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Preauthorization may be required; limitations may apply.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [mySiemensBenefits.com](http://mySiemensBenefits.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	10% coinsurance (minimum of \$5 at retail or \$10 for mail order)	100%. You are reimbursed 90% of 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. \$2,300 individual/\$3,500 family out-of-pocket maximum. Certain preventive medications are covered at 100%.
	Preferred brand drugs	30% coinsurance (minimum \$20 at retail or \$40 for mail order)	100%. You are reimbursed 70% of 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. \$2,300 individual/\$3,500 family out-of-pocket maximum.
	Non-preferred brand drugs	45% coinsurance (minimum \$35 at retail or \$70 for mail order)	100%. You are reimbursed 55% of 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. \$2,300 individual/\$3,500 family out-of-pocket maximum.
	<a href="#">Specialty drugs</a>	10% coinsurance	100%. You are reimbursed 90% of in-network cost after your submitted claim is approved.	30-day supply limit. For eligible drugs only. \$2,300 individual/\$3,500 family out-of-pocket maximum.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	None
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	15% coinsurance	15% coinsurance	Must be true medical emergency. If not, you are charged 100%.
	<a href="#">Emergency medical transportation</a>	15% coinsurance	15% coinsurance	Must be true medical emergency.
	<a href="#">Urgent care</a>	15% coinsurance	35% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Preauthorization required.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
<b>If you need mental</b>	Outpatient services	15% coinsurance	35% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, behavioral health, or substance abuse services	Inpatient services	15% coinsurance	35% coinsurance	Preauthorization required.
	Office visits	15% coinsurance	35% coinsurance	None
If you are pregnant	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	Hospital notification required; newborns must be enrolled in coverage within 30 days of their date of birth.
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	Hospital notification required; newborns must be enrolled in coverage within 30 days of their date of birth.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 90 visits per calendar year; no prior hospitalization is required.
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	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.
	<a href="#">Skilled nursing care</a>	15% coinsurance	35% coinsurance	Combined in-network and out-of-network limit of 60 days per calendar year; must be precertified.
	<a href="#">Durable medical equipment</a>	15% coinsurance	35% coinsurance	Limitations apply. Preauthorization may be required.
	<a href="#">Hospice services</a>	15% coinsurance	35% coinsurance	Preauthorization required.
If your child needs	Children's eye exam	Not covered	Not covered	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental and eye care (Child).</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs (except nutritional counseling)</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>• Acupuncture (limitations apply)</li> <li>• Bariatric surgery (if determined to be medically appropriate by claims administrator)</li> <li>• Chiropractic care (limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (limitations apply)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (if determined to be medically appropriate by claims administrator; limitations apply)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.hhs.gov](http://www.hhs.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: UnitedHealthcare at P.O. Box 740800, Atlanta, GA 30374 or Anthem Blue Cross Blue Shield at P.O. Box 105187, Atlanta, GA 30348-5187.

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-395-7495.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [mySiemensBenefits.com](http://mySiemensBenefits.com).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-395-7495.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[cost sharing\]](#) 15%
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) 15%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,645
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,205</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[cost sharing\]](#) 15%
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) 15%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,198
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,661
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,914</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[cost sharing\]](#) 15%
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) 15%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$64
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,564</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.