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Siemens Medical Solutions USA, Inc.

Summary Plan Description

Active Employee Coverage

Including

Summary of Material Modifications

The Summary Plan Description for the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program Active Employee Coverage dated May 1, 2018, was modified by, and includes the Summaries of Material Modifications dated January 1, 2024; January 1, 2023; January 1, 2022; January 1, 2021; April 2020; March 2020; January 1, 2020; and January 1, 2019, as follows:

If you have questions about this document, call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328.**

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SIEMENS Healthineers

Care that connects.

Your choices your way.

What's inside

2024 Annual Enrollment is October 16–October 27, 2023

Connecting you and your family with the benefits to help you live well is essential. To help you make choices that meet your needs in 2024, Siemens Healthineers provides several resources that let you explore your options, including what is new for next year.

We encourage you to read the following information as you get ready to enroll for benefits.

Get your benefits news online

You are receiving this print version of the 2024 Annual Enrollment materials because you do not have a valid preferred personal email address stored on **mySHSBenefits.com**. For a preferred personal email address to be valid, it must be listed and selected as your personal preferred email address.

To receive important benefits information via email, log on to **mySHSBenefits.com** and choose your communication preference by selecting the person icon in the upper right-hand corner of the homepage and then **Manage Communications**. If you prefer, you can call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** to add your preferred email address to your account.

Resources to help you decide

Siemens Healthineers understands that healthcare coverage is an integral part of the benefits provided to you. To ensure you get the most from your benefits in 2024, the Company encourages you to use the resources provided, including the **2024 Annual Enrollment section** of **BenefitsatSHS.com**, the HSA modeler, and medical plan videos to fully understand the benefit programs available to you. You may also want to take time to estimate your healthcare spending for the year ahead and compare plan costs. If you cover a spouse or domestic partner, consider discussing your choices together so your benefits meet your needs in the coming year.

Benefits at Siemens Healthineers website

The 2024 Annual Enrollment section provides details and access to resources to help you make important decisions about your 2024 benefits. There's a lot of great information, so be sure to visit **BenefitsAtSHS.com > 2024 Annual Enrollment**.

Medical benefits videos

You have access to quick-paced, easy-to-understand medical benefits videos where you can learn about your options and the healthcare accounts available to you.

- **Understand your medical plan options:** See the differences between the Health Reimbursement and Health Savings Medical Plan options, including which healthcare accounts are available through each option.
- **Compare costs under the medical plans:** Learn how costs compare between the Health Reimbursement and Health Savings Medical Plan options. This video walks you through the out-of-pocket costs an individual may pay through life's changes—from being single, to getting married, to growing a family.
- **Get to know the healthcare accounts:** Understand the differences between the Health Reimbursement Account (HRA), the Health Savings Account (HSA), and the Flexible Spending Accounts (FSAs) so you can get the most out of your benefits in 2024.

Siemens Healthineers Benefits Center (SHBC)

Get answers to your Annual Enrollment questions through web chat, available on **mySHSBenefits.com**. Go to **Enroll in Your Benefits** or **Contact Us** to start a chat. If you have general questions about your benefits, call the SHBC at **833-935-3328**. Representatives are available online or via telephone weekdays between 10 a.m. and 6 p.m. Eastern Time.

Alight Healthcare Navigation

When you need help navigating your healthcare journey, you've got Alight Healthcare Navigation to back you up. Connect with your Health Pro for assistance with finding highly-rated in-network providers, scheduling doctor's appointments, reviewing medical bills for accuracy, and more.

Visit **mySHSBenefits.com** or call **833-935-3328** to get in touch with your Health Pro.

New! Alight Benefits Guidance

When you need added assistance for enrollment, contact an Alight Benefits Guidance counselor to help you compare plan costs, recommend appropriate plans and benefits, answer your enrollment questions, and even help you enroll.

To schedule an appointment, go to: **shs.myannualenrollment.com**.

Estimate your medical expenses

When you log on to **mySHSBenefits.com**, you'll find it easy to navigate as you make your elections. As you enroll, consider your healthcare expenses to get a comparison of your estimated out-of-pocket expenses across medical plans. Simply provide your estimated medical and prescription drug usage assumptions, and the tool does the rest.

What's new for 2024

Medical

Contributions

Per-paycheck contributions for the medical plans will increase to reflect the continuously rising cost of healthcare.

Health Savings Medical Plan: Health Savings Account contributions

The Health Savings Account (HSA) individual contribution maximum for 2024 will increase from $3,850 to $4,150, and the family contribution maximum will increase from $7,750 to $8,300. You may elect HSA catch-up contributions on mySHSBenefits.com if you are age 55 or older. Remember to elect your HSA contribution for 2024.

Health Reimbursement and Health Savings Medical Plan options—access to care

For 2024, limitations on the number of visits for outpatient occupational/physical/speech therapy and nutritional counseling provided for a mental health or substance use disorder diagnosis will be removed.

Over-the-counter hearing aids will now be covered under the Plans' hearing aid benefits.

Kaiser HMO Plan (California employees)

If you participate in the Kaiser plan in 2024, you'll notice the following changes:

- Deductible changes from $500 individual/$1,000 family to $0 individual/family.
- Office visits change from $25 primary/$40 specialist to $25 primary/$45 specialist.
- Out-of-pocket maximum changes from $5,000 individual/ $10,000 family to $1,500 individual/$3,000 family.

Healthcare Flexible Spending Account (FSA)

For 2024, the maximum amount you can contribute to the Healthcare FSA will increase from $2,850 to $3,050. The Healthcare FSA rollover amount is also increasing to $610 in 2024. Here's what this means for you in 2024 and beyond:

- December 31, 2024, is the last day you may incur claims for the 2024 plan year (January 1–December 31, 2024), but you have until May 31, 2025, to submit 2024 claims.
- Unused 2023 balances up to $610* will automatically roll over to your 2024 Healthcare FSA and be available for claims for the 2024 plan year (January 1–December 31, 2024) after May 31, 2024. Any balances over $610* will be forfeited.
- If you do not make a 2025 Healthcare FSA election but have a rollover balance, you must use your rollover funds by December 31, 2025.
- If you enroll in the Health Savings Medical Plan option for 2025, the eligible rollover amount will only be available to use in a Limited-Use Healthcare FSA for eligible 2025 dental and vision expenses.
- Any rollover amount from the 2024 Healthcare FSA plan year does not count toward the 2025 Healthcare FSA contribution limit.

You must enroll to participate in the Healthcare FSA in 2024.

**Rollover maximum may change.*

What's new for 2024 *(continued)*

Prescription Drug Coverage

PrudentRx Copay Program

Siemens Healthineers has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications on the plan's specialty drug list and exclusively dispensed by CVS Specialty are included in the program and will be subject to 30% coinsurance (subject to deductible for members enrolled in the Health Savings Medical Plan). However, members enrolled in PrudentRx who get a copay card for their specialty medication (if applicable) or who are taking a specialty medication for which no copay card is available will have a $0 out-of-pocket responsibility if enrolled in the Health Reimbursement Medical Plan, or $0 after deductible for members in the Health Savings Medical Plan, for their prescriptions covered under the PrudentRx Copay Program.

What is copay assistance?

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost-share for select medications—in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce the cost-share for eligible medications, reducing out-of-pocket expenses. Participation in the program may require certain data to be shared with the administrators of these copay assistance programs, but be assured that this is done in compliance with HIPAA.

How am I notified that I qualify for this specialty drug program?

- If you currently take one or more medications included on the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx in December that provides specific information about the program as it pertains to your medication.
- All eligible members will be automatically enrolled in the PrudentRx program, but you may call **800-578-4403** to opt out once you receive your welcome letter.
- Some manufacturers require you to sign up to take advantage of the copay assistance they provide for their medications—in that case, you must speak to someone at PrudentRx at **800-578-4403** to provide any additional information needed to enroll in the copay program. PrudentRx will proactively contact you to initiate this process.
- PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full amount of the 30% coinsurance (subject to deductible in the Health Savings Medical Plan) on specialty medications that are eligible for the PrudentRx program.

If you and/or a covered family member are not currently taking but will start a new specialty medication covered under the PrudentRx Copay Program, you may reach out to PrudentRx to enroll; otherwise, they will proactively contact you so you can take full advantage of the PrudentRx program.

The PrudentRx Program Drug List may be updated periodically. The current drug list is available at **prudentrx.com/prudentexs**.

How does this program affect my plan costs and out-of-pocket maximum?

If an eligible specialty medication does not qualify as an "essential health benefit" under the Affordable Care Act, member cost-share payments for this medication, whether made by you or a manufacturer copayment assistance program, do not count toward the plan's prescription drug out-of-pocket maximum. A list of specialty medications that are not considered to be essential health benefits is available by contacting PrudentRx. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

How do I contact PrudentRx?

PrudentRx can be reached at **800-578-4403** to answer any questions regarding the PrudentRx Copay Program.

Dental

You'll see the following dental changes for 2024:

- Per-paycheck dental plan contributions will increase in 2024 to reflect rising costs.
- An additional dental plan option will be available in 2024: the DeltaCare Plan. If you enroll in the DeltaCare Plan, you'll receive coverage when you use in-network providers. There is no out-of-network coverage.
- The lifetime orthodontia maximum will increase from $1,500 to $2,000 in the Delta Dental Plan.

Vision

Basic Plan

- A discount schedule was added for the contact fit and follow-up services.

Enhanced Plan

- Out-of-network frames are now covered up to $78.
- Premium progressive tier 4: $175 copay.
- Premium anti-reflective tier 3: $85 copay.
- Out-of-network conventional and disposable contacts are now covered up to $63.
- Out-of-network medically necessary contacts are now covered up to $300.

Premier Plan

- Out-of-network frames are now covered up to $90.
- Premium progressive tier 4: $175 copay.
- Premium anti-reflective tier 3: $85 copay.
- Out-of-network conventional and disposable contacts are now covered up to $90. Out-of-network medically necessary contacts are covered up to $300.

Financial Planning

The Money in Motion® program, offered through The Ayco Company, L.P., will no longer be available beginning January 1, 2024.

Life Insurance and Personal Accident Insurance (PAI)

A $25,000 option will be added to the Dependent Life plan.

Special Active at Work Provisions

If you are not actively at work during Annual Enrollment, upon your return, you'll receive information to elect any changes to your life and disability insurance.

New! Healthy Rewards cancer screenings have been added for January 1, 2024. See further details on page 7.

Visit the pre-enrollment websites

These sites allow you to see if your providers are currently in-network.* You'll also find tools and resources, including smartphone apps, to help you get the most out of your medical plan throughout the year.

Carrier/ Claims Administrator	Website	Phone number
Blue Cross Blue Shield	enrollmentanthem.com/?id=siemenshealthineers&pending=true	833-969-3997
UnitedHealthcare	whyuhc.com/siemenshealthineers	866-238-2637
Kaiser Permanente	healthy.kaiserpermanente.org	800-464-4000
CVS Caremark	caremark.com	844-757-0414
Delta Dental (PPO, Premier, and DeltaCare Networks)	www1.deltadentalins.com/shs	800-592-0145
EyeMed (Insight Network)	member.eyemedvisioncare.com/SHS	866-800-5457

**Provider information is generally updated on a weekly basis. While it is important to check whether your provider is in the network of the plan you are considering, there is no guarantee that your provider will continue to participate in the network throughout the plan year.*

Finding quality care

If you need assistance finding a high-quality provider(s) or facility, you have access to the SmartSelect MD® tool online.

SmartSelect MD® is your digital personalized provider and facility search tool. This tool identifies the top-performing and most cost-efficient providers in your network. Unlike a traditional search directory, SmartSelect MD® helps inform you about the expertise and performance of a provider in specific as well as general conditions and diagnoses leading to the best care and patient outcomes.

Go online to **mySHSBenefits.com** or your mobile app to start searching recommendations tailored to your needs.

How to earn Healthy Rewards

Siemens Healthineers understands the importance of your overall well-being to you and your family. That's why if you enroll in either the Health Reimbursement or Health Savings Medical Plan option for 2024, you can earn additional company credits to your Health Reimbursement Account (HRA) or contributions to your Health Savings Account (HSA) through Healthy Rewards. Siemens Healthineers will reward you and your covered spouse or domestic partner for completing these activities between January 1 and December 31, 2024.

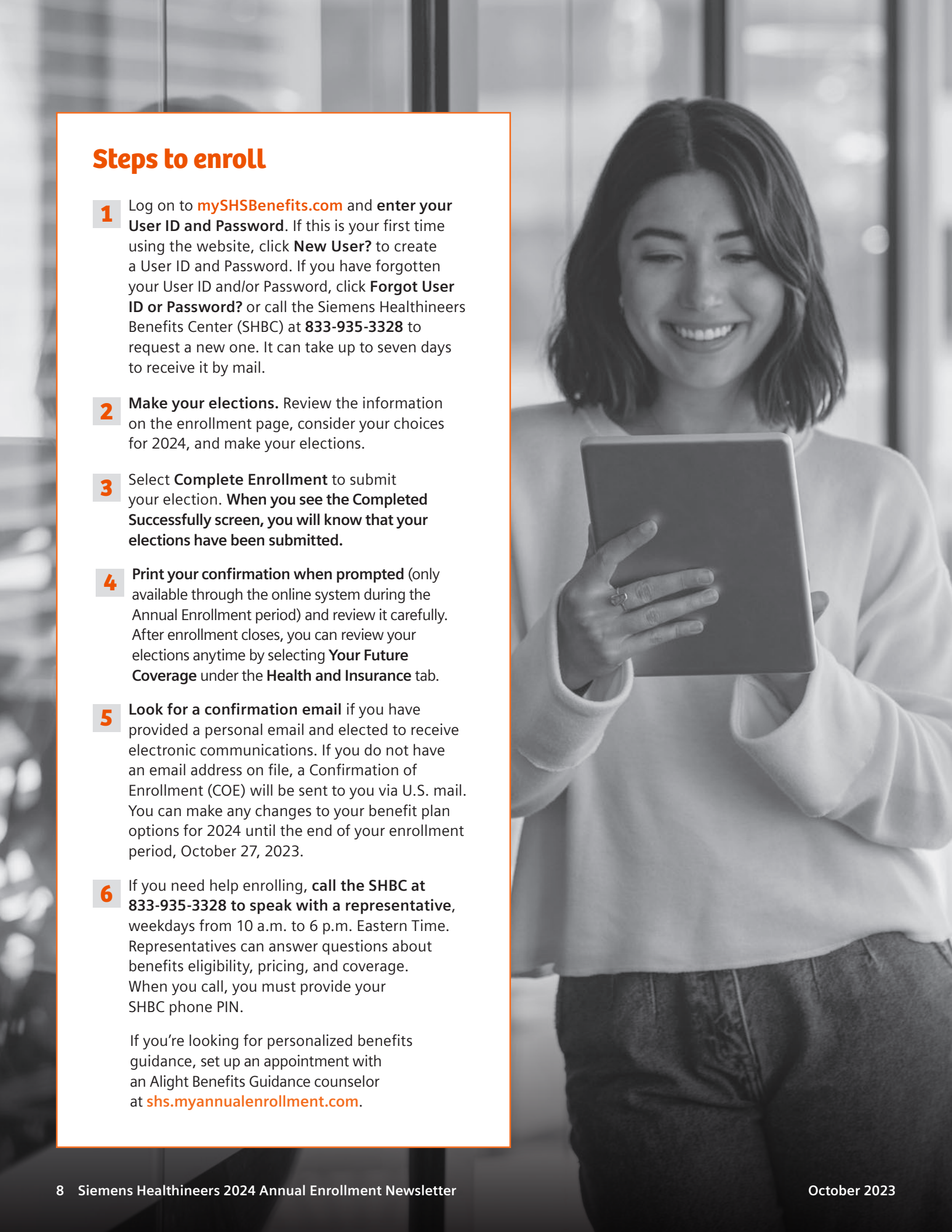
Earn Healthy Rewards for these activities:

Activity	Healthy Reward added to your 2024 HRA or HSA
Complete a Health Risk Assessment on your medical claims administrator's website: Blue Cross Blue Shield or UnitedHealthcare	**$ 100**
Receive an annual physical or well woman exam	**$ 150**
Receive an eye exam	**$ 50**
New! Receive a mammogram	**$ 50**
New! Receive a colon cancer screening	**$ 50**
New! Receive a skin cancer screening	**$ 50**
New! Receive a prostate cancer screening (PSA test)	**$ 50**

You and your covered spouse or domestic partner can earn even more Healthy Rewards in 2024 if you are eligible for and participate in these special programs:

Activity	Healthy Reward added to your 2024 HRA or HSA
Healthy Focus Maternity Program	
• Complete a pre-delivery screening/planning call	**$ 100**
• Complete a post-delivery call	**$ 100**
Healthy Focus Program (for individuals with a serious or chronic medical condition)	
• Enroll in a care/disease management program	**$ 100**
• Participate in a care/disease management program	**$ 100**
• Complete a post-hospital discharge call	**$ 100**

Note: *Any medical or personal information obtained as part of the Healthy Focus Program remains confidential between you and your medical plan administrator. It is not shared with Siemens Healthineers.*



Steps to enroll

1. Log on to **mySHSBenefits.com** and **enter your User ID and Password**. If this is your first time using the website, click **New User?** to create a User ID and Password. If you have forgotten your User ID and/or Password, click **Forgot User ID or Password?** or call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** to request a new one. It can take up to seven days to receive it by mail.

2. **Make your elections.** Review the information on the enrollment page, consider your choices for 2024, and make your elections.

3. Select **Complete Enrollment** to submit your election. **When you see the Completed Successfully screen, you will know that your elections have been submitted.**

4. **Print your confirmation when prompted** (only available through the online system during the Annual Enrollment period) and review it carefully. After enrollment closes, you can review your elections anytime by selecting **Your Future Coverage** under the **Health and Insurance** tab.

5. **Look for a confirmation email** if you have provided a personal email and elected to receive electronic communications. If you do not have an email address on file, a Confirmation of Enrollment (COE) will be sent to you via U.S. mail. You can make any changes to your benefit plan options for 2024 until the end of your enrollment period, October 27, 2023.

6. If you need help enrolling, **call the SHBC at 833-935-3328 to speak with a representative**, weekdays from 10 a.m. to 6 p.m. Eastern Time. Representatives can answer questions about benefits eligibility, pricing, and coverage. When you call, you must provide your SHBC phone PIN.

If you're looking for personalized benefits guidance, set up an appointment with an Alight Benefits Guidance counselor at **shs.myannualenrollment.com**.

Safeguarding your information

Siemens Healthineers wants to help you safeguard your information against fraudulent activity and identity theft. Since your mobile number is a safer way to communicate, Siemens Healthineers encourages you to receive select notifications via text messaging. You can review, add, or update your mobile number at **mySHSBenefits.com**.

- From the homepage, go to the person icon at the top right of the screen.
- Select **Manage Communications**, where you can add/update your mobile number and opt in for text messaging.

Understand how coordination of benefits (COB) works

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary.

If you don't enroll

All your current benefit elections—except for Flexible Spending Account (FSA) contributions and HSA contributions—will roll over to 2024. However, Siemens Healthineers encourages you to take the time to review all the options available and evaluate your choices to ensure you have the coverage you need next year.

Vendor contact information

Vendor name	Vendor address	Member Services phone number	Website
Alight Solutions (Siemens Healthineers Benefits Center–SHBC)	Dept. 09408 P.O. Box 1590 Lincolnshire, IL 60069-1590	**833-935-3328**	**mySHSbenefits.com** or **BenefitsAtSHS.com**
Blue Cross Blue Shield (BCBS)	220 Virginia Avenue Indianapolis, IN 46204	**833-969-3997**	**anthem.com**
Healthineers Life and Work Assistance Program	N/A	**800-433-7916**	**one.telushealth.com**
Cigna Global	Cigna Global Health Benefits NA P.O. Box 15050 Wilmington, DE 19850	**800-441-2668** (302-797-3100 outside the U.S.)	**cignaenvoy.com**
CVS Caremark	1 CVS Drive Woonsocket, RI 02895	**844-757-0414**	**caremark.com**
CVS Caremark Specialty pharmacy	800 Biermann Ct Ste B, Mt Prospect, IL 60056	**800-237-2767**	**CVSspecialty.com**
Delta Dental	P.O. Box 2105 Mechanicsburg, PA 17055-6999	**800-592-0145**	**www1.deltadentalins.com/shs**
EyeMed Vision Care	P.O. Box 8504 Mason, OH 45040-7111	**866-800-5457**	**member.eyemedvisioncare.com/SHS**
HealthEquity Claims Administrator	P.O. Box 14053 Lexington, KY 40512	**877-924-3967**	**healthequity.com/wageworks**
HMSA	P.O. Box 860 Honolulu, HI 96808	**808-948-6386 on Oahu or 855-260-5256 toll-free**	**hmsa.com**
Kaiser Foundation Health Plan, Inc.	One Kaiser Plaza 15L Oakland, CA 94612	**800-464-4000**	**healthy.kaiserpermanente.org**
Lincoln Financial Group Benefits Disability Claims	P.O. Box 7213 London, KY 40742-7211	**800-530-6506**	**mylincolnportal.com**
Optum Bank	P.O. Box 30777 Salt Lake City, UT 84130	**866-234-8913**	**optumbank.com**
The Hartford Group Benefit Claims	Life Claims Office P.O. Box 14299 Lexington, KY 40512-4299	**888-563-1124**	**thehartford.com**
UnitedHealthcare	P.O. Box 740800 Atlanta, GA 30374-0800	**866-238-2637**	**myuhc.com**
WINFertility	N/A	**855-556-9869**	**managed.winfertility.com/siemens-healthineers/**

Additional information and notices

Summary of Material Modifications

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2024. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2019, 2020, 2021, 2022, and 2023.

If you have any questions about this SMM or want a complete copy of the SPD, please contact the SHBC at **833-935-3328**.

Compare medical plans with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plans are available at mySHSBenefits.com. They summarize important information in a standard format, so you can compare across all the plans. To access the SBCs, from the homepage select **Plan Information** under **Health and Insurance**.

You may also obtain a paper version of the SBC for any of the medical plans, free of charge, by contacting the SHBC at **833-935-3328**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in health programs and activities

Learn how Siemens Healthineers is committed to protecting employees and their families from discrimination under our healthcare programs by reviewing the attached notice.

HIPAA Privacy Notice reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens Healthineers to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens Healthineers is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on mySHSBenefits.com or call the SHBC at **833-935-3328** to request a paper copy.

Right to designate a primary care provider; no referral or prior authorization for OB/GYN services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members.

You do not need prior authorization in any of the Siemens Healthineers medical plans to obtain access to obstetrical or gynecological care from an in-network healthcare professional who specializes in these services. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan ID card for a list of participating providers who specialize in obstetrics and gynecology.

Dropping dependent coverage during Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce, or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SHBC at **833-935-3328** within 30 days after the event. If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent **will not be eligible for COBRA** coverage. However, he or she may be able to obtain coverage through a state Health Insurance Marketplace.

Watch for your Form 1095 in late January

Watch for your Form 1095 medical coverage tax form in late January 2024, which shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage for 2023. You'll need this form to file your 2023 income taxes.

Forms for the 2023 tax year must be mailed no later than January 31, 2024. Please allow seven to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to mySHSBenefits.com and select the **Get Form 1095 Early** tile, then complete the contact information. Under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

Additional information and notices *(continued)*

Updates to the Life Insurance and Personal Accident Insurance Plan Provisions

The Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program Summary Plan Description (SPD) incorrectly reflects some plan provisions regarding **Supplemental Life and Personal Accident Insurance (PAI)**. The list below is intended to clarify these provisions.

- Under Supplemental Life and Personal Accident Insurance coverage, children are covered from live birth, not after 15 days. Children must also be unmarried.
- If approved, waiver of premium for Supplemental Life coverage is effective immediately after satisfying the nine-month waiting period.
- Dependent deferred effective date for life coverage—If on the date your dependent, other than a newborn, is to become covered under the policy for increased benefits or for a new benefit and they are confined in a hospital or confined elsewhere, such coverage will not start until they are discharged from the hospital or are no longer confined elsewhere, and have engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days. "Confined elsewhere" means your dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.
- Under Personal Accident Insurance coverage, the coma benefit does not have a set 50-month defined duration.
- Under Personal Accident Insurance coverage, there is no set benefit for brain damage; however, a traumatic brain injury is payable at 100%.
- Under Personal Accident Insurance coverage, the hospital confinement income benefit waiting period is 30 days.
- The Personal Accident Insurance policy does not cover any loss caused or contributed by:
  - — Intentionally self-inflicted injury;
  - — Suicide or attempted suicide, whether sane or insane;
  - — War or act of war, whether declared or not;
  - — Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
  - — Injury sustained while on any aircraft except a civil or public aircraft, or military transport aircraft;
  - — Injury sustained while on any aircraft:
    - As a pilot, crew member or student pilot;
    - As a flight instructor or examiner;
    - If it is owned, operated, or leased by or on behalf of the policyholder, or any employer or organization whose eligible persons are covered under the policy;
    - Being used for tests, experimental purposes, stunt flying, racing, or endurance tests;
  - — Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a physician;
  - — Injury sustained while riding or driving in a scheduled race or testing any motor vehicle on tracks, speedways, or proving grounds;
  - — Injury sustained while committing or attempting to commit a felony; or
  - — Injury sustained while intoxicated.

SIEMENS Healthineers

SIEMENS Healthineers

Your well-being. Our commitment.

What's inside

2023 Annual Enrollment is October 17–October 28, 2022

Siemens Healthineers is proud to offer many benefit choices from year to year to support your well-being—and that of your family. We also offer plenty of easy-to-access resources to help you choose wisely.

To ensure you get the most from your benefits in 2023 and are prepared to enroll, please explore your options, review the following information, and use the many resources available to help you choose the coverage you need next year.

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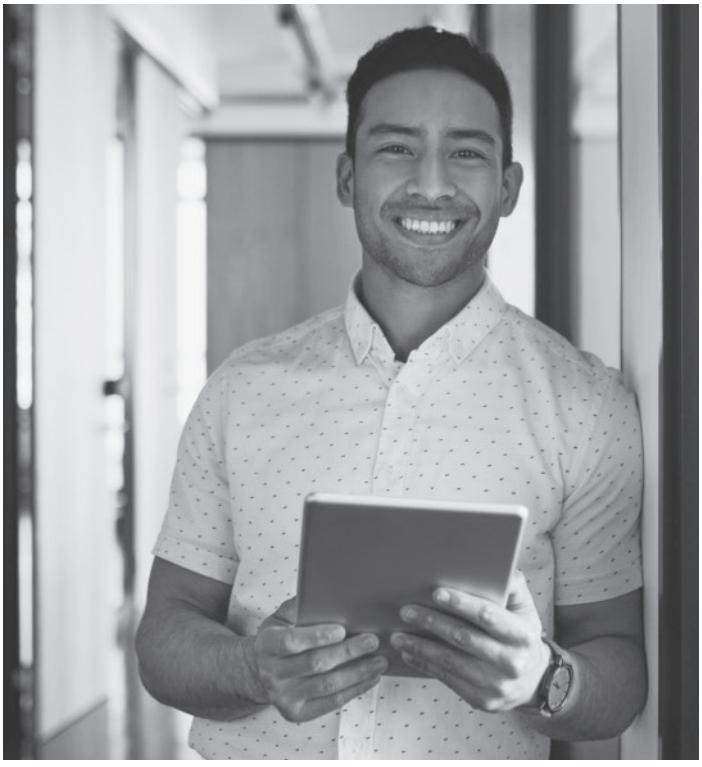
- **Get to know the healthcare accounts:** Understand the differences between the Health Reimbursement Account (HRA), the Health Savings Account (HSA), and the Flexible Spending Accounts (FSAs) so you can get the most out of your benefits in 2023.

Siemens Healthineers Benefits Center (SHBC)

Get answers to your Annual Enrollment questions through web chat, available on **mySHSBenefits.com**. Go to **Enroll in Your Benefits** or **Contact Us** to start a chat. If you have general questions about your benefits, call the SHBC at **833-935-3328**. Representatives are available online or via telephone weekdays between 10 a.m. and 6 p.m. Eastern Time.

Estimate your medical expenses

When you log on to **mySHSBenefits.com**, you'll find it easy to navigate as you make your elections. As you enroll, consider your healthcare expenses to get a comparison of your estimated out-of-pocket expenses across medical plans. Simply provide your estimated medical and prescription drug usage assumptions, and the tool does the rest.



What's new for 2023

Medical

Contributions

Per-paycheck contributions for the medical plans will increase to reflect the continuously rising cost of healthcare.

Health Savings Medical Plan — Health Savings Account Contributions

The Health Savings Account (HSA) individual contribution maximum for 2023 will increase from $3,650 to $3,850, and the family contribution maximum will increase from $7,300 to $7,750. You may elect HSA catch-up contributions on mySHSBenefits.com if you are age 55 or older. Remember to elect your HSA contribution for 2023.

Health Reimbursement and Health Savings Medical Plan options —Access to Care

To support the diverse needs of our employees, we will now offer a broad travel and lodging benefit when in-network care is not available within a 50-mile radius of the employee's home, as well as expand coverage for gender dysphoria care.

Travel and lodging benefit

The Health Reimbursement and Health Savings Medical Plan options will reimburse for reasonable travel and lodging expenses related to covered in-network services not available through an in-network provider within a 50-mile radius of the employee's home, unless expressly prohibited by law. Examples of covered services include, but are not limited to:

- Clinical trials
- Gender affirmation surgeries
- Mental health and substance abuse treatment (e.g., inpatient centers)
- Other complex surgeries (e.g., bariatric, cardiac, etc.)
- Reproductive procedures and abortions

Travel and lodging expenses are subject to the plan's deductible and are reimbursable up to $4,000 per year. You must complete a Travel and Lodging Reimbursement form, attest to the services provided, and submit all receipts in order for expenses to be reimbursed. If you have specific questions regarding the travel and lodging benefit, please call your medical plan claims administrator (UnitedHealthcare or BCBS) at the number on the back of your ID card.

The Health Reimbursement and Health Savings Medical Plan options cover expenses for travel and lodging for the patient and a companion, as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by the nearest in-network provider for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up.
- Eligible expenses for lodging the patient (while not a hospital inpatient) and one companion.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the nearest in-network provider.
- The travel and lodging benefit offers a combined overall maximum of $4,000 per covered person per year for all transportation and lodging expenses incurred by the patient and reimbursed under the medical plan option associated with all qualified procedures.

The claims administrator must receive valid receipts for such charges prior to reimbursement. The claims administrator will follow Internal Revenue Service (IRS) guidelines in determining eligible expenses and reimbursement rates. Current reimbursement rates are as follows:

Lodging

- A per diem rate, up to $50 per day, for the caregiver if the patient is in the hospital
- A per diem rate, up to $50 per day, for the patient if the patient is not in the hospital
- A per diem rate, up to $100 per day, for the patient and one caregiver if the patient is not in the hospital

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and nearest in-network provider
- Taxi fares (not including limos or car services)
- Economy or coach airfare
- Parking
- Trains
- Boat
- Bus
- Tolls

Examples of items that are not covered:

- Meals
- Groceries
- Alcoholic beverages
- Personal or cleaning supplies
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separately from the rent payment
- Phone calls, newspapers, or movie rentals

Please note: Transplant-related travel and lodging benefits are separate from the benefit outlined above.

What's new for 2023 *(continued)*

Medical *(continued)*

Expanded Gender Dysphoria Coverage

Today, Siemens Healthineers medical and prescription drug benefit plans cover certain services for the treatment of gender dysphoria. In 2023, this coverage will be expanded to reflect evolving standards of care and to better support those who need these services. The Health Reimbursement and Health Savings Medical Plan options will include coverage for the following services when medically necessary for treatment of gender dysphoria:

- Hair removal, including when required as part of reconstructive surgery
- Lipoplasty or body-contouring surgery
- Facial feminization procedures
- Voice modification surgery
- Voice modification therapy

All surgical procedures will require documentation including a psychological assessment from at least one qualified behavioral health provider experienced in treating gender dysphoria. The assessment must document that the covered person meets all of the following criteria:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Must be 18 years or older
- If significant medical or mental health concerns are present, they must be reasonably well controlled

Please call your medical plan claims administrator (UnitedHealthcare or BCBS) at the number on the back of your ID card for more information about how to access these benefits.

Annual Enrollment for delegates

The 2023 Annual Enrollment process for both inbound and outbound delegates will occur separately. Please look for your Annual Enrollment materials in the coming weeks.

Special Active at Work Provisions

If you are not actively at work during Annual Enrollment, upon your return, you'll receive information to elect any changes to your life and disability insurance.

Healthcare Flexible Spending Account (FSA)

For 2023, the maximum amount you can contribute to the Healthcare FSA will increase from $2,750 to $2,850. The Healthcare FSA rollover amount is also increasing to $570 in 2023. Here's what this means for you in 2023 and beyond:

- December 31, 2023, is the last day you may incur claims for the 2023 plan year (January 1–December 31, 2023), but you have until May 31, 2024, to submit 2023 claims.
- Unused 2023 balances up to $570* will automatically roll over to your 2024 Healthcare FSA and be available for claims for the 2024 plan year (January 1–December 31, 2024) after May 31, 2024. Any balances over $570* will be forfeited.
- If you do not make a 2024 Healthcare FSA election but have a rollover balance, you must use your rollover funds by December 31, 2024.
- If you enroll in the Health Savings Medical Plan option for 2024, the eligible rollover amount will only be available to use in a Limited-Use Healthcare FSA for eligible 2024 dental and vision expenses.
- Any rollover amount from the 2023 Healthcare FSA plan year does not count toward the 2024 Healthcare FSA contribution limit.

You must enroll to participate in the Healthcare FSA in 2023.

**Rollover maximum may change.*

Dental

Per-paycheck dental plan contributions will increase in 2023 to reflect rising costs.

Life Insurance and Personal Accident Insurance (PAI)

For 2023, you will continue to be able to purchase Supplemental, Spouse or Domestic Partner, Child Life Insurance, and PAI at reduced rates* in many cases.

**Based on coverage amount and age.*

Financial Planning

The cost/per-paycheck contributions for the Money in Motion® program, offered through The Ayco Company, L.P., will increase in 2023. You must actively enroll to have coverage in 2023.

How to earn Healthy Rewards

Siemens Healthineers understands the importance of your overall well-being to you and your family. That's why if you enroll in either the Health Reimbursement or Health Savings Medical Plan option for 2023, you can earn additional company credits to your Health Reimbursement Account (HRA) or contributions to your Health Savings Account (HSA) through Healthy Rewards. Siemens Healthineers will reward you and your covered spouse or domestic partner for completing these activities between January 1 and December 31, 2023.

Earn Healthy Rewards for these activities:

Activity	Healthy Reward added to your 2023 HRA or HSA
Complete a Health Risk Assessment on your medical claims administrator's website: Blue Cross Blue Shield or UnitedHealthcare	**$ 100**
Receive an annual physical or well woman exam	**$ 150**
Receive an eye exam	**$ 50**

You and your covered spouse or domestic partner can earn even more Healthy Rewards in 2023 if you are eligible for and participate in these special programs:

Activity	Healthy Reward added to your 2023 HRA or HSA
Healthy Focus Maternity Program	
• Complete a pre-delivery screening/planning call	**$ 100**
• Complete a post-delivery call	**$ 100**
Healthy Focus Program (for individuals with a serious or chronic medical condition)	
• Enroll in a care/disease management program	**$ 100**
• Participate in a care/disease management program	**$ 100**
• Complete a post-hospital discharge call	**$ 100**

Note: *Any medical or personal information obtained as part of the Healthy Focus Program remains confidential between you and your medical plan administrator. It is not shared with Siemens Healthineers.*

Visit the pre-enrollment websites

These sites allow you to see if your providers are currently in-network.* You'll also find tools and resources, including smartphone apps, to help you get the most out of your medical plan throughout the year.

Carrier/ Claims Administrator	Website	Phone number
Blue Cross Blue Shield	enrollmentanthem.com/?id=siemenshealthineers&pending=true	833-969-3997
UnitedHealthcare	whyuhc.com/siemenshealthineers	866-238-2637
Kaiser Permanente	healthy.kaiserpermanente.org	800-464-4000
CVS Caremark	caremark.com	844-757-0414
Delta Dental (PPO and Premier Networks)	www1.deltadentalins.com/shs	800-592-0145
EyeMed (Insight Network)	member.eyemedvisioncare.com/SHS	866-800-5457

**Provider information is generally updated on a weekly basis. While it is important to check whether your provider is in the network of the plan you are considering, there is no guarantee that your provider will continue to participate in the network throughout the plan year.*

Safeguarding your information

Siemens Healthineers wants to help you safeguard your information against fraudulent activity and identity theft. Since your mobile number is a safer way to communicate, Siemens Healthineers encourages you to receive select notifications via text messaging. You can review, add, or update your mobile number at **mySHSBenefits.com**.

- From the homepage, go to the person icon at the top right of the screen.
- Select **Manage Communications**, where you can add/update your mobile number and opt in for text messaging.

Steps to enroll

1. Log on to **mySHSBenefits.com** and **enter your User ID and Password**. If this is your first time using the website, click **New User?** to create a User ID and Password. If you have forgotten your User ID and/or Password, click **Forgot User ID or Password?** or call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** to request a new one. It can take up to seven days to receive it by mail.
2. **Make your elections.** Review the information on the enrollment page, consider your choices for 2023, and make your elections.
3. Select **Complete Enrollment** to submit your election. **When you see the Completed Successfully screen, you will know that your elections have been submitted.**
4. **Print your confirmation when prompted** (only available through the online system during the Annual Enrollment period) and review it carefully. After enrollment closes, you can review your elections anytime by selecting **Your Future Coverage** under the **Health and Insurance** tab.
5. **Look for a confirmation email** if you have provided a personal email and elected to receive electronic communications. If you do not have an email address on file, a Confirmation of Enrollment (COE) will be sent to you via U.S. mail. You can make any changes to your benefit plan options for 2023 until the end of your enrollment period, October 28, 2022.
6. If you need help enrolling, **call the SHBC at 833-935-3328 to speak with a representative**, weekdays from 10 a.m. to 6 p.m. Eastern Time. Representatives can answer questions about benefits eligibility, pricing, and coverage. When you call, you must provide your SHBC phone PIN.

Understand how coordination of benefits (COB) works

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary.

If you don't enroll

All your current benefit elections—except for Flexible Spending Account (FSA) contributions, HSA contributions, and the Financial Planning Program—will roll over to 2023. However, Siemens Healthineers encourages you to take the time to review all the options available and evaluate your choices to ensure you have the coverage you need next year.

Vendor contact information

Vendor name	Vendor address	Member Services phone number	Website
Alight Solutions (Siemens Healthineers Benefits Center–SHBC)	Dept. 09408 P.O. Box 1590 Lincolnshire, IL 60069-1590	**833-935-3328**	**mySHSbenefits.com** or **BenefitsAtSHS.com**
Ayco	100 Coliseum Drive Cohoes, NY 12047	**866-948-2926**	**ayco.com/login/siemenshealthineers**
Blue Cross Blue Shield (BCBS)	220 Virginia Avenue Indianapolis, IN 46204	**833-969-3997**	**anthem.com**
Cigna Employee Assistance Program (EAP)	Evernorth Behavioral Health, Inc. 6625 West 78th Street, Suite 100 Bloomington, MN 55439	**888-371-1125**	**myCigna.com**
Cigna Global	Cigna Global Health Benefits NA P.O. Box 15050 Wilmington, DE 19850	**800-441-2668** (302-797-3100 outside the U.S.)	**cignaenvoy.com**
CVS Caremark	1 CVS Drive Woonsocket, RI 02895	**844-757-0414**	**caremark.com**
CVS Caremark Specialty pharmacy	1 CVS Drive Woonsocket, RI 02895	**800-237-2767**	**CVSspecialty.com**
Delta Dental	P.O. Box 2105 Mechanicsburg, PA 17055-6999	**800-592-0145**	**www1.deltadentalins.com/shs**
EyeMed Vision Care	P.O. Box 8504 Mason, OH 45040-7111	**866-800-5457**	**member.eyemedvisioncare.com/SHS**
HealthEquity Claims Administrator	P.O. Box 14053 Lexington, KY 40512	**877-924-3967**	**healthequity.com/wageworks**
HMSA	P.O. Box 860 Honolulu, HI 96808	**808-948-6386 on Oahu or 855-260-5256 toll-free**	**hmsa.com**
Kaiser Foundation Health Plan, Inc.	One Kaiser Plaza 15L Oakland, CA 94612	**800-464-4000**	**healthy.kaiserpermanente.org**
Lincoln Financial Group Benefits Disability Claims	P.O. Box 7213 London, KY 40742-7211	**800-530-6506**	**mylincolnportal.com**
Optum Bank	P.O. Box 30777 Salt Lake City, UT 84130	**866-234-8913**	**optumbank.com**
The Hartford Group Benefit Claims	Life Claims Office P.O. Box 14299 Lexington, KY 40512-4299	**888-563-1124**	**thehartford.com**
UnitedHealthcare	P.O. Box 740800 Atlanta, GA 30374-0800	**866-238-2637**	**myuhc.com**
WINFertility	N/A	**855-556-9869**	**managed.winfertility.com/siemens-healthineers/**

Additional information and notices

Summary of Material Modifications

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2023. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2019, 2020, 2021, and 2022.

If you have any questions about this SMM or want a complete copy of the SPD, please contact the SHBC at **833-935-3328**.

Compare medical plans with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plans are available at mySHSBenefits.com. They summarize important information in a standard format, so you can compare across all the plans. To access the SBCs, from the homepage select **Plan Information** under **Health and Insurance**.

You may also obtain a paper version of the SBC for any of the medical plans, free of charge, by contacting the SHBC at **833-935-3328**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in health programs and activities

Learn how Siemens Healthineers is committed to protecting employees and their families from discrimination under our healthcare programs by reviewing the attached notice.

HIPAA Privacy Notice reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens Healthineers to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens Healthineers is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on mySHSBenefits.com or call the SHBC at **833-935-3328** to request a paper copy.

SIEMENS Healthineers

Right to designate a primary care provider; no referral or prior authorization for OB/GYN services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members.

You do not need prior authorization in any of the Siemens Healthineers medical plans to obtain access to obstetrical or gynecological care from an in-network healthcare professional who specializes in these services. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan ID card for a list of participating providers who specialize in obstetrics and gynecology.

Dropping dependent coverage during Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce, or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SHBC at **833-935-3328** within 30 days after the event. If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent **will not be eligible for COBRA** coverage. However, he or she may be able to obtain coverage through a state Health Insurance Marketplace.

Watch for your Form 1095 in late January

Watch for your Form 1095 medical coverage tax form in late January 2023, which shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage for 2022. You'll need this form to file your 2022 income taxes.

Forms for the 2022 tax year must be mailed no later than January 31, 2023. Please allow seven to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to mySHSBenefits.com and select the **Get Form 1095 Early** tile, then complete the contact information. Under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

SIEMENS Healthineers

Move your benefits forward in 2022

What's inside

Annual Enrollment is November 8– November 19, 2021

Siemens Healthineers knows it's important for you and your loved ones to have the benefits you need in 2022. We are proud of the variety of programs we offer to meet our employees' diverse needs. Annual Enrollment is your once-a-year-opportunity to elect coverages, including medical, dental, vision, flexible spending accounts (FSAs), life insurance, personal accident insurance, long-term disability, commuter benefits and financial planning. Be sure to take some time to review your choices so you can move your benefits forward in 2022.

Get your benefits news online

You are receiving this print version because you do not have a valid preferred personal email address stored on **mySHSBenefits.com**. For a preferred personal email address to be valid, it must be listed and selected as your personal preferred email address.

To receive important benefits information via email, log on to **mySHSBenefits.com** and choose your communication preference by selecting **Your Profile** in the upper right-hand corner of the home page, then **Manage Communications** to review and update your delivery preference. If you prefer, you can call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** to add your preferred email address to your account.

Resources to help you decide

Siemens Healthineers understands that healthcare coverage is an integral part of the benefits provided to you. To ensure you get the most value from your benefits in 2022, the Company encourages you to use the resources provided, including the 2022 Annual Enrollment section of BenefitsatSHS.com, the HSA modeler, and medical plan videos to fully understand the benefit programs available to you.

You may also want to take time to estimate your healthcare spending for the year ahead and compare plan costs. If you cover a spouse or domestic partner, both of you should discuss your choices so you can have benefits that meet your needs in the coming year.

Benefits at Siemens Healthineers website

The 2022 Annual Enrollment section provides details and access to resources to help you make important decisions about your 2022 benefits. There's a lot of great information, so be sure to visit BenefitsAtSHS.com > 2022 Annual Enrollment.

Medical benefits videos

You have access to quick-paced, easy-to-understand medical benefits videos where you can learn about your options and the healthcare accounts available to you.

- **Understand your medical plan choices:** See the differences between the Health Reimbursement and Health Savings Medical Plans, including which healthcare accounts are available through each option.
- **Compare costs under the medical plans:** Learn how costs compare between the Health Reimbursement and Health Savings Medical Plans. This video walks you through the out-of-pocket costs an individual may pay through life's changes—from being single, to getting married, to growing a family.
- **Get to know the healthcare accounts:** Understand the differences between the Health Reimbursement Account (HRA), the Health Savings Account (HSA), and the Flexible Spending Accounts (FSAs) so you can get the most out of your benefits in 2022.

Siemens Healthineers Benefits Center (SHBC)

Get answers to your Annual Enrollment questions through web chat. Go to **Enroll in Your Benefits** or **Contact Us** to start a chat. If you have general questions about your benefits, call the SHBC at **833-935-3328**. Representatives will be available online or via telephone weekdays between 10 a.m. and 6 p.m. Eastern Time.

Enhanced benefits enrollment system

You will experience an enhanced enrollment process on mySHSBenefits.com, making it easier to use and navigate as you make your 2022 elections.

What's new for 2022

Medical

Health Savings Medical Plan

- The **Health Savings Account (HSA)** individual contribution maximum for 2022 will increase from $3,600 to $3,650, and the family contribution maximum will increase from $7,200 to $7,300.
- You may elect HSA catch-up contributions on mySHSBenefits.com if you are age 55 or older.

Fertility services

- The **Health Reimbursement** and **Health Savings Medical Plans** will cover the following fertility services when provided by or under the direction of a physician, with or without a diagnosis of infertility:
  - **Assisted reproduction technologies (ART)** include in vitro fertilization, artificial insemination, intrauterine insemination, intrafallopian transfer, GIFT (gamete intrafallopian transfer), and ZIFT (zygote intrafallopian transfer) procedures.
  - **Fertility medications** administered by a medical provider in the provider's office will be covered under the medical plan. Oral, patch, or self-injectable medications will be covered under the CVS/Caremark prescription drug plan. Certain medications may require prior authorization to assure appropriate and safe dosages.
  - **Storage fees** cover the cost for storing frozen eggs, embryos, and sperm to use in covered procedures for up to 12 months.
  - **Pre-implantation genetic testing** includes testing for a monogenic disorder (PGT-M), chromosomal abnormality (PGT-A), or structural rearrangement (PGT-SR) of the embryo.
  - **Fertility preservation for medical reasons** includes planned cancer or other medical treatments likely to produce infertility/sterility. Coverage is limited to collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (longer than 12 months) are not covered.
- Fertility services are covered subject to your medical plan's deductible, coinsurance, and out-of-pocket maximum. In addition, these services will be **limited to a maximum of $15,000 per lifetime (in and out of network combined) for medical benefits and $10,000 per lifetime for prescription drug benefits**. Services for the diagnosis and treatment of an underlying cause of infertility are covered as described in the Summary Plan Description and are not subject to the fertility lifetime maximum benefit.
- The first step to using your fertility benefits is to call your medical plan claims administrator (UnitedHealthcare [UHC] or Blue Cross Blue Shield [BCBS]) at the number on the back of your new ID card. You must enroll with Fertility Solutions (UHC) or WINFertility (BCBS) to access benefits.

What's not covered

The following fertility services are **not covered** under the Health Reimbursement and Health Savings Medical Plans:

- Services provided when infertility is related to voluntary sterilization or failed reversal of a voluntary sterilization.
- Donor medical expenses, including the costs of donor eggs and donor sperm.
- Services or fees related to the use of a gestational carrier or surrogate.
- Services provided for a child dependent. Child dependents are eligible for fertility preservation when scheduled cancer treatments or other medical treatments are likely to produce infertility/sterility.

Prescription drugs

- Beginning September 1, 2021, you can access the CVS network of pharmacies to receive vaccines, such as: Seasonal influenza, Hepatitis A and B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Tetanus, Chicken Pox (Varicella), Diphtheria, and Zoster (Shingles). Show your prescription drug ID card. ***Reminder: You already have access to receive the COVID-19 vaccine through the CVS network of pharmacies.***
- Beginning January 1, 2022, the following medications will require prior authorization from CVS/Caremark: Athar (restricted to infantile spasm), Sucraid, Sitavig, and Duobrii.

What's new for 2022 *(continued)*

Dental Plan

Per-paycheck dental plan contributions will increase for 2022.

Flexible Spending Accounts (FSAs)

FSA administrator

The website address has changed from **wageworks.com** to healthequity.com.

Healthcare FSA (HCFSA)

Beginning January 1, 2022, the Company is moving to an HCFSA rollover feature.

- **What this means for you for the 2021 plan year**
  - — Current grace period continues:
    - If you have unused 2021 Healthcare FSA funds, you will have until March 15, 2022, to incur eligible expenses.
    - You will have until May 31, 2022, to submit 2021 claims.
- **What this means for you for the 2022 plan year, and beyond**
  - — ***December 31, 2022, is the last day you may incur claims for the 2022 plan year*** (January 1–December 31, 2022), but you have until ***May 31, 2023***, to submit 2022 claims.
  - — Unused 2022 balances up to $550* will automatically roll over to your 2023 HCFSA and be available for claims for the 2023 plan year (January 1–December 31, 2023) after May 31, 2023. ***Any balances over $550 will be forfeited.***
  - — If you do not make a 2023 HCFSA election but have a carryover balance, you must use your carryover funds by December 31, 2023.
  - — If you enroll in the Health Savings Medical Plan for 2023, the eligible rollover amount will be available to use in a Limited-Use HCFSA for eligible 2023 dental and vision expenses.
  - — Any rollover amount from the 2022 HCFSA plan year does not count toward the 2023 HCFSA contribution limit.

**Rollover maximum may change.*

Dependent Day Care FSA (DCFSA)

- The Consolidated Appropriations Act, 2021 legislation allows the Company to make changes to extend the grace period for your DCFSA from March 15 to December 31 for plan years 2020 and 2021. This allows you additional time to incur qualified dependent day care expenses.
- Between January 1, 2020, and December 31, 2021, you may incur expenses toward your available 2020 balance. Claims for your 2020 DCFSA must be submitted by May 31, 2022.
- For your 2021 DCFSA, you may incur expenses between January 1, 2021, and December 31, 2022.
- Your 2022 DCFSA may be used for expenses incurred between January 1, 2022, and March 15, 2023. Claims for your 2022 DCFSA must be submitted by May 31, 2023.

Life Insurance and Personal Accident Insurance (PAI)*

The Basic Life Insurance maximum will increase from $300K to $1M in 2022.

**Life and PAI amounts may differ for unions based on applicable collective bargaining agreements.*

Disability programs

The employee-paid long-term disability coverage per-paycheck contributions will increase for 2022.

Health plan ID cards

You'll receive new Siemens Healthineers medical, prescription drug, vision, FSA, and HSA cards via the U.S. mail for your coverage elections that begin January 1, 2022. As a reminder, Delta Dental does not issue ID cards, which are not needed to receive dental care.

Medical plan ID cards

- For 2022, the federal government is requiring that medical plan administrators add certain information on medical plan ID cards (e.g., deductibles).
- While ID cards will be reissued and mailed to homes, digital ID cards with this information will be available to download beginning in January 2022. You may also contact Member Services for assistance with ID cards. The number is located under **Carrier contact information** on page 7.

Earn Healthy Rewards

Siemens Healthineers understands the importance of your overall well-being to you and your family. That's why if you enroll in either the Health Reimbursement or Health Savings Medical Plan for 2022, you can earn additional company contributions to your Health Reimbursement Account (HRA) or Health Savings Account (HSA) through Healthy Rewards. Siemens Healthineers will reward you and your covered spouse or domestic partner for completing these activities between January 1 and December 31, 2022.

Earn Healthy Rewards for these activities:

Activity	Contribution to your 2022 HRA or HSA
Complete a Health Risk Assessment on your medical carrier's website: Blue Cross Blue Shield or UnitedHealthcare	**$ 100**
Get your annual physical or well woman exam	**$ 150**
Get an eye exam	**$ 50**

You and your covered spouse or domestic partner can earn even more Healthy Rewards in 2022 if you are eligible for and participate in these special programs:

Activity	Contribution to your 2022 HRA or HSA
Healthy Focus Maternity Program	
• Complete a pre-delivery screening/planning call	**$ 100**
• Complete a post-delivery call	**$ 100**
Healthy Focus Program (for individuals with a serious or chronic medical condition)	
• Enroll in a care/disease management program	**$ 100**
• Participate in a care/disease management program	**$ 100**
• Complete a post-hospital discharge call	**$ 100**

Note: *Any medical or personal information obtained as part of the Healthy Focus Program remains confidential between you and your medical plan administrator. It is not shared with Siemens Healthineers.*

Visit the carrier pre-enrollment websites

These sites allow you to see if your providers are currently in a carrier's network.* You'll also find tools and resources, including smartphone apps, to help you get the most out of your medical plan throughout the year.

Carrier name	Website	Phone number
Blue Cross Blue Shield	enrollmentanthem.com/?id=siemenshealthineers&pending=true	833-969-3997
UnitedHealthcare	www.whyuhc.com/siemenshealthineers	866-238-2637
Kaiser Permanente	kp.org	800-464-4000
CVS/Caremark	caremark.com	844-757-0414
Delta Dental (PPO and Premier Networks)	www1.deltadentalins.com/shs	800-592-0145
EyeMed (Insight Network)	member.eyemedvisioncare.com/SHS	866-800-5457

**Provider information is generally updated on a weekly basis. While it is important to check whether your provider is in the network of the plan you are considering, there is no guarantee that your provider will continue to participate in the network throughout the plan year.*

Safeguarding your information

The Company wants to help you safeguard your information against fraudulent activity and identity theft. Since your mobile number is a safer way to communicate, Siemens Healthineers encourages you to receive select notifications via text messaging. You can review, add, or update your mobile number at mySHSBenefits.com.

- From the home page, go to **My Profile** at the top right of the screen.
- Select **Manage Communications**, where you can add/update your mobile number and opt in for text messaging

Steps to enroll now!

1. Log on to mySHSBenefits.com and **enter your User ID and Password**. If this is your first time using the website, click **New User?** to create a User ID and Password. If you have forgotten your User ID and/or Password, click **Forgot User ID or Password?** or call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** to request a new one. It can take up to seven days to receive it by mail.
2. **Make your elections.** Review the information on the enrollment page, consider your choices for 2022, and make your elections.
3. **Select Complete Enrollment to submit your election.** When you see the Completed Successfully screen, you will know that your elections have been submitted.
4. **Print your confirmation when prompted** (only available through the online system during the annual enrollment period) and review it carefully. After enrollment closes, you can review your elections anytime by selecting **Your Future Coverage** under the **Health and Insurance** tab.
5. **Look for a confirmation email** if you have provided a personal email and elected to receive electronic communications. If you do not have an email address on file, a Confirmation of Enrollment (COE) will be sent to you via U.S. mail. You can make any changes to your benefit plan options for 2022 until the end of your enrollment period, November 19, 2021.
6. If you need help enrolling, **call the SHBC at 833-935-3328 to speak with a representative, weekdays from 10 a.m. to 6 p.m. Eastern Time**. Representatives can answer questions about benefits eligibility, pricing, and coverage. When you call, you must provide your SBSC phone PIN.

If you do not enroll

If you do not enroll during 2022 Annual Enrollment, you will continue in the same coverage you currently have — except for Flexible Spending Accounts (FSAs) and HSA contributions— with the same plan administrator.

Understand how coordination of benefits (COB) works

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary.

Carrier contact information

Carrier contact information will change, effective January 1, 2022.

Carrier name	Carrier address	Member Services phone number	Website
Alight Solutions (Siemens Healthineers Benefits Center–SHBC)	Dept. 09408 PO Box 1590 Lincolnshire, IL 60069-1590	**833-935-3328**	mySHSbenefits.com or BenefitsAtSHS.com
Ayco	100 Coliseum Drive Cohoes, NY 12047	**866-948-2926**	ayco.com/login/siemenshealthineers
Blue Cross Blue Shield (BCBS)	220 Virginia Avenue Indianapolis, IN 46204	**833-969-3997**	anthem.com
Cigna Employee Assistance Program (EAP)	Evernorth Behavioral Health, Inc. 6625 West 78th Street, Suite 100 Bloomington, MN 55439	**888-371-1125**	myCigna.com
Cigna Global	Cigna Global Health Benefits NA P.O. Box 15050 Wilmington, DE 19850	**800-441-2668** (302-797-3100 outside the U.S.)	cignaenvoy.com
CVS/Caremark	1 CVS Drive Woonsocket, RI 02895	**844-757-0414**	caremark.com
CVS/Caremark Specialty pharmacy	1 CVS Drive Woonsocket, RI 02895	**800-237-2767**	cvscaremarkspecialtyrx.com
Delta Dental	P.O. Box 2105 Mechanicsburg, PA 17055-6999	**800-592-0145**	www1.deltadentalins.com/shs
EyeMed Vision Care	P.O. Box 8504 Mason, OH 45040-7111	**866-800-5457**	member.eyemedvisioncare.com/SHS
HealthEquity Claims Administrator	P.O. Box 14053 Lexington, KY 40512	**877-924-3967**	healthequity.com/wageworks
HMSA	P.O. Box 860 Honolulu, HI 96808	**808-948-6386 on Oahu or 855-260-5256 toll-free**	hmsa.com
Kaiser Foundation Health Plan, Inc.	One Kaiser Plaza 15L Oakland, CA 94612	**800-464-4000**	kp.org
Lincoln Financial Group Benefits Disability Claims	P.O. Box 7213 London, KY 40742-7211	**800-530-6506**	mylincolnportal.com
Optum Bank	P.O. Box 30777 Salt Lake City, UT 84130	**866-234-8913**	optumbank.com
The Hartford Group Benefit Claims	Life Claims Office P.O. Box 14299 Lexington, KY 40512-4299	**888-563-1124**	thehartford.com
UnitedHealthcare	P.O. Box 740800 Atlanta, GA 30374-0800	**866-238-2637**	myuhc.com
WINFertility	N/A	**855-556-9869**	managed.winfertility.com/siemens-healthineers/

Additional information and notices

Summary of Material Modifications

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2022. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2018, 2019, 2020, and 2021.

If you have any questions about this SMM or want a complete copy of the SPD, please contact the SHBC at **833-935-3328**.

Compare medical plans with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plans are available at mySHSBenefits.com. They summarize important information in a standard format, so you can compare across all the plans. To access the SBCs, from the home page select **Plan Information** under **Health and Insurance**.

You may also obtain a paper version of the SBC for any of the medical plans, free of charge, by contacting the SHBC at **833-935-3328**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens Healthineers is committed to protecting employees and their families from discrimination under our healthcare programs by reviewing the attached notice.

HIPAA Privacy Notice reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens Healthineers to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens Healthineers is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on mySHSBenefits.com or call the SHBC at **833-935-3328** to request a paper copy.

SIEMENS Healthineers

Right to designate a primary care provider; no referral or prior authorization for OB/GYN services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members.

You do not need prior authorization in any of the Siemens Healthineers medical plans to obtain access to obstetrical or gynecological care from an in-network healthcare professional who specializes in these services. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan ID card for a list of participating providers who specialize in obstetrics and gynecology.

Dropping dependent coverage during Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce, or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SHBC at **833-935-3328** within 30 days after the event. If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent **will not be eligible for COBRA** coverage. However, your dependent may be able to obtain coverage through a state Health Insurance Marketplace.

Watch for your Form 1095 in late January

Watch for your Form 1095 medical coverage tax form in late January 2022, which shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage for 2021. You may need this form to prove you were adequately insured.

Forms for the 2021 tax year must be mailed no later than January 31, 2022. Please allow seven to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to mySHSBenefits.com and select the **Get Form 1095 Early** tile, then complete the contact information, and under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

SIEMENS
Ingenuity for life

benefits Siemens + You

Choose Your 2021 Benefits with Confidence
Annual Enrollment Is October 5–October 16, 2020

What's Inside

Get Your Benefits News Online

You are receiving this print version because you do not have a valid preferred personal email address stored on **mySiemensBenefits.com**. For a preferred personal email address to be valid, it must be listed and selected as your personal preferred email address.

To receive important benefits information via email, log on to **mySiemensBenefits.com** and choose your communication preference by selecting **Your Profile** in the upper right-hand corner of the home page, then **Manage Communications** to review and update your delivery preference. If you prefer, you can call the SBSC to add your preferred email address to your account.

Annual Enrollment is your once-a-year opportunity to elect the coverage that will best meet your needs. Your benefits include medical, dental, vision, flexible spending accounts (FSAs), life insurance, personal accident insurance, long-term disability, commuter benefits and financial planning. Siemens is proud to offer a competitive, comprehensive benefits package to meet the diverse needs of our employees.

Before You Make Your Enrollment Elections

Siemens provides a variety of resources—many of them new for 2021—to help you understand what's changing, the options available to you, and the actions to take to ensure you have the benefit coverages you need. We encourage you to use these new resources—including **Personal Benefits Advisors**, a **Personalized Medical Plan Comparison Statement**, educational medical plan **webinars** and the **HSA Modeler**—and to fully understand the benefit programs available to you. Also take time to estimate your potential health care spending for the year ahead and compare plan costs. If you cover a spouse or domestic partner, both of you should take time to discuss your choices so you can understand the options available to you.

Annual Enrollment Launch Pad

The Annual Enrollment Launch Pad provides details and access to resources to help you make important decisions about your 2021 benefits. There's a lot of great information here—so be sure to explore all areas. Visit the Annual Enrollment Launch Pad at **usa.siemens.com/benefitsquickstart**.

The content on this site may change periodically.

NEW! Personal Benefits Advisors

Helping you understand your benefit options is a high priority for Siemens.

These advisors are different from the Siemens Benefits Service Center (SBSC) representatives since they can provide one-on-one support to help you determine your needs and select your benefits before you actually make your enrollment choices. Through this Siemens-provided service (at no cost to you), you can speak with an expert who can help you evaluate which benefits may best fit your situation based on who you cover as well as your health care needs.

You may **schedule an appointment** with a benefits advisor through the **Personal Benefits Advisor** tile on the **mySiemensBenefits.com** home page. Appointments are available 8 a.m. to 8 p.m. Eastern Time, Monday through Friday, now through October 16, 2020.

NEW! Your Medical Plan Comparison Statement

This statement shows how your annual contributions and the cost of coverage compare under the Health Reimbursement and Health Savings Medical Plans. Be sure to take the time to review your statement and share it with anyone who helps you make your benefit decisions—including your Personal Benefits Advisor if you schedule an appointment.

Access your statement on **mySiemensBenefits.com** in the Secure Message Center (the envelope icon on the top right of the home page screen).

NEW! Educational Medical Plan Webinars

These webinars, held daily through October 9, 2020, provide information about the Health Reimbursement and Health Savings Medical Plans, including their similarities and differences. Don't miss out! Register to attend on **mySiemensBenefts.com**. Webinars will also be recorded and available starting October 5 at the Annual Enrollment Launch Pad on Benefits QuickStart (**usa.siemens.com/benefitsquickstart**) for you to review at your convenience.

What's Changing

For 2021, there are no changes to vision, disability, life insurance, personal accident insurance, business travel, commuter benefits or financial planning benefits. **This document only provides information on the changes for 2021.**

Medical

Contributions

- Per-paycheck contributions for all medical plans will increase to reflect the continuously rising cost of health care across the nation.

Preferred Provider Organization (PPO) Medical Plan

- As announced during last year's Annual Enrollment, the PPO **will no longer be available**. If you are a current PPO participant and do not actively select a medical plan, you will automatically be enrolled in the Health Reimbursement Medical Plan, with the same plan administrator and coverage tier you have today.

Health Savings Medical Plan

- Providing choice and flexibility is important to the Company. Effective January 1, 2021, the Health Savings Medical Plan will also be available through **Blue Cross Blue Shield**. This means that you may enroll in the Health Savings Medical Plan through either UnitedHealthcare or Blue Cross Blue Shield. Both plans have the same per-paycheck contributions and plan features, including deductibles, out-of-pocket maximums, coinsurance and access to a Health Savings Account (HSA) with the same Siemens contribution.
- The **Health Savings Account (HSA**) individual contribution maximum for 2021 will increase from $3,550 to $3,600, and the family contribution maximum will increase from $7,100 to $7,200.

Inbound Delegates

- If you are a delegate to the United States from another country, only the **Health Reimbursement Medical Plan** option is available to you and your eligible dependents. For any areas of the United States where this coverage is not available, the SBSC will assist you in finding an alternative coverage option. For 2021, you will automatically be enrolled in the Health Reimbursement Medical Plan, with the same plan administrator and coverage tier you have today.

Dental

- The Healthineers Summary Plan Description incorrectly indicates that diagnostic intraoral-periapical and extraoral dental X-rays are covered at 100%. Delta Dental will provide 100% coverage through December 31, 2020, for Healthineers employees, with coverage corrected to 80% beginning January 1, 2021.

Prescription Drugs

- Preventive services under the Affordable Care Act (ACA) have expanded to include coverage for human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) medications. HIV preventive medications will be covered with no member cost share as of January 1, 2021 (restrictions on specific products and/or quantities may apply).

Flexible Spending Accounts (FSAs)

WageWorks is now HealthEquity

- In addition to certain changes you may have already seen in your member portal, here's what you can expect in the coming months:
  - —Newly issued cards will reflect the new HealthEquity brand (excludes the Commuter Benefits Program).
  - —The **wageworks.com** web site will redirect you to **healthequity.com** for quick, easy access.

Health Care FSA

- The maximum amount you can contribute to the Health Care FSA in 2021 will increase from $2,700 to $2,750.

Please note: The CARES Act permits expenses incurred on or after January 1, 2020, for non-prescription, over-the-counter medical care products (including menstrual care) to be reimbursed by the Health Care FSA.

Remember to Use Your FSA Dollars

If you have any unused funds in your 2020 Health Care and/or Dependent Day Care FSA(s), you have until March 15, 2021, to incur eligible expenses. Be sure to submit claims for eligible expenses by **May 31, 2021**.

Two Ways to Enroll

You can make your 2021 benefit elections two ways:

- By logging on to **mySiemensBenefits.com** using your desktop, smartphone or tablet.
- If you do not have Internet access, call the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

If You Are a PPO Participant and Do Not Enroll

As announced during last year's Annual Enrollment, the PPO will no longer be available. If you are a current PPO participant and do not actively select a new medical plan, you will automatically be enrolled in the Health Reimbursement Medical Plan, with the same plan administrator and coverage tier you have today. If you currently participate in an FSA, your 2020 election will NOT carry over to 2021, and your elected contribution amount for 2021 will be set to $0.

If You Are Enrolled in a Medical Plan Other Than the PPO and Do Not Enroll

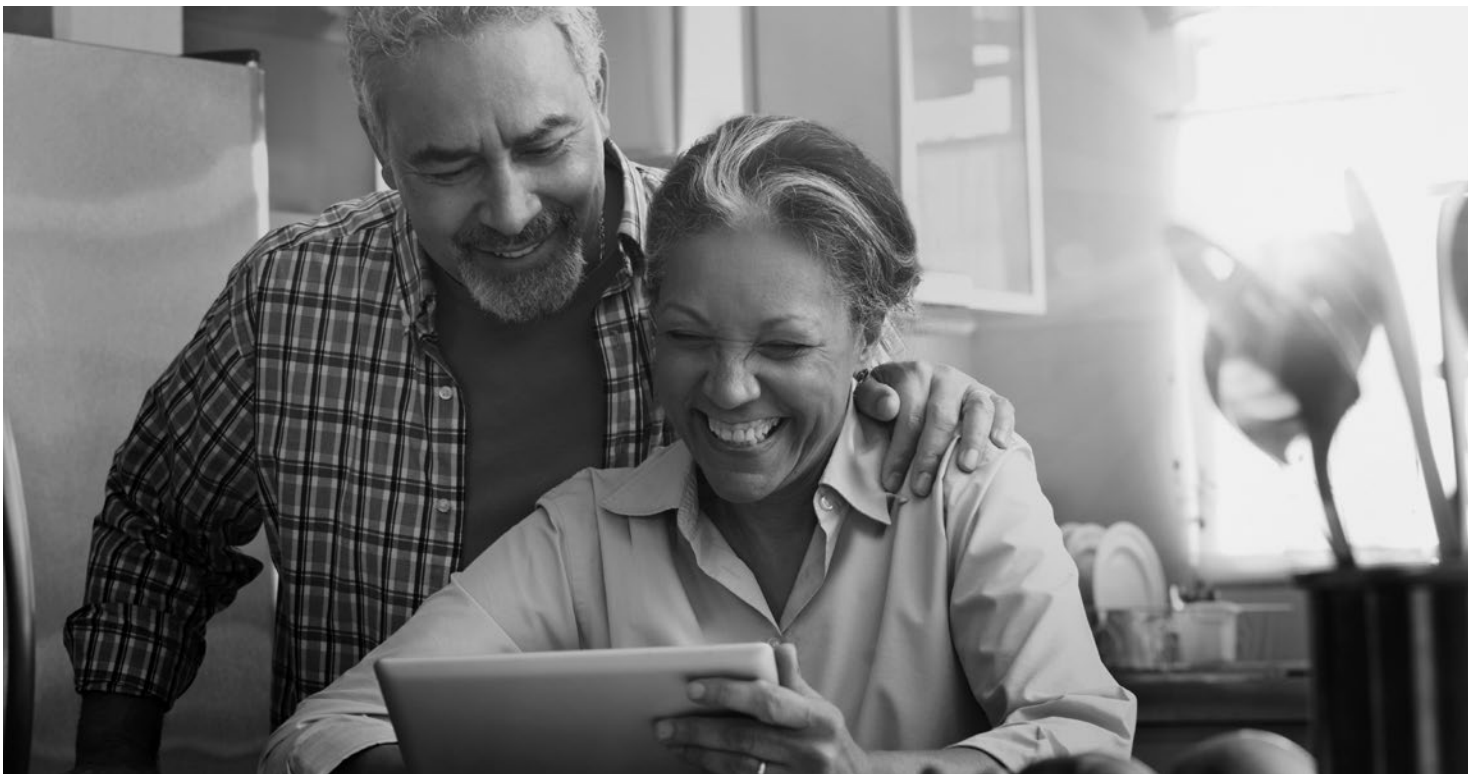
If you do not enroll during Annual Enrollment, you will continue in the same coverage you currently have with the same plan administrator. Your 2020 FSA and/or HSA elections will NOT carry over to 2021, and your elected contribution amount for 2021 will be set to $0.

Siemens Benefits Service Center (SBSC)

If you have questions about your benefits, call the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Prefer to chat online?

Get answers to your Annual Enrollment questions through web chat on **mySiemensBenefits.com**. Go to **Enroll in Your Benefits** or **Contact Us** to start a chat. Representatives will be available weekdays from 10 a.m. to 6 p.m. Eastern Time.



Additional Information and Notices

Summary of Material Modifications (SMM)

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2021. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in:

- The SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program dated January 1, 2016, and subsequent SMMs dated 2017, 2018, 2019 and 2020, and Benefits Updates March 2020 and April 2020
- The SPD for the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2019 and 2020, and Benefits Updates March 2020 and April 2020

Keep this 2021 document with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the SBSC at **1-800-392-7495**.

Compare Medical Plan Options with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plan options are available on **mySiemensBenefits.com**. They summarize important information in a standard format, so you can compare across all the plan options. To access the SBCs on the web site, simply select the **Health and Insurance** tab from the **mySiemensBenefits.com** home page, and then select **Summary of Benefits and Coverage**.

You may also obtain a paper version of the SBC for any of the medical plans, free of charge, by contacting the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens is committed to protecting employees and their families from discrimination under our health care programs by reviewing the enclosed notice.

HIPAA Privacy Notice Reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on **mySiemensBenefits.com** or call the SBSC at **1-800-392-7495** to request a paper copy.

How Coordination of Benefits (COB) Works

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary.

Additional Life Insurance and Disability Provisions

Siemens has at-work provisions for Supplemental Life Insurance and disability benefits. If you are not actively at work when your increase in coverage is scheduled to take effect, you will not be eligible for the increase until you return to work. Contact the SBSC at **1-800-392-7495** for guidance.

Dropping Dependent Coverage During Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SBSC at **1-800-392-7495** within 30 days after the event. If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent will not be eligible for COBRA coverage. However, they may be able to obtain coverage through a state Health Insurance Marketplace.

Experiencing a qualified life event?

Reminder: If you experience a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements) during the year, you must notify the SBSC within 30 days of the event.

Right to Designate a Primary Care Provider; No Referral or Prior Authorization for OB/GYN Services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. You do not need prior authorization in any of the Siemens medical plans to obtain access to obstetrical or gynecological care from an in-network health care professional who specializes in these services. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan option ID card for a list of participating providers who specialize in obstetrics and gynecology.

Watch for Your Form 1095 in Late January

Watch for your Form 1095 medical coverage tax form in late January 2021, which shows the months of the year that you and your dependents were offered or enrolled in medical coverage for 2020. You'll need this form to file your 2020 income taxes. Proving that you're adequately insured each year is required under the Affordable Care Act. If you aren't covered, you could face tax penalties—which is why it's important to keep this form with other important tax documents you'll need for the current tax year.

Forms for the 2020 tax year must be mailed no later than January 31, 2021. Please allow seven to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to **mySiemensBenefits.com** and select the **Get Form 1095 Early** banner, then complete the contact information, and, under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that, if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

Complete details of the various benefits offered under the Siemens and Healthineers benefit programs can be found in the legal plan documents and insurance contracts that govern the plans in the programs (i.e., the Summary Plan Description and applicable Summaries of Material Modifications and insurance contracts that govern the plan and program). Siemens Corporation and Siemens Medical Solutions, USA, Inc., as the plan sponsors of the Siemens and Healthineers benefit plans, respectively, reserve the right to amend or terminate the plans or any part of the plans they sponsor at any time and for any reason.

SIEMENS
Ingenuity for life

benefits Siemens You

April 2020

Dear Employee:

Siemens is routinely evaluating the impact of COVID-19 on our employees as information is made available and new directives are being issued by federal and local authorities. This document provides you with important benefits updates and reminders to help support you during this time.

Health & Group Benefits Updates

Telemedicine Visits for Siemens Group Medical Plan Members
If you or a dependent is covered under a Siemens medical plan option, you may have a telemedicine visit with a physician, 24/7—from your home (or wherever you may be). Using your smartphone, tablet or computer (with a webcam), you may connect with a virtual doctor. **Visits with UnitedHealthcare, Blue Cross Blue Shield and Humana telemedicine providers are available to members at no cost through June 30, 2020. A telemedicine provider refers to a virtual doctor visit provided through Siemens medical carriers' third-party telemedicine providers, including LiveHealth Online, Teladoc, AmWell and Doctor On Demand.** Members enrolled in Kaiser, Cigna International and HMSA should check their member web site for information on covered services.

You may schedule a telemedicine visit with a doctor via your health plan's web site.

Provider	Web Site	Telephone Number
Blue Cross Blue Shield	anthem.com	1-855-869-8137
UnitedHealthcare	myuhc.com	1-866-221-5901
Kaiser Permanente	healthy.kaiserpermanente.org	1-800-464-4000
HMSA Blue Cross Blue Shield of Hawaii	hmsa.com	• Oahu: 1-808-948-6111 (Toll-Free: 1-800-776-4672) • Maui Branch: 1-808-871-6295
Cigna International	cignaenvoy.com	• United States: 1-800-441-2668 • Outside United States: 1-302-797-3100
Humana (union only)	humana.com	1-888-393-6765

Over-the-Counter Medications
The CARES Act permits over-the-counter medical care products without a prescription from a physician as well as menstrual care expenses to be reimbursed by a Health Savings Account or Health Care Flexible Spending Account for expenses incurred on or after January 1, 2020.

Coverage of COVID-19 Vaccine and Preventive Care
When a vaccine (or preventive service) for COVID-19, which includes items, services and immunizations intended to prevent or mitigate COVID-19 that receive a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) or a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, is available to the general public, it will be provided as a preventive service within 15 days of the recommendation, which will allow plan participants to get the vaccine without cost-sharing.

Short-Term Disability
If you are on an approved unpaid leave of absence (i.e., Personal Leave of Absence) beginning March 23, 2020, or later, you will be considered actively employed through September 30, 2020, for disability purposes. This means if you are on an approved unpaid leave of absence and you become disabled on or before September 30, 2020, you may be eligible for disability benefits.

Summary of Material Modifications (SMM)
The Health and Group Benefits Updates section of this document serves as a Summary of Material Modifications (SMM) for benefit changes effective April 15, 2020. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program dated January 1, 2016, and subsequent SMMs dated 2017, 2018, 2019, 2020 and Benefits Update March 2020, and the SPD for Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2019, 2020 and Benefits Update March 2020. It also supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program – Retiree Coverages Parts 2, 2A, Part 2B and 2C dated January 1, 2019, and subsequent SMM dated 2020 and Benefits Update March 2020, and the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program – Retiree Coverage dated May 1, 2018, and subsequent SMMs dated 2019, 2020 and Benefits Update March 2020.

Keep this document with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the Siemens Benefits Service Center (SBSC) at **1-800-392-7495**.

Savings Plan Updates

Effective May 1, 2020, you will no longer be required to first exhaust your Savings Plan loan options in order to take a hardship withdrawal. To apply for a hardship withdrawal, please visit **mySiemensBenefits.com** or contact the SBSC.

For the 2020 calendar year, required minimum distributions (RMDs) from the Savings Plan are waived. If you would like to request your RMD, please visit **mySiemensBenefits.com** or contact the SBSC.

For the 2020 tax year, a new Coronavirus Related Distribution (CRD) is available to all Savings Plan participants who are impacted by the coronavirus. The CRD is for up to $100,000, is exempt from the 10% early withdrawal tax penalty and may be repaid to the Savings Plan or another qualified retirement plan/IRA within three years. For additional details on the CRD, please visit **mySiemensBenefits.com** or contact the SBSC after May 25. Participants impacted by the coronavirus may treat other payments already taken from the plan as a CRD when filing individual taxes for 2020. Any payments you take from any eligible retirement plan and/or IRAs which you intend to treat as a CRD count toward the $100,000 limit.

For the remainder of the 2020 calendar year, participants impacted by the coronavirus may elect to delay loan payments on new or existing Savings Plan loans for a period of 12 months. To elect to delay loan payments, please visit **mySiemensBenefits.com** or contact the SBSC after May 25.

To be eligible for either the CRD and/or to delay loan payments for a 12-month period, you must certify that you are impacted by the coronavirus on either **mySiemensBenefits.com** or by contacting the SBSC after May 25. Impacted by the coronavirus is defined as someone who:

1) Has been diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention, or
2) Has a spouse or dependent diagnosed with such virus or disease, or
3) Has experienced adverse financial consequences as a result of being quarantined, being furloughed or laid off or having work hours reduced due to such virus or disease, being unable to work due to lack of child care due to such virus or disease, closing or reducing hours of a business owned or operated by the individual due to such virus or disease, or other factors as determined by the Secretary of the Treasury.

If you have any questions about these Savings Plan changes, please visit **mySiemensBenefits.com** or contact the SBSC at **1-800-392-7495**.

Important Benefits Reminders

Employee Assistance Program (EAP)
The EAP provides free, confidential counseling and referrals in times of personal, family, legal and financial need. You and your eligible family members may receive up to six free short-term counseling sessions a year. And now we've expanded this program so that once you complete your six sessions, you may call Cigna at **1-800-547-5589** to request an EAP code for four additional sessions, if needed, for a maximum of 10 sessions with a counselor, to be used by September 30, 2020.

Personal and confidential video-based mental health and/or substance use care is also available through the EAP. It's easy to find a telemedicine provider who is right for you. Go to **mycigna.com** and log on to search for EAP providers; be sure the EAP box is checked in the search tool. Call to make an appointment with your selected provider as you would for a face-to-face visit. The provider will give you information on how to set up the video-based session according to the technology they are using.

You may also call **1-800-547-5589** to access an EAP counselor. Be sure to identify yourself as a Siemens employee or family member.

Ayco Financial Resources
Even if you did not enroll in Ayco's financial services for 2020, you may access resources provided by Ayco here to help navigate the uncertainty of the current financial environment.

Savings Plan
If you are thinking of taking money out of your Savings Plan soon, be sure your address, mobile phone number and financial institution information (i.e., direct deposit account information) are up to date, and change them if needed as soon as possible by visiting **mySiemensBenefits.com** or contacting the SBSC. You should also consider signing up for text messages, to ensure you receive notifications about your account, where applicable.

If you don't do this in advance of your request, you may experience a delay due to security requirements designed to protect your account.

Benefits QuickStart
As a reminder, the **Siemens Benefits QuickStart** portal is a comprehensive employee resource for Siemens benefits programs. The Novel Coronavirus (COVID-19) Benefits Resources section, which can be accessed through the home page, has been updated with these reminders as well as additional resources to support you.

While we collectively face daily challenges during this unprecedented period, we encourage you to stay safe, connected and informed of the latest developments and resources available to you.

Sincerely,

Siemens Benefits Service Center

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benefits Siemens + You

March 2020

Dear Employee,

The health and well-being of our employees and their families is our first priority as we work through these challenging and uncertain times. We are closely monitoring developments related to the Novel Coronavirus (COVID-19) and the impact on our employees.

With the outbreak continuing to evolve rapidly, it is vitally important to take measures to contain the virus and seek care in a timely manner. This document provides you with important benefits updates and reminders to support these efforts.

Medical Coverage for COVID-19 Testing
To ensure cost is not a barrier for you and your covered dependents, effective February 1, 2020, the **Siemens Group Medical Plan will provide coverage for COVID-19 diagnostic testing with no cost to members (including deductibles, copayments and coinsurance) or prior authorization requirements**. This coverage includes COVID-19 diagnostic testing as well as the visit associated with COVID-19 testing, whether it takes place at a doctor's office, urgent care center, emergency department or via a virtual appointment. Out-of-network coverage will be subject to reasonable and customary charges or maximum allowed amount limitations.

Virtual Doctor Visits for Siemens Group Medical Plan Members
If you or a dependent is covered under a Siemens medical plan option, you may have a virtual visit with a physician, 24/7—from your home (or wherever you may be). Using your smartphone, tablet or computer (with a webcam), you can connect with a doctor. Normal cost-sharing will apply unless the visit is related to COVID-19 testing, which is covered at 100%. You may schedule a virtual visit with a doctor via your health plan's web site.

Provider	Web Site	Telephone Number
Blue Cross Blue Shield	**anthem.com**	1-855-869-8137
UnitedHealthcare	**myuhc.com**	1-866-221-5901
Kaiser Permanente	**healthy.kaiserpermanente.org**	1-800-464-4000
HMSA Blue Cross Blue Shield of Hawaii	**hmsa.com**	• Oahu: 1-808-948-6111 (Toll-Free: 1-800-776-4672) • Maui Branch: 1-808-871-6295
Cigna International	**cignaenvoy.com**	• United States: 1-800-441-2668 • Outside United States: 1-302-797-3100
Humana (union only)	**humana.com**	1-888-393-6765

Employee Assistance Program (EAP)
The EAP provides free, confidential counseling and referrals in times of personal, family, legal and financial need. You and your eligible family members may receive up to six free short-term counseling sessions a year.

Personal and confidential video-based mental health and/or substance use care is also available through the EAP. It's easy to find a telehealth provider who is right for you. Go to **mycigna.com** and log on to search for EAP providers; be sure the EAP box is checked in the search tool. Call to make an appointment with your selected provider as you would for a face-to-face visit. The provider will give you information on how to set up the video-based session according to the technology they are using.

You may also call **1-800-547-5589** to access an EAP counselor. Be sure to identify yourself as a Siemens employee or family member.

Savings Plan
COVID-19 has spread uncertainty across global markets, contributing to extreme market volatility. During this time, it's important that you not make rushed decisions, but you may want to review your retirement investments with your long-term financial goals in mind. On **mySiemensBenefits.com** you may review your investment portfolio, learn about volatile market considerations and utilize tools to help manage your investments in the Savings Plan.

Benefits QuickStart
As a reminder, the Siemens Benefits QuickStart portal (**usa.siemens.com/benefitsquickstart**) is a comprehensive employee resource for Siemens benefits programs. The Company has created a specific Novel Coronavirus (COVID-19) Benefits Resources section, which can be accessed through the home page.

Summary of Material Modifications (SMM)
The Medical Coverage for COVID-19 Testing section of this document serves as a Summary of Material Modifications (SMM) for benefit changes effective February 1, 2020. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program dated January 1, 2016, and subsequent SMMs dated 2017, 2018, 2019 and 2020, and the SPD for Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMMs dated 2019 and 2020. It also supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program – Retiree Coverages Parts 2, 2A, Part 2B and 2C dated January 1, 2019, and subsequent SMM dated 2020, and the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program – Retiree Coverage dated May 1, 2018, and subsequent SMMs dated 2019 and 2020.

Keep this document with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the Siemens Benefits Service Center (SBSC) at **1-800-392-7495**.

Siemens comprehensive benefits coverage is designed to be accessible and to meet your varied health care needs. Thank you for your continued dedication and commitment to keeping yourself, your family and your colleagues safe during this extraordinary time.

Sincerely,

Siemens Benefits Service Center

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Focus on You in 2020
Annual Enrollment Is October 7–October 18, 2019

What's Inside

Get Your Benefits News Online

You are receiving this print version because you have not provided a valid preferred personal email address on **mySiemensBenefits.com**. For a preferred personal email address to be valid, it must be listed and selected as your personal preferred email address.

To receive important benefits information via email, log on to **mySiemensBenefits.com** and choose your communication preference by selecting **Your Profile** in the upper right-hand corner of the home page, then **Manage Communications** to review and update your delivery preference. If you prefer, you can call the Siemens Benefits Service Center (SBSC) at **1-800-392-7495** to add your preferred email address to your account.

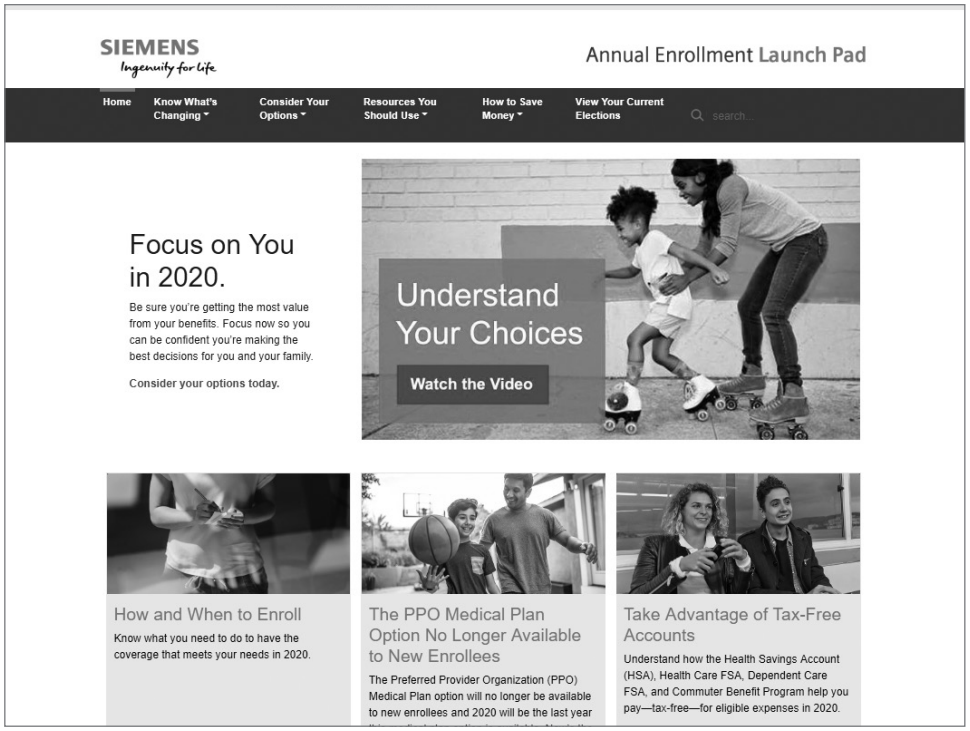
Annual Enrollment is your once-a-year opportunity to elect the coverage that you feel will best meet your needs. Your benefits include medical, dental, vision, flexible spending accounts (FSAs), life insurance, personal accident insurance, long-term disability, commuter benefits and financial planning.

Siemens is proud of the benefits package we offer. The programs and resources available provide competitive value as well as a variety of choices for the diverse needs of our employees. **This year focus on assessing your 2020 benefit needs. Why? Because understanding how you use your benefits will help you make informed and meaningful decisions—for you and your family**.

The Company encourages you to **take an active role** in your health, **compare costs** to fully understand your health care spending and **take the time** you need to make important benefit decisions. And if you cover a spouse or domestic partner, both of you should take time to discuss your choices so you can understand the options available to you.

Annual Enrollment Launch Pad

The Annual Enrollment Launch Pad provides details to help you make important decisions about your 2020 benefits. There's a lot of great information here—so be sure to explore all areas. Access the Annual Enrollment Launch Pad at **usa.siemens.com/benefitsquickstart** for additional information and resources to help you make your decisions.



The content on this site may change periodically.

PPO Medical Plan Option Not Available to New Enrollees

The Preferred Provider Organization (PPO) Medical Plan option **will no longer be available to new enrollees, and 2020 will be the last year this option is available**. What this means to you:

- **If you are currently enrolled in the PPO Medical Plan option...**

  You will be able to remain enrolled in the PPO for 2020 and have a year to think through your medical plan choices for 2021. Since 2020 is the last year you can remain in the PPO, you may want to take the time now to consider your other medical plan options.

- **If you are enrolled in the Health Reimbursement or Health Savings Medical Plan option...**

  You will continue to have these medical plan options as choices for 2020 and beyond. And you can continue to take advantage of Siemens' contribution to your Health Reimbursement Account (HRA) or Health Savings Account (HSA).

Why 2020 Is the Last Year Siemens Will Offer the PPO Medical Plan Option

Each year Siemens spends significant time carefully reviewing its programs to ensure employees have access to **competitive**, **cost-effective**, **quality health care**. The decision to make the PPO Medical Plan option available to current participants only in 2020, and to no longer offer the option in 2021, aligns with Siemens' focus on **employee health** and wellness while introducing much-needed **simplification**.

To meet the diverse needs of Siemens employees while promoting health, Siemens will continue to offer employee choice through the Health Reimbursement and Health Savings Medical Plan options. These options are offered through two national carriers and encourage members to focus on their health through the **Healthy Rewards** program—because being healthy and staying well are so important to each and every one of us.

As you look more closely at the Health Reimbursement and Health Savings Medical Plan options, you will see that they provide **better value** to employees than the PPO, which is no longer competitive and is the most expensive plan.

Your benefits are about you, so be sure you focus on the options available in 2020 and use the decision support tools available on **mySiemensBenefits.com**.

Decision Support Tools Available on mySiemensBenefits.com

Take a look at the resources available to help you make important decisions for you and your family.

Medical Expense Estimator tool

Wouldn't it be helpful to see into the future? With the Medical Expense Estimator tool, you can get a comparison of your estimated out-of-pocket expenses across medical plan options. Simply provide your estimated medical and prescription drug usage assumptions for 2020, and the tool does the rest.

Health Plan Comparison Charts

Seeing side-by-side comparisons can really help clarify your choices. With the Health Plan Comparison Charts, you can see how benefits compare under each of the medical, dental and vision plan options.

Provider Search Tool

It's important to know if your provider is in your plan. Through a provider search tool, you can see if your doctors, hospitals, etc., participate in the medical, dental and/or vision plan options you are considering. Don't forget to talk with your doctor's office to ensure it accepts your selected plan option.

What's Changing

For 2020, there are no changes to dental, life insurance, personal accident insurance, business travel, commuter benefits or financial planning benefits. ***This document only provides information on the changes for 2020***.

Medical

Contributions

- There will be a modest increase to per-paycheck contributions for all medical plan options to reflect the continuously rising cost of health care across the nation.

Preferred Provider Organization Medical Plan Option

- For 2020, the Preferred Provider Organization (PPO) Medical Plan option is available to current PPO participants but **will no longer be offered effective January 1, 2021**.
  - This means that if you are currently enrolled in the PPO Medical Plan option, you will be able to remain in the PPO for 2020 and have a year to think through your medical plan choices for 2021.

Health Reimbursement Medical Plan Option

- The administrator of the Blue Cross Blue Shield (BCBS) Health Reimbursement Account (HRA) will change from HealthEquity to Blue Cross Blue Shield.
  - You will continue to submit eligible 2019 claims to HealthEquity through March 31, 2020.
  - Eligible 2020 claims will be submitted to Blue Cross Blue Shield.
  - Find details on the Annual Enrollment Launch Pad, available at **usa.siemens.com/benefitsquickstart**.

Summary Plan Description Clarification for Company Couples

- Your HRA balance—provided by Siemens—is a great way to pay for eligible medical expenses. When determining who is paying for coverage, it's important to understand that your HRA balance will not transfer if you change who is paying for coverage (e.g., husband covered family in 2019, and wife covers family in 2020). If this type of change occurs, unused money in the HRA will be forfeited.

Health Savings Medical Plan Option

- The Health Savings Account (HSA) individual contribution maximum amount will increase from $3,500 to $3,550, and the family contribution maximum will increase from $7,000 to $7,100 in 2020. These limits include the automatic company contribution and any Healthy Rewards you may earn. If you are age 55 or older, you can continue to contribute an additional $1,000 to your HSA in 2020 through Optum Bank.

New Blue Cross Blue Shield (BCBS) ID Cards

- Enrollees in the BCBS Medical Plan options will receive new ID cards. If you don't receive a new BCBS medical ID card by December 31, 2019, please call BCBS at **1-855-869-8137**.

Please note: When receiving care, ensure you share your new ID card with your provider. While your identification number will remain the same, the group number is changing. Using your new ID card on or after January 1, 2020, will prevent billing issues.

Cigna International Medical Plan Option

- The Cigna International Medical Plan option network will change from the Preferred Provider Option network to the Cigna International Open Access Plus (OAP) network, providing higher discount levels and larger provider networks overseas.
  - The Dental and Vision networks are not affected by this change.
  - New ID cards will be issued to reflect this network enhancement.

Prescription Drugs

- **The CVS/caremark clinical management programs** will be expanded to ensure drug safety and encourage use of lower-cost, clinically effective alternatives:
  - A three-day limit for new opioid utilizers 19 years of age or younger
  - Enhanced specialty guideline management for members with hereditary angioedema and members who take Soliris

Vision

Contributions

- There will be a modest increase to per-paycheck contributions for the Enhanced and Premier Vision Plan options.

Flexible Spending Accounts (FSAs)

Health Care FSA

- The maximum amount you can contribute to the Health Care FSA in 2020 will increase from $2,650 to $2,700.

Short-Term Disability (STD) and Long-Term Disability (LTD)*

Contributions

- There will be a modest increase to per-paycheck contributions for employee-paid LTD.

**STD and LTD rules may differ for unions based on applicable collective bargaining agreements.*

How to Enroll

You can make your 2020 benefit elections two ways:

- By logging on to **mySiemensBenefits.com** using your desktop, smartphone or tablet.
- If you do not have Internet access, call the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

What Happens If You Do Not Enroll

If you do not enroll during Annual Enrollment, you will continue in the same coverage you currently have with the same claims administrator. Your 2019 FSA and HSA elections will NOT carry over to 2020, and your elected contribution amount for 2020 will be set to $0 if you take no action.

Siemens Benefits Service Center (SBSC)

If you have questions about your benefits, call the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Prefer to Chat Online?

Get answers to your Annual Enrollment questions through web chat on **mySiemensBenefits.com**. Go to **Enroll in Your Benefits** or **Contact Us** to start a chat. Representatives will be available weekdays from 10 a.m. to 6 p.m. Eastern Time.

Additional Information and Notices

Summary of Material Modifications (SMM)

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2020. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program dated January 1, 2016, and subsequent SMMs dated 2017, 2018, and 2019, and the SPD for Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program dated May 1, 2018, and subsequent SMM dated 2019. Keep this document with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the SBSC at **1-800-392-7495**.

Compare Medical Plan Options with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plan options are available on **mySiemensBenefits.com**. They summarize important information in a standard format, so you can compare across all the plan options. To access the SBCs on the site, simply select the **Health and Insurance** tab from the **mySiemensBenefits.com** home page, and then select **Summary of Benefits and Coverage**.

You may also obtain a paper version of the SBC for any of the medical plan options, free of charge, by contacting the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens is committed to protecting employees and their families from discrimination under our health care programs by reviewing the enclosed notice.

HIPAA Privacy Notice Reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on **mySiemensBenefits.com** or call the SBSC at **1-800-392-7495** to request a paper copy.

How Coordination of Benefits (COB) Works

If coverage for a health service is available under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be partially covered under the other plan, which is considered secondary.

Additional Life Insurance and Disability Provisions

Siemens has at-work provisions for Supplemental Life Insurance and disability benefits. If you are not actively at work when your increase in coverage is scheduled to take effect, you will not be eligible for the increase until you return to work. Contact the SBSC at **1-800-392-7495** for guidance.

Dropping Dependent Coverage During Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SBSC at **1-800-392-7495** within 30 days after the event. If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent will not be eligible for COBRA coverage. However, he or she may be able to obtain coverage through a state Health Insurance Marketplace.

Experiencing a Qualified Life Event?

Reminder! If you experience a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements) during the year, you must notify the SBSC within 30 days of the event.

Right to Designate a Primary Care Provider; No Referral or Prior Authorization for OB/GYN Services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. You do not need prior authorization in any of the Siemens medical plan options to obtain access to obstetrical or gynecological care from an in-network health care professional who specializes in these services. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan option ID card for a list of participating providers who specialize in obstetrics and gynecology.

Watch for Your Form 1095 in Late January

Watch for your Form 1095 medical coverage tax form in late January 2020, which shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage for 2019. You'll need this form to file your 2019 income taxes. Proving that you're adequately insured each year is required under the Affordable Care Act. If you aren't covered, you could face tax penalties—which is why it's important to keep this form with other important tax documents you'll need for the current tax year.

Forms for the 2019 tax year must be mailed no later than January 31, 2020. Please allow 7 to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to **mySiemensBenefits.com** and select the **Get Form 1095 Early** banner, then complete the contact information, and under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

Complete details of the various benefits offered under the Siemens and Healthineers benefit programs can be found in the legal plan documents and insurance contracts that govern the plans in the programs (i.e., the Summary Plan Description and applicable Summaries of Material Modifications and insurance contracts that govern the plan and program). Siemens Corporation and Siemens Medical Solutions, USA, Inc., as the plan sponsors of the Siemens and Healthineers benefit plans, respectively, reserve the right to amend or terminate the plans or any part of the plans they sponsor at any time and for any reason.

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Take Time to Consider Your Options
2019 Annual Enrollment is October 1–October 12, 2018

What's Inside

Annual Enrollment is your once-a-year opportunity to elect the coverage that you feel will best meet your needs. Your benefits include medical, dental, vision, flexible spending accounts (FSAs), life insurance, personal accident insurance, long-term disability, commuter benefits and financial planning.

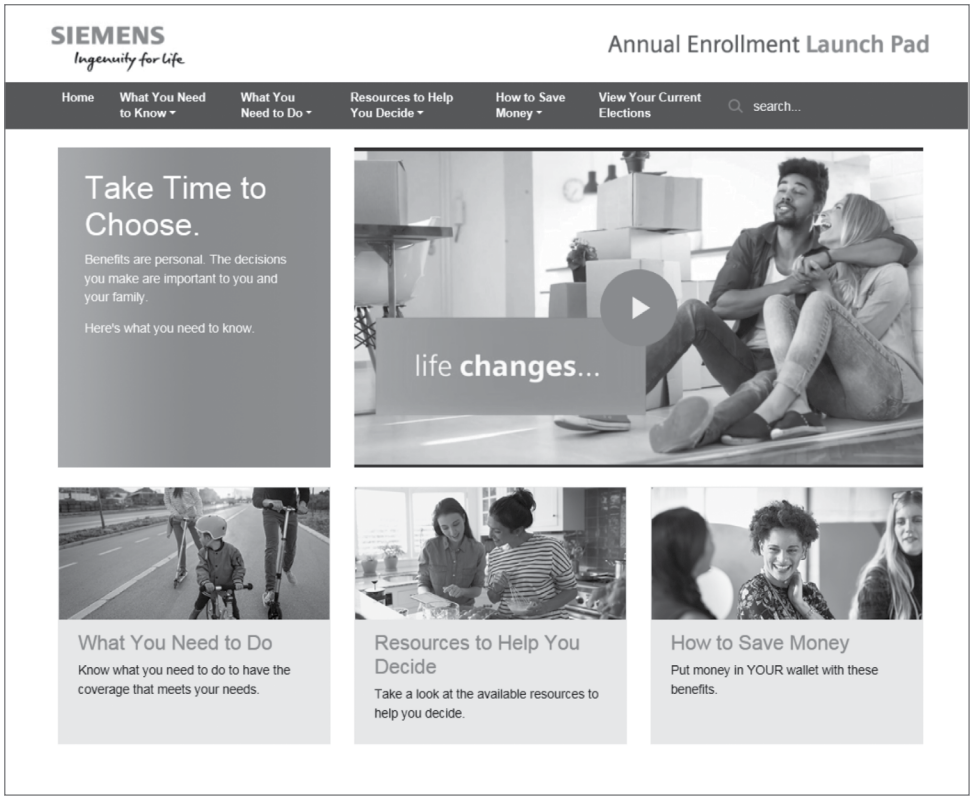
Siemens provides a variety of resources to help you understand what's changing for 2019, the options available to you, and the actions you need to take to ensure you have the benefit coverages that best fit your unique needs. Your benefits are about you, so be sure to take the time to review and consider your options. Don't forget, if you cover a spouse or domestic partner, be sure to discuss with them—because benefits affect them, too.

This year, the Annual Enrollment Launch Pad was created to provide a more streamlined experience that will make reviewing and evaluating your benefit options easier. Access the Annual Enrollment Launch Pad at **usa.siemens.com/benefitsquickstart** to help you make your decisions.

Get Your Benefits News Online

You are receiving this print version because you do not have a valid preferred personal email address stored on **mySiemensBenefits.com**. For a preferred personal email address to be valid, it must be listed and selected as your personal preferred email address.

To receive important benefits information via email, log on to **mySiemensBenefits.com** and choose your communication preference by selecting **Your Profile** in the upper right-hand corner of the home page, then **Manage Communications** to review and update your Delivery Preference. If you prefer, you can call the Siemens Benefits Service Center (SBSC) to add your preferred email address to your account.



What's Changing

For 2019, there are no changes to dental, vision, life insurance, personal accident insurance, business travel accident insurance, short-term and long-term disability, commuter benefits or financial planning benefits. ***The information on the changes for 2019 is shown below.***

Contributions

- Per-paycheck contributions will increase slightly for the PPO and Health Reimbursement Medical Plan options to reflect the continuously rising cost of health care across the nation.

Medical

Health Reimbursement Medical Plan Option

- All in-network copayments, including for office, urgent care and virtual doctor visits, will be eliminated, with all expenses subject to the deductible and coinsurance.
- The automatic company contribution to your Health Reimbursement Account (HRA) will be reduced from $450 to $400 for you and from $900 to $800 for you and your covered spouse or domestic partner.
- For the Health Reimbursement Account (HRA), the maximum amount that can be carried over for use on the next plan year's medical expenses will be $4,000 beginning December 31, 2019.
  - For example, if after all of your 2019 claims are processed, you have an HRA balance of $4,100, only $4,000 will roll over for use on 2020 medical expenses. You will still receive your automatic company contribution on January 1, 2020, and can continue to earn Healthy Rewards in 2020.

Health Savings Medical Plan Option

- The Health Savings Account (HSA) individual contribution maximum amount will increase from $3,450 to $3,500, and the family contribution maximum will increase from $6,900 to $7,000 in 2019. These amounts include the automatic company contribution and any Healthy Rewards you may earn. If you are age 55 or older, you can continue to contribute an additional $1,000 to your HSA in 2019 through Optum Bank.

Update to Covered Services

- Approved Residential Treatment Centers are covered and are removed from the exclusion list in the Summary Plan Description (SPD).

Employee Assistance Program (EAP)

- The Cigna EAP web site URL has changed from **cignabehavioral.com** to **mycigna.com**.

Dresser-Rand Olean Union Medical Plan Options

- The Olean Union PPO and Olean Union Health Savings Medical Plan options will change to the standard PPO and Health Savings Medical Plan options as agreed to in the most recent collective bargaining agreement:

Medical Plan Option	2018 Deductible	2019 Deductible	2018 Out-of-Pocket Maximum	2019 Out-of-Pocket Maximum
PPO (includes deductible and coinsurance; does not include prescription drug expenses)	**In-Network** $390 individual $920 family **Out-of-Network** $790 individual $1,840 family	**In-Network** $850 individual $2,300 family **Out-of-Network** $1,250 individual $3,400 family	**In-Network** $2,640 individual $5,280 family **Out-of-Network** $5,280 individual $10,560 family	**In-Network** $3,700 individual $10,000 family **Out-of-Network** $4,700 individual $14,000 family
Health Savings Medical Plan (includes deductible, coinsurance and combined medical and prescription drug expenses)	**In-Network** $2,700 individual $5,400 family **Out-of-Network** $3,300 individual $6,600 family	**In-Network** $2,000 individual $4,000 family **Out-of-Network** $3,000 individual $6,000 family	**In-Network** $3,960 individual $7,865 family* **Out-of-Network** $6,600 individual $13,200 family	**In-Network** $5,500 individual $11,000 family* **Out-of-Network** $7,000 individual $14,000 family

* *If an employee covers more than one individual under the **Health Savings Medical Plan option**, and one individual reaches $7,350 in eligible in-network out-of-pocket expenses, all remaining eligible in-network expenses will be paid at 100% for that individual only.*

- The automatic Health Savings Account (HSA) company contribution for Olean Union employees will change:

Coverage Tier	2018 HSA Contribution	2019 HSA Contribution
You Only	$1,000	$300
You + Spouse	$1,500	$600
You + Children	$2,000	$300
You + Family	$2,000	$600

Prescription Drugs

- The **CVS/caremark clinical management programs** will be expanded to ensure drug safety and encourage use of lower-cost, clinically effective alternatives:
  - Quantity limits on opioids based on CDC guidelines.
  - Prior authorization required for topical medical devices (e.g., creams, gels) and select saliva products when over-the-counter alternatives are available.
  - Use of other topical therapies prior to filling a Dupixent prescription. While current approvals are honored until prescription expiration, enhanced criteria will be applied for continued use.
  - The brand drugs Duexis and Vimovo will only be available if determined to be of "medical necessity," since over-the-counter alternatives are available.
- **Olean Union** prescription drug out-of-pocket maximums will change as follows:

Medical Plan Option	2018 Prescription Out-of-Pocket Maximum	2019 Prescription Out-of-Pocket Maximum
PPO	**In-Network** $1,650 individual $3,300 family	**In-Network** $2,300 individual $3,500 family
Health Savings Medical Plan (includes deductible, coinsurance and combined medical and prescription drug expenses)	**In-Network** $3,960 individual $7,865 family* **Out-of-Network** $6,600 individual $13,200 family	**In-Network** $5,500 individual $11,000 family* **Out-of-Network** $7,000 individual $14,000 family

* *If an employee covers more than one individual under the **Health Savings Medical Plan option**, and one individual reaches $7,350 in eligible in-network out-of-pocket expenses, all remaining eligible in-network expenses will be paid at 100% for that individual only.*

Remember, if you use a manufacturer copayment or discount card to fill your specialty medications, only the cost share that you pay out-of-pocket will be applied to your deductible and out-of-pocket maximum. Manufacturer contributions may reduce your overall cost for the medication, but will not count toward your deductible or out-of-pocket maximum. All specialty medications will be limited to a 30-day supply per fill.

Flexible Spending Accounts (FSAs)

Health Care FSA

- The maximum amount you can contribute to the Health Care FSA in 2019 will increase from $2,600 to $2,650.

Dependent Day Care FSA

- The maximum amount you can contribute to the Dependent Day Care FSA in 2019 will be $4,500 if you are a Highly Compensated Employee.

Short-Term Disability (STD) and Long-Term Disability (LTD)

- Liberty Life Assurance Company of Boston ("Liberty Mutual"), the administrator of the STD and LTD plans, is now a wholly owned subsidiary of The Lincoln National Life Insurance Company ("Lincoln Financial Group"). During the next few months, you may see references to both companies as materials continue to be updated.

MetLife Long-Term Care (LTC)

- Beginning January 1, 2019, if you are a participant in the LTC plan, you will pay your premium directly to MetLife rather than through payroll deduction. If you are impacted by this change, Siemens and MetLife will send you additional information later this year. If you have any questions, contact MetLife at **1-800-438-6388**.

Safeguarding Your Information

Your information is personal—and the Company wants to help you protect your privacy.

Your mobile number is a safer way to communicate
mySiemensBenefits.com now includes opt-in text messaging for select notifications. So, be prepared and add your mobile number to help safeguard against fraudulent activity and identity theft.

- **Step 1:** Go to **mySiemensBenefits.com**.
- **Step 2:** From **Your Profile** select **Personal Information**, and add or update your mobile number.
- **Step 3:** From **Your Profile** select **Manage Communications** to elect opt-in text messaging under **Delivery Preference**.

New URL and enhanced security of your information
In August, you received a communication regarding a new URL and security enhancements. These updates included:

- Replacement of the Your Benefits Resources™ URL with **mySiemensBenefits.com**.
- The need to create a new Password for **mySiemensBenefits.com** and a phone PIN for the SBSC.

If you haven't done so, you will need to create a new Password and phone PIN now to enroll in your benefits.

How to Enroll

You can make your 2019 benefit elections two ways:

- By logging on to **mySiemensBenefits.com** using your desktop, smartphone or tablet.
- If you do not have Internet access, call the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

What Happens if You Do Not Enroll

If you do not enroll during Annual Enrollment, you will continue in the same coverage you currently have with the same claims administrator. Your 2018 FSA and HSA elections will NOT carry over to 2019, and your elected contribution amount for 2019 will be set to $0 if you take no action.

Dresser-Rand Olean Union Medical Plan Participants

If you do not enroll in a medical plan option or select "No Coverage" by October 12, 2018, you will be defaulted into a medical plan option as shown below:

Currently enrolled in	2019 medical plan option default
Olean Union PPO	Blue Cross Blue Shield PPO Medical Plan
Olean Union HSA	UHC Health Savings Medical Plan

Additional Information and Notices

Summary of Material Modifications (SMM)

This letter serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2019. An SMM is a legally required notice that provides updates to a Summary Plan Description (SPD). This SMM supplements or modifies the information presented in the SPD for the Siemens Corporation Group Insurance and Flexible Benefits Program dated January 1, 2016, and subsequent SMMs dated 2017 and 2018, and the SPD for Siemens Medical Solutions USA, Inc., Group Insurance and Flexible Benefits Program dated May 1, 2018. Keep this document with the SPD you have already received. If you have any questions about this SMM or want a complete copy of the SPD, please contact the SBSC at **1-800-392-7495**.

Compare Medical Plan Options with Summaries of Benefits and Coverage (SBCs)

The SBCs for the medical plan options are available on **mySiemensBenefits.com**. They summarize important information in a standard format, so you can compare across all the plan options. To access the SBCs on the site, simply select the **Health and Insurance** tab from the **mySiemensBenefits.com** home page, and then select **Summary of Benefits and Coverage**.

You may also obtain a paper version of the SBC for any of the medical plan options, free of charge, by contacting the SBSC at **1-800-392-7495**, weekdays from 10 a.m. to 6 p.m. Eastern Time.

Nondiscrimination in Health Programs and Activities

Learn how Siemens is committed to protecting employees and their families from discrimination under our health care programs by reviewing the attached notice.

HIPAA Privacy Notice Reminder

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Siemens to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time you enroll in a Company-sponsored group health plan, and at certain other times. In addition, Siemens is required to notify you periodically of the availability of the Notice and how to obtain a copy of the Notice. The Notice includes a description of additional uses and disclosures of your protected health information that would require the plan to obtain your prior written authorization. It also provides notice that the plan is prohibited from using your protected health information that is genetic information for underwriting purposes, and that the plan will notify you if there is a breach of your unsecured protected health information. You may access the Notice on **mySiemensBenefits.com** or call the SBSC at **1-800-392-7495** to request a paper copy.

Additional Life Insurance and Disability Provisions

Siemens has at-work provisions for Supplemental Life Insurance and disability benefits. If you are not actively at work when your increase in coverage is scheduled to take effect, you will not be eligible for the increase until you return to work. Contact the SBSC at **1-800-392-7495** for guidance.

Dropping Dependent Coverage During Annual Enrollment

If you anticipate a qualified life event (such as marriage, birth of a child, divorce or a dependent no longer meeting the age requirements) for which you will need to drop and/or change dependent coverage during or close to Annual Enrollment, make sure you follow the change-in-status process by notifying the SBSC at **1-800-392-7495** within 30 days after the event.

If you voluntarily choose to drop coverage for your dependent child or spouse for any reason other than a qualified life event, your dependent will not be eligible for COBRA coverage. However, he or she may be able to obtain coverage through a state Health Insurance Marketplace.

Right to Designate a Primary Care Provider; No Referral or Prior Authorization for OB/GYN Services

If you are enrolled in an HMO, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. You do not need prior authorization in any of the Siemens medical plan options to obtain access to obstetrical or gynecological care from an in-network health care professional who specializes in these services. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or completing procedures for making referrals. Contact your health plan at the number shown on your medical plan option ID card for a list of participating providers who specialize in obstetrics and gynecology.

Watch for Your Form 1095 in Late January

Watch for your Form 1095 medical coverage tax form in late January 2019, which shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage for 2018. You'll need this form to file your 2018 income taxes. Proving that you're adequately insured each year is required under the Affordable Care Act. If you aren't covered, you could face tax penalties—which is why it's important to keep this form with other important tax documents you'll need for the current tax year.

Forms for the 2018 tax year must be mailed no later than January 31, 2019. Please allow seven to 10 business days for delivery. Or, if you'd like to receive your Form 1095 two to three weeks earlier, you can sign up for electronic notifications.

To be notified electronically that your Form 1095 is available online, go to **mySiemensBenefits.com** and select the **Get Form 1095 Early** banner, then complete the contact information, and under **Delivery & Notification Options**, indicate how you'd like to be notified—via email and/or text—when Form 1095 is available. Then select **Save Notification Option Settings**. Please note that if you elected to be notified electronically about your Form 1095 last year, you don't need to elect it again this year.

Complete details of the various benefits offered under the Siemens and Healthineers benefit programs can be found in the legal plan documents and insurance contracts that govern the plans in the programs (i.e., the Summary Plan Description and applicable Summaries of Material Modifications and insurance contracts that govern the plan and program). Siemens Corporation and Siemens Medical Solutions, USA, Inc., as the plan sponsors of the Siemens and Healthineers benefit plans, respectively, reserve the right to amend or terminate the plans or any part of the plans they sponsor at any time and for any reason.

Search by key words or use the .PDF bookmarks or the Table of Contents or hyperlinked text to navigate this document

Healthineers Benefits Program

Summary Plan Description

Active Employee Coverage

The Summary Plan Description for the Healthineers Benefits Program **Active Employee Coverage** includes the following sections: Eligibility and Enrollment, Medical, Dental, Vision, Employee Assistance Program, Flexible Spending Accounts, Life Insurance Programs, Personal Accident Insurance (PAI) , Long-Term Disability (LTD), Business Travel Accident Insurance (BTA), Long-Term Care Insurance, Plan Administration, including Appeal Procedures for Health Plans, Flexible Spending Accounts, Life, PAI and BTA, LTD, ERISA and Glossary.

The Healthineers Benefits Program is sponsored by Siemens Medical Solutions USA, Inc. and its full name is the Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program. Throughout this Summary Plan Description it will generally be referred to as the Healthineers Benefits Program or the "Plan."

If you have questions about this document, call the Siemens Benefits Service Center (SBSC) at **800-392-7495**.

May 1, 2018

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YOUR HEALTHINEERS BENEFITS PROGRAM

As a participant in the Healthineers Benefits Program, you have the opportunity to build a personalized program of protection to meet your current benefits coverage needs.

The Healthineers Benefits Program provides Medical (including Prescription Drug) coverage with plan options that include Healthcare Savings and Healthcare Reimbursement Account features, Vision, Dental, Long-Term Disability, Employee Basic Life, Supplemental Life Insurance (for employees, their spouses or domestic partners, and children); employee and family Personal Accident Insurance; Health Care, Limited-Use Health Care and Dependent Care Flexible Spending Accounts; an Employee Assistance Program, Business Travel Accident Insurance coverage and a financial planning program; as well as Long-Term Care Insurance (closed to new entrants). The Program provides you with the flexibility to change your benefit elections as your need for coverage changes. You should be aware, however, that your ability to make changes during a plan year may be limited for certain coverages, as described in each section of this Summary Plan Description ("SPD").

Here is how it works:

When you first become eligible, and at the beginning of each Annual Enrollment period, all the information you need to make your benefit elections will be readily available to you.

The cost of your benefits is affected by:

- Your **Pay** (Long-Term Disability, Employee Supplemental Life and Personal Accident Insurance only);
- Your age (Employee Supplemental Life Insurance only); and
- Whether you elect coverage for yourself only or for some or all of your eligible dependents (Medical, Vision, Dental, Life, Supplemental Life and Personal Accident Insurance).

If you are a regular full-time employee scheduled to work 30 or more hours per week, Healthineers pays most of the cost of your Medical coverage. If you are a regular part-time employee scheduled to work 20 to 29 hours per week, you will receive 50% of the subsidy that Healthineers provides to full-time employees enrolled in the same plan options.

You pay your share of the cost of most benefits provided under the Healthineers Benefit Program with **pre-tax deductions** from your pay-check. You pay for Employee Supplemental Life, Spouse or Domestic Partner Life, Child Life, Financial Planning, and Long-Term Care benefits with **post-tax deductions** from your paycheck. You decide whether to accept company-paid Long-Term Disability (with taxable benefits) or to pay for your coverage with post-tax deductions (with benefits exempt from federal taxation). Different federal and state tax rules apply with respect to the cost of benefits provided to your domestic partner. For more information, please contact the Siemens Benefits Service Center (SBSC) at **800-392-7495**.

Generally, subject to certain restrictions, the elections you make during each Annual Enrollment will take effect on the following January 1 and will remain in effect for one calendar year unless you experience a Qualified Life Event (described later in this section) that allows you to make a change within 30 days of the event.

Overview of Your Healthineers Group Insurance and Flexible Benefits Program (Healthineers Benefits Program)

The following table provides an overview of the options available to most employees under the Healthineers Benefits Program. Unless you are covered under a bargaining agreement that provides otherwise, you select one option in each benefit area.

In This Benefit Area	You May Choose
Medical [1]	• No coverage • Health Savings Medical Plan option with Health Savings Account (HSA) feature • Health Reimbursement Medical Plan option with Health Reimbursement Account (HRA) feature • Preferred Provider Organization (PPO) Medical Plan option • Health Maintenance Organization (HMO) Medical Plan option — where available
Dental	• No coverage • Delta Dental Plan
Vision [3]	• No coverage — if elected • Basic Vision Program • Enhanced Vision Program • Premier Vision Program
Long-Term Disability [2, 4]	• 60% of pay ($15,000 maximum monthly benefit) — company-paid (benefits received are taxable) • 60% of pay ($15,000 maximum monthly benefit) — employee-paid (benefits received are exempt from federal taxation)
Employee Basic Life Insurance [2]	• 1 times pay (company-paid, $300,000 maximum benefit)
Employee Supplemental Life Insurance [2, 4]	• No coverage • 1 to 10 times pay ($2,500,000 maximum)
Spouse or Domestic Partner Life Insurance [2, 4, 5]	• No coverage • $10,000–$250,000 in $10,000 increments (may not exceed 3 times employee's pay rounded to nearest $10,000; subject to certain limits)
Child Life Insurance [2, 4]	• No coverage • $5,000, $10,000, $15,000 or $20,000 (subject to certain limits)
Personal Accident Insurance (PAI) [2, 4, 5]	• Choice of 2 times pay for Employee only or 1 times pay for Family coverage (company-paid) • Additional coverage available at 3–12 times pay • Family PAI covers Employee at 100% of elected amount plus spouse or domestic partner (at 50%) and children (each at 10%) • Coverage maximum (company-paid plus additional coverage you elect) is $1,000,000

In This Benefit Area	You May Choose
Flexible Spending Accounts	• **Health Care Account** reimburses permitted health care expenses for you and your eligible dependents that are not covered under the medical, vision and dental plan options you elect. If you are enrolled in the Health Reimbursement Medical Plan option, you need to submit medical claims to your HRA before you can submit them to your Health Care Account. If you are enrolled in the Health Savings Medical Plan option, you can only elect a Limited-Use Health Care Account. • **Limited-Use Health Care Account**, which can be elected if you and your eligible dependents are covered under the Health Savings Medical Plan Option, reimburses permitted dental and vision care expenses that are not covered under the dental and vision plan options you have elected. • **Dependent Care Account** reimburses dependent day care expenses for your child(ren) under age 13 and/or older disabled child, spouse, parent or in-law who lives in your home. The Dependent Care Account does not reimburse health care expenses for your dependents. • You choose the amount, if any, that you want to contribute to either or both types of account (up to certain maximums). • For employees hired during October, November or December, this benefit is not available until the next calendar year. • Life event changes to these accounts are not allowed for events occurring in October, November or December of the year in which the change occurred.
Financial Planning	• No coverage • The *Money in Motion*® Personal Finance Program

[1] Medical coverage includes prescription drug coverage. The Health Savings Medical Plan option includes an HSA feature with employer contributions; you may also contribute. The Health Reimbursement Medical Plan option includes an employer-funded HRA feature.

[2] Based on bargaining agreements in effect on May 1, 2018, exceptions for union employees include:

- New York IBEW Local 3 employees receive Employee Life insurance and PAI coverage equal to two times pay, can choose between company-paid or employee-paid LTD at 60%, and are not eligible for Supplemental or Dependent (Spouse or Child) Life coverage.

[3] The Basic Vision Program is provided at no cost to all employees and enrolled dependents who are eligible for medical coverage, regardless of whether they are enrolled in medical coverage. However, you have the right to opt out of this coverage.

[4] If you were not actively at work on the date you elect to modify your Long-Term Disability election or to increase PAI or life insurance coverage for yourself or family member(s), such changes will not become effective until you again become actively at work.

[5] To initially enroll or increase PAI or life insurance coverage for your domestic partner and/or the children of your domestic partner, you must complete and submit a Domestic Partner Affidavit provided by the Siemens Benefits Service Center and must be approved by Siemens Benefits Service Center before coverage will go into effect.

Options and Plan Provisions in effect as of May 1, 2018

Table 1 —Healthineers Group Insurance and Flexible Benefits Program

ELIGIBILITY AND ENROLLMENT

You are eligible for the Healthineers Benefits Program if you are a:

- regular, full-time employee of a participating employer scheduled to work at least 30 hours a week; or
- regular, part-time employee of a participating employer scheduled to work at least 20 hours a week. Due to certain state and local laws, in certain locations a lower number of scheduled hours may be sufficient for eligibility. You will be notified if this applies to you.

Employees covered by a collective bargaining agreement are not eligible for the Healthineers Benefits Program unless the agreement specifically provides for such coverage.

Your family members may also be eligible for coverage as shown in the following table:

For These Coverages	These Family Members Are Eligible
Medical, Dental, Vision, Spouse / Domestic Partner / Dependent Life Insurance [1, 2]	Your spouse or domestic partner You and your spouse or domestic partner must meet the following conditions in order for him or her to be eligible for coverage: • you are married to each other or have registered as domestic partners pursuant to an ordinance or law of a state or local government —OR— • your partner is age 18 or older; *and* • your partner has lived with you for at least 12 months and you and your domestic partner have a serious, committed relationship; *and* • your partner is financially interdependent with you; *and* • your partner is not related to you in a way that would prohibit legal marriage and is not legally married to anyone else Certain coverages require a Domestic Partner Affidavit for domestic partners and their children to be covered. Healthineers' contribution toward benefits for your domestic partner and/or his or her child(ren) will be considered imputed income and subject to federal taxes, unless it can be shown that such domestic partner or his or her child is your dependent for federal tax purposes. Different rules may apply for state tax purposes. For more information, please contact the SBSC at **800-392-7495**. Your child(ren) and/or the child(ren) of your spouse or domestic partner up to the last day of the month in which each child reaches age 26 (***or***, for coverage other than medical, vision and dental, the last day of the month in which each child reaches age 19). Eligibility for Child Life and Personal Accident Insurance coverage may be extended up to the last day of the month in which each child reaches age 25 as long as the child is a full-time student. You may be required to provide evidence of your child's status as a full-time student. Children include your natural children, legally adopted children (from the date of placement in the home or from birth, provided that a written agreement to adopt the child has been entered into prior to the child's birth), stepchildren who live with you, and any other children for whom you are the legal guardian as defined by a court order. Under the medical, vision and dental plans, a child is considered "placed with you for adoption" when you assume and retain a legal obligation for support of that child in anticipation of adoption. The child is no longer considered "placed

For These Coverages	These Family Members Are Eligible
	with you for adoption" when this legal obligation ends. If both you and your spouse or domestic partner are employees of a participating employer or affiliate, your children may be covered as the dependents of only one parent for medical, dental, child life insurance, and personal accident insurance. As long as you are a Healthineers Benefits Program member, coverage may be continued indefinitely for your unmarried child who is incapable of self-care and dependent on you for a significant portion of living expenses and other financial support because of a physical or mental handicap (as determined by the claims administrator of your life, PAI and/or medical plan option and subject to periodic review). However, the handicap must have occurred before the child reached age 19 (for dependent life and PAI) or before the child's eligibility ceased or would have ceased had they been a covered dependent under the Healthineers Benefits Program (for medical, dental and vision). A final determination by the plan's claims administrator must be made as to the child's handicapped status ***before*** the child's eligibility ceased.
Personal Accident Insurance [2]	Your spouse or domestic partner (to age 70), and your unmarried, dependent child(ren) (until age 19, or until age 25 if a full-time student)
Flexible Spending Accounts	Any individuals you declare as dependents on your federal income tax return (but only children under age 13 for the dependent care account, unless incapable of self-care).

[1] If both you and your spouse or domestic partner are employees of a participating employer or an affiliate, you and/or your spouse or domestic partner may not be covered as both an employee and a dependent under the Medical, Dental and Vision Plans.

[2] To initially enroll or increase PAI or life insurance coverage for your domestic partner and/or the children of your domestic partner, you must complete and submit a Domestic Partner Affidavit provided by the Siemens Benefits Service Center and must be approved by the Siemens Benefits Service Center before coverage will go into effect.

Table 2 – Eligibility

Who Is Not Eligible

"Table 2 – Eligibility" lists and describes the family members who are or may be eligible to be enrolled in coverage under the Healthineers Benefits Program. A member or former member of your family or household who is not listed or described in "Table 2" is not eligible to be enrolled in coverage under the Healthineers Benefits Program even if the individual is considered your dependent for federal or state tax purposes and/or even if you have a legal or contractual responsibility to provide coverage for the individual. Individuals who are not eligible for coverage under the Healthineers Benefits Program include an ex-spouse or former domestic partner, friend, parent, grandparent, aunt, uncle, or any child for whom you are not a legal guardian as defined by a court order. In certain situations, an ex-spouse, former domestic partner or child who was previously eligible and enrolled in a Medical, Dental and/or Vision Plan option as your dependent and who has lost eligibility for coverage as your dependent may be able to continue coverage for a limited period under COBRA. Healthineers uses a dependent verification procedure for benefit eligibility purposes. If you have a question regarding eligibility, contact the SBSC at **800-392-7495**.

You are responsible for notifying the SBSC if an enrolled family member loses eligibility for coverage as the result of divorce, legal separation, loss of custody, age or other change. If you enroll or

continue enrollment for an individual who is found to be or have become ineligible, coverage for the individual will be retroactively terminated. You will be liable for reimbursement of benefit payments made on behalf of this individual and may be subject to discipline, up to and including termination of employment.

Enrollment Restrictions

During your initial enrollment — and during each Annual Enrollment — you generally may choose any option you wish. However, you should be aware of certain restrictions that may apply to changing certain types of elections. These restrictions are described in this section.

How to Enroll

The information and tools you need to enroll are on the *Your Benefits Resources*™ (YBR) website, which can be accessed from any computer or mobile device with an Internet connection. The YBR website is your primary source for enrolling or obtaining information about your benefits. If you are unable to enroll or complete your enrollment by using the YBR website, you can enroll by calling the Siemens Benefits Service Center (SBSC) at **800-392-7495**. The YBR website provides several resources to help you make informed benefit enrollment decisions and get the most out of your benefits, no matter how simple or complex the situation.

Resource	How to Access
Your Benefits Resources™ (YBR) website	Type http://resources.hewitt.com/siemens and enter your User ID and password[1]
The SBSC's automated voice response system, or VRS	Call **800-392-7495** and enter the last 4 digits of your SSN, your date of birth and password, then follow the system prompts.
SBSC representatives	Call **800-392-7495** and then say "representative" after entering the last 4 digits of your SSN, your date of birth and password.

[1] You create your own User ID and password to access YBR or the SBSC. When you log on to the website, click on "*Are you a new user?*" and follow the instructions. If you do not have Internet access, you can call the SBSC at **800-392-7495** to create a User ID and password.

Table 3 — SBSC Resources

For most situations, you will want to go first to the YBR website. The website can handle most of your enrollment and information needs and is available 24 hours a day, Monday through Saturday, and after 1 p.m. Eastern Time on Sunday.

When you have a situation or question that cannot be handled through the website, you can talk to an SBSC representative by calling **800-392-7495** weekdays between 10 a.m. and 6 p.m. Eastern Time.

Evidence of Insurability

If you postpone enrolling in certain coverages until after you first become eligible, or if you decide to increase coverage after your initial enrollment, you may be required to provide evidence of insurability for yourself or your family member(s) at your own expense. These situations are described in the appropriate individual sections of this Summary Plan Description for each type of coverage.

Medical Plan Enrollment Restriction for Delegates

If you are a delegate **from** the United States **to** another country, only the Cigna International Plan option, administered by Cigna, is available to you and your eligible family members. If you are a delegate **to** the United States **from** another country, only the Preferred Provider Organization (PPO) options are available to you and your eligible family members. See Delegates below.

The Cost of Coverage

Both Healthineers and you contribute toward the cost of your benefits.

- Your contributions toward the cost of your benefits are generally made through payroll deduction. The amount of your deductions will reflect the coverage options you have elected and other factors.
- Payroll deductions (and the estimated amount of coverage) for Life, Personal Accident, and Long-Term Disability Insurance will be based on your pay as of June 30th of the prior year or, in the case of new hires, as of the date of employment.
- Payroll deductions for Supplemental Life Insurance and Personal Accident Insurance will also be based on your age as of January 1 of the year for which you are enrolling.
- Payroll deductions will depend on the Medical, Vision and Dental plan option and coverage category you elect (for example, whether you elect no coverage, or coverage for yourself only, for yourself and your spouse or domestic partner, for yourself and your child(ren), or for yourself and your family).

Payroll deductions are made on a **pre-tax** basis for Medical, Dental, Vision, Personal Accident Insurance, Health Savings Account (HSA), and the Flexible Spending Accounts. Your contributions for Employee Supplemental Life, spouse or domestic partner or child life, financial planning, and Long-Term Care benefits are paid for with **post-tax deductions** from your paycheck. You decide whether to accept company-paid Long-Term Disability (with taxable benefits) or to pay for your coverage with post-tax deductions (with benefits exempt from federal taxation). In addition, your share of the cost of coverage for your domestic partner and/or his or her child (if not otherwise a "dependent" as defined under the Internal Revenue Code) is also paid for with post-tax deductions from your paycheck.

Healthineers' contribution toward benefits is generally not considered taxable income. However, under federal regulations, Healthineers' contributions toward your company-paid life insurance in excess of $50,000 and toward benefits for your domestic partner or your domestic partner's child will be considered imputed income and subject to federal taxes, unless it can be shown that such domestic partner or child is your dependent for federal tax purposes.

For purposes of state and local income taxes, the treatment of both your contributions and Healthineers' contributions toward the cost of benefits may differ from the federal tax treatment described in this SPD. You are encouraged to consult your tax advisor if you have any questions.

Pre-Tax Dollars

Pre-tax dollars come out of your pay before taxes are calculated, lowering your taxable income. As a result, your federal income and Social Security taxes and, in most areas, your state and local income taxes will be less. Medical, Dental, Vision, Health Savings Account, and Flexible Spending Account contributions are paid with pre-tax dollars.

If your taxable earnings are below the Social Security wage base (the income level on which you pay Social Security, or FICA taxes), using pre-tax dollars may result in a slight reduction to your Social Security benefits. The difference, however, is usually quite small.

Pre-tax contributions do not affect your pay-related benefits, such as 401(k) or the amount of your employee life insurance, personal accident insurance, and long-term disability coverages. These will be based on your annual pay before any deductions are made.

Post-Tax Dollars

Supplemental Life, Long-Term Care Insurance and financial planning are paid with **post-tax** dollars. You may also elect to pay for your Long-Term Disability coverage with post-tax deductions. Post-tax contributions come out of your pay after taxes have been calculated and, therefore, do not reduce your taxes.

WHEN COVERAGE BEGINS

If you are employed by a participating Healthineers employer and are enrolled in the Siemens Corporation Group Insurance and Flexible Benefits Program ("Siemens Benefits Program") on April 30, 2018, you are automatically enrolled in the Healthineers Benefit Program effective May 1, 2018. All of your benefits elections and 2018 financial accumulations, for example, amounts paid toward deductibles, will carry over from the Siemens Benefits Program.

New Employees

If you are a new — or newly eligible employee — you must actively enroll in your benefits by using the YBR website or by calling the SBSC within thirty (30) days of your date of hire or the date you first become eligible for the Healthineers Benefits Program. Coverage for your enrolled family members begins when your coverage begins — generally as of your first day of employment. Employees covered by a collective bargaining agreement who are eligible for benefits under the Healthineers Benefits Program may have a waiting period for benefits, which establishes the effective date of coverage under the Program.

IMPORTANT!

If you need to seek medical or dental care during your first 30 days of employment and you have not yet enrolled for coverage, notify the SBSC in advance by calling **800-392-7495**. You can elect coverage at that time for yourself and your eligible family members, and it will be retroactive to your eligibility date (in most cases, your first day of employment). In an emergency, seek care right away and call the SBSC immediately afterwards.

You must enroll your newborn or newly adopted child during the 30-day period that begins with the birth, adoption or placement for adoption. You can do this by using the YBR website or by calling the SBSC. **If your child does not yet have a valid U.S. Social Security Number, you will need to call the SBSC to add him/her to your coverages.** In addition to adding the child as a dependent to your record, be sure to indicate which coverages you want to begin for your child (medical, dental, life, etc.). Medical coverage for a newborn child begins on the date of birth provided the child has been timely enrolled in coverage as a dependent.

IMPORTANT!

If you do not contact the SBSC within 30 days of your hire date or benefits-eligibility date, you will NOT be able to enroll yourself or your family members until the NEXT Annual Enrollment period. Similarly, if you do not enroll your Spouse, Domestic Partner or Child(ren) during the 30-day period that BEGINS with your marriage or qualification as domestic partners or the birth or adoption of your child(ren), you will NOT be able to enroll your new family member(s) until the NEXT Annual Enrollment period.

New hires can enroll in the Money in Motion® Personal Finance Program by calling The Ayco Company at **800-437-6383**. Ayco will bill you directly for the cost of the program. If you enroll in the financial planning program during an Annual Enrollment period, you will pay for the program through payroll deductions.

If you are an employee hired or rehired during the last quarter of the calendar year, or if you experience a Qualified Life Event during October, November or December, you cannot enroll in or make any changes to the amount of your current contributions to your Flexible Spending Accounts during the current calendar year. You may enroll in the Flexible Spending Accounts during Annual Enrollment for participation during the following calendar year. Employees hired during the last quarter of the year must process benefit elections for the remainder of the current year before processing benefit elections for the following calendar year.

NOTE: If you terminate your employment with Healthineers and are rehired in the same calendar year, your benefit elections will be reinstated. You cannot make changes to your benefit elections until the next Annual Enrollment period, unless you experience a Qualified Life Event (for instance, a change of residence that affects your eligibility for medical coverage).

If You Do Not Enroll

If you do not enroll by the deadline indicated on the YBR website, you will be assigned the default coverages: vision coverage under the "Basic" option for yourself only; employee basic life in an amount equal to one times your base pay (to a maximum of $300,000); personal accident insurance for yourself only in an amount equal to two times your base pay (to a maximum of $300,000); and long-term disability coverage under the 60% company-paid option. You will not have medical or dental coverage. You will not be able to enroll or change your coverages until the next Annual Enrollment, unless you experience a Qualified Life Event. You will also be required to provide evidence of insurability, at your own expense, to initially enroll in or increase the amount of any life insurance coverages during subsequent annual enrollments.

Annual Enrollment

During the Annual Enrollment period, you can use the Your Benefits Resources™ (YBR) website at http://resources.hewitt.com/siemens or call the Siemens Benefits Service Center (SBSC) at **800-392-7495** to review your plan options and make new elections before the enrollment deadline indicated. Unless you make changes to your participation, your coverages as of December 31 will automatically carry forward into the next calendar year with the exception of the Health Savings Account and Flexible Spending Account plans. If your plan option is no longer available, you and your covered dependents will be assigned to the closest available plan option.

If you drop coverage for a family member during Annual Enrollment, that individual is not eligible for coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act). See the section in this SPD captioned **Other Medical, Dental, Vision and EAP Provisions** for information on continuing Medical, Dental, Vision and/or EAP coverage under COBRA.

Benefit elections made during Annual Enrollment take effect on the following January 1st and generally remain in effect until the end of that calendar year unless you have a Qualified Life Event and make an election consistent with that event. Elections requiring insurance company approval will take effect on January 1st or when insurance company approval is received, if later.

If you are on a leave of absence or not actively at work at the time a requested change to your long-term disability insurance election or supplemental life or PAI coverage for yourself or family member(s)

would otherwise become effective, the change will not become effective until you actively return to work.

Enrollment in the financial planning program during an Annual Enrollment period allows you to pay for this coverage through payroll deductions. However, you can enroll in this program at any time during the year. Your election to participate must remain in effect for the entire year.

Changing Your Elections

Healthineers Benefits Program and Internal Revenue Service (IRS) rules generally permit you to change your enrollment elections only during an Annual Enrollment period.

If you experience an IRS-defined Qualified Life Event, you may modify your Healthineers Benefits Program coverage if:

- You register your Qualified Life Event and change your enrollment by logging on to the *YBR* website at http://resources.hewitt.com/siemens or by calling the SBSC at **800-392-7495** during the 30-day period that begins with the effective date of the Qualified Life Event (for example, marriage); ***and***
- the adjustment you make is consistent with the Qualified Life Event. For example, if you get married, you may add coverage for your new spouse or you may change the medical option that you are enrolled in; ***and***
- the change in your enrollment is retroactive to the Qualified Life event.

NOTE: If you wait longer than 30 days from the effective date of the Qualified Life Event to notify the SBSC, you will have to wait until the next Annual Enrollment to add family members or modify your coverage.

Qualified Life Events allow you to modify one or more enrollment elections due to a ***loss or gain of benefit eligibility*** or a significant ***increase or decrease in benefit cost*** for you or a family member. If there is no change in eligibility or cost, then generally no change in enrollment is allowed.

Qualified Life Events include:

- Your marital status changes
  - You get married or your domestic partner becomes eligible for coverage
  - You get divorced, or legally separated, have your marriage annulled, or your domestic partnership ends
  - Your spouse or domestic partner dies
- The number of your eligible children changes
  - You have or adopt a child

    NOTE: If your child does not yet have a Social Security Number, you will need to call the SBSC at 800-392-7495 to add him/her to your coverages. In addition to adding the child as a dependent to your record, be sure to indicate which coverages you want to begin for your child (medical, dental, life, etc.)
  - Your child gains or loses eligibility for coverage under the Healthineers Benefits Program
  - Your child dies
- Your eligibility for a benefit option changes because you move to a new address
- Your benefits eligibility changes because:
  - You take or return from a leave of absence
  - You gain or lose eligibility as a result of a change in work schedule or status

- Your family member's benefits eligibility changes because of a change in his or her eligibility or coverage under another employer's plan(s):
  - He or she gains or loses eligibility as a result of a change in work schedule or status
  - He or she gains a benefit option or loses coverage
  - His or her cost for coverage increases or decreases significantly
  - He or she makes new coverage choices during his or her employer's Annual Enrollment
- You or your family member's COBRA coverage from another employer expires
- You or your family member becomes entitled to or loses Medicare or Medicaid
- You or your family member loses coverage under a government's or educational institution's plan

Table 4 on the following pages summarizes the Qualified Life Events and the elections that are permitted based on the event. All changes must be consistent with the event and may require evidence of insurability according to Healthineers Benefits Program rules.

Mid-Year Benefit Plan Changes You May Request

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
Marital status changes					
Marriage	Change Option Enroll Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase Decrease Drop[2]	Start Increase Decrease Drop[2]
Divorce, legal separation or annulment	Change Option Enroll Drop	Drop Spouse Life Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase Decrease Drop[2]	Start Increase Decrease Drop[2]
Number of eligible children changes					
Birth or adoption of a child	Change Option Enroll Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase Decrease Drop[2]	Start Increase Decrease Drop[2]
Child gains eligibility for coverage	Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase	Start Increase
Child gains eligibility for coverage under QMSCO	Change Plan Option Enroll Add Child	No changes allowed	No changes allowed	Start Increase Decrease[2] Drop[2]	Start Increase Decrease[2] Drop[2]
Child loses eligibility for coverage due to no longer qualifying as a dependent	Drop Child Child may elect COBRA	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Decrease[2] Drop[2]	Decrease[2] Drop[2]

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
Child loses eligibility for coverage due to employee electing to drop the child's coverage pursuant to a QMCSO	Drop Child	No changes allowed	No changes allowed	Decrease[2] Drop[2]	No changes allowed
Child dies	Drop Child	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase Decrease[2] Drop[2]	Start Increase Decrease[2] Drop[2]
Home address or work site changes					
ZIP Code change results in change in plan eligibility	Change Plan Option Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]
Employee's benefits eligibility changes					
Paid FMLA Leave begins	Drop	Spouse or Child Life only: Enroll Increase Decrease Drop	No changes allowed	Drop[2]	Decrease[2] Drop[2]
Unpaid FMLA Leave begins	Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Drop[2]	Decrease Drop[2]
Paid non-FMLA Leave begins	No changes allowed	No changes allowed	No changes allowed	No changes allowed	No changes allowed
Unpaid non-FMLA Leave begins	Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Drop[2]	Drop[2]
Paid FMLA Leave ends	Enroll	Spouse or Child Life only: Enroll Increase Decrease Drop	No changes allowed	Start Reinstate	Start Reinstate
Unpaid FMLA Leave ends	Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Enroll Increase Decrease[2] Drop[2]	Start Reinstate
Paid non-FMLA Leave ends	No changes allowed	No changes allowed	No changes allowed	No changes allowed	No changes allowed

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
Unpaid non-FMLA Leave ends, results in gain in benefits eligibility	Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Reinstate	Start Reinstate
Significant change in dependent day care arrangement (as long as provider is not a relative) [2]					
Cost of dependent day care changes before September 30 [2]	No changes allowed	No changes allowed	No changes allowed	No changes allowed	Start Increase Decrease[2] Drop[2]
Eligibility changes due to change in work schedule or status					
Gain eligibility due to change in work schedule or status	Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Reinstate	Start Increase Decrease[2] Drop[2]
Lose eligibility due to change in work schedule or status	Change Plan Option Enroll Increase	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Drop[2]	Start Increase Decrease[2] Drop[2]
Change from full-time to part-time work schedule without loss of eligibility [2, 3]					
Work schedule changes from at least 30 hours per week to at least 20 but fewer than 30 hours per week [2, 3]	Change Plan Option Drop	No changes allowed	No changes allowed	Decrease[2] Drop[2]	No changes allowed
Family member's benefits eligibility changes					
Gains eligibility due to change in work schedule or status	Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Decrease[2] Drop[2]	Decrease[2] Drop[2]
Loses eligibility due to change in work schedule or status	Change Plan Option Enroll	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	Start Increase Decrease[2] Drop[2]	Start Increase Decrease[2] Drop[2]
Family member gains a benefits option	Drop	Decrease Drop	Change to Company-Paid LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]
Family member loses coverage under another employer's plan					
Loses coverage under another employer's plan	Change Plan Option Enroll	Enroll Increase[1]	Change to Employee-Paid LTD Plan Option	No changes allowed	Start Increase
Cost of coverage under another employer's plan increases significantly	Change Plan Option Enroll	Enroll Increase[1]	Change to Employee-Paid LTD Plan Option	No changes allowed	Start Increase

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
Cost of coverage under another employer's plan decreases significantly	Drop	Decrease Drop	Change to Company-Paid LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]
Elects new coverage choices during other employer's Annual Enrollment	Enroll Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	No changes allowed	Enroll Increase Decrease[2] Drop[2]
COBRA coverage under another employer's plan changes					
COBRA coverage expires	Change Plan Option Enroll	No changes allowed	No changes allowed	No changes allowed	No changes allowed
Employee or family member's Medicare or Medicaid eligibility changes					
Individuals affected by change of eligibility	Enroll Drop	No changes allowed	No changes allowed	Start Increase Decrease[2] Drop[2]	No changes allowed
Coverage under a government or educational institution's plan terminates					
Individuals affected by change of eligibility	Change Plan Option Enroll	No changes allowed	No changes allowed	No changes allowed	No changes allowed
Domestic partnership changes					
Domestic Partner becomes eligible for coverage	Change Plan Option Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]
Domestic partnership ends	Change Plan Option Enroll Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]
Domestic Partner dies	Change Plan Option Enroll Drop	Enroll Increase[1] Decrease Drop	Change LTD Plan Option	No changes allowed	Start Increase Decrease[2] Drop[2]

[1] If you have previously elected Employee Supplemental Life Insurance at one times pay or two times pay, you may increase your Supplemental Life coverage by one level (i.e., from one times pay to two times pay or from two times pay to three times pay), provided your new coverage does not exceed $300,000, without providing Evidence of Insurability. You will need to provide Evidence of Insurability that is approved by The Hartford before any other change in life coverage will become effective.

You must complete and submit a Domestic Partner Affidavit provided by the Siemens Benefits Service Center and must be approved by the Siemens Benefits Service Center before any new life or personal accident insurance coverage for your domestic partner and/or the children of your domestic partner will go into effect.

[2] If you are making a change to your Health Care, Limited-Use Health Care or Dependent Care Flexible Spending Account, your new annual goal amount cannot be less than the amount of your year-to-date payroll and/or direct bill contributions. Changes to Flexible Spending Accounts are not permitted in October, November or December even if you have a qualified life event. At no time during the year are you allowed to reduce Flexible Spending Account contribution goal amounts to less than the amount that has already been contributed through payroll deductions.

[3] If you have been a full-time employee with a work schedule of at least 30 hours per week and you change to a part-time work schedule of at least 20 but fewer than 30 hours per week, you have not lost eligibility. However, you may drop your coverage under a Healthineers medical plan option during the 30-day period that begins with the effective date of your reduction in scheduled hours, provided that you and any dependents covered under the Healthineers Benefits Program option enroll or will enroll in other minimum essential coverage that will be effective no later than the first day of the second month following the effective date of your reduction in scheduled hours. You may enroll in any group health plan that provides minimum essential coverage. This may include "a Qualified Health Plan through a Marketplace," your spouse's or domestic partner's employer's plan, or other plan.

Table 4 — Mid-Year Benefit Plan Changes You May Request

NOTES: Any change in your benefits elections that you make as the result of a Qualified Life Event must be consistent with the life event — for instance, loss (or gain) of dependent status means you can reduce (or increase) coverages. These changes must be elected during the 30-day period that begins with the event. **These changes can only be made by processing a life event change on the YBR website or by calling the SBSC.** You may expect to see any decrease or increase in your benefits deductions that results from the requested change in your benefits elections to appear on your pay check one or two payroll periods following the date you requested the change. Retroactive adjustments will be made if and only to the extent that it takes more than two payroll periods following the date of your request for the new deduction amounts to appear on your paycheck.

Under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), you and/or your dependents may have the right to continue your Medical, Dental, Vision, and/or EAP coverage for certain periods of time by paying 102% of the cost of the coverage (includes 2% for administration). You may also continue your Health Care Flexible Spending Account by making after-tax contributions.

Long-Term Care Insurance (LTC) is a post-tax, fully contributory benefit. Therefore, a change in coverage can be made without the occurrence of a life event. Employees can change or drop LTC coverage during the course of the year by calling MetLife at 800-GET-MET8 (800-438-6388). The LTC program was closed to new entrants effective December 31, 2011.

Any change in coverage will generally take effect on the same day as the status change. Changes requiring insurance company approval (such as increasing the amount of your life insurance, or electing or increasing the amount of life insurance for your spouse or domestic partner) will take effect only if insurance company approval is received.

Special Enrollment Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009

If you are eligible for but not enrolled in a Medical coverage option under the Plan (or your dependent is eligible for but not enrolled in such coverage), a special enrollment period is available, and you may enroll yourself and/or your eligible dependent, if either of the following conditions is met:

1. You or your dependent is covered under a Medicaid plan or under a State Children's Health Insurance Program (CHIP) and your coverage, or your dependent's coverage, under such a plan terminates as a result of loss of eligibility for such coverage, and your request for enrollment in a Medical plan option is made within 60 days after the date of termination of such coverage; or
2. You or your dependent becomes eligible for premium assistance as to coverage under a Medical plan option under a Medicaid plan or CHIP plan, and your request for enrollment is made within 60 days after the date you or your dependent becomes eligible for the premium assistance.

If you meet one of these special enrollment conditions and would like to enroll in a Medical plan coverage option, you must call the SBSC at **800-392-7495** within 60 days of such termination or determination of eligibility.

NOTE: If you wait longer than 60 days from such termination or determination of eligibility to notify the SBSC, you will have to wait until the next Annual Enrollment to enroll.

Changing Your Medical Coverage Election

If you elect "No Coverage" because you have medical coverage elsewhere and lose that coverage during the year, you can enroll for coverage for yourself and your eligible family members during the 30-day period that begins immediately after your other coverage ends. Furthermore, if you elect "No Coverage" and then during the year you add a family member, you can elect coverage for yourself and your eligible family members during the 30-day period that begins with the marriage, birth or adoption. However, you must enroll during the 30-day period that begins with the occurrence of the Qualified Life Event by using the YBR website or by calling the SBSC at 800-392-7495.

If You Change from Full-Time to Part-Time Employment Status Mid-Year

If your work schedule changes from full-time (at least 30 hours per week) to part-time (generally at least 20 but fewer than 30 hours per week), you remain eligible for coverage under this Program. If you do not make any change in your benefits elections that may be available to you as a result of the change, your payroll contribution deductions for medical and dental coverage will increase. The cost of your vision coverage will not change. The cost of your employee supplemental life and PAI — and the amount of your coverage — will remain unchanged during the plan year in which the schedule change occurs because coverage is based on Frozen Pay and does not decrease even though your income is reduced. (However, the cost of your employee supplemental life and PAI — and the amount of coverage — will be reduced at the beginning of the next plan year.) There is no change in the cost or amount of coverage of your spouse or child life.

MAKING YOUR CHOICES

Before you make your benefit elections, you should have a good understanding of how each option works. Read each section of this SPD, which describes each Plan option in detail.

Medical

When choosing a Medical Plan option (which includes Prescription Drug coverage), it is important to carefully weigh the coverage each option provides as well as your share of the costs (such as contributions, Deductibles, Coinsurance, and Maximum Out-of-Pocket limits). Generally, all of the options cover the same medical services, but there are certain exceptions. The options mostly differ in the amounts they cover, what you pay for the care you receive, and whether a Health Savings Account (HSA) or Health Reimbursement Account (HRA) feature is included.

All options provide at least some financial protection against the high cost of health care. The Healthineers Benefits Program lets you change your coverage each year during the Annual Enrollment period.

Five Medical Plan options, under three types of plan design, are available to Healthineers employees across the U.S. and provide access to In- and Out-of-network providers in every state —

- The Health Savings Medical Plan option with its Healthcare Savings Account (HSA) feature is administered by UnitedHealthcare.
- The two Health Reimbursement Medical Plan options, which both offer a Health Reimbursement Account (HRA) feature, are administered by UnitedHealthcare and Anthem BCBS.
- The two Preferred Provider Organization (PPO) Medical Plan options are administered by UnitedHealthcare and Anthem BCBS.

Employees in Hawaii may choose coverage under the BCBS-affiliated Hawaii Medical Services Association (HMSA) PPO plan. Kaiser Permanente Health Maintenance Organization (HMO) plans are available to many Healthineers employees in Northern and Southern California, depending on their home ZIP Code. If you are considering an HMO, you should carefully review the information in the enrollment decision toolkit on the YBR website or call the SBSC. Keep in mind when you choose HMO coverage, you must receive all of your medical care from in-network providers, except in a true emergency. Additionally, medical care received outside the United States is not covered by Kaiser Permanente.

Choosing a Coverage Category

When you choose a Medical Plan option, you also decide if you want coverage for:

- yourself only;
- yourself and your spouse or domestic partner;
- yourself and your children, stepchildren and/or children of your domestic partner; or
- your family (you, your spouse or domestic partner, and any children).

If your spouse or domestic partner has medical coverage with another employer, you may want to choose coverage under your spouse's or domestic partner's plan or elect coverage for yourself only or for yourself and your children under Healthineers coverage. You should compare the costs and coverages of the Healthineers options with your spouse's or domestic partner's plan and how they coordinate with each other.

Dental

The Delta Dental Plan allows you to go to any Dentist of your choice for treatment. However, using In-Network providers may reduce your cost.

Vision

You automatically receive coverage under the EyeMed Vision Care Basic vision plan option, regardless of whether or not you enroll for medical coverage, and you may enroll your eligible dependents. If you prefer not to have Basic Vision coverage, you may opt out when you enroll as a newly eligible employee or during Annual Enrollment. If you prefer more comprehensive coverage, you can elect to enroll in one of two additional buy-up programs — Enhanced Plan or Premier Plan — to meet your eye care needs. The Vision Program allows you to choose from network private practice providers and retail chain providers, as well as out-of-network providers.

Flexible Spending Accounts

There are two types of Flexible Spending Accounts: Health Care and Dependent Care. You may contribute to either or both types of account. Depending on your medical plan option, you may select a "regular" Health Care Flexible Spending Account (HCFSA) or a Limited-Use Health Care Flexible Spending Account (Limited-Use HCFSA) to reimburse healthcare expenses for you and your eligible family members. The Dependent Care Flexible Spending Account (DCFSA) reimburses expenses for dependent day care for your eligible child(ren) under age 13 or for your disabled dependent (older child, spouse, parent or in-law) who lives in your home. You will need to make a separate election for each type of account. These elections will not carry over in future Annual Enrollments. In order to continue coverage, you must actively enroll during each year's Annual Enrollment.

All Other Coverages

Match your need for coverage with the available options and make your elections. Keep in mind that if you do not elect certain coverages when first eligible, you may need to provide evidence of insurability to enroll at a later date or benefits may be payable according to your prior election until you meet plan requirements.

Retiree Coverages

For information about Retiree Medical, Retiree Dental and Retiree Vision coverages available to retirees under age 65 and retiree dependents under age 65, even if eligible for Medicare as a result of a disability, see the Retiree Coverages Summary Plan Description. You can obtain a copy of the Retiree Coverages Summary Plan Description through the YBR website on the Plan Information page or by calling the SBSC at **800-392-7495**.

Overview of Your Medical Options

The Healthineers Benefits Program offers most employees a choice of three types of ***self-funded*** or self-insured Medical Plan designs — a Health Savings Medical Plan option with a Health Savings Account (HSA) feature (the HSA Plan), a Health Reimbursement Medical Plan option with a Health Reimbursement Account (HRA) feature (the HRA Plan), and a Preferred Provider Organization Medical Plan option (the PPO Plan). UnitedHealthcare (UHC) administers the Health Savings Medical Plan option. Both UHC and Anthem Blue Cross and Blue Shield (Anthem BCBS) administer the Health Reimbursement and PPO Medical Plan options. When you choose one of these options, you also choose whether you prefer the UHC or Anthem BCBS network of providers. Limited groups of employees are eligible for coverage under the Hawaii Medical Services Association (HMSA) PPO, Kaiser Permanente HMO or Cigna International plans, which are fully insured.

Healthineers' Self-Funded Medical Plan Options

	UnitedHealthcare	Anthem BCBS
Medical plan option names	**Health Savings Health Reimbursement PPO**	**Health Reimbursement PPO**
Medical plan member website	www.myuhc.com	www.anthem.com
Member services phone number	**866-221-5901**	**855-869-8137**
Prescription drug vendor	***CVS/caremark***	***CVS/caremark***
Prescription drug website	www.caremark.com	www.caremark.com
Prescription drug member services phone number	**866-478-5802**	**866-478-5802**
Specialty Pharmacy program vendor	***CVS/specialty***	***CVS/specialty***
Specialty Pharmacy website	www.CVSCaremark SpecialtyRx.com	www.CVSCaremark SpecialtyRx.com
Specialty Pharmacy phone number	**800-237-2767**	**800-237-2767**

Table 5 – Claims Administrators for Healthineers' Self-Funded Medical Plan Options

Under Healthineers' self-funded Medical Plan options that are available to most employees, claims are administered by two major health insurance carriers — UnitedHealthcare (UHC) and Anthem Blue Cross and Blue Shield (Anthem BCBS) — according to nearly uniform plan designs. The UHC and Anthem BCBS networks supply In-Network medical care, including mental health and substance abuse treatment, nationwide. Out-of-Network coverage and claims administration are also available under each Medical Plan option. Prescription drug coverage under each of the self-funded Medical Plan options is provided through ***CVS/caremark*** with specialty medications through ***CVS/specialty***. Healthineers makes no guarantees as to the selection of In-Network health care providers or the level or quality of service provided by any provider.

Here is a summary of coverage under the ***self-funded*** Medical Plan options —

	Health Savings [1]	Health Reimbursement [1]	PPO [1]
Plan Type	**High-Deductible Consumer-Driven Health Plan**	**High-Deductible Consumer-Driven Health Plan**	**Preferred Provider Organization**
Plan Names	**UHC HSA**	**UHC HRA** **Anthem BCBS HRA**	**UHC PPO** **Anthem BCBS PPO**
Highlights	• Higher deductible • Lower employee paycheck contributions • Lower coinsurance • Choose In-Network or Out-of-Network providers • In-Network care is lower in cost • Health Savings Account (HSA) helps offset the higher deductible	• Higher deductible • Lower employee paycheck contributions • Lower coinsurance • Choose In-Network or Out-of-Network providers • Office visit copayments • In-Network care is lower in cost • Health Reimbursement Account (HRA) helps offset the higher deductible	• Lower deductible • Higher employee paycheck contributions • Higher coinsurance • Choose In-Network or Out-of-Network providers • In-Network care is lower in cost
Company Contribution	**Healthineers contributes to your HSA[2]:** • $300 for you, *plus* • $300 for your enrolled spouse or domestic partner • You can increase Healthineers' contributions by earning ***Healthy Rewards*** **You can contribute to your HSA[2] pre-tax:** • Up to $3,150 you-only • Up to $6,300 you + one or more • If you don't use all the money in your HSA, you carry the balance to the following year	**Healthineers contributes to your HRA:** • $450 for you, *plus* • $450 for your enrolled spouse or domestic partner • You can increase Healthineers' contributions by earning ***Healthy Rewards*** • You can carry over unused HRA funds to the next year as long as the HRA Medical Plan option continues to be offered and you remain enrolled in this option	Not applicable
Medical Services Annual Deductible	**In-Network [4, 5]** $2,000 you only $4,000 you + one or more (includes prescription drugs) **Out-of-Network [4, 5]** $3,000 you only $ 6,000 you + one or more (includes prescription drugs)	**In-Network [3, 4]** $1,500 per individual $3,000 you + one $3,700 you + two or more **Out-of-Network [4]** $2,250 per individual $4,500 you + one $5,550 you + two or more	**In-Network [3, 4]** $850 per individual $1,700 you + one $2,300 you + two or more **Out-of-Network [4]** $1,250 per individual $2,500 you + one $3,400 you + two or more

	Health Savings [1]	Health Reimbursement [1]	PPO [1]
Copayment/ Coinsurance	**In-Network** [4, 5] • Preventive care: Plan pays 100% for most services; not subject to the deductible • Other services: Plan pays 85% coinsurance after deductible is met **Out-of-Network** [4, 5] • Plan pays 65% of R&C charges after deductible is met • You pay the balance of the billed amount	**In-Network** [3, 4] • Preventive care: Plan pays 100% for most services; not subject to the deductible • Office visits: You pay $25 copayment • Specialist office visits: You pay $40 copayment • Other services: Plan pays 85% coinsurance after deductible is met **Out-of-Network** [4] • Plan pays 65% of R&C charges or MAA after deductible is met • You pay the balance of the billed amount	**In-Network** [3, 4] • Preventive care: Plan pays 100% for most services; not subject to the deductible • Inpatient Hospital: You pay $250 copayment per episode or admission, then 20% coinsurance • Other services: Plan pays 80% coinsurance after deductible is met **Out-of-Network** [4] • Plan pays 60% of R&C charges or MAA after deductible is met • You pay the balance of the billed amount • Inpatient Hospital: You pay $250 copayment per episode or admission, Plan pays 60% of R&C charges or MAA, and you pay balance of the billed amount
Medical Annual Maximum Out-of-Pocket (MOOP) [1]	**In- Network** [4, 5] **(includes deductible)** $5,500 you-only $11,000 you + one or more [6] **Out-of-Network** [4, 5] **(includes deductible)** $7,000 you-only $14,000 you + one or more	**In-Network** [3, 4] **(includes deductible and copayments)** $3,700 per individual $7,400 you + one $10,000 you + two or more **Out-of-Network** [4] **(includes deductible)** $4,700 per individual $9,400 you + one $14,000 you + two or more	**In-Network** [3, 4] **(includes deductible and inpatient copayments)** $3,700 per individual $7,400 you + one $10,000 you + two or more **Out-of-Network** [4] **(includes deductible and inpatient copayments)** $4,700 per individual $9,400 you + one $14,000 you + two or more
Prescription Drug MOOP (Rx MOOP)	Included with Medical	**In-Network** $2,300 per individual $3,500 you + one or more	**In-Network** $2,300 per individual $3,500 you + one or more

[1] Only Medically Appropriate services and supplies are covered under any Medical Plan option. Plan reimbursements for Covered Health Services provided by ***Out-of-Network*** providers – including any portion of the billed amount that is applied to the annual deductible or annual out-of-pocket maximum – are limited to the Reasonable and Customary ("R&C") charge, as determined by UnitedHealthcare, or the Maximum Allowed Amount ("MAA"), as determined by Anthem BCBS and detailed in the Glossary. If you use an Out-of-Network provider, you will be responsible for both your share of the R&C or MAA, plus any charges over and above R&C or MAA that may be billed by your provider ("balance billing"). These charges may be significant.

[2] Contribution limits are subject to adjustment each year by the IRS, based on an inflation index. ***Healthy Rewards*** will reduce the amount you can contribute. Once you reach age 55, you are also eligible to contribute an additional "catch up" contribution. For 2018, the catch up contribution limit is $1,000.

[3] Generally, In-Network services are billed based on amounts agreed upon by the Claims Administrator and the provider. If Anthem BCBS is your Medical Plan Claims Administrator and your services are rendered outside Anthem BCBS's fourteen (14) state service area, the claims may be priced using the Local BCBS plan's provider fee schedule/rate or pricing arrangements. Please refer to the Inter-Plan program details which can be found at www.anthem.com once you have registered as a user.

[4] Expenses applied to the In-Network deductible are not applied to the Out-of-Network deductible and vice-versa. Expenses applied to the annual In-Network Maximum Out-of-Pocket are not applied to the Annual Out-of-Network Maximum Out-of-Pocket and vice-versa.

[5] Except for preventive care services covered In-Network at 100%, you must meet the entire In-Network or Out-of-Network deductible, as applicable, before the Health Savings Medical Plan pays benefits, including coverage of prescription drugs. If you have at least one enrolled dependent, you must meet the entire In-Network or Out-of-Network family deductible (even if a family member has met the applicable individual deductible) before the Health Savings Medical Plan pays benefits.

[6] Embedded Individual Maximum Out-of-Pocket applies. Once In-Network expenses for one enrolled family member reach the Embedded Individual MOOP ($7,350 in 2018), In-Network medical services and prescription drugs are covered at 100% for that individual for the rest of the year. Total In-Network Maximum Out-of-Pocket can be met only with a combination of accumulations from the family.

Table 6 — Summary of Self-Funded Medical Plan Options

Fully Insured Medical Plan Options

Outbound Delegates are covered under the fully insured Cigna International medical plan option. The Hawaii Medical Services Association (HMSA) PPO medical plan is available to employees in Hawaii. Kaiser Permanente Health Maintenance Organization (HMO) medical plan options are available in most areas of Northern and Southern California. Provisions of coverage under the fully insured medical plan options may vary both among the fully insured plan options and from coverage offered under any of Healthineers' self-funded medical plan options. For general information, consult the Health Plan Comparison Charts available on the YBR website (http://resources.hewitt.com/siemens), use the member website provided by each carrier, or call the carrier and ask for a Summary of Benefits. Healthineers is not responsible for the range of covered services or the selection of in-network health care providers of any of the fully insured plan options.

Fully Insured Medical Plan Options		
Plan Name	**Member Services Phone Number(s)**	**Member Website**
Cigna International (Outbound Delegates)	From inside United States: **800-441-2668** Outside United States: **302-797-3100**	www.cignaenvoy.com
Hawaii Medical Services Association (HMSA)	**808-948-6111**	www.hmsa.com
Kaiser Permanente	**800-464-4000**	http://my.kp.org/siemens

Table 7 – Claims Administrators for Healthineers' Fully Insured Medical Plan Options

Delegates

Outbound* –** If you are a delegate ***from the United States ***to*** another country, only the **Cigna International** medical plan option with dental coverage provided under the Cigna Comprehensive option, both administered by Cigna, is available to you and your eligible family members.

- If you do not have medical coverage under a Healthineers Benefits Program option prior to the start of your delegation, you alone will be enrolled by default in medical coverage under the Cigna International medical plan. If you have both medical and dental coverage under Healthineers Benefits Program options prior to the start of your delegation, you and any enrolled dependents will be enrolled in the Cigna International medical and Cigna Comprehensive dental options by default. If you do not have medical and/or dental coverage prior to your delegation, or if you need to enroll dependents, you will need to call the SBSC during the 30-day period that begins with your delegation to elect coverage. Unless you waive coverage, the Cigna International medical option (and the Cigna Comprehensive dental option, if you are enrolled) will continue through the end of your delegation.
- There are three tiers or levels for annual deductibles, coinsurance and annual maximum out-of-pocket limits under the Cigna International medical plan, based on whether expenses are ***International*** (incurred outside the U.S.) or are incurred ***In-Network*** or ***Out-of-Network*** inside the U.S.

	International outside the U.S.	**In-Network** inside the U.S.	**Out-of-Network** inside the U.S.
Cigna International Medical Plan Coverage Summary			
Annual deductible (medical charges you pay in full before Coinsurance begins)	$300 per individual, maximum $900 per family	$850 per individual, maximum $2,300 per family	$1,250 per individual, maximum $3,400 per family
Coinsurance for medical services (percentage of charge that you pay)	20% after you meet the annual deductible	20% after you meet the annual deductible	40% of Maximum Reimbursable Charge after you meet the annual deductible
Coinsurance for prescription drugs and related supplies	20%, deductible does not apply	20%, deductible does not apply	40%, deductible does not apply
Annual maximum out-of-pocket limit (includes prescription drugs)	$1,500 per individual, maximum $4,500 per family	$3,500 per individual, maximum $10,500 per family	$4,500 per individual, maximum $13,500 per family

For Delegates enrolled in the Cigna International Medical Plan option, reimbursement for out-of-network providers in the U.S. will be the lesser of (a) the provider's normal charge for a similar service or supply (b) a percentage of a schedule that Cigna International has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market

For U.S. Out-of-Network claims, the amount that will be applied to your annual deductible, your coinsurance, and the amount the plan will pay will be the lesser of (a) the provider's normal charge for a similar service or supply (b) a percentage of a schedule that Cigna International has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. You will be responsible for paying any provider charges in excess of the Maximum Reimbursable Charge

("balance billing"), and the excess amount will not be applied to the annual maximum out-of-pocket limit.

For specific provisions on what is covered under the Cigna International medical and Cigna Comprehensive dental options or other administrative details, register for the member portal, www.CIGNAEnvoy.com, or call Cigna at **800-441-2668** (or **302-797-3100** from outside the U.S.).

- When you return to the United States, you will need to elect another medical (and dental) plan option. If you remain eligible for coverage under the Healthineers Benefits Program and you do not elect a new medical (and dental) plan option during the 30-day period that follows the end of your delegation, you and any dependents who were enrolled in medical (and dental) coverage before the end of your delegation will be assigned default coverage under the PPO Medical Plan option administered by UnitedHealthcare (and Delta Dental, if you had dental coverage as a delegate).

Inbound – If you are a delegate *to* the United States ***from*** another country, only the **Preferred Provider Organization (PPO)** medical plan option is available to you and your eligible dependents. For any area of the United States where no PPO coverage is available, the SBSC will assist you in finding an alternative coverage option.

- You alone will be automatically enrolled in medical coverage under the PPO Medical Plan option administered by UnitedHealthcare. You will also be automatically enrolled in company-paid life insurance at one times Pay and personal accident insurance at two times Pay, and in company-paid long-term disability coverage. During the first 30 days of your delegation, you will need to enroll your dependents in medical coverage, to make an election of dental and vision coverage for yourself and any dependents, and to elect life and personal accident insurance above the default levels. In making your enrollment, you may decide whether you (and your enrolled dependents) would prefer to continue in the PPO plan option administered by UnitedHealthcare or choose the PPO plan option administered by Anthem BCBS, instead; and you may decide whether to pay for your long-term disability insurance with post-tax deductions.
- If you do not yet have a valid U.S. Social Security Number (SSN), you will need to use the temporary or "dummy" National ID assigned to you by Healthineers Human Resources to log on to the Your Benefits Resources™ (YBR) website (http://resources.hewitt.com/siemens) to set up your User-ID and password and to familiarize yourself with benefit options. If you have any difficulty enrolling, or if you and all of your dependents do not yet have valid U.S. Social Security Numbers, you will need to call the SBSC at **800-392-7495** — using the same User-ID and password you set up on YBR — to complete your enrollment.

PROVISIONS OF COVERAGE UNDER HEALTHINEERS' SELF-FUNDED MEDICAL PLAN OPTIONS

This section of the Summary Plan Description describes and compares the provisions of the Healthineers sponsored self-funded Medical Plan options that are available to most employees.

The Annual Deductible

The annual Deductible is the amount of covered medical expenses that you pay each year before Coinsurance applies and benefits are paid. The amount of the Deductible depends on the Medical Plan option you elect and whether your providers are In-Network or Out-of-Network, as follows:

	Health Savings	Health Reimbursement	PPO
Annual Medical Deductible	**In-Network** $2,000 you only $4,000 you + one or more Includes Prescription Drug expenses **Out-of-Network** $3,000 you only $6,000 you + one or more Includes Prescription Drug expenses	**In-Network** $1,500 you only $3,000 you + one $3,700 you + two or more Does not include Prescription Drug expenses **Out-of-Network** $2,250 you only $4,500 you + one $5,550 you + two or more Does not include Prescription Drug expenses	**In-Network** $850 you only $1,700 you + one $2,300 you + two or more Does not include Prescription Drug expenses **Out-of-Network** $1,250 you only $2,500 you + one $3,400 you + two or more Does not include Prescription Drug expenses

Table 8 – Annual Medical Plan Deductibles

The annual Deductible applies to all covered medical expenses, except In-Network preventive care, as defined under each Plan. An expense that is not covered will not be applied to any deductible. In-Network and Out-of-Network deductibles do not cross-accumulate. This means that an expense that is applied to your In-Network Deductible will not also be applied to your Out-of-Network Deductible, and vice-versa. The amount applied to the annual Out-of-Network Deductible for Covered Health Services is limited to the Reasonable and Customary ("R&C") charge or the Maximum Allowed Amount ("MAA"), as determined by the Claims Administrator of your Medical Plan option.

- If you are enrolled in the Health Savings Medical Plan option and you cover at least one family member, you have "family" coverage and you must meet the entire family (or "you + one or more") Deductible before the plan pays benefits, even if one family member has met the individual (or "you only") Deductible amount. Expenses for any combination of family members will be applied to the family In-Network and Out-of-Network Deductible amounts. Once you have met the entire family In-Network Deductible, In-Network expenses for every member of the family will be covered with In-Network Coinsurance. You must meet the entire family Out-of-Network Deductible before the plan will cover eligible Out-of-Network expenses, even if one family member has met the individual Out-of-Network Deductible.
- If you are enrolled in a Health Reimbursement or PPO Medical Plan option, once covered medical expenses for one family member reach the corresponding In-Network or Out-of-Network Deductible, Coinsurance will apply to that member. If you are enrolled as a family of three or more, expenses for any combination of family members will be applied to the corresponding In-Network or Out-of-Network "family" Deductible, but one family member cannot satisfy more than his or her own individual amount. Once the corresponding family Deductible has been met,

Coinsurance will apply to all family members even if one or more members have not met their individual Deductibles.

The Annual Deductible for the Health Reimbursement and PPO Plan Options

To help limit the number of Deductibles you and your covered family members need to pay, the Health Reimbursement and PPO Medical Plan options include the following features:

- **Family Maximum Deductible** – The family maximum for a family of two is an amount equal to two times the individual Deductible. For a family of three or more, the family Deductible is met once the expenses applied toward the Deductible for each covered individual in your family equal the corresponding In-Network or Out-of-Network family Deductible amount.
- **Common Accident** − If two or more family members are injured in the same accident, only one Deductible is required for all Covered Health Services resulting from that accident.
- **Multiple Births** – If you have twins, triplets or another multiple birth, each child has its own calendar-year Deductible, up to the corresponding In-Network or Out-of-Network Family Maximum Deducible. However, for the PPO, only one Hospital confinement Copayment is required for covered expenses for any or all of the infants who remain hospitalized after the mother is discharged. The PPO Hospital confinement Copayment is waived for any of the infants who is readmitted to the hospital in the year of birth due to premature birth, abnormal congenital condition, or an illness that begins within 30 days after birth. Be sure to enroll each baby as soon as possible and within 30 days from the date of their birth.

Coinsurance (Percentage Paid by Plan)

The coinsurance percentages listed below are the share of covered expenses that your Medical Plan option generally pays after you have met the corresponding In-Network or Out-of-Network annual Deductible and until you meet the corresponding In-Network or Out-of-Network Maximum Out-of-Pocket annual limit. Out-of-Network Coinsurance for Covered Health Services is limited to the Reasonable and Customary ("R&C") charge or the Maximum Allowed Amount ("MAA") as determined by the Claims Administrator of your Medical plan option.

	Health Savings	Health Reimbursement	PPO
Coinsurance Percentage	**In-Network** Plan pays **85%** until In-Network Maximum Out-of-Pocket is met **Out-of-Network** Plan pays **65%** of R&C charge until Out-of-Network Maximum Out-of-Pocket is met	**In-Network** Plan pays **85%** until In-Network Maximum Out-of-Pocket is met **Out-of-Network** Plan pays **65%** of R&C or MAA until Out-of-Network Maximum Out-of-Pocket is met	**In-Network** Plan pays **80%** until In-Network Maximum Out-of-Pocket is met **Out-of-Network** Plan pays **60%** of R&C or MAA until Out-of-Network Maximum Out-of-Pocket is met

Table 9 – Coinsurance Percentage

Maximum Out-of-Pocket Limits

The Maximum Out-of-Pocket (MOOP) annual limits protect you from potentially catastrophic costs due to serious illness or injury. The Medical Plan options have **separate** annual Maximum Out-of-Pocket limits for In-Network (INN MOOP) and Out-of-Network (OON MOOP) expenses. The MOOPs limit the amount of Coinsurance you have to pay each year. Once your Coinsurance payments have reached the corresponding In-Network or Out-of-Network Maximum Out-of-Pocket limit, the Plan pays 100%

for Covered Health Services for the rest of that calendar year. For Out-of-Network claims, the amount applied to your Out-of-Network Maximum Out-of-Pocket is limited to the Reasonable and Customary ("R&C") charge or the Maximum Allowed Amount ("MAA") as determined by the Claims Administrator of your Medical plan option.

	Health Savings	Health Reimbursement	PPO
Annual Maximum Out-of-Pocket (MOOP) Limits	**In-Network** $5,500 you only $11,000 you + one or more Includes Deductible and Prescription Drug expenses	**In-Network** $3,700 you only $7,400 you + one $10,000 you + two or more Includes Deductible and Copayments; Prescription Drug expenses not included	**In-Network** $3,700 you only $7,400 you + one $10,000 you + two or more Includes Deductible and Hospital Copayments; Prescription Drug expenses not included
	Out-of-Network $7,000 you only $14,000 you + one or more Includes Deductible and Prescription Drug expenses	**Out-of-Network** $4,700 you only $9,400 you + one $14,000 you + two or more Includes Deductible; Prescription Drug expenses not included	**Out-of-Network** $4,700 you only $9,400 you + one $14,000 you + two or more Includes Deductible and Hospital Copayments; Prescription Drug expenses not included

Table 10 – Maximum Out-of-Pocket Limits

The In-Network and Out-of-Network annual Maximum Out-of-Pocket limits do not cross-accumulate. This means that an expense that is applied to the In-Network Maximum Out-of-Pocket (INN MOOP) will not also be applied to the Out-of-Network Maximum Out-of-Pocket (OON MOOP), and vice-versa.

Expenses for any combination of family members will be applied to the corresponding In-Network or Out-of-Network MOOP but, except under the Health Savings Medical Plan option, one family member cannot satisfy more than the "individual" amount that corresponds to "You-Only" enrollment.

- **If you are enrolled in the Health Savings Medical Plan option** and the total amount you have paid for In-Network expenses for one member of your family meets the ***embedded individual In-Network Maximum Out-of-Pocket*** ($7,350 for plan year 2018), eligible In-Network prescription drug and medical expenses will then be 100% covered for that individual for the balance of the year. The "embedded individual Out-of-Pocket Maximum" is calculated by adding the amount applied to the family In-Network Deductible for one family member plus the total amount of In-Network Coinsurance that you have paid for the same individual's In-Network expenses. Other family members will continue to pay Coinsurance for eligible In-Network prescription drug and medical services until the family reaches the In-Network MOOP. Out-of-Network prescription or medical services will not be included in the "embedded individual Out-of-Pocket Maximum."
- **If you are enrolled in a Health Reimbursement or PPO Medical Plan** option and one member of your family meets the individual In-Network MOOP, eligible In-Network expenses will be covered at 100% for that individual for the rest of the calendar year. However, other family members will continue to pay Coinsurance until the In-Network MOOP for the second enrolled individual or the family is met.

The following expenses do ***not*** apply toward the INN MOOP or the OON MOOP under any of the Medical Plan options:

- any amounts you pay because of failure to follow the pre-certification review procedures;
- the portion of any covered expense that exceeds the Reasonable and Customary (R&C) charge or Maximum Allowed Amount, as determined by the Claims Administrator;

- prescription drug expenses (except under the Health Savings Medical Plan option); and
- expenses not covered by the Plan.

Each Medical Plan option covers a broad range of services and supplies. Benefits for Covered Health Services depend on the type of expense and whether you receive services from In-Network or Out-of-Network providers. In all cases, benefits are based In-Network on contracted provider charges and Out-of-Network on the Reasonable and Customary (R&C) charge or Maximum Allowed Amount as determined by the Claims Administrator for your Medical Plan option. Only Medically Appropriate services and supplies are covered under the Plan regardless of whether the provider is In-Network or Out-of-Network. For a detailed explanation, refer to the Glossary section of this SPD.

HSA, HRA or PPO — Which Is Best for You?

	Health Savings Account	Health Reimbursement Account	PPO
Healthineers' automatic annual contribution			
You only	$300 [a]	$450	N/A
You + child(ren)	$300 [a]	$450	
You + spouse or domestic partner	$600 [a]	$900	
You + family	$600 [a]	$900	
Additional Healthineers' contributions			
Earn ***Healthy Rewards***	**Yes**	**Yes**	No
Maximum total annual tax-free contributions (Healthineers' plus your own) [b]			
You only	$3,450 [a, b]	No	No
You + child(ren)	$6,900 [a, b]		
You + spouse or domestic partner	$6,900 [a, b]		
You + family	$6,900 [a, b]		
Can you increase tax savings with a Flexible Spending Account (FSA)?			
Health Care FSA (HCFSA)	No	**Yes** [d]	**Yes**
Limited-Use Health Care FSA	**Yes** [c]	N/A	N/A

[a] You will no longer be eligible to receive or make HSA contributions once you enroll in Medicare or receive health benefits under TRICARE.

[b] 2018 annual limits (employer plus employee) on tax-free contributions to an HSA. The IRS sets limits for each calendar year. The annual limits include Healthineers' contributions, any ***Healthy Rewards***, your contributions to your Healthineers' HSA or any contributions to another HSA account.

[c] Your Limited-Use Health Care FSA can be used to reimburse eligible dental and vision expense only.

[d] Medical claims must be submitted to your HRA before they can be reimbursed from the HCFSA. Prescription drug, dental and vision claims should be submitted directly to your HCFSA.

Table 11 — Health Savings, Health Reimbursement and PPO Medical Plan Options Compared

A Health Savings Account (HSA) or Health Reimbursement Account (HRA) can help you cover the annual Deductible or other expenses under the Health Savings or Health Reimbursement Medical Plan options. Coordinating your Medical Plan option with a careful choice of a Health Care Flexible Spending Account (HCFSA) or Limited-Use Health Care Flexible Spending Account (Limited-Use HCFSA) may best meet your family's medical and financial needs.

- **If you are enrolled in the Health Savings Medical Plan option**, you can use your HSA to pay or reimburse eligible *medical and prescription drug* expenses and other health care expenses as defined by the IRS. You can also elect to contribute to a ***Limited-Use HCFSA***, which can be used only to reimburse *dental and vision* expenses. However, neither account can be used to pay or reimburse expenses for your domestic partner, civil union partner or a child of your domestic partner who is not also your child — even if the family member is enrolled in coverage—unless the individual is also your dependent for federal tax purposes.
- **If you are enrolled in the Health Reimbursement Medical Plan option**, you can use your HRA to pay or reimburse *covered medical expenses* for you or any family member who is enrolled in the Health Reimbursement Medical Plan option. You can also elect to contribute to an ***HCFSA***. The IRS has rules that govern the order in which medical expenses must be submitted by individuals who have both an HRA and an HCFSA —
  - You always have the option of paying for a covered medical expense out-of-pocket rather than submitting it for reimbursement to either the HRA or HCFSA.
  - Expenses that are eligible for reimbursement from both the HRA and the HCFSA must be submitted to your HRA first. This includes out-of-pocket medical expenses such as your Deductible, Coinsurance and Copayments. After your HRA balance for the year has been exhausted, medical expenses may be submitted directly to your HCFSA for the rest of the year.
  - Expenses that are not eligible for reimbursement from the HRA (including prescription drug, vision and dental claims) may be paid from the HCFSA.

  Your HCFSA cannot be used to pay or reimburse expenses for your domestic partner, civil union partner or a child of your domestic partner who is not also your child — even if the family member is enrolled in coverage — unless the individual is also your dependent for federal tax purposes.
- **If you are enrolled in the PPO Medical Plan option**, you can also elect to contribute to an ***HCFSA***, which can be used to reimburse *any eligible health care expenses* — including medical, prescription drug, dental and vision. However, the HCFSA cannot be used to pay or reimburse expenses for your domestic partner, civil union partner or a child of your domestic partner who is not also your child — even if the family member is enrolled in coverage — unless the individual is also your dependent for federal tax purposes.

Earn Healthy Rewards

If you are enrolled in the Health Savings or a Health Reimbursement Medical Plan option, you and your covered spouse or domestic partner can earn ***Healthy Rewards***, which are additional Healthineers contributions to your HSA or HRA, by completing certain activities between January 1 and December 31 each year. For 2018, federal regulations cap Healthy Rewards at $1,200 per family.

Activity	Contribution to Your HSA or HRA
Complete a Health Risk Assessment on your medical carrier's website	$100
Have your annual physical or well-woman exam	$150
Receive your annual vision exam	$50
Healthy Focus Maternity Program	

Activity	Contribution to Your HSA or HRA
Complete a pre-delivery screening or planning call	$100
Complete a post-delivery call	$100
***Healthy Focus* Program**	
Enroll in Healthy Focus care- or disease-management program	$100
Complete a Healthy Focus care plan	$100
Complete a post-hospital discharge call	$100

Healthy Rewards will be deposited to your HSA or HRA up to 60 days following the date you earn them and will then be available for reimbursement of eligible expenses. To learn more about earning Healthy Rewards, log on to your member website, www.myuhc.com or www.anthem.com.

The Pre-Admission or Prior Authorization Review Program

Each Medical Plan option includes programs for pre-admission review, pre-certification or prior authorization for admission to a hospital or skilled nursing care facility, and for outpatient diagnostic and treatment facilities (including laboratory and radiology), private duty nursing, home health care, and hospice care. Pre-admission review promotes efficient use of Plan benefits and helps you avoid unnecessary medical expenses.

Before you or a covered dependent enters the Hospital or Skilled Nursing Care Facility, you or your doctor must have the admission pre-certified and receive a certification number for the expected admission. Pre-certification of inpatient medical care is your responsibility. All you need to do is call the Claims Administrator's toll-free number (**located on the back of your ID card**) for the Medical Plan option you elected. If you do not have your ID card, call the member services number for your Claims Administrator (UHC at **866-221-5901** or Anthem BCBS at **855-869-8137**). You can call 24-hours a day, seven days a week. Leave a message and telephone number if a representative is not available.

When you call, you will speak with a health care professional who will review the length of your proposed hospital stay or skilled nursing care facility stay. If your admission is approved, you will receive written notice prior to your admission if time allows. You will also receive written notice if your stay is not approved. When you call to pre-certify, take careful note of the date and time of your call, the name(s) of the representative(s) who assist you, and the certification number.

Going Out-of-Network?

You may call Member Services for an estimate of Provider Charges, too

Member services for UHC (**866-221-5901**) and Anthem BCBS (**855-869-8137**) services can assist you in determining the Reasonable and Customary ("R&C") charge or Maximum Allowed Amount ("MAA") that will be covered under your Medical Plan option for a particular Covered Health Service from an Out-of-Network provider. To calculate your responsibility, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) and the charges for the service. Although member services can assist with this information, the final R&C charge or MAA for your claim will be based on the actual claim submitted by the provider.

In an Emergency, you may not have time to call for pre-certification. In that case, you, a family member or your doctor must provide "**Hospital Notice**" by calling for certification within 48 hours after the hospital admission or skilled nursing care facility admission (or on the first business day following admission).

To receive *maximum* plan benefits, you *must* follow the option's pre-admission review procedures. For Out-of-Network services under the Health Savings, Health Reimbursement or PPO Medical Plan options, if you fail to precertify, you will pay the first $300 in charges, then 50%

Coinsurance if the facility is Out-of-Network. This applies to hospital, outpatient treatment facilities and skilled nursing facility confinements, private duty nursing, home health care and hospice care.

No pre-certification is required for expenses related to the delivery of a baby unless the length of the mother's hospital stay is going to exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section, but you or a family member will need to notify your Claims Administrator of this hospitalization. If your baby must remain in the hospital after the mother is released, you must pre-certify the child's extended hospital stay within 48 hours from the original certification stay.

In accordance with federal law, your Medical Plan option generally cannot restrict its benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). In any case, under federal law, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay of 48 hours (or 96 hours) or less.

The Medical Plan options may require pre-certification for medical services and procedures in addition to hospital admissions. Failure to pre-certify these services or procedures — especially Out-of-Network — may result in penalties for not certifying. Listed below are some of these services:

- Accidental dental services
- Congenital heart disease services
- Durable medical equipment over $1,000 (purchase or cumulative rental)
- Home health care
- Hospice care
- Maternity care that exceeds 48 hours for normal delivery and 96 hours for caesarean birth
- Radiologic diagnostic procedures (including CT, PET scans, MRI, MRA) and nuclear medicine (including diagnostic catheterizations)
- Reconstructive procedures
- Skilled nursing or inpatient rehabilitation facility confinement
- Transplant services
- Breast reduction and reconstruction (except after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

Physician Expenses

Each Medical Plan option covers In-Network contracted provider charges and Out-of-Network Reasonable and Customary (R&C) expenses or the Maximum Allowed Amount (MAA) for office visits, surgery and inpatient Hospital visits.

Second Surgical Opinions

There is no mandatory requirement for a second surgical opinion. Before any surgical procedure, you should contact the Claims Administrator for your Medical Plan option at the toll-free number listed on the back of your insurance ID card to confirm that the procedure is covered.

Hospital Expenses

Each Medical Plan option covers In-Network contracted provider charges and Out-of-Network Reasonable and Customary (R&C) or Maximum Allowed (MAA) charges for semi-private hospital room and board, and Medically Appropriate services and supplies.

IMPORTANT!

The length of hospital stays is subject to the approval of the Claims Administrator for the Medical Plan option you elected. The Healthineers Medical Plan has two main Claims Administrators: UnitedHealthcare administers the HSA as well as the HRA and PPO Medical Plan options; and Anthem BCBS administers the HRA and PPO Medical Plan options. Benefits are **reduced** or are **not payable** unless authorized in advance. In an **Emergency**, you, a family member or your doctor must provide **Hospital Notice** by calling your Medical Plan Claims Administrator within 48 hours or on the first business day following the admission to a hospital or skilled nursing care facility. When you call, take careful note of the date and time of your call, the name(s) of the representative(s) who assist you, and the certification number.

Medically appropriate services and supplies include:

- anesthesia
- general nursing care
- hospital-administered drugs and medication
- x-rays and lab tests
- licensed ambulance service (if medically appropriate) to or from the nearest hospital capable of providing the needed medical care and treatment
- emergency room charges.

The following table shows the benefits provided for Hospital expenses under each type of Medical Plan option.

	Health Savings	Health Reimbursement	PPO
Inpatient Care			
Hospital copay and coinsurance	**In-Network** 85% covered after deductible is met; preauthorization required; if maternity, hospital notice required **Out-of-Network** 65% covered after deductible is met; preauthorization required; if maternity, hospital notice required; $300 penalty then 50% covered if not preauthorized	**In-Network** 85% covered after deductible is met; preauthorization required; if maternity, hospital notice required **Out-of-Network** 65% covered after deductible is met; preauthorization required; if maternity, hospital notice required; $300 penalty then 50% covered if not preauthorized	**In-Network** $250 copay per episode or admission; thereafter 80% covered after deductible is met; preauthorization required; if maternity, hospital notice required; new copay required if baby remains inpatient after mother is discharged **Out-of-Network** $250 copay per episode or admission; thereafter 60% covered after deductible is met; preauthorization required; if maternity, hospital notice required; new copay required if baby remains inpatient after mother is discharged; $300 penalty then 50% covered if not preauthorized

	Health Savings	Health Reimbursement	PPO
Hospital semi-private room (or private room when medically appropriate or semi-private room is not available; limited to Reasonable and Customary or Maximum Allowed rate for semi-private room)	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty then 50% covered if not preauthorized	**In-Network** 85% covered after deductible are met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty then 50% covered if not preauthorized	**In-Network** $250 copay per episode or admission; thereafter 80% covered after deductible is met; preauthorization required **Out-of-Network** $250 copay per episode or admission; thereafter 60% covered after deductible is met; preauthorization required; $300 penalty then 50% covered if not preauthorized
Inpatient lab and X-ray	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Inpatient physician and surgeon services	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Emergency Care			
Emergency room (not followed by admission)	**In-Network** 85% covered after deductible is met; must be true emergency; non-emergency not covered **Out-of-Network** 85% covered after deductible is met; must be true emergency	**In-Network** 85% covered after deductible is met; must be true emergency; non-emergency not covered **Out-of-Network** 85% covered after deductible is met; must be true emergency; non-emergency not covered	**In-Network** 80% covered after deductible is met; must be true emergency; non-emergency not covered **Out-of-Network** 80% covered after deductible is met; must be true emergency; non-emergency not covered
Ambulance service (for licensed ambulance service, if medically appropriate, to or from the nearest hospital where the needed care and treatment can be provided)	85% covered after deductible is met; must be true emergency	85% covered after deductible is met; must be true emergency	80% covered after deductible is met; must be true emergency

Table 12 - Hospital Expenses

Outpatient Medical Care and Physician Expenses

Each Medical Plan option covers In-network contracted provider charges and Out-of-Network Reasonable and Customary (R&C) or Maximum Allowed (MAA) charges for outpatient medical care and physician expenses as shown on the following Table. Once you have met the corresponding In-Network or Out-of-Network Deductible for your Medical Plan option, Coinsurance will apply. If you are enrolled in a Health Reimbursement Medical Plan option, the In-Network Copay may apply, as indicated.

	Health Savings	Health Reimbursement	PPO
Outpatient Medical Care			
Primary doctor office visit	**In-Network** **85%** covered after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In Network** **$25** copay; all other services 85% after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In-Network** **80%** covered after deductible is met **Out-of-Network** **60%** covered after deductible is met
Specialist office visit	**In-Network** **85%** covered after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In Network** **$40** copay; all other services 85% after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In-Network** **80%** covered after deductible is met **Out-of-Network** **60%** covered after deductible is met
Surgery [1] (performed inpatient, outpatient or in the physician's office) and diagnostic procedures [2]	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Second surgical opinion	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In Network** $40 office visit copay; other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Urgent care clinic visit	**In-Network** 85% covered after deductible is met	**In-Network** $35 copayment, then 100% covered	**In-Network** 80% covered after deductible is met

[1] Multiple surgical procedures performed during one operating session result in payment reduction of 50% relative to the surgery or surgeries with the lesser charge(s). The most expensive procedure is paid as any other surgery.

[2] Multiple procedure payment reductions will apply to secondary services performed at the same time and related to endoscopies, radiology interpretations, and the technical portion (i.e., the technicians and use of equipment) needed to perform certain diagnostic cardiology and ophthalmology procedures. Reimbursement will be based on the service with the highest total relative value. Services with lower total relative value will be subject to reduction. If you use Out-of-Network providers, you may be subject to balance-billing.

Table 13 – Outpatient Medical Care and Physician Expenses

Dental Care and Surgery

In general, the medical plan options do not cover surgical expenses related to the teeth or gums. However, they do cover In-Network contracted provider charges and Out-of-Network Reasonable and Customary (R&C) or Maximum Allowed (MAA) expenses related to certain dental procedures and based on medical necessity, including:

- alveolectomy (removal of mandibular and/or maxillary bone)
- surgical removal of tumors, cysts, and fractures
- dental charges necessary because of injury to natural teeth resulting from an accident. Treatment must begin within six (6) months of the original accident that caused the injury.
- surgical and non-surgical treatment for temporomandibular joint dysfunction (TMJ) including splints and appliances

	Health Savings	Health Reimbursement	PPO
Dental Care			
Dental implants	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered
Accidental injury to teeth	**In-Network** 85% covered after deductible is met; treatment must begin within six months of injury; subject to medical review **Out-of-Network** 65% covered after deductible is met; treatment must begin within six months of injury; subject to medical review	**In-Network** 85% covered after deductible is met; treatment must begin within six months of injury; subject to medical review **Out-of-Network** 65% covered after deductible is met; treatment must begin within six months of injury; subject to medical review	**In-Network** 80% covered after deductible is met; treatment must begin within six months of injury; subject to medical review **Out-of-Network** 60% covered after deductible is met; treatment must begin within six months of injury; subject to medical review
Alveolectomy; Surgical removal of tumors and cysts	**In-Network** 85% covered after deductible is met; subject to medical review **Out-of-Network** 65% covered after deductible is met; subject to medical review	**In-Network** 85% covered after deductible is met; subject to medical review **Out-of-Network** 65% covered after deductible is met; subject to medical review	**In-Network** 80% covered after deductible is met; subject to medical review **Out-of-Network** 60% covered after deductible is met; subject to medical review

Table 14 – Dental Treatment Covered under Self-Funded Medical Plan Options

For more information on what is covered, contact the Claims Administrator for your medical plan option. Dental procedures covered under the Medical Plan are not covered under the Dental Plan.

Preventive Care Expenses

Preventive care is intended to evaluate your health when you are ***symptom-free***. The goal of preventive care is to enable you to obtain an early diagnosis and treatment, which may help you avoid more serious health problems. **Diagnostic care** is medical treatment — including screenings, laboratory tests and on-going care — to assess, manage or treat an ***already-identified*** health issue.

When provided according to approved age, gender and frequency guidelines, preventive care services are covered at 100% ***In-Network*** under all three of the self-funded Medical Plan options. Under the Health Reimbursement and PPO Medical Plan options, coverage for Out-of-Network preventive care is not subject to the annual Out-of-Network Deductible but is limited to Reasonable and Customary ("R&C") or Maximum Allowed ("MAA") rates. For Health Savings Medical Plan participants, Out-of-Network preventive care is covered at 65% of R&C or MAA rates after the annual Out-of-Network Deductible has been met. For details on preventive coverages, check the web links below.

	Health Savings	Health Reimbursement	PPO
Preventive Care Cost-Sharing			
Annual physical exam—see **NOTE** below	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible **Out-of-Network** 65% covered; not subject to deductible	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 60% covered; not subject to deductible
Cancer screenings; Cardiovascular screenings	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible **Out-of-Network** 65% covered; not subject to deductible	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 60% covered; not subject to deductible
Well-woman exam (includes pap); Mammogram (preventive)[1]; Women's preventive and maternity services 100% covered *in-network* per ACA guidelines—see **NOTE** below	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible **Out-of-Network** 65% covered; not subject to deductible	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 60% covered; not subject to deductible
Pediatric exams; Immunizations (child)	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible **Out-of-Network** 65% covered; not subject to deductible	**In-Network** 100% covered; not subject to deductible **Out-of-Network** 60% covered; not subject to deductible
[1] 3-D mammography is covered 100% under preventive care when received in-network			

	Health Savings	Health Reimbursement	PPO
Preventive Care Cost-Sharing			
NOTE: Federal Affordable Care Act (ACA or health care reform law) guidelines apply to Preventive services. Non-preventive or diagnostic services incurred and billed within a preventive visit may have costs associated with those specific services. **Women's preventive and maternity services that are covered at 100% *In-Network*** in accordance with Affordable Care Act guidelines include: • contraceptive counseling and FDA-approved contraception methods– • contraceptive drugs (covered under Prescription Drug Program): all generics and brands without direct generic equivalents, regardless of method (oral, transdermal, etc.), covered at 100%; brands with direct generic equivalents covered according to formulary with coinsurance; • over-the-counter barrier methods such as condoms or spermicidal foam when prescribed for a woman by her healthcare provider and purchased In-Network under the Prescription Drug Program; and • prescribed contraceptive devices such as Depo-Provera, diaphragms and IUDs, along with services to inject, fit, place, or remove them; • female sterilization procedures such as transcervical surgical sterilization implant and tubal ligation (but not reversal of voluntary sterilization); • human papillomavirus (HPV) DNA testing (beginning at age 30, and every 3 years thereafter); • screening and counseling on human immunodeficiency virus (HIV), other sexually transmitted infections (STIs), and domestic violence; • screening for gestational diabetes; • prenatal and postnatal lactation counseling and breastfeeding support, including assistance in identifying In-Network providers, rental or purchase of equipment (including a breast pump supplied In-Network); and • BRCA-related cancer preventive screening and risk assessment, genetic counseling and genetic testing, if appropriate for a woman as determined by her attending provider.			

Table 15 – Preventive Care Coinsurance

Evidence-informed items and services will be covered as "preventive care" and will be covered ***In-Network*** with no cost-sharing when provided following the age, gender and frequency guidelines issued under the Patient Protection and Affordable Care Act (health care reform), which are posted on the website of the Health Resources and Services Administration of the U.S. Department of Health and Human Services (http://www.hrsa.gov/), and as indicated below:

Well Baby Care (includes newborns through age 2), Pediatric Preventive Care, and Immunizations. For details, visit the web links listed in Table 16 below.

- **Adult Care and Immunizations.** For details, visit the web links listed in Table 16 below.
- **Preventive Medications.** Certain preventive medications are covered at 100% when purchased through the ***CVS/caremark*** Prescription Program described below. Preventive medications include aspirin (to prevent cardiovascular diseases), fluoride supplements (for children at risk with inadequate access to fluorinated water), folic acid supplements (for women who are planning to become or are pregnant), and iron supplements (for children at risk of iron deficiency). See the section entitled, "The Prescription Drug Program," for details.
- **Lactation Support and Counseling.** Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. However, the Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service. **Where an appropriate In-Network provider is not available, Out-of-Network services and supplies will be covered with no cost-sharing.** For details, visit the web link listed in Table 16 below (Web Links for Preventive Care and Immunizations).

Guidelines and Coverage Information

Detailed information about federal preventive care and immunization guidelines and coverage provided under Healthineers' self-funded Medical Plan options is readily available on the following websites:

Vendor websites
UnitedHealthcare — Health Savings, Health Reimbursement or PPO http://www.uhcpreventivecare.com
Anthem BCBS — Health Reimbursement or PPO https://www.anthem.com/health-insurance/health-and-wellness/preventive-care
U.S. Preventive Services Task Force (USPSTF) Preventive Care Guidelines
Describes evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF with respect to the individual involved (except for the Task Force's recommendations on breast cancer screening, mammography, and prevention issued in 2009, which explicitly requires compliance with prior USPTF guidelines issued in 2002) http://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers
Health Resources and Services Administration Preventive Care and Screenings Guidelines
Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders
Bright Futures recommendations for pediatric preventive health care http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf
Recommended preventive care and screenings for women http://www.hrsa.gov/womensguidelines
Pre- and postnatal lactation support and counseling http://www.dol.gov/ebsa/faqs/faq-aca29.html
BRCA-related cancer preventive screenings and risk assessment for women http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing
US Dept. of Labor FAQs on Affordable Care Act Implementation http://www.dol.gov/ebsa/healthreform/regulations/acaimplementationfaqs.html
Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention
Recommended immunization schedule for persons aged 0 through 18 years http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf
Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than one month behind http://www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf
Recommended adult immunization schedule [1] [2] http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf
[1] Immunizations for travel are generally not covered. [2] The human papillomavirus (HPV) immunization is covered at 100% In-Network.

Table 16 – Preventive Care and Immunization Web Links

Other Covered Services

Each Medical Plan option pays benefits In-Network at contracted provider rates or Out-of-Network up to the Reasonable and Customary (R&C) or Maximum Allowed (MAA) limits, as determined by the Claims Administrator, for the covered services shown in the following table:

	Health Savings	Health Reimbursement	PPO
Family Planning/Maternity Care			
Prenatal services 100% covered *in-network* per ACA guidelines—see **NOTE** below	**In-Network** 100% covered; not subject to deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 60% covered after deductible is met
Office visit: Prenatal / postnatal –other services; see **NOTE** below	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** $40 copay initial visit only; subsequent visits 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
In-hospital delivery services—hospital notification required; preauthorization required for all scheduled admissions and for maternity stays exceeding 48 hours (vaginal delivery) or 96 hours (Caesarean section)	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized	**In-Network** $250 inpatient hospital copay, then 80% covered after deductible is met **Out-of-Network** $250 inpatient hospital copay, then 60% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized
Newborn medical and nursery services—preauthorization required for newborn remaining inpatient after mother is discharged; for PPO, also new $250 inpatient hospital copay	**In-Network** 85% covered after deductible is met	**In-Network** 85% covered after deductible is met	**In-Network** 80% covered after deductible is met
	You must enroll your newborn within 30 days of the date of birth by *calling* the SBSC at 800-392-7495. No Social Security Number is required.		
	Out-of-Network 65% covered after deductible is met	**Out-of-Network** 65% covered after deductible is met	**Out-of-Network** 60% covered after deductible is met

	Health Savings	Health Reimbursement	PPO
Female tubal ligation; Trans-abdominal surgical sterilization; Transcervical surgical sterilization implant	**In-Network** 100% covered; not subject to deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to copay or deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 65% covered after deductible is met	**In-Network** 100% covered; not subject to deductible; for details on federal guidelines and plan option coverage, see Table 15 above **Out-of-Network** 60% covered after deductible is met
Male vasectomy; Female tubal ligation —for purpose other than contraception	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Fertility services—limited to testing and diagnosis; see below	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In Network** $40 office visit copay; other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
In-vitro fertilization; Artificial insemination —see Expenses Not Covered	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered
Family Planning and services and items not included in ACA guidelines—see below	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In Network** $40 office visit copay; other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Hearing			
Hearing evaluations	**In-Network** 85% covered after deductible is met; covered at 100% for newborn **Out-of-Network** 65% covered after deductible is met	**In-Network** $40 office visit copay; other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met

	Health Savings	Health Reimbursement	PPO
Hearing aids— limited to one per ear (or one set) in a 48-month period; combined In- and Out-of-Network limit; referral by an otolaryngologist or audiologist required	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Outpatient Treatment			
Allergy tests and treatments	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** $25 office visit copay, includes testing, injections, and serums; if no office visit copay is charged, then 85% covered after deductible **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible **Out-of-Network** 60% covered after deductible is met
Outpatient Occupational and/or Physical Therapy— subject to review for medical necessity; combined limit for In- and Out-of-Network Occupational and Physical Therapy of 60 visits per year — see **NOTE** below	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Outpatient Speech Therapy—subject to review for medical necessity; combined In- and Out-of-Network limit of 60 visits per year—see **NOTE** below	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Chiropractic— subject to review for medical necessity; not "maintenance" in nature; combined In- and Out-of-Network limit of 25 visits per year	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met

	Health Savings	Health Reimbursement	PPO
Acupuncture—subject to review for medical necessity; combined In-and Out-of-Network limit of 18 visits per year	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Other Medical Services			
Noncustodial home health care— "visit" means up to four hours of services provided on a single calendar day; combined In- and Out-of-Network limit of 90 visits per calendar year; see **NOTE** below	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 85% covered after deductible is met; preauthorization required; **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 80% covered after deductible is met; preauthorization required **Out-of-Network** 60% covered after deductible is met; preauthorization required
Private duty nursing provided at home— "visit" means up to eight hours of services provided on a single calendar day; combined In- and Out-of-Network limit of 90 visits per calendar year; see **NOTE** below	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 85% covered after deductible is met; preauthorization required; **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 80% covered after deductible is met; preauthorization required **Out-of-Network** 60% covered after deductible is met; preauthorization required
Hospice care—see below	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required	**In-Network** 80% covered after deductible is met; preauthorization required **Out-of-Network** 60% covered after deductible is met; preauthorization required

	Health Savings	Health Reimbursement	PPO
Prescribed care in noncustodial Skilled Nursing or Inpatient Rehabilitation facility—must be medically necessary; must be preauthorized; combined In- and Out-of-Network limit of 60 days per calendar year —see **NOTE** below	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized	**In-Network** 80% covered after deductible is met; preauthorization required **Out-of-Network** 60% covered after deductible is met; $300 penalty, then 50% covered if not preauthorized
Durable medical equipment—subject to medical review (except breast pumps covered *In-Network* under Affordable Care Act); preauthorization may be required (check with plan) —see **NOTE** below)	**In-Network** 85% covered after deductible is met; subject to medical review; limitations apply **Out-of-Network** 65% covered after deductible is met; preauthorization required; limitations apply	**In-Network** 85% covered after deductible is met; subject to medical review; limitations apply **Out-of-Network** 65% covered after deductible is met; preauthorization required; limitations apply	**In-Network** 80% covered after deductible is met; subject to medical review; limitations apply **Out-of-Network** 60% covered after deductible is met; preauthorization required; limitations apply

NOTE: **Prenatal services covered *In-Network* at 100% according to Affordable Care Act (health care reform law) guidelines:** include pre-conception counseling, routine prenatal obstetrical office visits, all lab services explicitly identified in the health care reform law, tobacco cessation counseling specific to pregnant women, and immunizations recommended by the Advisory Committee on Immunization Practices. Maternity coverage is provided equally for any enrolled female, including a dependent daughter.

Prenatal services not covered at 100% under the health care reform law ─ including but not limited to radiology (such as obstetrical ultrasounds), high-risk prenatal services, and delivery ─ are covered with In− or Out−of−Network Coinsurance as may be applicable.

NOTE: **Physical, occupational, or speech therapy:** Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. In order to be covered, services must be performed by an appropriate licensed therapy provider, under the direction of a Physician.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. In addition, benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if Manipulative treatment goals have previously been met. Benefits under this section are not available for "maintenance" or preventive Manipulative Treatment.

Physical, occupational, and speech therapies are covered for autism, pervasive developmental disorder, and developmental delays. The Plan will pay benefits for restorative speech therapy only when the speech impediment or dysfunction results from injury, sickness, stroke or cancer or is needed following the placement of a cochlear implant.

The annual limit of 60 visits for occupational and/or physical therapy applies to the combined total of visits for either or both types of therapy provided In- or Out-of-Network. An annual limit of 60 visits applies to speech therapy provided In- or Out-of-Network.

NOTE:	**Non-custodial home health care:** Home health care is limited to 90 visits in a calendar year. For purposes of determining what constitutes a "visit" under this limit, up to ***four*** hours is considered one visit, and any more than four hours of services in one day will be considered multiple visits even if the services are provided within the same 24-hour period.
NOTE:	**Private duty nursing services provided at home**: Private duty nursing services provided at home are limited to 90 visits in a calendar year. For purposes of determining what constitutes a "visit" under this limit, up to ***eight*** hours is considered one visit, and any more than eight hours of services in one day will be considered multiple visits even if the services are provided within the same 24-hour period.
NOTE:	**Skilled nursing care facility** — covered services include the cost of semi-private care in a skilled nursing care facility for the length of the convalescent period. Confinement must be for convalescence from a disease or injury. Benefits are subject to pre-admission approval and a maximum period established by the Claims Administrator for your medical plan option on a case-by-case individual review (not to exceed 60 days per calendar year In- and Out-of-Network combined). Plan benefits do not include Custodial Care.
NOTE:	**Durable medical equipment – breast pumps covered *In-Network* under the Affordable Care Act (health care reform law):** Breastfeeding counseling and supplies prescribed by and obtained from In-Network providers will be covered at 100%. Breast pumps (rental or purchase) may be limited to one per year.

Table 17 — Other Covered Services, Comparative Rates

Healthineers' self-funded Medical Plan options pay benefits, In-Network at contracted provider rates or Out-of-Network up to the Reasonable and Customary (R&C) or Maximum Allowed (MAA) limits, for certain other services that are listed on Table 18 below. Once you have met the corresponding In-Network or Out-of-Network Deductible for your Medical Plan option, Coinsurance will apply. If you are enrolled in a Health Reimbursement Medical Plan option, the In-Network Copay may apply, as indicated. To verify coverage, call UHC at **866-221-5901** or Anthem BCBS at **866-221-5901**.

Other Services Covered under the Self-Funded Medical Plan Options
Allergy tests and treatment • **HRA Plan In-Network only:** $25 copayment for office visit (includes testing, injections, antigens and serum) • If no office visit copay is charged, allergy care is covered, after the Deductible, at the percentage that corresponds to In- or Out-of-Network care as may be applicable
Artificial aids limited to: • One wig per lifetime after a cycle of chemotherapy treatment • 2 pairs of elastic stockings per year in lieu of varicose vein surgery
Bariatric Centers of Excellence • Bariatric Centers of Excellence facilities meet strict standards, including access to top-performing, quality bariatric surgery hospitals and surgeons. • Program provides pre- and post-surgical telephonic clinical case management • Healthy Focus Nurses provide support and education and guidance during the pre-surgery and post-surgery phases *To enroll, contact Anthem BCBS at 1-855-869-8137 or UnitedHealthcare at 1-866-221-5901.*
Bunion (hallux valgus) corrective surgery • Medically Necessary, bone/capsular, with or without sesamoidectomy; not palliative or cosmetic
Disposable medical supplies • Enteral nutrition (formula) covered In- or Out-of-Network with Coinsurance after Deductible is met; must be sole source of nutrition and required due to an inborn error of metabolism • Ostomy supplies and dressings covered In- or Out-of-Network with Coinsurance after Deductible is met • Diabetic supplies are covered under the Prescription Drug Program, not the Medical Plan options

Other Services Covered under the Self-Funded Medical Plan Options

Family Planning services and items not included in Affordable Care Act guidelines

- **HRA Plan In-Network:** $40 copayment for office visit; other office services covered, after the deductible, at the percentage that corresponds to In- or Out-of-Network care as may be applicable
- **Covered under each Medical Plan option:**
  - Abortion (elective and non-elective)
  - Infertility testing and treatment, limited to:
    - Testing performed specifically to determine the cause of infertility
    - Testing and treatment services performed in connection with an underlying medical condition
- **Not covered under any Medical Plan option:**
  - Treatment and/or procedures performed specifically and solely to restore fertility (for instance, procedures to correct an underlying medical condition that may have resulted in infertility)
  - Reversal of voluntary surgical sterilization
  - Artificial insemination, in-vitro fertilization
  - Fertility drugs

Foot care limited to:

- Medically Necessary foot care required as part of the treatment of diabetes or impaired circulation to the lower extremities (peripheral vascular disease)
- Surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail
- Routine foot care is ***not*** covered

Other Services Covered under the Self-Funded Medical Plan Options

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
- Cross-sex hormone therapy administered by a medical provider (for example during an office visit).
- Cross-sex hormone therapy dispensed from a pharmacy. Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:
    - Augmentation Mammoplasty
    - Clitoroplasty (creation of clitoris)
    - Labiaplasty (creation of labia)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Urethroplasty (reconstruction of female urethra)
    - Vaginoplasty (creation of vagina)
    - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).

  Female to Male:
    - Bilateral mastectomy or breast reduction
    - Hysterectomy (removal of uterus)
    - Metoidioplasty (creation of penis, using clitoris)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vulvectomy (removal of vulva)

Other Services Covered under the Self-Funded Medical Plan Options

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
    - Persistent, well-documented Gender Dysphoria.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must be 18 years or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
    - Persistent, well-documented Gender Dysphoria.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must 18 years or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
    - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
    - The two letters need to be signed within 12 months of the request for surgery.
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

Hospice Care Program and **Hospice Care Services** when you or a covered family member has a terminal illness and life expectancy is fewer than six months; subject to approval by the Claims Administrator for your Medical Plan option

Hyperhidrosis

Infusion therapy

- Infusion therapy service administered in doctor's office covered with In- or Out-of-Network Coinsurance after the Deductible
- If provider is not in possession of the infusion medication, it must be ordered from and covered by CVS/caremark under the Prescription Drug Program

Nutritional counseling

- Nutritional counseling services on the Affordable Care Act "preventive" list are covered at 100% In-Network, not subject to Deductible; or covered with Out-of-Network Coinsurance after the Deductible.
- Non-preventive nutritional counseling covered with In- or Out-of-Network Coinsurance after the Deductible is met; limit of three individual sessions per lifetime for each condition.

Other Services Covered under the Self-Funded Medical Plan Options

Obesity Surgery covered with In- or Out-of-Network Coinsurance after the Deductible is met; limited to gastric bypass, banding/lap band, and sleeve gastrectomy surgery, as long as the following conditions are met:

- Person is 18 years old or older
- Body mass index (BMI) of 40 or greater for 2 Years
- BMI of 35 to 39 for at least 2 years with evidence of co-morbid conditions attributable to obesity: sleep apnea, Type 2 Diabetes, asthma, hypertension, CHD, osteoarthritis, gall bladder disease, several types of cancers, among other conditions
- Evidence of nutritional counseling by a physician for at least 6 months within 2 years of surgery date

Pre-certification required

Organ and Bone Marrow Transplant

- At a Transplant Center of Excellence (when available) if precertified: for Health Savings Plan participants, covered at 100% after Deductible; for Health Reimbursement and PPO Plan members, covered at 100% with no Deductible or inpatient copay
- Otherwise, covered with In- or Out-of-Network Coinsurance after the Deductible (and inpatient hospital copay for PPO plan members) if precertified
- Human organ, tissue, stem cell and bone marrow transplants and infusions — including necessary evaluation for transplant, acquisition procedures, mobilization, collection and storage — ***services*** and benefits will be provided to you in connection with a covered organ or tissue transplant, if you are:
  - The organ or tissue recipient, and the donor is also an enrolled Healthineers Medical Plan member;
  - The organ or tissue donor, and the recipient is also an enrolled Healthineers Medical Plan member; or
  - The organ or tissue recipient, and the organ or tissue donor is not an enrolled Healthineers Medical Plan member
  - If you are the organ or tissue donor, and the organ or tissue recipient is not an enrolled Healthineers Medical Plan member, no benefit will be payable under the Healthineers Medical Plan
  - To maximize your benefit, as soon as you think you may need a transplant and before you have an evaluation and/or work-up, call UHC or Anthem BCBS and ask to speak with the Transplant Coordinator to learn details of what is covered and exclusions that may apply
  - **For your transplant to be covered, your Doctor must request precertification** and the transplant must be approved as Medically Necessary (and not Experimental or Investigational or Unproven) and consistent with the diagnosis of your condition. This requirement applies to:
    - **Inpatient admission for *all* organ, bone marrow and stem cell transplants**, including
      - Bone marrow or stem cell transplant with or without myeloablative therapy
      - Heart transplant
      - Liver Transplant
      - Lung or double lung transplant
      - Simultaneous pancreas/kidney transplant
      - Kidney transplant
      - Small bowel transplant
      - Multi-visceral transplant

    — **Outpatient stem cell and bone marrow transplants**, including
      - Bone marrow or stem cell transplant with or without myeloablative therapy
      - Donor leukocyte infusion
  - **Travel services:** if you live more than 50 miles from the facility; $10,000 lifetime maximum
  - **Outpatient care:** if a Center of Excellence is not used, covered In- or Out-of-Network with In-Network Coinsurance

Other Services Covered under the Self-Funded Medical Plan Options
Orthognathic surgery in the following situation: • Jaw deformity resulting from facial trauma or cancer • A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following: 1. inability to incise solid foods 2. choking on incompletely masticated solid foods 3. damage to soft tissue during mastication 4. speech impediment determined to be due to the jaw deformity, malnutrition and weight loss due to inadequate intake secondary to the jaw deformity
Reconstructive procedures when a physical impairment resulting from an injury, sickness or congenital anomaly exists and the primary purpose is to improve or restore physiological function; includes surgery or other procedures

Table 18 — Other Services Covered under the Self-Funded Medical Plan Options

Additional Services Available

The following services are available at no charge under the self-funded Medical Plan options. You and covered members of your family are encouraged to maximize the benefits under your Medical Plan by taking advantage of these important services.

- **Your Medical Plan Option's Toll−Free Care Line.** You may speak with a registered nurse (RN) 24 hours a day, 7 days a week at no cost to you by calling the toll−free number listed on your member ID card or one of the following numbers:
  - UnitedHealthcare: **866-796-2041**
  - Anthem Blue Cross and Blue Shield: **877-825-5276**

  RNs can help answer general benefit questions — such as preauthorization or pre-admission certification ─ and can provide assistance in locating doctors, hospitals, and other health care services. All calls are confidential.
- **The Healthy Focus Program.** Healthy Focus is an integrated health management program available to all members (employees and covered dependents) enrolled with UnitedHealthcare or Anthem Blue Cross and Blue Shield. Healthy Focus provides education, counseling, tools and connections to help you navigate the healthcare system and make informed healthcare decisions. It includes a multidisciplinary team of health professionals ─ including RNs, social workers, pharmacists, dietitians and physicians ─ who are all ready to support you with your health care issues, needs, or concerns.

Throughout the year, a Healthy Focus Nurse may contact you or a family member ─ or you may contact the Healthy Focus Program directly to seek information or help ─ ***if***

- You are scheduled for an ***inpatient admission*** and/or need ***pre-certification***. Your Healthy Focus Nurse can:
  - before your visit, help you understand what to expect, make you aware of any potential safety issues, and give you an opportunity to ask questions.
  - during your visit, discuss your progress and ongoing treatment plan, as well as next steps.
  - after your visit, get you the support you need once you are back at home.
- You need information to help you ***understand your treatment alternatives***. If your doctor recommends a medical procedure ─ such as back surgery, hip replacement or a hysterectomy ─ your Healthy Focus Nurse can help you understand what the treatment involves, how long you'll need to recover, and how to keep your family on track until you're back on your feet.
- You need assistance ***managing lifestyle issues or chronic conditions***, such as tobacco cessation, weight loss, exercise and stress, or diabetes, chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure (CHF) or coronary artery disease (CAD).
- You are being actively treated for ***cancer***.
- You are being evaluated for a solid ***organ transplant*** or ***bone marrow transplant***.
- You would like to speak to a nurse, social worker, dietician, or pharmacist.
- You have financial needs, including payment for medications and co-payments.
- Whether you or your family members are living with a chronic condition, are healthy and want to stay that way, or fall somewhere in between, **for any questions related to the *Healthy Focus* program**, call:
  - UnitedHealthcare: **866-221-5901**
  - Anthem Blue Cross and Blue Shield: **855-869-8137**

Participation in the Healthy Focus program is voluntary.

Clinical Trials

The self-funded Medical Plan options (including the Prescription Drug Program) generally do not cover expenses related to **experimental or investigational procedures**. A drug, device, medical treatment, procedure or service is Experimental or Investigational if:

- the drug or device or treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("FDA") or the American Medical Association, as appropriate, and approval for marketing has not been given at the time the drug or device or medical treatment is furnished, and neither the FDA nor the American Medical Association has given approval; or
- reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of an ongoing Clinical Trial or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, regardless of whether the trial is actually subject to FDA oversight. An approved Clinical Trial is any of the four phases that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The trial has to be federally funded, funded by a government agency, or a non-government agency that is recognized by the National Institutes of Health; or
- reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

"Reliable evidence" means only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of any other facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treatment facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

However, if you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment), the applicable Claims Administrator may, in its discretion, determine that an Experimental or Investigational medical service (drug, device, or medical treatment or procedure) meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Claims Administrator for the option must determine that the drug, device, or medical treatment or procedure is promising, but unproven, and that the medical service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. If the Claims Administrator determines that the Experimental or Investigational medical service is a Covered Health Service for your sickness or condition and is not otherwise excluded under the Plan, then expenses that you incur at the same time as you are receiving the Experimental or Investigational medical service (for instance, hospitalization) will also be covered.

Benefits are available when the Covered Health Services are provided by either In-Network or Out-of-Network providers. However, your Out-of-Network provider must agree to accept the In-Network level of reimbursement by signing a Network Provider Agreement specifically for you as the patient enrolling in the trial. Out-of-Network benefits are not available if your Out-of-Network provider does not agree to accept the In-Network level of reimbursement.

A determination by a Claims Administrator of the Medical Plan option in which you are enrolled applies only while you are covered under that option. If you change options, you will need to receive a determination by the Claims Administrator for the new Medical Plan option in which you are then enrolled that the drug, device or medical treatment is covered under that option.

NOTE: Even though a drug may be categorized by the FDA as an "orphan drug," it still will not be covered until it receives the approval of the U.S. Food and Drug Administration.

Devices that are FDA-approved under the "Humanitarian Use Device" exemption are not considered to be Experimental or Investigational.

Telemedicine

Healthineers is making it easier and more convenient for you to access doctors with virtual visits if your medical plan administrator is Anthem Blue Cross Blue Shield or UnitedHealthcare. With virtual visits, you can access doctors 24/7 without an appointment through your smartphone, tablet or computer with a webcam.

When To Use a Virtual Doctor

You can use virtual visits when your doctor is not available, you become ill while traveling, or you are considering an emergency room visit for a routine, non-life-threatening health condition.

You don't have to wait to see a doctor any longer. In fact, most people typically are connected to a doctor within 10 to 15 minutes. And you'll pay the same amount or less than what you would pay to visit a doctor under your medical plan option.

Medical Plan Option	What You Pay for an In-Network Virtual Doctor Visit
Health Reimbursement Medical Plan Option	You pay $25
Health Savings Medical Plan Option	You pay 15% after deductible
Preferred Provider Organization Medical Plan Option	You pay 20% after deductible

You will be required to pay with a credit card or debit card at the conclusion of your virtual visit.

Know Your Virtual Doctors

Doctors who participate in the virtual program include board-certified doctors who are mainly primary care physicians and are specially trained for online visits.

Common Conditions Virtual Doctors Treat

Virtual doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

Allergies	Migraine/headaches
Bladder infection/urinary tract infection	Pinkeye
Bronchitis	Rash
Cold/flu symptoms	Sinus problems
Diarrhea	Sore throat
Fever	Stomachache

In addition, doctors can write prescriptions for most drugs, if needed, that you can pick up at your local pharmacy. Please note that prescription drug services may not be available in all states. Visit the virtual provider web sites for information on availability of prescription services. Prescription drug costs are based on your prescription drug benefit plan.

Expectant mothers who are covered under an Anthem Blue Cross Blue Shield medical plan option receive free virtual visits with a lactation consultant or registered dietitian experienced in providing personalized postpartum nutrition and lactation support

Know Who Your Virtual Provider Is
The virtual provider available to you depends on the medical plan administrator.

If your medical plan administrator is …	Anthem Blue Cross Blue Shield	UnitedHealthcare*
You'll have access to virtual doctor visits through…	LiveHealth® Online	▪ Amwell™ and ▪ Doctor on Demand™
How to access virtual doctor visits	Go to **livehealthonline.com** or download their app at the AppStore℠ or Google Play™.	Go to **myuhc.com** or the **Health4Me®** app and choose a provider. You can also go directly to the Amwell or Doctor on Demand web site (**amwell.com** or **doctorondemand.com**) or download their app at the App Store℠ or Google Play™.
What you'll need at time of registration	You'll be asked your medical history, pharmacy preference, primary care physician contact information and insurance information.	

*The difference between Amwell and Doctor on Demand is whether the group operates and prescribes in the state where you need care. If both providers operate in your area, you can switch providers at any time.

Expenses Not Covered

There are some expenses that the self-funded Medical Plan options do not cover. These include – but are not limited to – the following items, even if recommended or prescribed by a doctor:

- expenses for services or supplies received by a covered person before medical coverage is in effect
- expenses that count toward the annual Deductible and the portion of expenses that exceed any calendar year maximum benefit
- expenses for care, treatment, surgery, or supplies that are not considered essential for the necessary care and treatment of an injury, illness, or pregnancy
- air ambulance, unless medically appropriate
- expenses for services determined not to be Medically Appropriate (such as speech therapy for a participant who is not progressing in goal-directed rehabilitation services or has already failed to meet rehabilitation goals previously set, ambulance for elective surgery, etc.)
- preventive care expenses for services that do not conform to approved guidelines for the age and gender of the covered individual
- routine physical exams (except the preventive care benefits specifically included under the Plan)
- expenses related to services that are specifically limited or excluded under the Plan option
- any visits exceeding the maximum specifically included under the Plan option
- expenses that exceed what the Claims Administrator for the Plan option determines to be over the Reasonable and Customary (R&C) charge or Maximum Allowed Amount for the medical service rendered. Reasonable and Customary rates or Maximum Allowed Amounts are determined by the Claims Administrator of your Medical Plan using databases of providers' billed charges in similar geographic areas and other information. You need to be aware that your Out-of-Network provider is not obligated to accept as payment in full the amount determined by the Claims Administrator to be Reasonable and Customary or the Maximum Allowed. In addition to any portion of the charge that is applied to your annual deductible and your Coinsurance amount, you may be liable for payment of the difference between the amount billed by the Out-of-Network provider and the R&C rate or Maximum Allowed Amount. Your deductible and coinsurance will apply to your out-of-pocket maximum. The remaining amount you owe — called "balance billing" — does not apply to the Deductible or Maximum Out-of-Pocket limit and cannot be reimbursed from your HRA but may be eligible for reimbursement from your HSA or HCFSA
- that portion of expenses that exceed the Reasonable and Customary (R&C) or Maximum Allowed amounts, as determined by the Claims Administrator for the Plan
- expenses resulting from inappropriate billing procedures, such as:
  - procedure unbundling, or
  - separate billing for procedures considered incidental to a primary procedure, or
  - incorrect application of CPT-4 code rules.
- expenses for medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination in a particular case, are determined to be **Experimental or Investigational** except as described in this SPD in the section captioned "***Clinical Trials***"
- expenses for services or supplies that are furnished, paid for, or otherwise provided by reason of the past or present service of any person in the armed forces of a government
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared
- expenses related to on-the-job accidents or for disease or occupational sickness that is job-related

- expenses for services or supplies covered by any other plan sponsored by the Company or provided by any other group or prepayment plan
- expenses for services or supplies that are paid for or otherwise provided for under any law of a government (including Medicare) except where the payment or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents
- unless otherwise covered in this plan, for reports, evaluations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations
- expenses where payment is received as the result of legal action or settlement, or in any other way by the person responsible for an illness or injury
- expenses paid or payable under a state automobile insurance policy. This exclusion applies whether or not you have waived medical coverage under your automobile insurance policy
- expenses for services not performed or recommended by a doctor licensed to practice in the specific area of medicine
- expenses for a second opinion by a doctor who is financially associated with the doctor who recommends the first course of treatment
- expenses related to:
  - assistant surgeons (coverage may be available in very limited circumstances)
  - stand-by doctor (coverage may be available in very limited circumstances related to complicated or high-risk procedures, provided that the doctor is actually in the operating room during the performance of a procedure and is prepared to proceed with the surgical procedure)
- charges made by any covered provider who is a member of your family or your Dependent's family
- Hospice Care Program and Hospice Care Services (except as provided under case management when an employee or covered family member has a terminal illness where life expectancy is under six months)
- Private Duty Nursing unless determined to be medically appropriate by the Claims Administrator for your Medical Plan option
- Custodial Care or services, educational training and programs, except for educational training and programs related to Diabetes Mellitus (which is subject to the approval of the Claims Administrator for your Medical Plan option)
- cost of biologicals that are immunizations or medications for the purpose of travel or to protect against occupational hazards and risks
- doctors' fees for patient controlled analgesia (PCA) and epidural narcotic administration, unless performed by a licensed MD, anesthesiologist, physician, surgeon, DMD/DDS, or certified registered nurse anesthetist (CRNA) and not included in the surgeon's bill
- acupuncture, unless for medically appropriate care as approved by the Claims Administrator of your Medical Plan option and within plan visitation limits
- massage therapy (unless services are medically appropriate and are provided by a licensed doctor or licensed physical therapist)
- regardless of clinical indication for acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- hypnotherapy
- homeopathic treatment
- aromatherapy
- light boxes

- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- blood administration for the purpose of general improvement in physical condition
- services, supplies, or treatment (including drug therapy or injectable drugs) provided for infertility (for example, artificial insemination, in-vitro fertilization, sperm injection, laparoscopic retrieval or aspiration of eggs, fertilization and/or implantation of eggs, embryo transfer procedure, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), etc.)
- Lamaze training
- fetal sex determination (amniocentesis, CVS, ultrasound, or any other procedures requested solely to determine the sex of the fetus)
- reversal of voluntary sterilization
- transsexual surgery or any treatment for sexual inadequateness that does not qualify for Gender Dysphoria treatment
- except at described in the other covered services section, expenses for Gender Dysphoria treatment as follows:
  - reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
  - sperm preservation in advance of hormone treatment or gender surgery.
  - cryopreservation of eggs or fertilized embryos.
  - cosmetic procedures including the following:
    - Abdominoplasty.
    - Blepharoplasty.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Gluteal augmentation.
    - Hair removal.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction.
    - Mastopexy.
    - Pectoral implants for chest masculinization.
    - Rhinoplasty.
    - Skin resurfacing.
    - Voice modification surgery.
    - Voice lessons and voice therapy.
- weight reduction or obesity surgery except as described in this Summary Plan Description
- dental charges, unless as defined in Dental Care and Surgery in the Medical Plan section of this Summary Plan Description
- eye exams, eyeglasses and contact lenses (except for first pair of eyeglasses following cataract surgery, subject to limits)
- tonometry for glaucoma testing

- charges made for or in connection with eye exercises
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery
- aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books
- cardiac and pulmonary rehabilitation programs (such as counseling and monitored exercise to maintain or improve general health), unless approved by the Claims Administrator for your Medical Plan option
- fitness and exercise programs, centers, and equipment
- cosmetic surgery or therapy that does not qualify for Gender Dysphoria treatment
- cosmetics, dietary supplements and health and beauty aids
- routine foot care to improve comfort or appearance including routine care of corns, bunions (except capsular or related surgery), calluses, toenails, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints; however, foot care for diabetes and peripheral vascular disease is covered
- except as described above, artificial aids including corrective orthopedic shoes or orthotics, dentures, elastic stockings (after two pairs are prescribed in a 12-month period instead of varicose vein surgery), garter belts and corsets
- nutritional supplements and formula except for infant formula needed for the treatment of inborn errors of metabolism
- medical supplies (unless billed by a Home Health Care Agency as necessary for the services being provided or medically appropriate supplies not covered by the Prescription Drug plan)
- smoking cessation programs and treatment of nicotine addiction except for preventive counseling as provided by the Claims Administrator for your Medical Plan option or drugs or supplies provided under the Prescription Drug Program as required under Health Care Reform
- treatment of mental illness or substance abuse (except what the Mental Health and Substance Abuse Program specifically includes under the behavioral health plan design)
- marriage counseling
- unless described as covered under the behavioral health section, any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and are therefore considered Experimental or Investigational or Unproven Services.

If you have a question about whether a particular expense is covered, contact the Claims Administrator for your Medical Plan option at the toll-free number on your ID card.

Claiming Benefits – When and How to Use Claim Forms

Hospital Benefits

Generally, Hospitals submit their bills directly to the Claims Administrator of your Medical Plan option for payment. If you do receive a hospital bill, review it for accuracy, attach it to a properly completed claim form and mail it to the Claims Administrator at the address listed below.

Other Benefits

You should submit a claim for benefits when you or a covered family member incurs covered expenses. You can obtain claim forms by logging on to the YBR website at http://resources.hewitt.com/siemens and following links in *Other Sites* on the Health Insurance menu to your medical plan claims website or by calling the Claims Administrator's toll-free number located on the back of your ID card**.**

When filling out the claim form:

- Complete the employee portion of the form in full. Have your doctor or other health care provider complete his or her portion too. Be sure that all questions are answered, even if the answer is "no" or "N/A" (does not apply)
- Attach all necessary documentation to the form:
  - a description of the services and supplies provided with a detailed description of the charge for each item
  - the diagnosis
  - the date(s) of service
  - the patient's name
  - the provider's name, address, phone number and degree
  - the provider's federal tax identification number or social security number.

You should complete a **separate** claim form for each person for whom benefits are being requested. If another plan is the primary payer, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form.

You must file a claim to receive benefits under your Medical Plan option within 12 months following the date the service was provided. No benefits will be paid for claims filed after these deadlines unless regulatory requirements dictate other timeframes or there are certain extenuating circumstances that caused the late filing.

IMPORTANT!

If you have a Health Care Flexible Spending Account and you are ***not*** enrolled in the Health Savings Medical Plan option, you have 2-1/2 months beyond the end of the calendar year — until March 15 of the following calendar year — to incur eligible health care expenses and until the end of May of the following calendar year to submit claims. If you are or were enrolled in the Health Savings Medical Plan option, please refer to the section on Flexible Spending Accounts and the Health Savings Medical Plan Option for special rules that may apply to you.

If you are:	You will:
Admitted into the hospital	Supply information at admission; all bills are generally sent directly to the Claims Administrator for your Medical Plan option by the hospital. Any bills you receive directly are to be attached to a claim form and sent by you to the claims address located on the back of your medical plan ID card.
Receiving outpatient Mental Health and Substance Abuse Program benefits and use an Out-of-Network provider	UnitedHealthcare participant, submit a claim for benefits to: **UHC Behavioral Health** **P.O. Box 740800** **Atlanta, GA 30374-0800** Anthem BCBS participant, submit a claim for benefits to: **Anthem Behavioral Health** **P.O. Box 105187** **Atlanta, GA 30348-5187**
Using a non-participating pharmacy to fill retail prescriptions under the Prescription Drug program	Submit a claim form to: **CVS/caremark** **P.O. Box 52196** **Phoenix, AZ 85072-2196** www.caremark.com **866-478-5802**
Receiving X-ray and/or laboratory bills that are sent to you directly	Arrange for the X-ray/laboratory billing office to file the claim for you by giving them your insurance information.

Table 19 - Claiming Benefits

THE PRESCRIPTION DRUG PROGRAM

This section of the Summary Plan Description describes prescription drug coverage under Healthineers' self-funded ***CVS/caremark*** Pharmacy Program and ***CVS/specialty*** Program for participants in the Health Savings, Health Reimbursement and PPO Medical Plan options. If you are a participant in a fully insured plan (including the Cigna International Medical Plan, HMSA or a Kaiser Permanente HMO), call the Claims Administrator for your medical plan option for information on your prescription coverage.

	Health Savings	Health Reimbursement or PPO
Prescription Drug Coverage		
Prescription drug vendor	***CVS/caremark***	***CVS/caremark***
Prescription drug website	www.caremark.com	www.caremark.com
Prescription drug member services phone number	**866-478-5802**	**866-478-5802**
Prescription benefits are covered under medical deductible	**Yes**	No
Annual prescription deductible	Subject to medical deductible (see above)	None
Prescription drug annual maximum out-of-pocket (Rx MOOP)	Subject to medical maximum out-of-pocket (see above)	$2,300 first individual $3,500 for two or more
Mail-Order refills available; Maintenance drugs	Yes, after one refill; 90-day supplies need to be filled at either CVS/caremark Mail Service or a local CVS pharmacy for the same coinsurance	Yes, after one refill; 90-day supplies need to be filled at either CVS/caremark Mail Service or a local CVS pharmacy for the same coinsurance
Oral contraceptives	Retail and Mail Service available	Retail and Mail Service available
Fertility drugs	Not covered	Not covered
Preventive low-to-moderate dose generic statins	Covered 100% for members ages 40 to 75	Covered 100% for members ages 40 to 75
* The Prescription Drug Program limits the quantity of opioids filled for new prescriptions and refills (except for cancer and end-of-life care), based on FDA approved guidelines. The program also restricts lidocaine prescriptions to the manufacturer limit guidelines to help prevent the drug being misused as a compound drug for topical pain relief.		

Table 20 – CVS/caremark Prescription Drug Program Benefits

Prescription Deductible for Health Savings Medical Plan

The annual Deductible is the amount you will pay before Coinsurance applies to eligible prescription expenses for the rest of the calendar year. Health Savings Medical Plan participants pay 100% of the cost of prescription medications filled through the ***CVS/caremark*** Pharmacy Program™ retail and mail order services until they reach the annual In-Network Deductible for their Medical Plan option.

If you cover at least one family member, you have "family" coverage under the Health Savings Medical Plan option and you must meet the entire family (or "you + one or more") Deductible before the plan pays benefits, even if one family member has met the individual Deductible amount.

Prescription Drug Maximum Out-of-Pocket

The annual Prescription Drug Maximum Out-of-Pocket (the "Rx MOOP") is the amount you will pay before the Plan pays 100% of your eligible prescription expenses for retail and mail order services under the ***CVS/caremark*** Pharmacy Program for the rest of the calendar year.

- For participants in the Health Savings Medical Plan option, the Rx MOOP is combined with the In-Network MOOP and Out-of-Network MOOP limits for other covered medical expenses. Once a family meets the entire family In-Network Deductible, Coinsurance will apply to eligible prescription drug expenses for every family member until the In-Network MOOP for the entire family is met.
- Health Reimbursement and PPO Medical Plan participants have a separate Rx MOOP of $2,300 (which covers the first covered individual whose claims reach that amount) or $3,500 (which covers the family, including the first covered individual plus any second, third or more covered individuals). Once a family meets the entire family Deductible, Coinsurance will apply to eligible prescription drug expenses for every family member until the family In-Network MOOP is met.

The Retail Pharmacy Program — Up to 30-Day Supply — Coinsurance

The ***CVS/caremark*** Retail Pharmacy Program enables you to purchase prescription drugs that you or a family member needs immediately at a participating local pharmacy. Prescription drug prices are discounted before Coinsurance is applied. More than 64,000 retail pharmacies participate in the ***CVS/caremark*** national network. At the present time, major chains include CVS/pharmacy, Target, Eckerd, Kmart, Osco, RiteAid, Walgreens and Walmart. To locate a nearby participating pharmacy, to request a directory of participating pharmacies, or if you have any questions regarding a prescription medication or claim, visit the ***CVS/caremark*** member website at www.caremark.com or call ***CVS/caremark*** Customer Service at **866-478-5802.**

If a minimum Copay applies and the actual full cost of the drug is less, you will be charged the full cost of the drug. For instance, for a Generic drug purchased at Retail where 10% Coinsurance or a $5 minimum Copay would apply, if the actual full cost is $3, you will pay $3. If the actual full cost is $30, you will pay the minimum Copay of $5. If the actual full cost is $100, you will pay Coinsurance of $10.

	Health Savings	Health Reimbursement or PPO
Retail generic	90% covered after medical deductible is met; $5 minimum Copay	90% covered; $5 minimum Copay
Retail preferred brand	70% covered after medical deductible is met; $20 minimum Copay	70% covered; $20 minimum Copay
Retail non-preferred brand	55% covered after medical deductible is met; $35 minimum Copay	55% covered; $35 minimum Copay

Table 21 – ***CVS/caremark*** Retail Pharmacy Benefits

Short-term medications are generally taken for a limited amount of time and have a limited number of refills, such as an antibiotic. Long-term or "maintenance" medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. The ***CVS/caremark*** Retail Pharmacy Program allows for each prescription to be filled once for up to a 30-day supply and, if appropriate, to be refilled once for up to a 30-day supply (for a total of two fills). Higher quantities are considered long-term or maintenance medications. The Retail Pharmacy program will not cover

maintenance medications after the first refill. After that, you must use a CVS/pharmacy drug store or the Mail Service Pharmacy program (described below) for that medication. If you continue to obtain 30-day supplies of a medication after the prescription has been filled two times, you will pay the full cost of the medication.

At a participating pharmacy, present your ID card at the time of purchase and the pharmacist will use an automated system to verify your coverage and prescription cost. At a non-participating pharmacy, you will pay the full price of the prescription at the time of purchase and you must complete a claim form for reimbursement. You will be reimbursed the amount the Plan would have paid if you had used a participating pharmacy. This reimbursement is based on the approved cost of the medication.

Claim forms can be printed from the ***CVS/caremark*** website at www.caremark.com and must be submitted for processing within 12 months of the date of purchase. All properly submitted claim forms should be sent to ***CVS/caremark***, P.O. Box 52196, Phoenix, AZ 85072-2196.

CVS/caremark Retail and Mail Service Pharmacy Program (Maintenance Choice®) — Up to 90-Day Supply — Coinsurance

Maintenance Choice®, the ***CVS/caremark*** Retail and Mail Service Pharmacy program, allows you and your eligible dependents to purchase prescription drugs you use on a regular basis ("maintenance drugs") at a CVS/pharmacy drug store or through the mail.

	Health Savings	Health Reimbursement or PPO
Mail-order or retail refill, generic	90% covered after medical deductible is met; $10 minimum Copay	90% covered; 10 minimum Copay
Mail-order or retail refill, preferred brand	70% covered after medical deductible is met; $40 minimum Copay	70% covered; $40 minimum Copay
Mail-order or retail refill, non-preferred brand	55% covered after medical deductible is met; $70 minimum Copay	55% covered; $70 minimum Copay

Table 22– CVS/caremark Maintenance Drug Benefits

At a CVS/pharmacy drug store or through the ***CVS/caremark*** Mail Service Pharmacy, you can purchase up to a 90-day supply of most prescription medications. There may be limitations on some prescriptions, such as controlled substances, that are subject to state and federal dispensing limitations. Ordering by mail is especially convenient if you need to take prescription drugs on an ongoing basis, such as for the treatment of anemia, arthritis, diabetes, heart disease, high blood pressure, ulcers or other chronic conditions. Mail Service prices are the lowest available, which makes Mail Service an economical source for smaller quantities or even single-use items, such as an EpiPen, that may be prescribed for you on an as-needed basis.

Your physician may call in or fax a prescription to:

Physician Phone Number: **800-378-5697**
Physician Fax Number: **800-378-0323**

Your customer service number for mail-order prescriptions is:

Member Services Number: **866-478-5802**

Prescriptions for maintenance medications may be mailed to:

CVS/caremark Mail Service Pharmacy
6935 Alamo Downs Parkway
San Antonio, TX 78238-4501

Any questions you may have regarding the ***CVS/caremark*** Retail Pharmacy Program or the ***CVS/caremark*** Mail Service Pharmacy program can be answered by calling **866-478-5802**, 24 hours a day 7 days a week, except on certain holidays. Customer Service Representatives and Pharmacists are available 24 hours a day, 7 days a week.

When you use a ***CVS/pharmacy*** drug store or the ***CVS/caremark*** Mail Service Pharmacy, you do not need to fill out any claim forms or wait for reimbursement. With your first mail-order prescription, you simply complete the "Patient Profile Questionnaire" as well as a ***CVS/caremark*** Mail-Order claim form and mail it with your prescription(s) and payment(s) to ***CVS/caremark*** Mail Service Pharmacy or visit the member website at www.caremark.com. You may make one payment for each prescription for up to a 90-day supply. Your prescription is delivered to your home, postage paid, by U.S. mail or UPS, along with instructions for refills.

Generic, Preferred Brand Name, and Non-Preferred Brand Name Coinsurance

IMPORTANT!

Some drugs have generic alternatives. Some drugs have "preferred brand-name" alternatives. When available, generic equivalent drugs will be **automatically** dispensed and the generic Coinsurance rate will apply.

- If you purchase a non-preferred brand drug and there is no preferred brand alternative, you will pay non-preferred brand Coinsurance.
- If you purchase a preferred brand-name drug and there is no generic alternative, you will pay preferred brand-name Coinsurance.
- If you purchase a generic drug, you pay generic drug coinsurance.

If you or your prescriber requests a brand-name drug when a generic or "preferred brand-name" equivalent is available, you pay an amount equal to the generic or "preferred brand-name" Coinsurance, as the case may be, plus the cost difference between the requested brand-name drug and the approved cost of the generic or "preferred brand-name" drug. This cost difference is sometimes called "product selection cost." **You will pay "product selection cost" even if your prescriber specifies "dispense as written" (DAW) on your prescription.** This is why "product selection cost" is also known as the "DAW penalty."

NOTE: The generic or "preferred brand-name" Coinsurance amount is applied to your annual deductible and maximum out-of-pocket. "Product selection cost" does not apply to your annual deductible or maximum out-of-pocket. If you are enrolled in a Health Reimbursement or PPO Medical Plan option and you have a Health Care Flexible Spending Account (HCFSA), you may be able to obtain reimbursement of the "product selection cost" amount from your HCFSA.

Formulary and Preferred Drug List (PDL)

The Healthineers self-funded Medical Plan options have adopted the ***CVS/caremark*** Formulary, including its Preferred Drug List (PDL), as the Plan's covered formulary. Drugs determined as "non-formulary" based on the prescription Claims Administrator's current formulary are not covered by the Plan.

Underlying principles of the ***CVS/caremark*** Formulary Development and Management Process include:

- ***CVS/caremark*** is committed to providing a clinically objective formulary;
- Decisions on formulary inclusions and exclusions are made by a committee of independent, unaffiliated clinical pharmacists and physicians;
- The prescribing physician always makes the ultimate determination as to the most appropriate course of therapy.

CVS/caremark regularly reviews and makes changes to the formulary and PDL. The PDL review process focuses on many factors, including the following:

- Adding products that have demonstrated enhanced clinical efficacy and/or provide more convenient dosage forms;
- Removing products that may require less convenient therapy dosing, may have more side effects or may cost more when compared to available options on the PDL.

If you have a question about whether a particular expense is covered, contact ***CVS/caremark*** at **866-478-5802**.

Pharmacy Prescription Contraceptives for Females

Generic oral contraceptive drugs and formulary brand contraceptive drugs for which there are no generic equivalents will be covered at 100% of cost if purchased through ***CVS/caremark*** at retail or Mail Service. If you are prescribed a non-formulary brand contraceptive drug for which there is a generic or formulary equivalent, you will pay the applicable cost share plus the difference in cost between the non-formulary brand drug and the generic or formulary brand drug. FDA-approved over-the-counter contraceptive products are covered if prescribed for a woman by her health care provider and if purchased through ***CVS/caremark*** at retail or mail order. Over-the-counter contraceptives are not covered without a prescription or if purchased Out-of-Network.

Compound Drugs and Topical Analgesics

A compound drug is a medication made by combining or mixing ingredients (some of which may not be subject to approval by the FDA), in response to a prescription, to create a customized drug that is not otherwise commercially available. There is a separate Coinsurance amount for each covered ingredient of a compound drug. The compounded formulation must be covered and, if it is reformulated, it must meet FDA-approved guidelines for the condition and all other plan provisions will apply. Ingredients, including bases and bulk compounding powders, that are not covered under the Prescription Plan will not be covered as part of a compound. For example, the Plan covers few over-the-counter products and then only under limited circumstances. Over-the-counter products that are not covered under the Plan but are commonly included in compounds — such as Benadryl, Maalox, Eucerin, and Hydrocortisone — will not be covered in a compound. Prior authorization will be required for any compound drug that costs $300 or more. For more information, see the section in this SPD captioned **Clinical Prior Authorization Process**.

Select topical analgesics (pain patches) are manufactured commercially and are not compound drugs. These pain patches may be marketed contrary to the Federal Food, Drug and Cosmetic Act. Pain patches typically contain ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. Such ingredients include, but are not limited to lidocaine, menthol, capsaicin and methyl salicylate. Select topical analgesics are not covered under the Prescription Plan.

CVS/specialty Program

The ***CVS/specialty*** Program provides care for patients with chronic or serious conditions who take Specialty Pharmacy medications that require injection, special handling, and monitoring during distribution and usage. These medications are used to treat conditions such as multiple sclerosis, rheumatoid arthritis, and hepatitis C and will be available only through the CVS/specialty Program. CVS/specialty Customer Care representatives are trained to provide extra assistance for members who participate in the CVS/specialty Program. If a manufacturer copay or discount card is used to fill specialty medications, the cost share that is paid out-of-pocket is applied to the participant's deductible and out-of-pocket maximum. All specialty medications will be limited to a 30-day supply since the copay card assistance is provided on a per-fill basis. For answers to your questions regarding the CVS/specialty Program, visit www.CVSCaremarkSpecialtyRX.com or call CVS/specialty Customer Care at **800-237-2767**, Monday through Friday, from 8:00 a.m. to 8:00 p.m. Eastern Time.

Specialty Medications Require Prior Authorization

Authorization for Specialty Pharmacy is provided from ***CVS/caremark*** for certain prescriptions. For more information, see the section in this SPD captioned **Clinical Prior Authorization Process**.

Specialty Pharmacy Coinsurance

Participants in the Health Savings Medical Plan option will pay 100% of cost for Specialty Pharmacy drugs until they satisfy the individual or family annual deductible amount, then 10% Coinsurance will apply until they reach the corresponding individual or family In-Network or Out-of-Network MOOP for this Medical Plan option. The HSA Plan will begin to cover 100% of the cost for Specialty Pharmacy and other prescription drugs once participants reach the appropriate annual In- or Out-of-Network Medical MOOP or the embedded individual Maximum Out-of-Pocket ($7,350 for plan year 2018).

Participants in the Health Reimbursement and PPO Medical Plan options will pay 10% Coinsurance until they reach the annual Rx MOOP of $2,300 (for the first covered individual whose claims reach that amount) or $3,500. The HRA and PPO Plans will begin to cover 100% of the cost for Specialty Pharmacy and other prescription drugs once participants reach the appropriate individual or "family" Prescription Plan MOOP.

	Health Savings	Health Reimbursement or PPO
Specialty Pharmacy program vendor	**Specialty Customer Care**	**Specialty Customer Care**
Specialty Pharmacy website	www.CVSCaremarkSpecialtyRX.com	www.CVSCaremarkSpecialtyRX.com
Specialty Pharmacy phone number	**800-237-2767**	**800-237-2767**
Specialty Pharmacy coinsurance	90% covered for eligible drugs after medical plan deductible is met	90% covered for eligible drugs

Table 23 – CVS/caremark Specialty Pharmacy Benefits

NOTE: Most Specialty medications must be purchased through the ***CVS/specialty*** Program in order to qualify for the Specialty Pharmacy Coinsurance rate. Generally, if you do not use the ***CVS/specialty*** Program to fill your Specialty prescriptions, you will be responsible for the full cost for your Specialty medications. However, there are certain Specialty medications that are not subject to this provision and you can continue to fill them at the retail pharmacy. Call Specialty Customer Care at **800-237-2767** to find out if your Specialty medication is subject to this provision.

Clinical Prior Authorization Process

Some drugs in the Healthineers Prescription Drug Program — including Specialty Pharmacy products — require Prior Authorization from ***CVS/caremark***. Effective January 1, 2018, this includes Fetanyl products (participants currently receiving these drugs will be grandfathered) and two high-cost generic Metformin ER products used to treat Type 2 diabetes, as a lower-cost generic version (Glucophage) is available. The goal of the Prior Authorization program is to encourage safe and effective drug utilization, identify optimal drug use, and enhance members' health outcomes. Information about medications that require Prior Authorization is contained on www.caremark.com or you can call ***CVS/caremark*** at **855-240-0536**. ***CVS/caremark*** may change the list of drugs that require pre-service authorization at any time without prior notice. As new prescription drugs, generic drugs, or additional information about existing drugs become available, they will be considered for coverage under the prescription drug benefit as they are introduced. For current information on medications that may require pre-service authorization, please contact ***CVS/caremark***.

If your prescriber prescribes a drug that requires Prior Authorization, a message will be generated when the claim is processed that will direct the physician to call ***CVS/caremark*** to provide clinical information to help determine if use of the drug is appropriate under the clinical criteria that Healthineers has approved. Requests for Prior Authorization will be reviewed and either granted or denied by ***CVS/caremark***. Once your physician provides the necessary information, a decision is usually made within 72 hours. Your physician will receive a fax and you will receive a letter to notify you if your request is approved or denied. If your request is denied, the fax and letter will include the reason(s) for the denial and information on how to file an appeal.

Exceptions Process

Some drugs have generic alternatives. Some drugs have "preferred brand-name" alternatives. If your doctor thinks there is a clinical reason why one of these covered prescription drug options will not work for you or why you need to continue to use a drug that has been removed by ***CVS/caremark*** from the formulary, your prescriber should call ***CVS/caremark*** toll-free at **855-240-0536** to request prior approval for your current or newly prescribed drug(s).

Expenses Not Covered

The Prescription Drug Program does not cover some expenses. These include – but are not limited to – the following items even if prescribed or recommended by your prescriber:

- medical supplies, except needles, syringes, and diabetic supplies (such as chem-strips, lancets, testing agents, and alcohol swabs)
- any drug or supply that has not been approved by the U.S. Food and Drug Administration ("FDA") for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
- expenses for off-label use of drugs (in a case where FDA approval has a limited application for that drug and the FDA-approved application does not apply to your use)
- expenses for any drug that is included on the list of drugs that require Prior Authorization under the Healthineers Prescription Drug Program and for which such Prior Authorization is not obtained, unless it is determined by ***CVS/caremark*** or the Independent Medical Review Authorization that such usage is medically necessary. The list of drugs that require Prior Authorization under the Healthineers Prescription Drug Program is available at www.caremark.com or you can call **866-478-5802**
- drugs labeled "Caution—Limited by Federal Law to Investigational Use" even though a charge is made to the individual
- **expenses related to experimental or investigational drugs, devices or procedures** except as described elsewhere in this Summary Plan Description in the section captioned "***Clinical Trials***"

NOTE: Even if a drug may be categorized by the U.S. Food and Drug Administration as an "orphan drug," it still will not be covered until it receives the approval of the U.S. Food and Drug Administration.

- medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the covered person
- medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows operations on its premises of, a facility for dispensing pharmaceuticals
- prescriptions dispensed after one year from the original date of issue, more than six months after the date of issue for controlled substances, or prescriptions prohibited by applicable law or regulation
- any prescription refilled in excess of the number of refills specified by the prescriber, or any refill dispensed after one year from the prescriber's original order
- prescriptions exceeding a reasonable quantity as determined by ***CVS/caremark*** in its discretion
- prescriptions that do not meet ***CVS/caremark*** standards as determined by ***CVS/caremark*** requirements
- medications that do not meet Prior Authorization criteria (where applicable)
- medications in excess of allowed quantity limits (where applicable)
- drugs or supplies that are not for your personal use or that of your covered dependent
- drugs the intended use of which is illegal, unethical, imprudent, abusive, or otherwise improper
- drugs you purchase outside the U.S. that you are planning to use in the U.S.
- mail-order prescriptions that are not filled at a ***CVS/caremark*** Mail Service facility.
- prescription drug claims received beyond the 12-month timely filing requirement; ***CVS/caremark*** must receive claims within 12 months of the prescription drug dispensed date
- replacement of lost or stolen medications
- expenses that are not considered essential for the necessary care and treatment of an injury, illness, or pregnancy
- Rogaine (or similar drugs with the sole purpose of promoting or stimulating hair growth), or drugs that treat hair loss, thinning hair, unwanted hair growth or hair removal, and other lifestyle agents
- anorexiants (except with a Prior Authorization)
- fertility medications
- legend vitamins (vitamin compounds prescribed or recommended for specific medical conditions or nutritional deficiencies)
- non-federal legend drugs
- prescriptions for items that are available over-the-counter unless prescribed and included under coverage as preventive medications
- vitamins (including nutritional supplements, even if prescribed)
- dietary supplements and nutritional formulas (except when prescribed for the treatment of a metabolic disease or when necessary to sustain life)
- anabolic steroids
- growth hormones (except as specifically covered under the Specialty Pharmacy Program)

- therapeutic devices, appliances, and durable medical equipment, except for glucose monitors and other covered supplies

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

Coverage for mental health and substance abuse care under Healthineers' self-funded Medical Plan options is integrated with the plan option you elect. If you are a participant in a fully insured Medical Plan option (for instance, the Cigna International plan, HMSA or Kaiser Permanente HMO), call the Claims Administrator for your medical plan option for details on mental health and substance abuse benefits available to you.

	Health Savings [1]	Health Reimbursement [1]	PPO [1]
Behavioral Health (Mental Health and Substance-Abuse Treatment)			
Behavioral health provider	**UnitedHealthcare Behavioral Health** **www.myuhc.com** **866-221-5901**	**UnitedHealthcare Behavioral Health** **www.myuhc.com** **866-221-5901** **Anthem BCBS Behavioral Health** **www.anthem.com** **855-869-8137**	**UnitedHealthcare Behavioral Health** **www.myuhc.com** **866-221-5901** **Anthem BCBS Behavioral Health** **www.anthem.com** **855-869-8137**
Mental Health			
Mental Health: Outpatient coverage [2]	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% of R&C or MAA covered after deductible is met	**In-Network** Copay $25 individual, $10 group session; all other services 85% covered after deductible is met **Out-of-Network** 65% of R&C or MAA covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% of R&C or MAA covered after deductible is met
Mental Health: Inpatient coverage [3]	**In-Network** 85% covered after deductible is met; preauthorization required	**In-Network** 85% covered after deductible is met; preauthorization required	**In-Network** Copay $250 per episode or admission, then 80% covered; preauthorization required

1	Only Medically Appropriate services are covered under the Mental Health and Substance Abuse Program under any Medical Plan option. Plan reimbursements for Covered Health Services provided by ***Out-of-Network*** providers – including any portion of the billed amount that is applied to the annual deductible or annual out-of-pocket maximum – are limited to the Reasonable and Customary ("R&C") charge, as determined by UnitedHealthcare, or the Maximum Allowed Amount ("MAA"), as determined by Anthem BCBS and detailed in the Glossary. If you use an Out-of-Network provider, you will be responsible for both your share of the R&C or MAA, plus any charges over and above R&C or MAA that may be billed by your provider ("balance billing"). These charges may be significant.
2	Routine office visits with an In-Network provider do not need prior authorization; no limit on the number of sessions.
3	For emergency admissions, notification must be received by the next scheduled work day to be covered at In-Network benefit levels.

Table 24 – Behavioral Health and Substance Abuse

The amount of your mental health and substance abuse benefits will depend on whether or not you call the Claims Administrator for your Medical Plan option for pre-certification before you are admitted for inpatient treatment and whether or not you use the services of In-Network providers. Inpatient care will be covered at Out-of-Network rates, even if you use an In-Network provider or facility, if you do not call the Claims Administrator for your Medical Plan option for pre-certification before you are admitted for inpatient treatment.

Covered Expenses

The Mental Health and Substance Abuse Program covers the diagnosis and Medically Appropriate treatment of mental illness, depression and nervous disorders, care for other emotional health needs, and substance use disorders including alcohol abuse, drug abuse and chemical dependency. Eligible caregivers include psychiatrists, psychologists and licensed clinical social workers. Eligible facilities include a Hospital or treatment facility. All charges are subject to the Reasonable and Customary (R&C) or Maximum Allowed limit.

Neurobiological Disorders – Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.
- Providers are expected to contact the plan administrator to obtain prior and concurrent authorization.

Any treatments or other specialized services designed for Autism Spectrum Disorder that are *not* backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome would be considered Experimental or Investigational or Unproven Services and not covered under the Plan.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family and group therapy;
- Provider-based case management services; and
- Crisis intervention.

When ABA services have been approved by the Plan Administrator, benefits are as follows:

Health Savings	Health Reimbursement	PPO
In-Network **85%** covered after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In Network** **$25** copay*; all other services 85% after deductible is met **Out-of-Network** **65%** covered after deductible is met	**In-Network** **80%** covered after deductible is met **Out-of-Network** **60%** covered after deductible is met

*one copay per day per provider

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment,
- Partial Hospitalization/Day Treatment,
- Intensive Outpatient Treatment, and
- Outpatient treatment.

Other Mental Health and Substance Abuse Resources Available to You

If you or family members are experiencing mental health or substance-abuse problems, you are encouraged to consider and take advantage of other options for help that may match your needs and are available to you instead of — or in addition to — benefits that may be provided under the Mental Health and Substance Abuse Program.

The **Employee Assistance Program** (EAP, **800-547-5589**) is available at no cost to you and any members of your household, 24 hours a day, 7 days a week, regardless of whether you or your family members are enrolled in coverage under a Healthineers medical plan option. You can access online services at **www.myCigna.com** using Employer ID: Siemens), you will need to create a UserID and Password. The EAP can provide an immediate telephone consultation with an appropriate, trained therapist, up to six short-term counseling sessions per issue per individual with a local network EAP provider, and identify and refer you to an appropriate provider or facility for additional treatment as may be necessary.

If you need assistance in identifying an appropriate In-Network provider, treatment or facility, pre-authorization for inpatient treatment, or to coordinate a program of care, you may call the **Healthy Focus Nurse Line** for your medical plan option:

UnitedHealthcare Behavioral Health	**866-221-5901**
Anthem Blue Cross and Blue Shield Behavioral Health	**855-869-8137**

How the Program Works

To receive maximum benefits under the Mental Health and Substance Abuse Program, you must call the Claims Administrator for your Medical Plan option before receiving inpatient or outpatient mental health or substance abuse treatment:

UnitedHealthcare Behavioral Health	**866-221-5901**
Anthem Blue Cross and Blue Shield Behavioral Health	**855-869-8137**

When you call, you will speak with a professionally trained counselor who can help identify the most appropriate In-Network treatment resource.

If an emergency prevents you from calling the Claims Administrator for your medical plan option in advance, you or a family member or representative must call within 24 hours or the next business day after the care begins.

Following an initial assessment, the Clinical Team for your Medical Plan option will recommend the appropriate facility and/or provider in your area. Healthineers believes that needed care should be available to you in a timely way. The following timeframes for getting an appointment have been shared with network providers. If you are unable to arrange for an appointment that meets these expectations, call the Claims Administrator of your Medical Plan option for assistance.

Type of Care Needed	Time from Request for Care
Non-Life-Threatening Emergency	Within 6 hours
Urgent	Within 48 hours
Routine	Within 10 working days
Office Wait Times	15 minutes or less

Table 25 – Behavioral Health Response Times for Care

IMPORTANT!

If you need emergency services, go immediately to the nearest emergency room or behavioral health facility. The program benefits will apply to services needed to evaluate or stabilize treatment for a condition that is reasonably considered an emergency behavioral health condition.

Preauthorization Requirements for Inpatient and Out-of-Network Services

If the Claims Administrator for your Medical Plan option authorizes your care in advance and you use In-Network providers and facilities, you will receive maximum benefits. You or your doctor must call the Claims Administrator for your Medical Plan option to obtain preauthorization for inpatient hospital care, structured outpatient substance abuse care, or outpatient care instead of inpatient care — even if you use In-Network providers or facilities. If care has not been preauthorized by the Claims Administrator for your medical plan option, benefits will be paid at the Out-of-Network benefit levels. If you use Out-of-Network providers or facilities, you must call the Claims Administrator for your Medical Plan option within 24 hours after an admission and you must comply with recommendations of your Medical Plan Behavioral Health Case Manager. Otherwise, a $300 penalty and an additional 50% reduction to benefits will apply.

If you change Medical Plan options, you should review your treatment with the Claims Administrator for the new Medical Plan option under which you now covered.

In-Network Services

If you receive care on either an inpatient or outpatient basis through an In-Network provider, there are no claim forms to fill out. All the necessary paperwork is automatically processed for you. You will pay for services until you meet your annual Deductible and then Coinsurance will apply. You will be responsible for any remaining charges that you incur for failure to pre-certify. If you are a participant in a Health Reimbursement Medical Plan option or a fully insured HMO option, you may be responsible only for your out-of-pocket Copayment (Copay).

Treatment for Substance Abuse (Substance Use Disorder)

Each Medical Plan option covers In-Network contracted provider charges and Out-of-Network Reasonable and Customary (R&C) or Maximum Allowed (MAA) charges for Medically Appropriate treatment of substance abuse or substance use disorder. Preauthorization requirements apply to all participants, as described above.

	Health Savings	Health Reimbursement	PPO
Substance Abuse			
Detox: Outpatient coverage	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** Copay $25 individual, $10 group session; all other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met

	Health Savings	Health Reimbursement	PPO
Detox: Inpatient coverage [1]	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized	**In-Network** Copay $250 per episode or admission, then 80% covered after deductible is met; preauthorization required **Out-of-Network** Copay $250 per episode or admission, then 60% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized
Rehab: Outpatient coverage	**In-Network** 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** Copay $25 individual, $10 group session; all other services 85% covered after deductible is met **Out-of-Network** 65% covered after deductible is met	**In-Network** 80% covered after deductible is met **Out-of-Network** 60% covered after deductible is met
Rehab: Inpatient coverage [1]	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized	**In-Network** 85% covered after deductible is met; preauthorization required **Out-of-Network** 65% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized	**In-Network** Copay $250 per episode or admission, then 80% covered after deductible is met; preauthorization required **Out-of-Network** Copay $250 per episode or admission, then 60% covered after deductible is met; preauthorization required; $300 penalty, then 50% covered if not preauthorized

[1] For emergency admissions, notification must be received by the next scheduled work day to be covered at In-Network benefit levels.

Table 26 – Substance Abuse

Expenses Not Covered

The following expenses related to the treatment of mental health and substance abuse are not covered under the Mental Health and Substance Abuse Program even if prescribed or recommended by your care provider:

- amounts that exceed the Reasonable and Customary (R&C) or Maximum Allowed Amount (MAA), as determined by the Claims Administrator of your Medical Plan option
- court-ordered treatment
- Custodial Care
- education or development-related service
- halfway house
- residential treatment center
- experimental or investigational treatment
- psychological testing (except for diagnosis or treatment)
- therapies that do not meet the national standards for mental health professional practice
- services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that, in the reasonable judgment of the Claims Administrator for your medical plan option, are any of the following:
  - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
  - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
  - not consistent with the Claims Administrator's level of care guidelines or best practices as modified from time to time; or
  - not clinically appropriate for the patient's mental illness, substance abuse disorder or condition based on generally accepted standards of medical practice and benchmarks
- mental health services as treatments for R- and T-code conditions as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- mental health services as treatments for Z-code or other conditions that may be a focus of clinical attention in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- mental health services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, neurological disorders and other disorders with a known physical basis
- treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal)
- educational or behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning

- tuition for or services for children and adolescents that are school-based under the *Individuals with Disabilities Education Act*
- learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- methadone treatment as maintenance, LAAM (1-alpha-acetyl-methadol), cyclazocine, or their equivalents for drug addiction
- any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and are therefore considered Experimental or Investigational or Unproven Services.

Claiming Benefits

If you go to an Out-of-Network behavioral health professional, you will need to file a claim form for benefits. You can download a claim form from the website of the Claims Administrator for your Medical Plan option (www.myuhc.com or www.anthem.com).

If you have a question about a behavioral health claim, you can call the Claims Administrator for your Medical Plan option (UnitedHealthcare Behavioral Health at **866-221-5901** or Anthem Blue Cross and Blue Shield Behavioral Health at **855-869-8137**).

If You Are Enrolled in a Fully Insured Plan Option

Check with the Claims Administrator for your Medical Plan option for details on your mental health and substance abuse benefits. Details of coverage under the fully insured plan options may vary.

Behavioral Health for Fully Insured Medical Plan Options		
Plan Name	**Member Services Phone Number(s)**	**Member Website**
Cigna International (Outbound Delegates)	From inside United States: **800-441-2668** Outside United States: **302-797-3100**	www.cignaenvoy.com
Hawaii Medical Services Association (HMSA)	**808-948-6111**	www.hmsa.com
Kaiser Permanente	**800-464-4000**	http://my.kp.org/siemens

Table 27 — Behavioral Health for Fully Insured Medical Plan Options

AN OVERVIEW OF THE HEALTH SAVINGS ACCOUNT (HSA) AND HEALTH REIMBURSEMENT ACCOUNT (HRA) FEATURES

Health Savings Medical Plan Option — HSA Feature

The Health Savings Account (HSA) is an important feature of the Health Savings Medical Plan option. An HSA is a tax savings vehicle that allows you to save for health care costs. Depending on your needs, you can use the account to pay for eligible health care and prescription expenses now, or you can let the account grow with earnings that for the most part are tax-free, to use for health care costs during your later retirement years.

To be eligible to participate in the HSA, you:

- must be enrolled in the Health Savings Medical Plan option; and
- cannot participate in any other health plan that duplicates benefits covered under the Health Savings Medical Plan option — such as your spouse's or domestic partner's medical plan or healthcare Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) — unless it's a *Limited-Use FSA or HRA*; and
- cannot be enrolled in Medicare; and
- do not receive health benefits under TRICARE; and
- have not received Veterans Administration (VA) benefits within the past three months; and
- cannot be claimed as a dependent on another person's tax return.

Depending on your coverage election, Healthineers will deposit contributions, prorated on a per-paycheck basis, into your HSA. For 2018, Healthineers will contribute $300 for you and $300 for your enrolled spouse or domestic partner on an annual basis. The amount of Healthineers' contributions may change in future years. You and your spouse or domestic partner can earn further contributions by participating in the ***Healthy Rewards*** program.

You may also make pre-tax contributions via payroll deduction. If you specify an HSA contribution goal amount when you enroll in the Health Savings Medical Plan option or during Annual Enrollment, your contributions will be automatically deducted from your paychecks in equal amounts throughout the year. During the year, you may use the YBR website to set an HSA contribution goal amount and begin making pre-tax contributions or to change your HSA contribution goal and payroll deduction amounts, or you may choose to contribute by making lump-sum deposits directly into your HSA account at Optum Bank.

For 2018, the maximum combined amount you and Healthineers can contribute to the HSA is $3,450 for single coverage or $6,900 for family (you plus at least one enrolled dependent) coverage. Keep in mind that your automatic company contribution, any ***Healthy Rewards*** earned by you or your spouse or domestic partner, and contributions to any other HSA will count toward this limit.

IMPORTANT!

You must establish an HSA account with Optum Bank by completing an HSA application before you can receive any contributions from Healthineers and before you can make any contributions to your HSA. If you have questions about establishing your HSA, call Optum Bank at **800-791-9361**. If you do not establish an HSA account with Optum Bank, your enrollment in the Health Savings Medical Plan option will be changed to an enrollment "without an HSA."

Healthineers' contributions to your HSA will be deposited on a pro-rated per-paycheck basis about two weeks after your pay date. Contributions are prorated based on the portion of the year during which you (and your spouse or domestic partner) are enrolled in the HSA. ***Healthy Rewards*** are administered through the UHC claims administration process and may take up to 60 days from the date they are earned to appear in your Optum Bank HSA account.

HSA Debit Card: You will receive an Optum Bank HSA debit card in the mail approximately seven to ten days after Optum has received notice from the SBSC of your Health Savings Medical Plan enrollment and you have opened an individual HSA at Optum Bank. A personal identification number (PIN) for the card will arrive separately in the mail. You can request additional debit cards for family members by downloading a request form from the website listed on the back of your debit card. The debit card can be used for direct payment at a doctor's office, pharmacy or any health care facility that accepts cards with the MasterCard acceptance mark.

Domestic Partner or Domestic Child: You will be unable to claim reimbursement from your HSA for any expenses for your domestic partner or a domestic child (a child of your domestic partner who is not also your child) unless the individual qualifies as your dependent for federal tax purposes.

Prior-Year HCFSA Balance: If you are enrolled in the Health Savings Medical Plan option on January 1 and you were enrolled in a Health Care Flexible Spending Account (HCFSA) during the preceding plan year, you will not be eligible to receive HSA contributions from Healthineers until the balance in your prior-year HCFSA is determined to be $-0-. Once it is determined that you are eligible to receive HSA contributions, your HSA account balance will be brought up to the amount that you would have accrued if you had been receiving prorated payroll contributions beginning January 1.

Current-Year Limited-Use HCFSA: If you are enrolled in the Health Savings Medical Plan option and you enroll in a Health Care Flexible Spending Account, your account will be automatically designated as a *Limited-Use Health Care Flexible Spending Account* (*Limited-Use HCFSA*). While you are enrolled in the Health Savings Medical Plan option, only your HSA can be used for permissible medical and prescription drug expenses. This means that any unused balance in a *prior-year* "regular" HCFSA can only be used to reimburse vision or dental expenses (but *not* medical or prescription drug expenses) ***incurred*** after your Health Savings Medical Plan enrollment date. Your Limited-Use Health Care Flexible Spending Account can be used only for permissible dental and vision expenses.

Savings and Investment Vehicle: The HSA is a savings account that is credited with interest. Once your account balance reaches $2,100, you can start investing your balance in a selection of mutual funds. For information on the investment options, call Optum Bank at **800-791-9361**, Monday through Friday, 8:00 a.m. to 8:00 p.m. ET, or visit www.OptumBank.com.

Catch-Up Contributions: From age 55 until you become eligible for Medicare, you can make additional catch-up contributions to your HSA up to $1,000 (in 2018) beyond the IRS contribution limit. If eligible, your spouse may also make catch-up contributions for the same amount. You can set up and deposit catch-up contributions directly with Optum Bank.

No "Use It or Lose It" Rule: The money in your HSA is always yours. Your account is yours even if you change medical coverage, change employers, become unemployed, get married or divorced, or move to another state. Each year you have the HSA, any unused balance in your account rolls over to the next calendar year and remains in the account until spent or until the account is closed. You have the right, at any time, to transfer all or any part of your HSA to another financial institution that offers an HSA.

If you choose to contribute directly to your HSA through Optum Bank or you are joining the Health Savings Medical Plan option midyear, it is your responsibility to ensure that your HSA contributions do not exceed the IRS annual limits.

If you die before using the entire balance in your HSA, the account automatically becomes your spouse's HSA. If you are not married, the value of your HSA will pass on to the Beneficiary you designated on your HSA application.

There are important rules you need to know about the Health Savings Medical Plan option, particularly with respect to the HSA. For more information about HSAs, visit the U.S. Treasury website at http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

IRS Publication 502 provides additional information on eligible medical and dental expenses that can be paid using the HSA, and is accessible at www.irs.gov or by calling 800-TAX-FORM (829-3676).

Health Reimbursement Medical Plan Option — HRA Feature

The Health Reimbursement Account (HRA) is an integral feature of the Health Reimbursement Medical Plan options administered by UnitedHealthcare and Anthem BCBS. If you are enrolled on January 1 each year, Healthineers will automatically make a lump-sum contribution to your HRA. For 2018, Healthineers will contribute $450 to your HRA as well as an additional $450 if you cover your spouse or domestic partner. The annual amount of Healthineers' contributions may change in future plan years. If you enroll or change your enrollment after January 1, Healthineers' contribution to your HRA will be prorated based on the portion of the year you (and your spouse or domestic partner) are enrolled in the plan. You and your spouse or domestic partner can also earn further contributions by participating in the ***Healthy Rewards*** program. Healthy Rewards are administered through the claims administration process and may take up to 60 days from the date they are earned to appear in your HRA account with UnitedHealthcare or Anthem BCBS.

UHC — If you are enrolled in the Health Reimbursement Medical Plan option administered by UnitedHealthcare, you can access your HRA by registering on the **myuhc.com** website.

- Go to www.myuhc.com and click on the "Register Now" button. Enter the information from your medical plan ID card. Select a username, password, security question and agree to website "Terms and Conditions."
- Track your Healthy Rewards by choosing the *Health & Wellness* tab at the top of the page.
- You can get reimbursed from your HRA by enrolling in automatic payment from your HRA to pay a provider directly, by completing the online claim submission form, or by mailing or faxing a paper Claim Submission/Withdrawal Request Form.
- To request that claims be paid automatically from your HRA, log on to **myuhc.com**, choose *Claims & Accounts* from the homepage, select *Automatic Payment Options* from the left toolbar, select *Enroll,* then choose *Confirm*.
- The HRA Plan design assumes that you pay copayments directly to the provider at the time of service, so any eligible copayment will be reimbursed directly to you. If you have questions or do not have access to a computer, call UnitedHealthcare member services at **866-221-5901** (TDD services at **800-828-1120**) for assistance.

Anthem BCBS — If you are enrolled in the Health Reimbursement Medical Plan option administered by Anthem BCBS, you will have a ***HealthEquity HRA***.

- The first time you log on to the Anthem website at www.anthem.com, you will be asked to create a username and password to allow access to the Anthem website. If you are a first-time user with *HealthEquity*, you will be asked to create a *HealthEquity* User-ID and Password.
- Once your *HeathEquity* User-ID and Password have been created, you will be able to access your HRA directly from the Anthem website simply by selecting the link titled *Access your HealthEquity HRA*, which will take you directly to the *HealthEquity* homepage.
- After your provider has submitted a claim to Anthem BCBS and it has been processed, you can select which claims you would like to pay from your HRA. You can choose to send a payment directly to the provider or to yourself by selecting Unresolved Claims on the *HealthEquity* homepage.
- If you have any questions or you do not have access to a computer, contact the Anthem BCBS customer service team at **855-869-8137** or *HealthEquity* Member Services at **877-713-7712** and request a claim form be mailed to you. The claim form includes the mailing address and fax number with instructions on how to submit a paper claim.

As an employee, you can use your HRA member website to view your HRA balance for any Healthy Rewards you or your covered spouse or domestic partner have earned, and you will have access to view all the medical claims for yourself and your covered dependents. You will choose how and when to use your HRA, including when to pay for a covered medical expense and when you will pay out of pocket and save your HRA for future medical expenses. You are responsible for requesting payment or reimbursement from your HRA, unless you elect to have your claims automatically paid from your HRA.

Your HRA can be used to pay covered medical expenses for you and any dependents who are enrolled in the Health Reimbursement Medical Plan option. A covered medical expense will generally include any type of expense that is managed through the UnitedHealthcare or Anthem BCBS claims process. This specifically excludes prescription drug expenses, which are administered under the CVS/caremark Prescription Drug Program.

If you also have a Health Care Flexible Spending Account (HCFSA), you must use your HRA first to pay for all covered medical expenses. If you have submitted a claim to your HRA and part of the expense has been deemed a charge in excess of the Reasonable and Customary (R&C) charge or the Maximum Allowed Amount, as determined by the Claims Administrator of your Medical Plan option, or if you still have outstanding medical expenses and have exhausted your HRA, you can then submit medical claims to the HCFSA for reimbursement. **Prescription drug, dental and vision expenses, and charges exceeding the Reasonable and Customary (R&C) charge or the Maximum Allowed Amount cannot be reimbursed from the HRA** — these expenses must be submitted directly to the HCFSA for reimbursement.

Not Portable: Healthineers' contributions to your HRA are intended solely for reimbursement of qualified medical expenses. Claims must be filed against your HRA not later than 90 days from the end of the calendar year in which the expense was incurred.

At the end of each calendar year, any balance in your HRA account will be rolled into your HRA account for the next year if you re-enroll in the same HRA Medical Plan option. However, the transfer will not post to your new plan year account until after March 31. If you change your enrollment from the Health Reimbursement Medical Plan option administered by UnitedHealthcare to the Health Reimbursement Medical Plan option administered by Anthem BCBS (or vice-versa), any balance in your prior-year HRA will be transferred to your account with the new plan administrator after the end of the 90-day claims run-out period in April of the new plan year.

IMPORTANT!

If you do not re-enroll in a Health Reimbursement Medical Plan option or you terminate employment, or if Healthineers ceases to offer a Medical Plan option with an HRA feature, any balance in your HRA account will be forfeited.

OVERVIEW OF YOUR DENTAL OPTIONS

The Healthineers Benefits Program offers the Delta Dental Plan option described below. You may elect "No Coverage" (waiver of coverage).

Here is a summary of your dental benefits paid by the plan:

Delta Dental Plan	In-Network	Out-of-Network
Annual Deductible	$50 per person; $150 per family	$100 per person; $300 per family
Diagnostic & Preventive Services	100% no deductible	100% no deductible
Basic Services	80% after deductible	60% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontic Services	50% no deductible	50% no deductible
Annual Benefits Maximum (excludes Orthodontia)	$2,000 In- and Out-of-Network combined	
Orthodontia Maximum Lifetime Benefit for each person	$1,500 In- and Out-of-Network combined	
NOTE: Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.		

Table 28 – Dental Options

Enrollment Restriction

If you elect "No Coverage" because you have dental coverage elsewhere and you lose that coverage during the year, you can enroll for coverage for yourself and your eligible dependents during the 30-day period that immediately follows the end of your other coverage.

THE DELTA DENTAL OPTION

This section of the Summary Plan Description describes the benefits of Siemens' self-insured Delta Dental Plan administered by Delta Dental of New York.

In the Delta Dental Plan, you and your eligible dependents may choose any licensed dentist. You will receive your dental care at the lowest cost through the Delta Dental PPO Network. In Texas, Delta Dental offers a Dental Provider Organization (DPO) plan. These dentists have agreed to contracted fees, and you will not be charged more than your expected share of the bill. In addition, all of the dentists in the Delta Dental PPO Network satisfy strict credentialing requirements. You can find a PPO dentist at www.deltadentalins.com/siemens.

If you cannot find a PPO dentist, Delta Dental Premier dentists offer the next best opportunity to save. Unlike non-Delta Dental dentists, they have agreed to set fees, and you will not get charged more than your expected share of the bill. With a PPO or Premier dentist, you will be assured that amounts charged by the provider are "Reasonable and Customary," as required by the Plan. Reasonable and Customary ("R&C") or Maximum Allowed expenses under the Delta Dental program are based on what most providers in your area charge for a covered service.

If you use a Delta Dental PPO or Premier In-Network dentist, you will pay a lower deductible and lower coinsurance for most services compared to using an Out-of-Network dentist. Out-of-Network dentists may also charge more than the R&C amount. If you use a non-Delta provider, you are

required to pay any charges over the R&C amount in addition to applicable deductibles and coinsurance.

Set up an Online Services account at www.deltadentalins.com/siemens or call Delta Dental at **1-800-592-0140** to check benefits and eligibility information. You and your family members will not need a Delta Dental ID card to visit the dentist, but you may view and print your Delta Dental ID card from the website.

It is best to mention Delta Dental whenever you receive dental services – the provider may participate in the PPO or be a Delta Dental Premier dentist and, therefore, you will benefit from the discounted fees and higher level of coverage. If you are also covered under another dental plan, ask your dental office to include information about both plans with your claim and Delta Dental will coordinate benefits.

The Deductible

The deductible is the amount you pay each year before the Delta Dental Plan pays benefits for basic and major restorative services received from In-Network or Out-of-Network dentists. There is no deductible for Diagnostic and Preventive services or Orthodontic services received from In-network or Out-of-Network dentists.

Annual Deductible	In-Network Delta Dental PPO and Premier Dentists	Out-of-Network Non-Delta Dental Dentists
Individual Deductible	$50	$100
Family Maximum	$150	$300

Table 29 – Delta Dental Plan Annual Deductibles

To help limit the number of deductibles you and your covered dependents need to pay, the Plan includes a family maximum. The most any family has to pay in deductibles in a calendar year is three times the individual deductible. Once the annual family deductible is satisfied, no further individual deductibles need to be met for the balance of the calendar year, regardless of how large your family may be.

NOTE: The deductible does not apply towards the annual maximum benefit of $2,000 per person.

Annual Maximum

The annual maximum is the most the Plan will pay in benefits for covered services for each covered person in a calendar year. The annual maximum for the Delta Dental Plan is $2,000 for each covered person per year and is combined for both In-Network and Out-of-Network services you use during the year. You will always be responsible for 100% of the cost of any non-covered services that you incur.

Covered Expenses

The Delta Dental Plan covers a broad range of services and supplies. In all cases, benefits are based on reasonable and customary (R&C) or maximum allowed charges.

Diagnostic and Preventive Care (Type A Services)

The goal of preventive dentistry is that each covered person maintains optimal oral health. For this reason, the Delta Dental Plan provides benefits for diagnostic and preventive care (Type A services) at:

- 100% of reasonable and customary (maximum allowed) charges with no deductible, if services are received from In-Network *or* Out-of-Network dentists – subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic (Type B) and major (Type C) services of $2,000 for each covered person
- Benefits are subject to limits on frequency of service.

Service	Frequency/Limitations	Coverage
Diagnostic and Preventive Care (Type A Services)		
Oral exams	2 per calendar year	**In-Network or Out-of-Network** 100% no deductible
Cleaning of teeth (oral prophylaxis)	2 per calendar year	
Periodontal maintenance	4 times per calendar year less the number of teeth cleanings received during the calendar year	
Full-mouth X-rays **or** Panoramic X-ray	1 every 60 calendar months	
Bitewing X-rays	1 set per calendar year	
Intraoral-periapical and extraoral X-rays	1 every 60 months	
Fluoride application	2 per calendar year for persons under age 19	
Sealants	1 treatment per tooth every three calendar years for persons under age 16	
Space maintainers	No limit	
Emergency care to relieve pain	No limit	
Pulp vitality and bacteriological studies	Based on individual necessity	

Definitions of Covered Diagnostic and Preventive Care

Prophylaxis is the scaling and polishing procedure performed to remove calculus, plaque, and stains from the teeth.

Periodontal maintenance involves the removal of plaque and calculus from pockets between the teeth and gums below the gumline, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Full-mouth X-rays are X-rays that display all of the teeth and surrounding structures and areas; typically consists of 18 X-rays (14 periapical and 4 bitewing).

Panoramic X-ray is a rotational X-ray technique that displays the full mouth on one X-ray film.

Bitewing X-rays are X-rays taken of the crowns of the teeth to check for decay.

Intraoral-periapical and extraoral X-rays are taken inside (intraoral) and outside (extraoral) the mouth. Intraoral-periapical X-rays show the tooth and surrounding tissues. Extraoral X-rays are taken to identify large areas of the skull on one X-ray.

Fluoride application is placed on the outer layer of the teeth to make them more resistant to decay.

Sealants are a resin material that is placed in the pits and fissures (biting surface) of molars and premolars to prevent future decay.

Space maintainer is a dental appliance that fills the space of a lost tooth or teeth and prevents the other teeth from moving into the space.

Pulp vitality and bacteriological studies determine the health of the nerve tissue that fills the center of the tooth.

Basic Restorative Care (Type B Services)

The Delta Dental Plan covers basic restorative care (Type B services) at:

- 80% of reasonable and customary (maximum allowed) charges after the deductible is met, if services are received from In-Network dentists
- 60% of reasonable and customary (maximum allowed) charges after the deductible is met, if services are received from Out-of-Network dentists
- Benefits are subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic restorative (Type B) and major restorative (Type C) services of $2,000 for each covered person.

Service	Frequency/Limitations	Coverage
Basic Restorative Care (Type B Services)		
Fillings	No limit	**In-Network** 80% after deductible is met **Out-of-Network** 60% after deductible is met
Veneers	Limited to anterior teeth; 1 per tooth every 84 months	
Root canal therapy (endodontics)	Any related X-ray, test, laboratory exam or follow-up care is considered part of the charge for root canal therapy and not a separate dental service	
Denture adjustments, relinings and rebasings	Excluding any adjustment of a denture within six months of its installation	**In-Network** 80% after deductible is met **Out-of-Network** 60% after deductible is met
Periodontal scaling and root planing; other non-surgical services	1 per quadrant every 36 months for periodontal scaling and root planning	

Service	Frequency/Limitations	Coverage
Basic Restorative Care (Type B Services)		
Periodontal surgery	Including gingivectomy, gingivoplasty, gingival curettage and osseous surgery; limited to 1 surgery every 36 months per quadrant	
Simple extractions [1]	Simple extractions only	
Repair or re-cementing of crowns, inlays/onlays or bridgework	No limit	
Occlusal adjustments	No limit	
Consultations	No limit	
[1] Includes routine postoperative care for simple extractions.		

Definitions of Covered Basic Restorative Care

Fillings are a material that is used to fill a cavity or replace part of a tooth; usually amalgam (silver colored filling used on the posterior teeth) or composite acrylic resin (matched to the color of the tooth).

Veneers are used to reshape the anatomy of an anterior (in the front of the mouth) tooth.

Root canal therapy removes the pulp (nerve) from the tooth and replaces it with a filling material.

Periodontal scaling and root planning involves the removal of irritants from deep pockets below the gumline (scaling) and smoothing (planning or shaving) of the root surface.

Extraction is the removal of a tooth. Simple extractions involve the removal of a tooth that is already erupted in the oral cavity. Surgical extractions involve the removal of a tooth that may be impacted in soft tissue (gum).

Occlusal adjustments made to the chewing surface of the posterior teeth (pre-molars and molars) to promote healthy periodontal tissues.

Major Restorative Care (Type C Services)

The Delta Dental Plan covers major restorative care (Type C services) at:

- 50% of reasonable and customary (maximum allowed) charges after the deductible is met, if services are received from In-Network dentists or Out-of-Network dentists.
- Benefits are subject to a combined annual maximum benefit for diagnostic and preventive (Type A), basic restorative (Type B) and major restorative (Type C) services of $2,000 for each covered person.
- Type C services are subject to clinical review and Prior Authorization.

Services	Frequency/Limitations	Coverage
Major Restorative Care (Type C Services)		
Anesthetics[1]	Local anesthesia. General anesthesia and IV sedation when medically or dentally necessary, with Prior Authorization	**In-Network** 50% after deductible is met **Out-of-Network** 50% after deductible is met
Crowns [2]	One per tooth every 84 months; plastic processed to gold, porcelain fused to gold, full cast gold, prefabricated stainless steel or prefabricated resin	
Inlays/Onlays	One per tooth every 84 months	
Dentures (full and partial) [2]	Once every 84 months	
Bridges [2]	Once every 84 months; cast gold, porcelain fused to gold, plastic processed to gold	
Surgical extractions and all other oral surgery	No limit	
Implants (including prosthetic devices) [2]	Once every 84 calendar months for prosthetic devices; *repair* of implants limited to once in a 12-month period	
Gold restorations (if necessary as the result of extensive cavities or fracture and if restoration with amalgam, silicate, acrylic or plastic is not possible)	Once every 84 months	
Posts and cores	No limit	
Bruxism	Including, but not limited to occlusal guards and night guards	

[1] Anesthesia is covered when provided with two or more surgical extractions or three or more simple extractions; otherwise paid when medically or dentally necessary. Anesthesia use during prophylaxis cleanings (e.g., nitrous oxide) is not covered by the dental plan.

[2] Replacement of an existing partial removable denture, bridge, implant or crown, to replace extracted natural teeth will be considered only if the existing denture, bridge, implant, or crown was installed at least 84 months prior to its replacement and cannot be made serviceable according to common dental standards.

Table 30 – Major Restorative Care (Type C Services)

Definitions of Covered Major Restorative Care

Anesthetics are drugs that eliminate or reduce pain. General anesthetics (including analgesic gas and IV sedation) cause the patient to become unconscious and feeling is lost during a dental procedure.

Crown is a dental restoration that covers the entire tooth and restores it to its original shape (also called a "cap").

Inlay is porcelain filling used to replace missing tooth structure within the tooth, between the cusps (the pointed or round mounds on the top or highest part, of the tooth). **Onlay** is porcelain filling that covers one or all of the tooth's cusps.

Denture is a removable appliance used to replace teeth. A complete/full denture replaces all of the upper teeth and/or all the lower teeth; a partial denture is a removable appliance used to replace one or more lost teeth.

Bridge is a non-removable restoration that is used to replace missing teeth.

Oral surgery focuses on the diagnosis and treatment of diseases, injuries, and malformations. It involves surgery for both functional and esthetic aspects of the face, jaws, mouth, neck, and head. The Delta Dental Plan covers some oral surgery procedures, including extraction of impacted teeth, gingivectomy (removal of diseased gum tissue) and osseous surgery (removal of defects or deformities in the bone caused by periodontal disease and other related conditions), but certain oral surgery procedures may be covered by the medical plan option you elect. Check with Delta Dental and your retiree medical plan option for details on coverage.

Implant is an artificial device, usually made of a metal allow or ceramic material, that is implanted within the jawbone as a means to attach an artificial crown, denture or bridge.

Gold restorations involve several layers of pure gold to fill a cavity.

Bruxism is grinding of the teeth. Treatment for temporomandibular joint dysfunction (TMJ) is not covered under the Delta Dental Plan, but may be covered under your medical plan. Check with your medical plan option for details on coverage.

Posts are fitted in the canal of a tooth that had root canal therapy to stabilize the tooth for a restoration. **Core** buildup materials are placed around the post to fill the tooth cavity before the restoration is cemented in place.

Orthodontic Services

The Delta Dental Plan covers orthodontic services at:

- 50% of reasonable and customary (maximum allowed) charges with no deductible, if services are received from In-Network providers or Out-of-Network providers
- Benefits are subject to a lifetime maximum benefit of $1,500 for each covered person.

Payment for orthodontic charges is made in installments. The initial payment is made when braces are first installed. Thereafter, prorated payments are made quarterly, based on the estimated duration of the orthodontic treatment.

Orthodontic Services	**Coverage**
Preliminary X-rays, diagnostic casts and treatment plan	In-Network *or* Out-of-Network 50% with no deductible
Fixed or cemented appliances	
Lifetime Maximum (**In-**and **Out-of-Network** combined)	$1,500 per person

Alternate Benefits

When a condition can be suitably treated in more than one way, Plan benefits will be based on the least expensive alternative.

For example, the amount included as covered dental expenses for an inlay, gold filling or crown will be limited to the reasonable and customary (maximum allowed) charge for restoration of the tooth with an amalgam, silicate, acrylic, or equivalent filling, unless the tooth can only be restored by using the inlay, gold filling or crown.

This provision enables the Plan to provide benefits for professionally adequate levels of care, but not to provide benefits for care or treatment that is a matter of choice or more expensive than is necessary.

Pretreatment Estimate of Benefits

A pretreatment estimate of benefits allows you to find out, before you incur any expenses:

- Estimated cost for treatment
- Estimated benefit payment
- Possible alternative treatments that may be more Cost-Effective

A pretreatment estimate does not guarantee benefits from the Plan. However, it can help you understand more about how the Plan works for your specific need so you can make an informed decision about treatment.

You should use the pretreatment estimate of benefits feature whenever your dentist proposes extensive dental work in excess of $200 or to find out if the procedure your dentist is recommending is covered under the Plan.

To request a pretreatment estimate of benefits, ask your dentist to describe the proposed work and its cost, using the dental claim form, and submit it to Delta Dental's claims office for review. Delta Dental will let both you and your dentist know – in advance – which charges are covered and how much the Plan will pay. The actual benefits payable, if any, will depend on the benefits you qualify for when the work is completed. If there is a major change in your treatment plan, your dentist should submit a revised claim form.

Claiming Benefits

You do not need a Delta Dental ID card when you visit the dentist. All your dentist will need to file a claim for you is your name, date of birth, and enrollee ID or Social Security number. If your family members are covered under your plan, Delta Dental will need your information. However, if you would prefer to have a paper or electronic ID card, you can print one from your computer or pull it up on your smartphone through Delta Dental's Online Services at deltadentalins.com/siemens.

When you are treated by a Delta Dental PPO, Dental HMO or Premier© dentist, Delta Dental will pay your dentist directly and send you a notice explaining your portion of the bill. You are only responsible for your annual deductible and coinsurance amount under the Plan. If you visit a non-Delta Dental dentist, you may have to pay the full cost of treatment and submit a claim for reimbursement. You can obtain the appropriate claim form from Delta Dental's Online Services at www.deltadentalins.com/siemens or by calling Delta Dental at **1-800-592-0140**. Representatives are available Monday through Friday from 8 a.m. until 8 p.m. Eastern time.

When submitting a claim for covered dental expenses:

- Complete your portion of the form in full (the Subscriber and Patient Information) and have your dentist complete his or her portion. Be sure that all questions are answered, even if the answer is "no" or "N/A" ("Not Applicable," does not apply).
- Attach all necessary documentation to the form:
  - A description of the services and supplies provided with a detailed description of the charge for each item
  - The diagnosis
  - The date(s) of service
  - The patient's name
  - The provider's name, address, phone number and degree
  - The provider's federal tax identification number or social security number.

You should complete a separate claim form for each person for whom benefits are being requested. If you also have coverage under another dental plan, ask your dental office to include information about both plans with your claim and Delta Dental will coordinate benefits.

Your dentist may have the ability to file claims electronically with Delta Dental. This expedites the processing of your claim, along with payment to your dentist as well as any reimbursement to you, if applicable. Mail claims to:

Delta Dental of New York
P.O. Box 2105
Mechanicsburg, PA 17055-2105

For information about a claim you have already submitted, call Delta Dental Claims Processing at **1-800-932-0783** or (717) 766-8500 (TTY/DD 1-888-373-3582).

You must file a claim to receive benefits before the end of the year following the year in which the claim was incurred (that is, if the dental service occurs in 2018, claims must be filed with your dental plan before the end of 2019). No benefits will be paid for claims filed after the deadline.

Expenses Not Covered

The Delta Dental Plan will not pay benefits for charges incurred for:

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which Delta Dental deems medically experimental or investigational in nature
- Services for which you would not be required to pay in the absence of dental insurance
- Services or supplies received by you or your dependent(s) before the dental insurance starts for that person
- Services which are neither performed nor prescribed by a dentist, except for those services of a licensed dental hygienist, which are supervised and billed by a dentist, and which are for: scaling and polishing of teeth or fluoride treatments
- Services which are primarily cosmetic
- Appliances which restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease
- Restorations or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss

- Decoration or inscription of any tooth, device, appliance, crown or other dental work
- Missed appointments
- Services:
  - Covered under any Workers' Compensation or occupational disease law
  - Covered under any employer liability law
  - For which the employer of the person receiving the services is not required to pay; or
  - Received at a facility maintained by Siemens, labor union, mutual benefit association, or VA hospital
- Services covered under other coverage provided by Healthineers
- Prescription drugs
- Services when the submitted documentation indicates a poor prognosis
- The following, when charged by the dentist on a separate basis:
- Claim form completion
- Infection control, such as gloves, masks, and sterilization of supplies; or
- Local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide
- Dental services due to accidental injuries to teeth and the supporting structures, except for injuries to the teeth due to chewing or biting of food
- Caries susceptibility tests
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics
- Adjustment of a denture made within six months after installation by the same dentist who installed it
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance, cast restoration or denture
- Repair or replacement of an orthodontic device
- Diagnosis and treatment of temporomandibular joint disorders
- Charges in excess of reasonable and customary (maximum allowed) limits

If you have a question about whether a particular dental procedure is covered, contact the Delta Dental claims office at **1-800-592-0140**.

Dental Benefits Extension

If your dental coverage ends after the following treatment has started, your expenses to complete the treatment will be covered if they are incurred within three months after coverage ends:

- impressions for bridgework or dentures
- preparation work for crowns, inlays/onlays, or root canal therapy.

If you are not eligible for an extension of benefits under Plan rules, you may be eligible to continue coverage at your own expense through COBRA.

Siemens Healthineers makes no guarantees as to the level or quality of service received from Delta Dental providers.

Dental Plan Enrollment Restriction for Outbound Delegates

If you become a delegate **from** the United States **to** another country and you have previously elected dental coverage under the Delta Dental option, then dental coverage during your Outbound Delegation will be provided through the Cigna Comprehensive plan under the Cigna International Plan option. If you did not have coverage under a Healthineers-sponsored dental plan prior to the start of your delegation, you can elect dental coverage under the Cigna Comprehensive plan with the CIGNA International plan during the first 30 days of your delegation. Otherwise, you can elect dental coverage during Annual Enrollment. To elect dental coverage or to add dependents to your dental coverage, call the SBSC at **800-392-7495** (or at **847-883-0676** from outside the U.S.).

For information about your dental coverage, use the member website, www.CIGNAEnvoy.com, or call Cigna at **800-441-2668** (**302-797-3100** from outside the U.S.). See Delegates above.

This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

Services	Coverage
Calendar Year Maximum (for Class I, II & III) **Lifetime Maximum** (for Class IV)	$2,000 $1,500
Class I Preventive Care For diagnostic and preventative services including: • Oral Exam - 2 per person, per year • Cleanings - 2 per person, per year • Bitewing X-rays - 2 per person, per year • Fluoride Applications - 1 per person, per year (Up to age 19) • Sealants - 1 per tooth, per 3 years • Full Mouth X-rays – 1 per person, per 3 years • Panoramic X-rays - 1 per person, per 3 years	100% not subject to deductible
Class II Basic Restorative For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80%
Class III Major Restorative For Major Restorations: • Dentures • Bridgework • Crowns	60%
Class IV Orthodontia	50%

OVERVIEW OF YOUR VISION PROGRAM

Vision care services and claims administration for the Healthineers Vision Program are provided under three Plan options by EyeMed Vision Care, LLC ("EyeMed"), and underwritten by Fidelity Security Life Insurance Company. All employees automatically receive coverage under the EyeMed ***Basic*** Vision Plan, regardless of whether they enroll for medical coverage. You can enroll any eligible dependents, who will also receive coverage under the EyeMed Basic Vision Plan at no charge, also regardless of whether they are enrolled for medical coverage. If you prefer not to have Basic Vision coverage, you may opt out when you enroll as a newly eligible employee or during Annual Enrollment. If you prefer more comprehensive coverage, you can elect to enroll in one of two additional buy-up programs — ***Enhanced*** Plan or ***Premier*** Plan — to meet your eye care needs.

The Vision Program allows you to choose from a network of private practice providers and retail chain providers, as well as Out-of-Network providers. You will maximize your benefits if you always confirm your provider is in the ***Insight Network*** prior to receiving care. The EyeMed network includes ophthalmologists, optometrists and national retailers such as LensCrafters®, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision locations. To find an EyeMed network provider, search the online directory at www.eyemedvisioncare.com/siemens and choose the ***Insight Network*** or call EyeMed's Customer Care Center at **844-378-9360**. EyeMed's Customer Care Center can be reached Monday through Saturday, 7:30 a.m. to 11:00 p.m. and Sunday 11:00 a.m. to 8:00 p.m. EST.

Each of the three Healthineers Vision Program options provides for a comprehensive eye exam each calendar year (January 1st through December 31st) for each covered person. Retinal imaging has been provided as an additional discount. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Your provider can determine if you are a candidate for retinal imaging.

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
In-Network Exam and Contact Lens Fitting Benefits			
Comprehensive Eye Exam with Dilation as Necessary	$10 copay — available once every calendar year		
Retinal Imaging Discount	Member pays up to $39 — available once every calendar year		
Contact Lens Fit and Follow-Up	Not available	Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed	
Standard *	Not available	$40 copay covers fit and two follow-up visits	
Premium **	Not available	10% off retail price *minus* $55 allowance, *plus* $40 copay	
Out-of-Network Exam and Contact Lens Fitting Reimbursements			
Comprehensive Eye Exam with Dilation as Necessary	Up to $40 reimbursement — available once every calendar year		
Retinal Imaging Benefit	Not available		
Contact Lens Fit and Follow-Up	Not available	Up to $40 reimbursement – available once every calendar year once a comprehensive eye exam has been completed	

* A standard contact lens fit covers lenses that are spherical power only, which includes soft lens materials, and the lenses are used as daily wear (removed prior to sleep) mode only.

** A premium contact lens fit covers all lens powers and designs other than spherical powers (i.e., toric, multifocal, etc.), which are extended or overnight wear, and rigid or gas-permeable materials.

Table 31 — Annual Eye Exam Benefits

If you (and your spouse or domestic partner) are enrolled in the Health Savings or the Health Reimbursement Medical Plan option, you can earn ***Healthy Rewards*** by getting your annual vision exam.

Eyeglass Benefits

The Healthineers Vision Program offers each member a ***choice*** of coverage for spectacle (eyeglass) lenses ***or*** contact lenses (one or the other, not both). You will maximize your eyeglass benefits by seeking coverage with EyeMed's Network providers. In Maryland and Texas, members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Prior to your appointment, you should confirm with your provider that discounts are offered.

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
In-Network Eyeglass Benefits			
Frame** — any available frame at provider location	35% off retail price*	$0 copay; $130 allowance; 20% off balance over $130 — available once every two calendar years	$0 copay, $150 allowance, 20% off balance over $150 — available once every calendar year
Standard Plastic Lenses** — available once per year			
Single Vision	$50	$10 copay	$15 copay
Bifocal	$70		
Trifocal	$105		
Lenticular	20% off retail price		
Progressive Lenses			
Standard	$135	$60 copay	$15 copay
Premium — Tier 1	20% off retail price	$90 copay	$35 copay
Premium — Tier 2		$90 copay	$45 copay
Premium — Tier 3		$100 copay	$60 copay
Premium —Tier 4		20% off retail price *minus* $120 allowance, *plus* $60 copay	20% off retail price *minus* $120 allowance, *plus* $15 copay
Anti-Reflective Coating			
Standard	$45	$35 copay	$35 copay
Premium — Tier 1	20% off retail price	$47 copay	$47 copay
Premium — Tier 2		$58 copay	$58 copay
Premium — Tier 3		20% off retail price	20% off retail price
Other Lens Options			
UV Treatment	$15	$12 copay	$0 copay
Tint (Solid or Gradient)	$15	$0 copay	
Standard Plastic Scratch Coating	$15	$0 copay	
Standard Polycarbonate — Adult	$40	$30 copay	
Standard Polycarbonate — Child Under 19	$40	$0 copay	

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
In-Network Eyeglass Benefits			
Polarized	20% off retail price	$75 copay	$75 copay
Photocromatic / Transitions Plastic	20% off retail price	$65 copay	$65 copay
Any Other Add-Ons	20% off retail price	20% off retail price	20% off retail price
Additional Pairs Benefit *	Unlimited pairs* at negotiated rates shown above	40% discount off purchase of complete pair of eyeglasses* once the funded benefit has been used	

* Frame, lenses and lens options must be purchased in the same transaction to receive full discount. If purchased separately, members receive 20% off the retail price.

** The Benefit Frequency for spectacle lenses and lens treatments ***or*** contact lenses is once each calendar year under both the Enhanced and Premier Vision Plan options. The benefit frequency for eyeglass frames is once every two calendar years under the Enhanced Vision Plan or once each calendar year under the Premier Vision Plan. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Table 32 – In-Network Eyeglass Benefits

Eyeglass benefits are also available Out-of-Network if you elect coverage under the Enhanced or Premier Vision Plan options. You are responsible to pay the Out-of-Network provider in full at the time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
Out-of-Network Eyeglass Reimbursements *			
Frame	Not available	$40 — available once every two calendar years	$60 — available once every calendar year
Standard Plastic Lenses	Not available		
Single Vision		$25	$25
Bifocal		$40	$40
Trifocal		$55	$55
Lenticular		$70	$70
Progressive Lenses		$40	$40
Lens Options	Not available		
Anti-Reflective Coating		$5	$5
UV Treatment		$5	$10
Tint (Solid and Gradient)		$5	$5
Standard Plastic Scratch Coating		$5	$5
Standard Polycarbonate — Adult		$10	$28
Standard Polycarbonate — Child Under 19		$10	$28
Polarized		$5	$5
Photocromatic / Transitions Plastic		$5	$5

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
Out-of-Network Eyeglass Reimbursements *			
Any Other Add-Ons		Not available	Not available
* Member reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the Out-of-Network provider.			

Table 33 — Out-of-Network Eyeglass Reimbursements

Contact Lens Benefits

If you need or prefer contact lenses, you may decide to use the contact lens benefit instead of the spectacle lens benefit. Contact lenses are not covered if you have already used the spectacle lens benefit. You cannot use the spectacle lens benefit if you have already used the contact lens benefit. However, you can use your eyeglass frame benefit with your contact lens benefit. For prescription contact lenses for only one eye, the Plan will pay one-half the amount payable for contact lenses for both eyes. The Enhanced and Premier Vision Plan options offer Out-of-Network coverage for contact lenses.

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
In-Network Contact Lens Benefits*			
Conventional Lenses — available once per calendar year instead of spectacle lenses	15% off retail price	$0 copay; $105 allowance, then 15% off balance over $105	$0 copay; $150 allowance, then 15% off balance over $150
Disposable — available once per calendar year instead of spectacle lenses	No discount	$0 copay; $105 allowance, plus balance over $105	$0 copay; $150 allowance, plus balance over $150
Medically Necessary	Not available	$0 copay (paid in full); limited to one pair per calendar year	
Replacement Lenses	Conventional only — 15% off retail price	15% discount off conventional contact lenses once the funded benefit has been used	
Out-of-Network Contact Lens Reimbursements**			
Conventional Hard Lenses — available once per calendar year instead of spectacle lenses	Not available	$40	$80
Disposable — available once per calendar year instead of spectacle lenses		$40	$80
Medically Necessary		$40	$80

* Discounts and benefits apply only to contact lenses. Plan discounts may not be combined with any other discounts or promotional offers.

  You can save money by using your In-Network contact lens benefit and ordering your contact lenses at competitive prices through www.contactsdirect.com. Complete the online transaction form and the contacts will be delivered directly to your home.

  Lost or damaged contact lenses will not be replaced except in the next calendar year when contact lenses would next become available.

** You are responsible to pay the Out-of-Network provider in full at the time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

Table 34 — Contact Lens Benefits and Reimbursements

Medically Necessary Contact Lenses

The Healthineers Vision Program provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses are necessary for other eye conditions or visual improvement.

Mail Order Contact Lens Replacement Program

You can save money by using your In-Network contact lens benefit and ordering your contact lenses at competitive prices through www.contactsdirect.com. Complete the online transaction form and the contacts will be delivered directly to your home.

Additional Discounts

EyeMed provides an In-Network discount on products and services once your In-Network benefits for the applicable benefit period have been used. The In-Network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at Network providers

These In-Network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand-name vision materials in which the manufacturer imposes a no-discount practice or policy. Prior to your appointment, you should confirm with your provider that discounts are offered.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, offers discounts to you for LASIK (Laser-Assisted In Situ Keratomileusis) and PRK (Photorefractive Keratectomy). You receive a discount when using a Network provider in the U.S. Laser Network. The U.S. Laser Network offers

many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call **877-5LASER6** (877-552-7376).

After you locate a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and have scheduled treatment, you must call the U.S. Laser Network again at **877-5LASER6** (877-552-7376) to activate the discount.

Expenses Not Covered

The following expenses, some of which may be covered under the Healthineers Medical Plan or other -sponsored program, are not covered under the Healthineers Vision Program even if prescribed or recommended by your vision care provider:

- orthoptic or vision training
- subnormal vision aid and any associated supplemental testing
- aniseikonic lenses
- medical and/or surgical treatment of the eye, eyes or supporting structures
- any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment
- safety eyewear
- services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- non-prescription lenses and/or non-prescription contact lenses;
- non-prescription sunglasses
- two pair of glasses in lieu of bifocals
- services rendered after the date an individual ceases to be covered under the Healthineers Vision Program, except when vision materials ordered before coverage ends are delivered, and the services rendered to the individual are within 31 days from the date of such order
- services or materials provided by any other group benefit plan providing vision care
- replacement of lost or broken lenses, frames, eyeglasses or contact lenses before the commencement of a new period of eligibility to receive such benefit—i.e., before the beginning of a new calendar year or completion of two calendar years, as may apply.

Claiming Benefits

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay any applicable copayments and the cost of any services or eyewear that exceeds any allowances.

If you use an Out-of-Network provider, you will pay for the full cost at the point of service. To receive your Out-of-Network reimbursement, complete and sign an out-of-network claim form, which is accessible from the EyeMed Vision Care website (www.eyemedvisioncare.com/siemens) or by calling EyeMed's Customer Care Center at **844-378-9360**. Attach your itemized receipts to the claim form and send them to First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

FAA will process claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to process a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to process the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing. Claims must be submitted within 12 months of the date of service.

If you have questions about your vision benefits, visit the EyeMed Vision Care website at www.eyemedvisioncare.com/siemens and choose the *Insight* Network. You may also call EyeMed's Customer Care Center at **844-378-9360**. EyeMed's Customer Care Center can be reached Monday through Saturday, 7:30 a.m. to 11:00 p.m. and Sunday 11:00 a.m. to 8:00 p.m. EST.

OVERVIEW OF YOUR EMPLOYEE ASSISTANCE PROGRAM

Healthineers provides an Employee Assistance Program (EAP) through Cigna Behavioral Health. The EAP is an assessment, referral and short-term counseling program that is available to you and everyone in your household, whether or not you enroll in any benefit plan options under the Healthineers Benefits Program. Benefits under the EAP are separate from your behavioral health care benefits under your medical plan option — with no copayment required.

The EAP can provide confidential, professional assistance and support for your emotional well-being and life events. The table below provides a summary of the support and information you can receive and/or access from the EAP through Cigna Behavioral Health.

EAP Services		
Service Level	• 24 hours a day, 7 days a week	
	• Provider referrals	
Participant Services	• Telephone consultation	
	• Crisis intervention services	
	• Community resources	
	• Life at Work resources	
	• Discounts on health- and wellness-related products and services	
	• Emotional well-being online (assessment tools, FAQs, article library, online access and referral, awareness series)	
Full-Service Life Events		
Telephone Services	• Child Care	Child care centers, family child care homes, in-home care, baby-sitting agencies and options, nanny agencies and options, au pair agencies and options, preschools/nursery schools, before- and after-school programs
	• Senior Care	Home health agencies, nursing homes, assisted living facilities, continuing care retirement communities, social and recreational programs, long distance care-giving, backup care, respite care
	• Prenatal Care	Birthing methods, nutrition, exercise and diet, child care pre-planning, breastfeeding and formula feeding
	• Parenting	Child development, sibling rivalry, separation anxiety, sleep and bedtime routines, toilet training, child safety, discipline, raising adolescents
	• Summer Care	Residential camps, day camps, traditional camp programs, specialized camp programs
	• Special Needs	Common childhood illnesses, children with multiple disabilities, developmental delays, mentally challenged/ill
	• At-Risk/High-Risk Adolescents	Transitional living programs, day and residential treatment facilities, positive after-school alternatives, mentoring programs
	• Pet Care	Veterinarians, insurance, pet-sitting resources, obedience training, pet store, pet supply catalogs

EAP Services		
	• Adoption	State adoption specialists, adoption support groups, private adoption, national adoption organizations
	• Education	Kindergarten programs, before- and after-school programs, public schools, undergraduate and graduate programs
	• Financial	30-minute telephonic consultation on financial information and needs. Spending habits, budgeting strategies, managing credit, debt management, debt consolidation, college savings, buying a home. 25% discount on tax preparation.
Online Services	• Family and Caregiving	Adoption, child care, parenting, senior care, education, pet care, caregiver assistance
	• Health & Wellness	Live healthy, health and aging, common health concerns
	• Daily Living	Consumer information, travel and recreation, finances, legal issues
	• Working Smarter	Teambuilding, career transition and growth, supervisory issues, diversity, productivity, recognition
	• Relocation Center	Climate, crime rates, education levels, income, housing prices, marital status, types of homes, school listings, hospitals, places of worship
	• Savings Center	Everyday discounts, in-store shopping events, savings on local shops and restaurants, seasonal shopping guides and promotions
	• Self-Search Provider Locators	
	• Educational Materials	
	• Personal Assessments	
	• Interactive Tools	
Referrals & Fulfillment	• Up to 3 qualified sources provided where available	
	• Life events turnaround time: 12 business hours; emergency is 6 hours	
	• Online and print materials	

Table 35 – EAP Services

EAP Services for Managers and Supervisors

The EAP is also a resource for managers and supervisors when they need additional support and counseling for employee-related challenges. EAP services for managers and supervisors are available in the following areas:

- Management consultation
- Mandatory referrals to the EAP
- Fitness for duty/behavioral risk assessment referrals
- Critical incident counseling
- Management training

Consult with your local human resources professional for assistance in determining when you should contact the EAP.

Accessing EAP Services

You can access the EAP 24 hours a day, seven days a week, by calling Cigna Behavioral Health at **800-547-5589**. In order to receive the support and information you need, you must identify yourself as a Healthineers employee or COBRA participant, dependent or household member.

A professionally trained counselor will answer your call. Depending on the nature of the call, the counselor's assistance may include:

- identification and evaluation of individual or family issues
- short-term counseling up to a maximum of six free sessions* per issue (*if your issue cannot be resolved in six visits, you may be referred to a provider in your medical plan option)
- referrals, when necessary, to professional service agencies or individuals
- follow-up counseling, and
- follow-ups to ensure satisfaction with referrals (new referrals may be made if you are not satisfied with an original referral for any reason).

You can also access online services at **www.mycigna.com**.

When Benefits End

Your EAP benefits end 30 days after your termination of employment.

If Cigna Behavioral Health authorizes up to six counseling sessions before you terminate your employment, these counseling sessions can extend past the 30-day period after your termination of employment.

You have the further right to elect continuation of your EAP benefits under COBRA.

OTHER MEDICAL, DENTAL, VISION AND EAP PLAN PROVISIONS

Qualified Medical Child Support Orders

Payments under the Medical, Prescription Drug, Dental and/or Vision plan options will be made according to the terms of a "Qualified Medical Child Support Order" (QMCSO), which generally includes a judgment, decree, or order by a court requiring a non-custodial divorced or separated employee to provide medical, prescription drug, dental and/or vision coverage to a child under the Company's medical, prescription drug, dental and/or vision plans. If you have not previously been enrolled in an appropriate medical, prescription drug, dental and/or vision plan options, then the Plan Administrator will enroll you and the subject child or children in plan option(s) that will permit coverage for the child or children. If the Plan Administrator determines that a medical child support order qualifies, benefit payments from the Healthineers Benefits Program options may be made according to the qualified order to the child or children named in the order, or to the custodial parent or legal guardian, where appropriate, or to health care providers (if benefits have been properly assigned by the child or children or by the custodial parent or legal guardian).

If You Become Disabled

IMPORTANT!

The Medical Plan eligibility provisions in the section captioned, "**Your Other Benefits During Disability**" below apply to Healthineers employees whose disabilities began on or after May 1, 2018. For rules that generally apply if you became disabled or partially disabled prior to May 1, 2018, refer to the Summary Plan Description for the Siemens Corporation Group Insurance and Flexible Benefits Program if effective at the time you became disabled. contact the SBSC at **800-392-7495** for more information.

If you become disabled and you are determined to be "Disabled" as defined by the Short Term Disability Plan or "Disabled" or "Partially Disabled" as defined by the Long-Term Disability (LTD) Plan, as applicable (see definitions in the Glossary), the Dental and Vision Plan options available to active employees will continue to be available to you for the first 12 months of disability (including the period of short-term disability). After 12 months of disability, you will be offered COBRA (see "Extensions of Coverage – COBRA" below).

If You, Your Spouse and/or Your Domestic Partner Are Eligible for Medicare

The Healthineers Medical Plan provides **primary** coverage for the following covered Medicare-eligible individuals:

- active employees and/or their spouses age 65 or older (however, Medicare is primary for non-employee domestic partners aged 65 or older)
- individuals who are on renal dialysis for 30 or fewer months (there may be some exceptions which will make Medicare primary)
- covered disabled dependents of active employees

If you are an active employee and your non-employee domestic partner reaches age 65, he or she is eligible for Medicare and will need to enroll in both Medicare Part A and Part B coverages. Under federal requirements, Medicare provides **primary** coverage and the Healthineers Medical Plan provides **secondary** coverage for a non-employee domestic partner who is age 65 or older.

If you are an active employee age 65 or over and eligible for Medicare, you can elect primary coverage under Medicare. However, if you do, no benefits will be payable under the Healthineers Medical Plan.

If you are an active employee enrolled in a Healthineers Medical Plan option, you (and/or your spouse) should register for Medicare Part A when initially eligible. You (and your spouse, if Medicare-eligible) can sign up for Medicare Part B without any penalty for late enrollment if you apply anytime you are still covered by the Healthineers Medical Plan option or during the eight-month period that begins the month after your employment ends (or the month in which your Healthineers' active-employee coverage ends, whichever happens first). Once you enroll in Part B, your six-month Medigap Open Enrollment Period begins. For more information, visit Medicare.gov or call **800-772-1213**. Once you cease to be an active employee, if you are eligible for Medicare, Medicare will be your primary payer and the Healthineers Medical Plan option will be your secondary coverage. This provision will also apply to any family member who is or may become eligible for Medicare. Any medical benefit payments ─ including payments made under COBRA coverage ─ will be determined as if you are enrolled in Medicare Part A and Part B, regardless of whether you have actually enrolled in coverage under either Part.

If you are disabled or have End-Stage Renal Disease, you should register for both Medicare Part A and Part B coverages when initially eligible. If you have received Social Security Disability benefits for at least 24 months, you are eligible for Medicare.

If You Die

If you die while you are an active employee (or within the first 12 months of disability as defined by the Company's short−term and long−term disability plans, as applicable) and you had coverage for your spouse or domestic partner and/or other eligible family members, coverage for your spouse or domestic partner and other eligible family members continues for two years, under COBRA, at no cost to them (as long as your spouse or domestic partner is not a Healthineers employee who is eligible to participate in the Healthineers Benefits Program). Your spouse or domestic partner and eligible family members may continue their coverage under COBRA for up to an additional 12 months beyond that two-year period at their own cost. Therefore, coverage under COBRA may be continued for up to a total of 36 months. **The two-year period during which coverage continues after your death will count towards and reduce the maximum period COBRA coverage may continue.**

However, if your surviving spouse or your surviving domestic partner remarries or enters into a new domestic partnership — or a dependent becomes eligible for Medicare — his or her coverage ends on the latest of:

- the date of remarriage or domestic partnership or the 180th day after your death, whichever is later;
- the date your dependent becomes eligible for Medicare or the 180th day after your death, whichever is later.

Your dependent will no longer be eligible for the two-year extension of Company subsidized COBRA coverage on the date a dependent no longer qualifies as a dependent under the Plan.

If you would otherwise have been eligible for post-retirement medical (including prescription drug coverage), dental and vision benefits, your spouse or domestic partner and eligible dependents may apply for those benefits after the COBRA period (subsidized or un-subsidized) has ended.

Dental Benefits Extension

If your Dental coverage ends after any of the following treatments has started, your expenses to complete the treatment will be covered if they are incurred within three months after coverage ends:

- impressions for bridgework or dentures
- preparation work for crowns, inlays or onlays, or root canal therapy.

If you are not eligible for an extension of benefits under Plan rules, you may be eligible to continue coverage at your own expense through COBRA.

When Coverage Ends

Your coverage under the Plan ends on the date you:

- terminate employment with all participating employers, unless you are eligible to participate in the Healthineers post-retirement medical, dental and/or vision benefits program (in which case, coverage ends on the last day of the month in which your employment ends; see the **Summary Plan Description for Retiree Coverages** or call the SBSC at **800-392-7495** for details);
- are no longer eligible;
- fail to make the required contributions;
- cancel your coverage or the Plan is terminated; or
- you die (whichever occurs first).

Coverage for a dependent ends when yours does, or whichever of the following occurs first:

- on the last day of the calendar plan year if you do not elect coverage for the dependent for the succeeding plan year;
- on the date you fail to make the required contributions for dependent coverage or you retire;
- on the last day of the month in which he or she no longer qualifies as a dependent (i.e., your child reaches age 26).

When coverage ends, you or your dependent(s) may be eligible for COBRA continuation coverage. See the section on COBRA below.

NOTE: If you voluntarily end a dependent's coverage during Annual Enrollment, it is viewed as a voluntary cancellation and COBRA coverage will not be offered.

Conversion Privileges

There are no conversion privileges with respect to any of the options under the Healthineers Medical (including Prescription Drug), Dental or Vision Plans.

Extensions of Coverage (COBRA)

When you, your spouse or domestic partner, or another covered family member would otherwise lose coverage under the Employee Assistance Program (EAP) or under a Healthineers Medical (including Prescription Drug coverage), Dental, and/or Vision plan option, you and your family may be able to continue coverage under COBRA, as described below. You will be required to pay contributions for this continued coverage. If you have a Health Care Flexible Spending Account (HCFSA), you may also continue your HCFSA by making after-tax contributions through the end of the plan year in which your participation would otherwise end, as described elsewhere in this Summary Plan Description.

Your legal rights to continuation coverage under COBRA:

Under a federal law called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), Healthineers is required to offer covered employees, and their covered spouses and dependents, the opportunity to continue group health coverage temporarily at group rates after coverage under the Healthineers Benefits Program would otherwise cease. This extension is called COBRA continuation coverage. The Healthineers Benefits Program also extends these COBRA rights to covered domestic partners (same or opposite sex). Evidence of your good health is not required for this extension.

As an employee participating in the EAP or medical (including prescription drug coverage), dental, and/or vision plan options under the Healthineers Benefits Program, you have the right to elect

COBRA continuation coverage if you lose coverage (or your benefit premium payments or contributions or payroll deductions for coverage increase) because:

- your hours of employment are reduced,
- your employment is terminated for reasons other than gross misconduct, or
- your employer starts bankruptcy proceedings, if you are a retired employee.

Your spouse or domestic partner (same or opposite sex) may elect COBRA continuation coverage under the EAP or Healthineers medical (including prescription drug coverage), dental, and/or vision plan options if he or she loses coverage, or benefit premium payments or contributions or payroll deductions for coverage increase, because:

- your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- you die;
- you divorce or are legally separated; or
- your employer starts bankruptcy proceedings, and you are retired.

Your dependent child may elect COBRA continuation coverage under the EAP or Healthineers medical (including prescription drug coverage), dental, and/or vision plan options, if he or she loses coverage, or benefit premium payments or contributions or payroll deductions for coverage increase, because:

- he or she loses dependent status under the EAP or Healthineers medical (including prescription drug coverage), dental, and/or vision plan options;
- your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- you die;
- you and your spouse or domestic partner divorce or are legally separated; or
- your employer starts bankruptcy proceedings, and you are retired.

A child born to or placed for adoption with the covered employee during the continuation coverage period is also entitled to elect COBRA continuation coverage. Such child's coverage period will be determined according to the date of the qualifying event that gave rise to the covered employee's COBRA coverage.

NOTE: If you voluntarily end a dependent's coverage during Annual Enrollment, it is viewed as a voluntary cancellation and COBRA coverage will not be offered.

Under COBRA, you (or your spouse or domestic partner or dependent child, if applicable) must notify the SBSC at **800-392-7495** within 60 days after:

- you and your spouse or domestic partner are divorced or legally separated; or
- one of your children loses dependent status under the Plan.

You and your spouse or domestic partner or dependent child will be notified of the right to elect continuation coverage and the cost to do so. You and your spouse or domestic partner or dependent child can separately elect to continue coverage. Therefore, even if you do not elect coverage, your spouse or domestic partner or dependent child can do so.

The deadline for electing continuation coverage is 60 days after the date you or your spouse or domestic partner or dependent child would lose coverage under the EAP or Healthineers medical (including prescription drug coverage), dental, and/or vision plans, or the date you are notified of your right to elect COBRA continuation coverage, whichever is later.

If you, your spouse or domestic partner or dependent child does not elect continuation coverage, coverage will stop. If you and your spouse or domestic partner or dependent child chooses dependent coverage, the EAP or Healthineers medical (including prescription drug coverage), dental, and/or vision plan options will provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among medical (including prescription drug coverage), dental, and/or vision plan options available during an Annual Enrollment. However, you and your spouse or domestic partner or dependent child must pay 102% of cost for this coverage.

If a covered employee or spouse or domestic partner of a covered employee elects COBRA without specifying which coverage category is being elected, the election will be considered to be on behalf of all other qualified beneficiaries with respect to that qualifying event.

COBRA Continuation Period

1. If the original qualifying event causing the loss of coverage was the *death of the employee, divorce, legal separation, or loss of "dependent" status* of a dependent child under the Healthineers Benefits Program, then each qualified beneficiary will have the opportunity to elect **36 months** of continuation coverage from the date of the qualifying event.
2. If the qualifying event for which you (or your spouse or domestic partner or dependent child) loses coverage under the Healthineers Benefits Program is the *termination of your employment* or *reduction in your hours of employment*, the maximum COBRA continuation period will be **18 months** from the date of the qualifying event.

   In addition, this 18-month period may be extended up to a total maximum period of **36 months** for your spouse, domestic partner or dependent child if they experience a second qualifying event that would have resulted in loss of coverage if it had occurred before or instead of the initial qualifying event. Such second qualifying events include *your death, divorce or legal separation, or your dependent child's loss of "dependent" status* under the Healthineers Benefits Program. In order to have COBRA coverage extended for this second qualifying event, you or your spouse or domestic partner or dependent child must provide notice of this second qualifying event to the SBSC, and elect the extended COBRA coverage, within 60 days of the occurrence of this second qualifying event. You can notify the SBSC by calling the SBSC at **800-392-7495**. However, in no event will your spouse's or domestic partner's or dependent child's continuation coverage extend for more than a total of 36 months from the date of the initial event.
3. If the qualifying event is your termination of employment or reduction in hours and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse or domestic partner and dependents may be available. Your spouse or domestic partner and dependents can be eligible to receive up to 36 months of continuation coverage from the date of

your entitlement to Medicare. For example, if you became entitled to Medicare 10 months before the date your employment terminates, COBRA continuation coverage for your spouse or domestic partner and dependents can last up to 36 months following after the date of Medicare entitlement — that is, 36 months minus the 10 months that precede your termination (the qualifying event) or equal to 26 months following the date of your termination (36 months minus 10 months prior to the qualifying event).

IMPORTANT!

If you and/or your spouse reach age 65 prior to your COBRA qualifying event, Medicare coordination rules apply. This means that Medicare coverage will pay primary and Healthineers COBRA coverage will pay secondary. (For a domestic partner who reaches age 65, Medicare is primary coverage even while the employee continues to be actively employed.) Therefore, you and/or your spouse or domestic partner will need to enroll in Medicare Part A and Part B coverages either immediately before or as soon as possible following your COBRA qualifying event to avoid excess out-of-pocket expenses. If you do not enroll in Medicare and you utilize medical services, the Healthineers COBRA plan will pay secondary **(regardless of whether or not you are enrolled in Medicare Part A or Part B coverage)**.

See below with respect to the effect of you and or your spouse or domestic partner or covered dependent becoming eligible for Medicare after the applicable COBRA qualifying event.

4. ***Disability*** has special rules. If the Social Security Administration determines that you (or your spouse or domestic partner or dependent child) are disabled *any time before the end of the first 60 days of the continuation coverage period,* or, in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, *during the first 60 days after the child's birth or placement for adoption,* then your continuation coverage period as well as your spouse's or domestic partner's and any dependent's continuation coverage periods may be extended from 18 months to **29 months**. To qualify, you (or your spouse or domestic partner or dependent child) must notify the SBSC within 60 days of the date of the Social Security determination and during the initial 18-month continuation coverage period. If there is a final determination that the qualified beneficiary is no longer disabled, the SBSC must be notified by the qualified beneficiary within 30 days of the determination, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

5. In certain circumstances, *bankruptcy of the employer* will entitle you to continuation coverage. If the qualifying event causing the loss of coverage was the bankruptcy of the employer, then each covered retired employee will have the opportunity to receive continuation coverage **until the death of the covered retired employee**. Covered spouses or domestic partners, surviving spouses or domestic partners, and dependents of the covered retired employee will have the opportunity to elect continuation coverage for a period that will terminate **36 months** following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

6. Your right to continuation coverage (or your spouse's or domestic partner's or dependent child's right) under COBRA ends if:
   - the Company ceases to provide group benefits coverage to its employees;
   - you (or your spouse or domestic partner or dependent child) fail to pay the premium within 30 days after its monthly due date;
   - you (or your spouse or domestic partner or dependent child) become covered, after the date of your COBRA election, under another group benefits plan, **including Medicare** or any other governmental plan, that does not contain any exclusion or limitation with respect to any

preexisting condition of such beneficiary (other than an exclusion or limitation that may be disregarded under the law);

- you (or your spouse or domestic partner or dependent child) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- the maximum required COBRA continuation period expires; or
- for cause, such as fraudulent claim submission, which would result in termination of coverage for similarly situated active employees.

Cost for COBRA Coverage

If you (or your family members) elect continuation of coverage under COBRA, you must pay 102% of the cost of coverage, as determined by. Coverage will not be effective until you pay your premium within 45 days of your election to continue coverage.

Additional information about COBRA continuation coverage is available by contacting the SBSC at **800-392-7495.**

You, your spouse or domestic partner or dependents, may have other options available upon a loss of group health coverage. These options may include obtaining coverage through the Health Insurance Marketplace, Medicaid, or other group health plan (such as a spouse's employer's plan). Some of these options may cost less than COBRA continuation coverage. You can learn more about some of these options at www.healthcare.gov.

Overpayments

The Plan will make reasonable and diligent efforts to recover benefit payments made in error, but in good faith, and will apply subsequent benefits otherwise payable to offset any overpayments.

You and your covered dependent(s) are required to reimburse the Plan for overpayments. If you and/or your covered dependent(s) refuse to reimburse the Plan, Healthineers will take appropriate legal action.

Coordination of Benefits

The Plan contains a Coordination of Benefits ("COB") feature, which is described below. For information on Coordination of Benefits for a fully insured Medical option, refer to the benefit book provided by the Claims Administrator. The COB feature comes into play when you or a family member is covered by more than one group health plan. COB limits payments from all plans combined to no more than the Healthineers Benefits Program would have paid if there had been no other coverage.

The coordination of benefits provision does not apply to any personal policy, except No-Fault automobile insurance (whether or not you waived medical coverage under your automobile insurance policy).

When the Healthineers Benefits Plan pays benefits second, it will pay benefits for covered expenses the other plan does not fully cover — to bring your total benefit up to the amount the Healthineers Benefits Program would pay if it were the only Plan. Different rules may apply to No-Fault automobile insurance.

For example, suppose your spouse's medical plan covers a hospital bill at 85% — the same as the Healthineers Benefits Program would have paid. Because your spouse is entitled to receive benefits

from his or her plan equal to what the Healthineers Benefits Program would pay, the Healthineers Benefits Program pays no additional benefits.

In determining the amount (if any) it will pay, the Healthineers Benefits Program assumes that you follow the procedures of the other plan — for example, hospital pre-certification, second surgical opinion or pre-treatment estimate requirements. The Healthineers Benefits Program will not cover any "penalties" you pay under the other plan for failure to comply with such procedures.

The following rules determine which plan is primary (pays benefits first) and which plan is secondary (pays benefits second):

- As a Healthineers employee, the Healthineers Benefits Program is always primary for your covered expenses.
- If your spouse or domestic partner is covered under the Healthineers Benefits Program as a dependent and under another group plan as an employee, the plan covering your spouse or domestic partner as an employee is primary and the Healthineers Benefits Program is secondary.
- If you have dependent children covered by both the Healthineers Benefits Program and your spouse's or domestic partner's plan, the plan of the parent whose birthday (month and day) is earlier in the calendar year is primary; the other parent's plan is secondary. This is called the "birthday rule."
- If you are separated or divorced, benefits for your children are determined in accordance with any court decree.
- If the parent with custody has not remarried, the plan of the parent with custody is primary; the other parent's plan is secondary.
- If the parent with custody has remarried, the plan of the parent with custody is primary; the stepparent's plan is secondary; and the plan of the parent without custody pays third.
- If none of the above apply, the plan covering the person for the longest period is primary.
- If you are divorced or end your domestic partnership, your former spouse or domestic partner may continue coverage only under a COBRA election.

NOTE: If your spouse or domestic partner works for, he or she may not be covered as both an employee and a family member, and only one of you may cover any dependent children.

NOTE: The rules above do not apply if you are disabled and eligible for Medicare (see "If You Are Eligible for Medicare" section above).

The Delta Dental Plan contains a coordination of benefits feature. This feature comes into play when you or a family member is covered by more than one group dental plan. It limits payments from all plans combined to no more than the Delta Dental Plan would have paid if there had been no other coverage. The coordination of benefits provision does not apply to any personal policy, except No-Fault automobile insurance (regardless of whether you waived health coverage under your automobile insurance policy).

When the Delta Dental Plan pays benefits second, it will pay benefits for covered expenses the other plan does not fully cover – to bring your total benefit up to the amount the Delta Dental Plan would pay if it were the only Plan.

For example –
Suppose your Spouse's dental plan covers a bill at 80% – the same as Healthineers' Delta Dental Plan would pay for the same service. Because your spouse is entitled to receive benefits from his or her plan equal to what Healthineers' Delta Dental Plan would pay, no additional benefits are paid by the Healthineers Benefits Program.

In determining what (if anything) it will pay, the Delta Dental Plan assumes that you follow the procedures of the other plan. The Delta Dental Plan will not cover any "penalties" you pay under the other plan for failure to comply with such procedures.

For further information, see *Coordination of Benefits*.

NOTE: If your Spouse or Domestic Partner works for Healthineers, he or she may not be covered as both an employee and a dependent, and only one of you may cover any dependent children.

Right of Subrogation and Reimbursement

The Healthineers Benefits Program has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid medical or dental benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor, or insurer, in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan and its administrators in protecting the legal and equitable rights of the Plan to subrogation and reimbursement in a timely manner, including, but not limited to:
- Notifying the Claims Administrator, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Claims Administrator or its agents.
    - Signing and/or delivering such documents as the Claims Administrator or its agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.

- Obtaining the consent of the Claims Administrator or its agents before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Claims Administrator or its agents is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon request from the Claims Administrator or its agents, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.
- The Plan may, at its option, take necessary and appropriate action to preserve the rights of the Plan under these provisions, including but not limited to, providing or exchanging medical

payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

AN OVERVIEW OF YOUR FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts allow you to pay for certain eligible expenses with pre-tax dollars.

The flexible spending accounts, funded with pre-tax contributions deducted from your pay, lowers your taxable income by allowing you to pay less:

- Federal income tax
- Social Security tax (if your earnings are below a certain level)
- State and local income taxes in many states.

The Health Care and Dependent Care flexible spending accounts are two valuable ways that help expand your benefit program and strengthen the level of your coverages by reimbursing you for expenses that are not covered or reimbursed under other plans.

The flexible spending accounts program is administered by WageWorks®. If you have a question regarding the provisions of the program, call WageWorks® customer service at **877-924-3967 (877-WageWorks)** or visit their website at www.wageworks.com and enter your user name and password (or click on the First Time User? link to go through the simple registration process).

Your Flexible Spending Accounts

There are two types of flexible spending accounts – health care and dependent care – available to most employees. A "regular" **Health Care Flexible Spending Account (HCFSA)** can be used to help pay for health care services and supplies that are not paid by the medical (including prescription drugs), vision or dental plan options you select for you and your eligible dependents. If you are a participant in the Health Savings Medical plan option, you may only enroll in a Limited-Use HCFSA to pay for dental and vision (but not medical) expenses. An HCFSA or Limited-Use HCFSA can also be used to pay permissible medical expenses for a person you claim as a dependent on your federal tax return but cannot claim as a dependent for purposes of the medical, vision and/or dental plan options.

NOTE: An HCFSA or Limited-Use HCFSA may not be used to reimburse expenses incurred for dependent care expenses.

A **Dependent Care Flexible Spending Account (DCFSA)** can help pay expenses for day care services for your eligible children, parents, grandparents or handicapped spouse.

NOTE: A DCFSA may not be used to reimburse health care expenses for you or your dependents.

Even if you or your family members are not covered by the medical or dental plan options under the Healthineers Benefits Program, you may enroll in the HCFSA or the DCFSA. However, only eligible expenses incurred during your period of coverage — January 1 of the current Plan year through March 15 of the following Plan year — may be submitted. **Participants in the Health Savings (HSA) or Health Reimbursement (HRA) Medical Plan options should be aware of further restrictions, described below.**

If you discontinue contributions to the HCFSA and/or DCFSA as the result of a valid status change, coverage under that account terminates on the date your contributions cease. Contribution deductions may continue for one or two payroll periods following the date your request is received. You will be eligible for a refund of excess HCFSA or DCFSA deductions if and only to the extent that contribution deductions continue for more than two payroll periods following the date your request is received. You can submit claims for reimbursement for expenses incurred before your contributions ceased according to the claim filing deadline described in the "Claiming Benefits" section.

Expenses incurred before your participation in a Flexible Spending Account began are not eligible expenses for reimbursement. If you terminate employment, you may elect to continue your

participation in the HCFSA (but not in the DCFSA) under COBRA, but not longer than through the end of the calendar year in which you terminate employment, by making after-tax contributions. Health care expenses will be eligible for reimbursement, up to the full amount of your plan year election, if incurred through the last date of your contributions. Dependent day care expenses will be eligible for reimbursement, up to the full amount of your contributions, if incurred through the end of the calendar year in which you terminate employment.

Flexible Spending Accounts and the Health Savings Medical Plan Option

You are not eligible to participate in a "regular" Health Care Flexible Spending Account (HCFSA) during any year in which you are enrolled in the Health Savings (HSA) Medical Plan option, regardless of whether you participate in the Health Savings Account (HSA) feature of that option. While the HSA is similar to the Health Care FSA, they have different regulations regarding eligible expenses and are therefore used for different purposes. However, you are eligible to participate in a **"Limited-Use" Health Care Flexible Spending Account** (Limited-Use HCFSA). You may participate in both the HSA and Limited-Use HCFSA accounts, but keep in mind:

- The Health Savings Account (HSA) is available only if you enroll in the Health Savings Medical Plan option.
- The Health Savings Account (HSA) can be funded with employer and employee contributions.
- Any expenses reimbursed, or eligible to be reimbursed, 100% through the Optum Bank HSA cannot be reimbursed through the Limited-Use HCFSA.
- **The Limited-Use HCFSA can only be used for eligible dental and vision care expenses, not medical or prescription expenses that are otherwise covered by your Optum Bank HSA.**

For example, if you are enrolling in the Health Savings Medical Plan option for the first time in 2018 and you participated in a regular HCFSA during 2017, you will need to submit claims for reimbursement from your 2017 HCFSA of any eligible ***medical, dental or vision care*** expenses that were incurred (but not reimbursed) on or before December 31, 2017. (You will not be able to use your WageWorks® Visa spending account card after December 31, 2017, to pay expenses from your 2017 HCFSA.) You may submit paper or online claims for reimbursement from your 2017 HCFSA for eligible ***dental and vision care*** expenses incurred January 1, 2018, through March 15, 2018. Any claims for ***medical*** expenses incurred on or after January 1, 2018, can be reimbursed only from your HSA.

If you are a participant in the Health Savings Medical Plan option and you elect to contribute to an HCFSA, your election will be automatically converted to an election to contribute to a Limited-Use Health Care FSA, regardless of whether you elect to contribute to an HSA. Contributions to a Limited-Use Health Care FSA cannot be converted to or redesignated as contributions to an HSA.

Flexible Spending Accounts and the Health Reimbursement Medical Plan Option

If you are a participant in the Health Reimbursement Medical Plan option and you elect to contribute to an HCFSA, you must submit claims for reimbursement of covered medical expenses first to your HRA. You may submit medical expense claims to the HCFSA only after you have exhausted the balance in your HRA. Claims for prescription drug, dental and vision expenses cannot be reimbursed by your HRA and should be submitted directly to the HCFSA.

Your Contributions

When you enroll, you decide how much, if anything, to contribute to your flexible spending accounts. You will need to make a separate decision for each account. **You must make a new election every year at Annual Enrollment.**

- **Health Care Account**: For 2018, your annual contribution may not be less than $120 and not more than $2,600.
- **Limited-Use Health Care Account**: For 2018, your annual contribution may not be less than $120 and not more than $2,600.
- **Dependent Care Account**: Eligible dependent day care expenses are those necessary for you (and your spouse, if you are married) to work or attend school. You may contribute between $120 and $5,000 each year ($2,500 if you and your spouse file separate tax returns). If either you or your spouse has an annual taxable income of less than $5,000, your contribution may not be more than the lesser of your two incomes. In addition, if your spouse also has an employer-sponsored Dependent Care Spending Account, your combined annual contributions may not exceed $5,000.

Dependent Care Accounts provide particular tax advantages to participants and are subject to IRS regulations on discrimination testing. These IRS limitations are intended to ensure that the use of the Dependent Care Account does not inadvertently favor highly compensated employees. For the 2018 plan year, an employee who in 2017 earned total compensation over $120,000 is considered for the purpose of the Dependent Care Account to be a highly compensated employee. Healthineers periodically monitors its Dependent Care Account participation to determine if any limitations need to be placed on the accounts of highly compensated employees. Therefore, the amount that a highly compensated employee has elected to contribute to the Program may be limited by the Company as necessary to meet applicable IRS regulations.

If your spouse is either a full-time student or incapable of self-care, your spouse will be considered to have an annual income of $2,400 if you have dependent care expenses for one eligible dependent; $4,800 if you have expenses for two or more eligible dependents.
The annual amount you elect to contribute to your flexible spending accounts will be divided by the number of paychecks you receive each year, and this amount will be deposited into your flexible spending account based on your payroll schedule. As the year progresses, you will build a fund of tax-free dollars.

Special Rules to Consider

The following rules are important to keep in mind to ensure that you obtain the maximum value from this plan:

- Elections to participate have to be made for a full calendar year.
- Elections must be made before the calendar year begins.
- **Elections are irrevocable** – they cannot be changed once that calendar year begins.
- Once your contributions begin, the government will not allow them to be changed during the year unless you experience a Qualified Life Event. Refer to the Qualified Life Event table in the "Eligibility and Enrollment" section of this Summary Plan Description for a list of these events. Whatever amount you select for either or both accounts must continue until year-end.
- **Transfer of money between the accounts is not permitted**. This means you should consider your contribution decision carefully. Before enrolling or re-enrolling in the plan, you should estimate your total health care and dependent day care expenses — and your contributions to cover them.

- **Amounts you do not use by the end of the covered period may not be returned to you.** You have 2-1/2 months beyond the end of the calendar year – until March 15 – to incur ***eligible*** health care and dependent day care expenses, and until the end of May to submit claims to the Health Care, Limited-Use Health Care and Dependent Care accounts. For example, for the 2018 plan year and provided you have a balance remaining in your account, you can file claims for expenses incurred through March 15, 2019, and you have until May 31, 2019, to file claims. Note special rules above if you elect to participate in the Health Savings Medical Plan option in a year following your participation in an HCFSA.

Eligible Health Care Expenses

Generally, you can use a "regular" Health Care Flexible Spending Account to be reimbursed for health care expenses considered tax-deductible by the IRS. However, you cannot receive a tax deduction and be reimbursed from your account for the same expenses. In addition, you may not be reimbursed for any expenses that are paid by the medical plan, your HSA or HRA, the vision or dental plans or by any other health plan that covers you or your family.

NOTE: This list is a sample of eligible health care expenses — expenses not listed may be eligible for reimbursement. See Claiming Benefits below.

- If you are a participant in the Health Savings Medical Plan option, your enrollment in a Health Care Flexible Spending Account will be automatically designated as an enrollment in a Limited-Use Health Care FSA. You may use a Limited-Use Health Care FSA only for eligible dental and vision care expenses, not medical or prescription drug expenses that are otherwise covered by your Health Savings Account.
- If you are a participant in a Health Reimbursement Medical Plan, you may use your HCFSA for eligible dental and vision and prescription drug expenses, but you must generally exhaust the balance in your HRA before they can use the HCFSA for medical expenses.
- If you are a participant in a PPO Medical Plan option, the entire list applies fully to you.

Eligible **dental and vision expenses** include:

- dental expenses not covered by insurance (except for cosmetic purposes) — X-rays, fillings, braces, extractions, false teeth, treatments, etc.
- deductibles, coinsurance and copays – balance not paid by your Dental or Vision Plan or any other health insurance
- contact lenses, solutions and cleaners
- eyeglasses — lenses, frames, exams
- lasik or other vision correction surgery
- optometrist – fees for examinations

Eligible **prescription drug expenses** include:

- birth control
- diabetic supplies
- prescription and over-the-counter (see **NOTE** below) medicines for allergy relief
- medicines – prescribed and legally obtained drugs and medicines (but generally not medications you can purchase without a doctor's prescription, see **NOTE** below)
- over-the-counter medicines and drugs prescribed to alleviate or treat an illness or injury (see **NOTE** below)
- over-the-counter medications prescribed for smoking cessation (see **NOTE** below)
- vitamins and dietary supplements prescribed for the treatment of illness

Eligible **medical expenses** include:

- abortion
- acupuncture performed by a licensed practitioner
- payment to a treatment center for alcoholism or drug dependency
- ambulance service
- analysis — psychotherapy by a licensed practitioner
- car controls for the handicapped
- chiropractors — services within scope of license
- Christian Science practitioners
- crutches – purchase or rental
- deductibles and coinsurance – balance not paid by your medical plan or any other health insurance
- doctors' fees
- fertility treatments
- founder's fee – monthly lump-sum fee to a retirement home (covers portion specifically for lifetime medical care)
- guide dog for the blind or deaf
- halfway house – the cost of keeping a person who is intellectually and developmentally disabled in a special home, not the home of a relative, on the recommendation of a psychiatrist, to help the person adjust from life in a mental hospital to community living
- health screenings
- hearing aids
- hospitalization
- injections, vaccinations and immunizations
- laboratory fees
- learning disabilities – tutoring by a licensed school or therapist for a child with severe learning disabilities
- lifetime care – advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient
- maternity (e.g., ovulation kits, home pregnancy test, childbirth prep classes, midwife fees)
- medical alert bracelet
- medical information plan – fees paid to a plan maintaining an individual's medical information by computer
- medical supplies used to aid a person who is injured or ill (e.g., bandages, thermometers, braces or supports, wheelchairs, etc.)
- nursing home confinement for treatment of illness or injury
- nursing services for medical care
- oxygen
- physical therapy
- prosthesis
- psychologist — services within scope of license
- schools – special schooling to relieve handicap

- sterilization
- surgery – including an experimental procedure, as long as it is a legal operation and is not an excluded cosmetic procedure
- telephone – special equipment for the deaf
- television – audio display equipment for the hearing impaired
- therapy – physical or occupational therapy by a licensed therapist for medical treatment
- transplants
- weight loss program fees to treat a medical condition diagnosed by a healthcare provider (e.g., obesity, diabetes, high blood pressure)
- wheelchairs
- X-ray fees.

IRS Publication 502, which contains a complete list of health care expenses eligible for reimbursement, is available at www.irs.gov or by calling 800-TAX-FORM (800-829-3676). You can also access an Eligible Expense Guide on the WageWorks® website at http://www.wageworks.com. You may want to check with your tax advisor for further information.

NOTE: Certain over-the-counter medications are eligible for reimbursement when prescribed by your physician under state law to alleviate or treat a specific medical condition. Your request for reimbursement must be accompanied by (1) either a receipt with the Rx Number identified or a receipt indicating a description of what was purchased and (2) a prescription from a provider on an Rx pad dated on or before the purchase.

IRS Publication 502 and the WageWorks® Eligible Expense Guide do not apply fully to the Limited-Use Health Care FSA.

Health Care Expenses *Not* Eligible

Expenses not eligible for reimbursement under either a regular Health Care account or a Limited-Use Health Care account include:

- expenses incurred before your participation for a specific calendar year
- cosmetic dental treatment (e.g., teeth whitening or bleaching)
- non-prescription sunglasses
- dietary supplements or vitamins
- circumcision performed by a non-healthcare provider (e.g., a rabbi or mohel)
- cosmetics or toiletries
- cosmetic surgery and procedures – face lifts, electrolysis, etc.
- cost of sending a problem child to a special school – for benefits the child may receive from the course of study and disciplinary methods
- custodial care in an institution
- funeral and burial expenses
- health or fitness club dues
- household and domestic help – even if recommended by a physician because of an inability to perform household work
- insurance premiums for hospitalization or medical care
- marriage or family counseling

- maternity clothing or diaper service
- salary expenses for a nurse incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother during childbirth)
- social activities – even if recommended by a physician for general health improvement
- transportation expenses to and from work even if a physical condition requires special means of transportation
- vacation or travel – even when taken for general health purposes.
- weight loss programs to improve your general health and appearance

Eligible Dependent Care Expenses

Eligible dependent care expenses are those necessary for you to work. (If you are married, your spouse must also work outside the home or be a full-time student.) You can be reimbursed for care provided for a qualified dependent — i.e., anyone you claim as a dependent on your tax return, including children under age 13, a disabled older child, your disabled spouse and/or parents and grandparents who spend at least eight hours each day in your home.

Generally, eligible dependent care expenses include those that could be taken as a tax credit on your income tax return. However, you may not receive a tax credit and be reimbursed from your account for the same expenses.

Eligible expenses include:

- dependent care services provided in your home
- dependent care services provided through an outside source, such as an individual, summer day camp, day care or elder care center. (If the center provides day care services for more than seven persons, it must comply with all state and local laws.)

The care provider must have a Social Security Number, Employer Identification Number (EIN), Individual Taxpayer Identification Number (ITIN) or a Taxpayer Identification Number (TIN).

Dependent Care Expenses *Not* Eligible

Dependent day care expenses not eligible for reimbursement include:

- expenses incurred in a specific calendar year before your participation began
- activity fees from a care provider (e.g., field trips, dancing or swimming lessons, art supplies)
- weekend or “evening out” babysitting
- overnight summer camp
- institutional care, such as nursing home services for an elderly parent or grandparent
- care provided by someone you claim as a dependent on your income tax return
- tuition fees for kindergarten or a higher grade

In addition, dependent day care expenses you prepay in one calendar year for services rendered in the next calendar year are not eligible for reimbursement through the Dependent Care Account. This is true even if the expense would have been eligible had it been provided and paid for in the same calendar year.

IRS Publication 503, which contains a detailed explanation of eligible and ineligible dependent care expenses, is available at www.irs.gov or by calling 800-TAX-FORM (829-3676). You can also access an Eligible Expense Guide on the WageWorks® website at http://www.wageworks.com.

Claiming Benefits

As you incur eligible expenses throughout the year, you use your WageWorks® Visa spending account card to pay for eligible medical expenses and/or submit claims to your account for eligible health care or dependent day care expenses and are reimbursed in **tax-free** dollars. You do not pay taxes on your flexible spending account contributions as they are deducted from your paychecks. You do not pay taxes on the money you receive as reimbursement from your accounts, either.

IMPORTANT!

***You* have 2-1/2 months beyond the end of the calendar year – until March 15 – to incur eligible health care and dependent day care expenses and until the end of May to submit claims to the Health Care, Limited-Use Health Care and Dependent Day Care accounts.** For plan year 2018, for example, expenses incurred through March 15, 2019, will be eligible for reimbursement, and you have until May 31, 2019, to file claims.

If you are enrolling in the Health Savings Medical Plan option for the first time in 2019 and you participated in a regular Health Care FSA during 2018, you will need to submit paper or online claims for reimbursement from your 2018 Health Care FSA of any eligible ***medical, dental or vision care*** expenses that were incurred but not reimbursed on or before December 31, 2018. (You will not be able to use your WageWorks® Visa spending account card after December 31, 2018, to pay for or gain reimbursement from your 2018 HCFSA.) You may submit paper or online claims for reimbursement from your 2018 HCFSA for eligible ***dental or vision care*** claims incurred January 1, 2019, through March 15, 2019. Any claims for ***medical*** expenses incurred on or after January 1, 2019, can be reimbursed only from your HSA.

Health Care Expenses Spending Account Card

If you elect to contribute to a Health Care FSA or Limited-Use Health Care FSA, you will receive a spending account card that is generally valid for two plan years (provided you elect to contribute during the second plan year). You can use your WageWorks® spending account card to pay for eligible healthcare purchases and the funds are automatically deducted from your FSA account, just like a debit card. This eliminates the need to pay first and then file a claim for reimbursement. Even though this card makes it easier to use your FSA, there are some things you need to keep in mind:

1. You can only use the spending account card for eligible health care expenses incurred during the current plan year. For instance, on or after January 1, 2019, you cannot use your spending card to pay any expense incurred in 2018 ─ even if you contributed to a Health Care FSA during 2018 and still have funds remaining in your 2018 account. If you have eligible expenses incurred during 2018 that have not been posted to your spending account card or otherwise reimbursed before January 1, 2019, you will need to submit claims by mail or on-line.
2. You **cannot** use your spending account card for reimbursement from a Dependent Care FSA.
3. You **must** save all of the receipts for expenses that you pay for with your card. The IRS requires full proof of the eligibility of an expense. To ensure compliance, some of your transactions may need to be substantiated, in which case WageWorks® will request your receipts to check the validity of your card transactions. You will be required to supply receipts to substantiate the expense. If you do not have a receipt that matches the expense, you may reimburse your account or substitute a receipt for another eligible expense that may have been incurred at a later date. Failure to submit requested receipts within 90 days of the request will result in suspension of your card.

4. You should not use your card to pay for non-eligible health care expenses. This is prohibited and subject to claim audit. If you do happen to use your card to pay for non-eligible expenses, you **must** reimburse your account.
5. You may order additional cards for your family at no additional cost by calling the toll-free number on the back of your card.
6. The spending account card has an expiration date. If you contribute to the Health Care FSA or Limited-Use Health Care FSA in subsequent years, you will use the same card until it expires.
7. The spending account card is reloaded with your new contribution amount at the beginning of the Plan year, on January 1. For plan year 2019, the total amount available for payment of eligible health care expenses using the card is the amount you elect to contribute for the plan year. Any funds that may be remaining in your 2018 account balance can be used to reimburse eligible expenses incurred through March 15, 2019, but you will need to submit a paper claim by mail or on-line.

Using Your WageWorks® Health Care Card

When you enroll in a Health Care FSA or Limited-Use Health Care FSA, WageWorks® will automatically send you a WageWorks® debit card. You may also request additional cards for your family at no additional cost. As a reminder, the IRS requires WageWorks® to verify that all purchases made using your Health Care or Limited-Use Health Care FSA are considered eligible expenses. So be sure to keep all receipts throughout the year.

If your expense requires verification, you will see a notification on your WageWorks® account page at www.wageworks.com. Simply log on and check the right side of the page under "Manage My Account." If you see an orange box called "Submit Receipts for Health Care Card Use," you are required to verify your expense. To do so, simply click the orange button and select the link to verify your transaction(s). Once there, you'll have the option to:

- **Submit your receipts online** by clicking the "Select Upload Receipts Now" button and following the instructions. Details can be found at www.wageworks.com/techtips.
- **Use the traditional Card Use Verification (CUV) Form process** by completing the form and mailing it, along with required documentation, to the address provided. Details can be found at www.wageworks.com/webcuv.

You need to verify all expenses within 90 days or your card will be suspended. If your card becomes suspended, you may reinstate your card when you submit the appropriate documentation or pay back the expense if you inadvertently used your card to pay an ineligible expense. For more information, including details on when a receipt is required, please go to www.wageworks.com/card.

Check Your Receipts Before Submitting

Your receipt must include the following criteria in order to be considered a "valid" HCFSA expense by the IRS:

- The patient's name
- The provider's name
- The date of service
- A description of the service
- The amount you were charged or your cost — your deductible, copayment or the portion not covered by your insurance (coinsurance)

If you are submitting an explanation of benefits (EOB), a statement of work or a provider invoice, it is sometimes helpful to also include a copy of the Health Care Card receipt (must include provider name), which provides the exact amount paid.

Dependent Care Expenses

For eligible Dependent Care expenses, reimbursement forms must be accompanied with proof of your expense. You must include your day care provider's name, address, Social Security number (or taxpayer ID number) and the dates care was provided. Canceled checks and other non-itemized receipts will not be accepted.

You may be reimbursed only up to the amount deposited in your account when you submit your claim. If your claim is larger than your account balance, you will be reimbursed as you make more deposits during the year.

Dependent Care Reporting Requirements

To use the Plan's Dependent Care Account, you must report the name, address and taxpayer identification number of your dependent day care provider on your individual tax return. If the organization providing the care is exempt from paying federal taxes, you are still required to report their name and address.

Claim Forms for Reimbursement

There are separate claim forms for health care and dependent care expenses. For instant access to your account and fast reimbursement, you can submit a claim and upload and attach documentation from the WageWorks® website at www.wageworks.com or by using the **EZ Receipts^{tm} WageWorks Mobile Application**. (To learn more, go to www.wageworks.com/aboutmobile.) If this is not convenient, you can download and print a claim form from the WageWorks® website or you can call **877-924-3967 (877-WageWorks)** to request a form. You can also access the WageWorks® website through the YBR website by selecting *Other Sites* from the *Health Insurance* page. When you fax your claims, along with documentation of your expenses, WageWorks® will confirm receipt by sending you an e-mail confirmation provided that your e-mail address is on file or was provided on the reimbursement request form. You can also mail the form and documentation to the address listed on the form. We recommend that you keep a copy of all claim forms you submit for reimbursement. You can view your faxed and mailed documents from your online account.

If you are not sure if a particular health care or dependent day care service will be reimbursed through your account, contact WageWorks® at **877-924-3967 (877-WageWorks)** or visit their website at www.wageworks.com.

If you or your dependents are covered by one or more medical plans, you should submit claims for reimbursement to those plans first. Then attach a copy of each Plan's explanation of benefits (EOB) to your flexible spending account reimbursement form. The EOB must indicate the type of expense and what you paid toward it. The unpaid amount may be reimbursed through your Health Care FSA.

You must attach itemized bills for those eligible medical or dental expenses that:

- are not covered by a medical or dental plan, **and**
- you incur for any person you claim as a dependent on your federal tax return.

Canceled checks and other non-itemized receipts will not be accepted. If you request reimbursement of an amount greater than your Health Care FSA or Limited-Use Health Care FSA account balance

and your claim is accepted, it will be paid up to the amount you have agreed to contribute for the year, less amounts already paid to you.

How to Take Advantage of the FSA Extended Grace Period

The FSA extended grace period allows you more time to use any remaining funds in your Health Care, Limited-Use Health Care and/or Dependent Day Care FSA.

What is the extended grace period? A period under IRS rules in which you have an additional 2-½ months — until March 15 of the following plan year — to use your Health Care, Limited-Use Health Care and/or Dependent Care FSA. For example, the deadline for incurring expenses for the 2018 plan year is March 15, 2019.

If you incur eligible expenses during the grace period — January 1 through March 15 — from which account will your funds be reimbursed if you contribute to an FSA two years in a row? It depends on when you incur your expenses. For example, suppose you contribute in 2018 and again contribute in 2019, if you incur expenses …

- In 2018 — You will be reimbursed from your 2018 FSA provided there is a balance in your account.
- In 2019, by March 15, 2019 — Your claim will be reimbursed from your 2018 FSA if you have a remaining balance. Once the 2018 account is exhausted, you will be reimbursed from your 2019 account.

What is the deadline for submitting claims? The deadline for submitting claims is May 31 of the following plan year. For instance, you must submit claims for 2018 funds by May 31, 2019.

- **What happens after May 31, 2019?** After May 31, 2019, you will no longer be able to use any remaining 2018 funds. If you have a remaining 2018 balance, you will forfeit this money.

Where can you get a claim form? You can submit a claim and attach documentation or download a claim form at www.wageworks.com/ or request a form by calling WageWorks® at **877-924-3967 (877-WageWorks)**.

Termination of Employment

If your employment terminates or if you retire, you may continue to submit claims for expenses incurred prior to the date you terminate or retire (up to the balance remaining in your Health Care FSA). You can also elect to continue coverage of your Health Care FSA through COBRA by making after-tax contributions on a month-to-month basis through the balance of the calendar year in which your employment terminates. If you do, you can continue to submit claims to WageWorks® for eligible expenses incurred through the date you cease contributing to the COBRA Health Care account.

Eligible expenses incurred through the date you cease contributing to the Health Care FSA, either as an active employee or as a COBRA participant, will be reimbursed up to the full amount of your contribution election for the plan year, even if the total amount of your contributions is less, provided your claims are timely filed. On the other hand, any unused balance in your account will be forfeited.

IMPORTANT!

Expenses you incur after termination of employment or retirement cannot be submitted for reimbursement from your Health Care FSA unless you elect COBRA. When you terminate employment or retire, if you have a balance remaining in your Health Care FSA, it can be used as reimbursement for expenses incurred after your termination or retirement only if you elect COBRA and make after-tax contributions. Contact the SBSC at **800-392-7495** for information on how to elect COBRA.

Upon termination of employment or retirement, all contributions to your Dependent Care Account stop. However, you can continue to submit claims for eligible expenses incurred after your termination or retirement, up to the balance remaining in your account, through the last day of the Plan year.

In Case of Your Death

If you die with a Health Care and/or Dependent Care FSA balance, your surviving spouse — or the administrator of your estate — may continue to submit claims for expenses incurred prior to the date of your death, up to the balance remaining in your Health Care and/or Dependent Care FSA. However, the claims must be submitted by May 31 of the following year.

OVERVIEW OF YOUR EMPLOYEE LIFE INSURANCE OPTIONS

There are two categories of employee life insurance:

- Employee Basic Life Insurance (employer-paid)

and

- Employee Supplemental Life Insurance (employee-paid)

Healthineers provides Employee Basic Life Insurance coverage for most employees at one times pay (1 X Pay) to a maximum of $300,000. Certain groups of employees who are represented by collective bargaining units have different coverage amounts or no coverage in accordance with the terms of their collective bargaining agreements.

Eligible Employees can also elect Employee Supplemental Life Insurance and Personal Accident Insurance (PAI) coverage, in some cases subject to the Evidence of Insurability rules described below.

Employee Basic Life, Employee Supplemental Life and Personal Accident Insurance are provided under group term life contracts and have no individual cash surrender value.

The Employee Basic and Supplemental Life Insurance options are administered and insured by The Hartford Life and Accident Insurance Company (The Hartford) under Certificate No. GL-681347, and the Personal Accident Insurance options are administered and insured by The Hartford under Certificate No. ADD-S08909.

Pay and Frozen Pay

For the purposes of Employee Basic Life, Employee Supplemental Life Insurance and Personal Accident Insurance coverages, benefits are calculated using **Pay** — rounded up to the nearest $1,000 — defined as follows:

- **Salaried and Hourly Employees**– the greater of Frozen Pay (defined below) **or** base salary in effect as of the date of your death plus your actual short-term annual bonus paid within the last 12 months preceding your date of death. It does not include any overtime, long-term incentive bonuses, retention bonuses, or special bonuses. *This definition of pay also applies to sales employees who are not paid commissions based on products sold.*
- **Sales and Commission Employees** – the greater of Frozen Pay (defined below) **or** your base salary in effect as of your date of death plus the average of your actual sales commissions for the last three calendar years. It does not include bonuses, overtime pay, or extra compensation.
    - If you have between two and three years of service, pay is your base salary plus the average of your last two calendar years of paid commissions.
    - If you have less than two years of service, pay is your base salary plus all commissions paid since your hire date, divided by the number of your full months of service, multiplied by 12.

Premiums for your Employee Basic Life, Employee Supplemental Life Insurance and Personal Accident Insurance coverage — and the estimated amount of your coverage under each plan option — are based on **Frozen Pay**. For the purpose of determining the amount of your life insurance premiums and estimating the amount of your life insurance coverage, **Frozen Pay** is defined as your base salary on June 30 of the prior year plus your last 12 months of short-term bonuses paid (if applicable) or the last 12 months of commissions paid (if applicable). If your Pay increases or decreases during the year, your premium contributions will not change until January 1 of the following year.

If Your Pay Changes

If your Pay increases during the year, your employee life insurance coverage will automatically increase (subject to the maximum) as of the first day you are actively at work on or after the effective date of the increase. If your Pay decreases, your employee life insurance coverage and premium contributions will not change until January 1 of the following year.

Employee Basic Life Insurance

Here is a summary of your Employee Basic Life insurance (see the Supplemental Life Insurance section below for details on the Employee Supplemental Life Insurance plan).

Employee Basic Life Insurance	
Coverage Amount	**Maximum Coverage**
1 times pay [1]	$300,000
[1] Pay is rounded to the next highest $1,000, unless it is already a multiple of $1,000.	

Table 36 – Employee Basic Life Insurance Options

Imputed Income

The federal government assigns a value to all employer-provided group term life insurance over $50,000 and taxes this amount as imputed income. Information on how this value is calculated is contained in **IRS Publication 15-B**, available at www.irs.gov, under the heading "Group Term Life Insurance Coverage."

If You Continue Working or Receive Benefits on an Approved STD or LTD Claim After Age 65

If you continue working for the Company or are receiving benefits on an approved STD or LTD claim after reaching age 65, your Employee Basic Life Insurance benefit will be reduced as follows based on the amount of coverage in force immediately preceding the first reduction:

- 65% of your full coverage amount on the January 1st following the date you reach age 65
- 50% of your full coverage amount on the January 1st following the date you reach age 70

The reduced amount of coverage will be rounded up to the next higher multiple of $500, if not already a multiple of $500. Reductions will also apply if you become eligible for Employee Basic Life Insurance or your coverage increases on or after the date you reach age 65.

Accelerated Benefit

A special provision of the Employee Life Insurance program is the Accelerated Benefit feature, which may pay benefits after The Hartford receives acceptable medical documentation that you have been diagnosed with a terminal illness and that your life expectancy is 24 months or less. For details on the Accelerated Benefit feature, which is also available to your covered spouse or domestic partner, see the Supplemental Life Insurance section below.

If You Become Disabled

If you become "Disabled" within the meaning of the Healthineers Short Term Disability ("STD") Plan or as defined in the Long-Term Disability ("LTD") section of this SPD, as applicable, and as determined

by the Claims Administrator for those coverages, the Employee Basic Life Insurance coverage (less any Accelerated Benefit that is paid) in effect as of your last day worked will continue in effect for as long as you continue to receive benefits on an approved STD or LTD claim. Employee Basic Life coverage will terminate on the date that STD and LTD coverage ceases (i.e., when you no longer receive STD or LTD benefits, as applicable) and you are no longer a Healthineers employee on that date. There is no cost to you for this coverage. However, if you elected "No Coverage" under the Employee Basic Life Insurance plan in effect before January 1, 2012, and your disability commenced before January 1, 2012, then no Employee Basic Life Insurance is available if you become Disabled.

Your Beneficiary and Claiming Benefits

For information on designating your beneficiary and payment of benefits, see the Supplemental Life Insurance section below. In case of your death, your beneficiary should immediately call the SBSC at **800-392-7495**. The Hartford will send your beneficiary claim forms, and other assistance will be provided. No benefits may be paid until the forms and necessary proof of loss have been submitted to The Hartford.

When Coverage Ends

Your Employee Basic Life insurance coverage ends when:

- you are no longer eligible for the Plan
- the policy is canceled; or
- your active service ends (some coverage may continue while disabled).

Portability and Conversion Privilege

If you leave the company or otherwise become ineligible for coverage under the Healthineers Employee Basic Life Insurance program, you may continue your coverage or a portion of your coverage, without providing Evidence of Insurability, by exercising your right to portability and/or conversion and then paying premiums directly to The Hartford. For details on portability and conversion, which is also available for your covered spouse or domestic partner or covered child(ren), see the Supplemental Life Insurance section below.

OVERVIEW OF YOUR SUPPLEMENTAL LIFE INSURANCE OPTIONS

The Supplemental Life Insurance Options allow you to:

- provide portable term life insurance protection at affordable group rates, which is in addition to your Employee Basic Life Insurance coverage
- provide portable term life insurance coverage for your spouse or domestic partner
- provide portable term life insurance coverage for your children.

Supplemental Life Insurance options are generally available to you and eligible members of your family.

The following information provides an overview of the Supplemental Life Insurance options. The Company has arranged to offer this coverage through the convenience of payroll deductions. The Supplemental Life Insurance options are administered and insured by The Hartford Life and Accident Insurance Company under Policy No. GL-681347.

To enroll, inquire about coverage information, make an assignment, or change your beneficiary, contact the SBSC at **800-392-7495.**

While you are an employee, changes in coverage must occur during an enrollment period, although you may stop coverage at any time.

Employee Supplemental Life Coverage

You may choose Employee Supplemental Life Insurance coverage of up to ten times your **pay**, subject to the following:

- the **minimum** coverage you may elect is one times your pay
- the **maximum** coverage available is $2,500,000.

For the purposes of Employee Supplemental Life Insurance coverage, your premium contributions and estimated benefit are calculated using **Pay** as defined in the "Overview of Your Employee Life Insurance Options – Pay and Frozen Pay" section above. Your Pay is always rounded up to the next highest $1,000 to determine your coverage. For example, if your Pay is $26,300 and you elect Supplemental Life coverage of two times pay, your coverage is equal to $54,000 ($27,000 x 2).

NOTE: Your Employee Supplemental Life Insurance premium contributions and the estimated amount of your coverage are based on **Frozen Pay**. If your Pay increases during the year, your Employee Supplemental Life Insurance coverage will automatically increase (subject to the maximum) as of the first day you are actively at work after the increase. Your premium contributions will remain unchanged for the remainder of the current Plan year. If your Pay decreases, your Supplemental Life Insurance coverage and premium contributions will not change until January 1 of the following year.

IMPORTANT!

Evidence of Insurability for you will be required as follows:

- If you are a newly hired employee, Evidence of Insurability is required if you elect coverage greater than three times your Pay, or your coverage exceeds $300,000. Until you submit Evidence of Insurability to The Hartford and The Hartford approves the Evidence of Insurability, however, you will only receive the highest available coverage that does not require Evidence of Insurability. Coverage must be elected before your enrollment deadline.
- If you currently have Employee Supplemental Life Insurance and wish to increase your coverage, you will have to submit Evidence of Insurability to The Hartford and The Hartford must approve your Evidence of Insurability before the increased coverage may take effect. If coverage is approved, it is effective on the first day you are actively work after the approval (but not earlier than January 1 for changes requested during the Annual Enrollment period).
- If you waived Employee Supplemental Life Insurance and then wish to purchase this coverage at a later date, you will have to submit Evidence of Insurability to The Hartford and The Hartford must approve your Evidence of Insurability before the coverage may take effect. In this event, the coverage will take effect when The Hartford approves your Evidence of Insurability. If coverage is approved, it is effective on the first day you are actively at work after the approval (but not earlier than January 1 for changes requested during the Annual Enrollment period).

In all cases, you must be actively at work for coverage to be effective. If you need an "Evidence of Insurability" form, please call the SBSC at **800-392-7495**.

Special Limited Option to Increase Employee Supplemental Life Coverage

Employees who have previously elected Employee Supplemental Life Insurance coverage at one times pay or at two times pay are able, either during Annual Enrollment or upon the occurrence of certain Qualifying Life Events, to increase their Employee Supplemental Life coverage from one times pay to two times pay or from two times pay to three times pay (to a limit of $300,000) without providing Evidence of Insurability. Employees who were or are on a leave of absence during Annual Enrollment may elect to increase their Employee Supplemental Life coverage under this option during the 30-day period that begins on the day they actively return to work.

Dependent Coverage

If you are an employee who is actively at work during an enrollment period, you may elect coverage for eligible members of your family. You may elect coverage for eligible members of your family even if you do not elect coverage for yourself. You may elect coverage for:

- Your spouse or domestic partner, provided he or she is under age 70 at the time you elect coverage; and
- Your children who are at least 15 days old and under the age of 19 (or under the age of 25 if they are in full-time attendance at an accredited institution of learning) or are age 19 or older and are incapable of self-care and dependent on you for support because of a physical or mental handicap that began before age 19, as determined by The Hartford.

On the date the dependent coverage would take effect, the dependent must ***not*** be:

- Confined at home under a doctor's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Coverage will take effect on the date the dependent no longer meets the conditions described above.

If you and your spouse or domestic partner are both Healthineers employees, you may be covered as both an employee and as a dependent. However, children can be covered as dependents of only one parent.

Coverage for Your Spouse or Domestic Partner

You may provide coverage for your spouse or domestic partner in multiples of $10,000 — from $10,000 up to $250,000 — but not to exceed three times your Pay rounded to the next highest $10,000. In addition, this coverage cannot exceed 100% of your combined Employee Basic and Employee Supplemental Life coverage amount. If you and your spouse or domestic partner are both Healthineers employees, you may be covered as both an employee and as a dependent.

Important! Evidence of Insurability for your spouse or domestic partner will be required as follows:

If you are a newly hired employee and elect coverage before your enrollment deadline — or if you are a newly married employee and elect coverage within 30 days of your marriage or domestic partnership — Evidence of Insurability is required if you elect coverage for your spouse or domestic partner that exceeds $10,000. Until your Evidence of Insurability is submitted to and approved by The Hartford, however, your spouse or domestic partner will only receive coverage of $10,000.

If you currently have coverage for your spouse or domestic partner and wish to increase his or her coverage, you will have to provide Evidence of Insurability for your spouse or domestic partner before

the increased coverage may take effect. In this event, the increased coverage will take effect when your Evidence of Insurability is submitted to and approved by The Hartford (but not earlier than January 1 for changes requested during the Annual Enrollment period).

If you waived supplemental life insurance coverage for your spouse or domestic partner and then wish to purchase this coverage at a later date, you will have to submit Evidence of Insurability for your spouse or domestic partner to The Hartford and have it approved by The Hartford before the coverage may take effect. In this event, the coverage will take effect when your Evidence of Insurability is submitted to and approved by The Hartford (but not earlier than January 1 for changes requested during the Annual Enrollment period).

If you need an "Evidence of Insurability" form, please call the SBSC at **800-392-7495**.

Coverage for Your Children

You may purchase portable term insurance in multiples of $5,000 — from $5,000 up to $20,000 — for each eligible child. Coverage ends when a child reaches age 19; except, however, that coverage may be continued for as long as your child is a full-time student up to age 25. If you and your spouse or domestic partner are both Healthineers employees, only one of you may cover each eligible child.

Cost of Coverage

Your total monthly contribution will reflect the premium for any coverage you elect (which is based on the amount of your coverage and your age) and the premium for any family coverage you elect. Coverage for your spouse or domestic partner will reflect his or her age and the amount of coverage in effect. Coverage for your children is a flat rate based on the amount of coverage you elect. Contact the SBSC at **800-392-7495** for details on the current rates for coverage. These rates are also available on the YBR website during the Annual Enrollment period.

Choosing Coverage in the Future

You may change the amount of your coverage during any Annual Enrollment period or during the 30-day period that begins with the occurrence of certain Qualifying Life Events. You may increase coverage only if you are actively at work. If you were on a leave of absence during Annual Enrollment, you have 30 days from the date you return to work to increase your coverage. If you choose to increase coverage, you must submit Evidence of Insurability to The Hartford and it must be approved by The Hartford before this increase in coverage will become effective. If you choose to decrease coverage, Evidence of Insurability is not required. If you are not actively at work when your increase in coverage is scheduled to take effect, you will not be eligible for the increase until you return to work.

In addition, if a dependent is confined at home under a doctor's care, receiving or applying to receive disability benefits from any source, or hospitalized, the increased coverage will not be effective until the conditions described above have ended.

During the Annual Enrollment period, Evidence of Insurability is required if you are not currently enrolled and elect Employee Supplemental Life coverage in any amount. However, if you are already enrolled, you are allowed to increase your coverage by one level (i.e., from one to two times, or from two to three times your Pay) up to three times your pay or $300,000 (whichever is less). Any election in excess of this amount will require submission of Evidence of Insurability to The Hartford and approval by The Hartford before this increase in coverage becomes effective. Adding or increasing coverage for your spouse or domestic partner also requires submission of Evidence of Insurability to The Hartford and approval of the Evidence of Insurability by The Hartford.

Accelerated Benefit

A special provision of the Healthineers Basic Life and Supplemental Insurance coverages is the Accelerated Benefit feature which applies to coverage in effect for you and your spouse or domestic partner. The Accelerated Benefit feature does not apply to coverage in effect for your children.

Under this feature, benefits may be paid after The Hartford receives acceptable medical certification that you or your covered spouse or domestic partner has been diagnosed with a terminal illness and that the life expectancy is 24 months or less.

The Accelerated Benefit would equal up to 80% (with a minimum of $3,000 and maximum of $500,000) of the coverage in effect for you or your spouse or domestic partner. This benefit is paid in a lump sum. The remaining 20% of the benefit will be paid to the beneficiary after death.

The option to request an Accelerated Benefit may be exercised only one time. As an employee, your option to request an accelerated payout of Employee Basic Life is combined with your option to request an accelerated payout of Employee Supplemental Life coverage and the $500,000 maximum Accelerated Benefit applies to the total paid out from either or both plans. At the time of making an application for an accelerated death benefit, you or your spouse or domestic partner must have life coverage of at least $10,000 and must be under the Social Security Normal Retirement Age.

Social Security Normal Retirement Age	
Year of Birth	**Age**
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943–1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67
NOTE: Persons born on January 1 of any year should refer to the normal retirement age for the previous year	

Table 37 – Social Security Normal Retirement Age

If You Become Disabled

If you are absent from work due to a Disability as defined under the Short Term Disability Plan or under the Long Term Disability Plan that began or begins after January 1, 2012, and you continue to pay the required premium, your Employee Supplemental Life Insurance coverage in effect as of the last day that you were actively at work (less any Accelerated Benefit that is paid) can be continued during the first twelve months that you are absent from work due to your Disability.

After you have been absent from work for a combined 12-month period due to a Disability and if you were under 65 years of age at the commencement of your Disability, your Employee Supplemental Life Insurance coverage can be continued at no cost to you if you apply and are approved for a ***waiver of premium*** or premium waiver by The Hartford, provided you are Disabled as defined in the Long-Term Disability Plan. If you are Disabled as defined in the Long-Term Disability Plan, you will need to apply for a premium waiver once you have been absent from work due to Disability for a combined period of at least nine months (the waiting period) but less than 12 months. If you return to work for five or fewer days during the first nine months of your Disability, your waiting period will not be interrupted. If you return to work for more than five days, you must satisfy a new waiting period. If you are approved by The Hartford for a waiver of premium, your Employee Supplemental Life Insurance coverage (less any Accelerated Benefit that is paid) will continue for as long as you continue to receive benefits on an approved LTD claim — up to age 65 if you become Disabled before age 60, or up to the maximum duration of your Long-Term Disability (LTD) benefits if you become Disabled at age 60 or older (see section labeled "*How Long LTD Benefits Continue*" in the LTD section of this Summary Plan Description).

To inquire about proof of Disability that is required to apply for a premium waiver, call **The Hartford** at **888-563-1124**. If you do not apply for a premium waiver before the end of your 12-month Disability period or your application for a premium waiver is denied, your Employee Supplemental Life Insurance coverage will be terminated as the date you have been absent from work for a combined 12-month period due to a Disability. You will need to contact The Hartford to ask about any further right to convert or port your Employee Supplemental Life Insurance coverage.

If you were approved by MetLife before January 1, 2012, for a premium waiver, then MetLife will continue to be the insurer of your Employee Supplemental Life Insurance coverage and your coverage (less any Accelerated Benefit that is paid) will continue for as long as you are Disabled, up to age 65 or until you have reached the maximum duration of your MetLife LTD benefits (if later). If you had already been absent from work due to Disability for a combined 12-month period before January 1, 2012, and you continued your supplemental life insurance coverage by making payments to the SBSC, your supplemental life insurance coverage (less any Accelerated Benefit that is paid) will be provided by The Hartford up to the maximum duration of your LTD benefits as long as you continue to pay the required premium to the SBSC.

If you have supplemental life insurance for your spouse or domestic partner and/or your dependent children, you must pay the required premium to continue their coverage.

Payment of Benefits and Your Beneficiary

The full amount of your Employee Basic Life and Supplemental Life Insurance (less any Accelerated Benefit) is paid to your named beneficiary if you die from any cause. The benefit payment will be placed into an account from which your beneficiary will be able to take partial distributions or full distribution at his or her discretion. Your beneficiary will be provided a checkbook for this purpose. Benefits are generally paid in a single, lump-sum cash payment. However, you or your beneficiary may elect any payment option offered by The Hartford (or MetLife, if your life insurance was continued

by MetLife). For details on the payment methods that are available and the procedure for claiming benefits, call The Hartford at **888-563-1124** (or MetLife at **877-275-6387**).

Subject to certain state legal requirements, you may name anyone as your beneficiary for your coverage, and you may change your beneficiary at any time. For details, visit the YBR website at http://resources.hewitt.com/siemens or call the SBSC at **800-392-7495**.

You are automatically the beneficiary under your spouse's or domestic partner's or dependent children's coverage.

If you have not designated a beneficiary at the time of your death or if your beneficiary dies before you, your insurance will be paid in the following order of priority:

- your spouse or domestic partner
- your child(ren)
- your parent(s)
- your sibling(s); or
- your estate.

To change your beneficiary, you can visit the YBR website at http://resources.hewitt.com/siemens or call the SBSC at **800-392-7495**. The change will be effective as of the processing date. The Hartford (or MetLife) is not liable for any additional payments, if a payment has been made before the beneficiary change has been processed.

When Benefits Are Not Paid

Benefits are not paid in the event of suicide within two years after the effective date of the person's coverage. In this event, the benefit will be limited to a refund of premium contributions. Further, if a covered person commits suicide within two years after the effective date of an increase to that person's coverage, the additional life insurance benefit will not be paid, and only the additional premium contribution will be refunded.

Claiming Benefits

Immediately after a death occurs, you, your beneficiary or a family member should **call the SBSC** at **800-392-7495**. Claim forms and other assistance will be provided. No benefits may be paid until the forms and necessary proof of loss have been submitted to the insurance company.

When Coverage Ends

Supplemental life insurance for you or your spouse or domestic partner ends on the earliest of:

- when you do not make required payments
- when you retire
- when you cancel the coverage; or
- when the covered individual dies.

Portable term insurance for dependent children ends on the earliest of:

- the date of termination of coverage for the employee
- the first of the month after the child no longer qualifies as an eligible dependent
- the date the employee cancels coverage for dependent children; or
- when a covered child dies.

Portability and Conversion Privilege

If you leave the Company or you otherwise become ineligible for coverage under the Employee Basic Life Insurance program, or if you, your spouse or domestic partner, or your dependent child(ren) become ineligible for coverage under the Healthineers Employee Supplemental Life Insurance program, you may continue coverage or a portion of coverage, without providing Evidence of Insurability, by exercising your right to portability and/or conversion and then paying premiums directly to The Hartford. Continuation coverage will begin as of the 32nd day following the individual's loss of eligibility under the Healthineers Employee Basic Life and/or Supplemental Life program (the "group coverage termination date").

Portability allows you, your spouse or domestic partner, and/or your dependent child(ren) a one-time opportunity to buy ***term life*** insurance coverage without providing Evidence of Insurability. Portability options are available for covered individuals who are under the Social Security Normal Retirement Age that corresponds to their year of birth. Portable coverage is available on an individual basis to you or your spouse or domestic partner in an amount that corresponds to 50%, 75% or 100% of the amount of coverage in effect as of the group coverage termination date.

- The minimum amount of portable coverage available to you as an employee is 50% of the amount of your Employee Basic Life coverage. The maximum amount of portable coverage available to you as an employee is either the combined amount of your Employee Basic and Supplemental Life coverage in effect as of your group coverage termination date or $1,000,000 (whichever is less) and must be elected at the same time as and includes any amount of Employee Basic Life coverage that you elect to port. Portable coverage will be reduced by 75% when you reach age 65, and coverage terminates at age 75.
- The minimum amount of portable coverage available for your spouse or domestic partner is $5,000; the maximum is $250,000. Portable coverage will be reduced by 75% when your spouse or domestic partner reaches age 65, and coverage terminates at age 70.
- Portable term life coverage is available in the multiples of $5,000 up to $20,000 for each dependent child.

Premiums for a portable term life policy are generally higher than the Healthineers group plan rates, and rates increase beginning with the year in which the age on the covered individual's birthday ends in 5 or 0 and thereafter every five years. Portability is not available if Healthineers terminates the group plan.

NOTE: If you are eligible and choose to elect the ***Waiver of Premium*** provision as outlined above and in your contract, you are not eligible for Portability. If you choose to elect Portability, a waiver of premium will not be available.

Conversion allows you to buy an individual ***whole life*** policy, in an amount that may range from a minimum of $5,000 to a maximum of 100% of the individual's coverage under the Healthineers Employee Basic Life and/or Supplemental Life program, at individual insurance rates. A conversion whole life policy accumulates cash value, and there are no mandatory age reductions. Coverage can continue with premium payment until the Scheduled Maturity Date (standardly age 121), at which time the Cash Surrender Value is paid out. Conversion is not available for any amount of Employee Supplemental Life coverage that has been approved for a waiver of premium. If you apply and are approved for conversion coverage and are subsequently approved for a waiver of premium for the same coverage, you will receive a refund of premiums.

Except for individuals who are not eligible for portable coverage based on age, you and your spouse or domestic partner have an individual right to elect either or both portable life coverage and conversion life coverage. However, the combined amount of continuation coverage for each covered individual cannot exceed the amount of coverage in effect on your group coverage termination date.

Your continuation coverage cannot exceed the combined amount of your Employee Basic and Supplemental Life coverage on your group coverage termination date.

- For instance, if the combined amount of your employee life coverage on your group coverage termination date is $1,500,000 ($300,000 Basic plus $1,200,000 Supplemental):
  - If you elect to **port** $150,000 (the minimum amount — i.e., 50% of $300,000 Basic), the maximum amount available to **convert** is $1,350,000
  - If you elect to **port** $1,000,000 (the maximum amount), then the maximum amount available to **conver**t is $500,000.
- Similarly, if coverage for your spouse or domestic partner is $250,000 on your group coverage termination date and you elect to port $125,000, you may convert up to $125,000.

Other restrictions may also apply.

The Hartford will send you a Notice of Continuation of Coverage as soon as possible following the termination of your employment or other loss of eligibility under the Healthineers Employee Basic or Supplemental Life program. (If you do not receive the Notice within three weeks of your group coverage termination date, please call the SBSC at **800-392-7495** to verify that your record shows that you are terminated or the family member is no longer eligible for coverage as your dependent and that the SBSC has sent this information to The Hartford.) To exercise your right to continuation coverage, you must designate the individual(s) for whom you are seeking continuation coverage on the reply form enclosed with the Notice of Continuation of Coverage and then mail or fax the completed form back to The Hartford within 15 days of the date of the Notice or 31 days from the group coverage termination date, whichever is later. (Send mail to The Hartford Portability and Conversion Unit, P.O. Box 248108, Cleveland, OH 44124-8108. The fax number is **440-646-9339**.) This will initiate a request for conversion policy options and rates. If you need information or have questions about your eligibility or the status of your request, you may call a Hartford representative at **877-320-0484**. Under no circumstances will continuation coverage for you or any family member be available beyond 91 days from your Healthineers' group coverage termination date.

In the event of a death during the 31-day conversion period — whether or not the covered individual had applied to continue coverage — the designated beneficiary will receive the amount of Employee Basic Life and/or Employee or Dependent (Spouse or Domestic Partner or Child) Supplemental Life Insurance in effect for the covered individual prior to your group coverage termination date.

Overview of Your Personal Accident Insurance Options

Personal Accident Insurance (PAI) pays benefits if you or your covered spouse or domestic partner and/or child(ren) are seriously injured or die as a result of an accident. The Personal Accident Insurance Plan is administered and insured by The Hartford Life and Accident Insurance Company (The Hartford) under Policy No. ADD-S08909.

The Healthineers Benefits Program provides PAI coverage for most employees — most with a ***choice*** of company-paid coverage at two times pay for employee-only or at one times pay for employee-plus-family. Under current collective bargaining agreements, PAI coverage options and minimum and maximum coverage amounts may vary among represented employee groups. You may choose to increase coverage for yourself only or for you and your spouse or domestic partner and eligible family members. However, coverage for your spouse or domestic partner is not available once he or she reaches age 70. If your spouse or domestic partner is an employee of the Company, you may not both elect family coverage. Only one of you may elect family coverage (employee and children only), and the other may elect employee-only coverage.

Here are your Personal Accident Insurance options and the family coverage available based on the makeup of your family:

Coverage Amount [1, 2]	Family Coverage Option Amount If Your Family Consists Of . . .		
	Spouse or Domestic Partner and Children	Spouse or Domestic Partner Only	Children Only
1 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
2 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
3 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
4 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
5 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
6 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
7 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
8 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
9 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
10 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
11 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%
12 X Pay [1, 2]	50% Spouse or Domestic Partner / 10% Child	60%	15%

[1] Pay is rounded to the next highest $1,000, unless it already is a multiple of $1,000. Company-paid default coverage is Employee-Only at two times Pay.
[2] Coverage maximum (company-paid plus additional coverage you elect) is $1,000,000.

Table 38 – Personal Accident Insurance Options

For the purposes of Personal Accident Insurance coverage, benefits are calculated using **Pay** as defined in the **Overview of Your Employee Life Insurance Options** section. Your Personal Accident Insurance premium contributions and estimated coverage are also based on **Frozen Pay**, as defined above.

Choosing Coverage in the Future

During an Annual Enrollment period, you may elect coverage (if you previously waived coverage) or you may increase or decrease existing coverage without providing evidence of insurability.

Plan Benefits

Personal Accident Insurance provides 24-hour-a-day coverage, at home or while traveling, including flying as a passenger in any licensed civilian aircraft or in military transport aircraft operated by the Military Airlift Command or similar service of a foreign country. Benefits are paid if, as a result of an accident, you or a covered dependent:

- dies;
- loses limb, eyesight or speech and/or hearing;
- is paralyzed.

If you or a covered dependent sustains more than one loss in the same accident, you will receive payment for the loss that provides the larger benefit. The payment is pro-rated among the employees or their beneficiaries involved in the accident.

The amount of the benefit depends on the extent of the loss, as shown in the following table:

If Within One Year of an Accident You or a Covered Dependent Loses …	Percent of Coverage Amount Payable
Life	100%
Both hands or both feet, or sight in both eyes, or speech and hearing (both ears)	100%
Quadriplegia (total paralysis of both upper and lower limbs)	100%
One entire limb (arm or leg)	100%
One hand and one foot, or one hand or one foot and the sight in one eye	100%
Paraplegia (total paralysis of both lower limbs)	100%
Hemiplegia (total paralysis of upper and lower limbs of same side of the body)	100%
One hand, or one foot, or sight in one eye	50%
Speech or hearing (both ears)	50%
Brain damage	50%
Thumb and index finger of the same hand	25%
Coma	2% monthly beginning on the 5th day of the coma, for the duration of the coma, to a maximum of 50 months

Table 39 – Personal Accident Insurance Benefits Payable

Definitions of Covered Losses

Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech means the entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following the accidental injury.

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must be apparent within 30 days of the accidental injury, require a hospitalization of at least five days and persists for 12 consecutive months after the date of the accidental injury.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for five consecutive days.

Other Plan Benefits

In addition to the benefits described above, your Personal Accident Insurance may pay the following additional benefits:

- **Child Care Benefit**. If benefits are paid because of your accidental death and you have children under age 12 who are enrolled in a licensed day care center (or are enrolled in a licensed day care center within one year of the accident), the Plan will pay a child care center benefit. This benefit equals 5% of your coverage, up to $7,500 per year. It will be paid for up to a maximum of five consecutive years, or until the date a child reaches age 12, whichever is earlier.

  If you do not have a child who could qualify for this benefit at the time of the accident, your beneficiary will receive an additional $1,000.

- **Child Education Benefit**. If benefits are paid because of your accidental death and you have a child who was enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade (or within one year after the date of your death enrolls as a full-time student), the Plan will pay a child education benefit. This benefit equals 10% of your coverage, up to an academic year maximum of $20,000, for up to four consecutive years.

  If you do not have a child who could qualify for this benefit at the time of the accident, your beneficiary will receive an additional $1,000.

- **Spouse or Domestic Partner Education Benefit** If benefits are paid because of your accidental death and you have a spouse or domestic partner who was enrolled as a full-time student in an accredited school (or within one year after the date of your death enrolls as a full-time student), the Plan will pay a spouse or domestic partner education benefit. This benefit equals 10% of your coverage, up to an academic year maximum of $20,000, for up to four consecutive years.

  If you do not have a spouse or domestic partner who could qualify for this benefit at the time of the accident, your beneficiary will receive an additional $1,000.

- **Hospital Confinement Benefit**. If a covered individual is hospitalized as a result of an accident, that person will receive a monthly Hospital benefit. Benefits start if the covered individual continues to be hospitalized on the fifth day after the accident and will continue for as long as the individual remains hospitalized, up to a maximum of 12 months. The monthly benefit equals the

lesser of 1% of that individual's coverage or $2,500 a month (pro-rated for partial months). Benefits are payable for only one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

- **Repatriation Expense**. If a covered individual dies as a result of a covered accident outside of the territorial limits of the state or country of the deceased person's place of residence, the Plan will pay for expenses to prepare and transport the deceased's body to the city of the deceased's principal residence, up to a maximum of $5,000.
- **Seat Belt Benefit**. If a covered individual dies as a result of a covered accident while wearing a properly fastened seatbelt or properly secured child restraint (that meets the requirements of state law) in a private car, an additional benefit equal to 10% of that individual's coverage will be paid, with a minimum benefit of $1,000 up to a maximum benefit of $20,000.
- **Common Disaster Benefit**. If a covered employee and his/her covered spouse or domestic partner both die in the same accident, the benefit for the spouse or domestic partner is increased to match the employee benefit.

Exclusions

Personal Accident Insurance does **not** cover losses that are the result of:

- service in the armed forces of any country or international authority including the military reserve, except the United States National Guard
- intentionally self-inflicted injuries
- suicide or attempted suicide
- travel in experimental aircraft or device
- war, whether declared or undeclared; or act of war, insurrection, rebellion, riot or terrorist acts
- physical or mental illness, or the diagnosis or treatment for the illness
- an infection, unless it is caused by an external wound which was sustained in an accident
- operating, learning to operate or serving as a member of a crew of an aircraft, or while in any aircraft operated by or under any military authority
- while in any aircraft used or designed for use beyond the earth's atmosphere
- alcohol, voluntarily taken, in combination with any drug, medication or sedative
- voluntary use of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician or an over-the-counter drug, medication or sedative taken as directed
- committing or attempting to commit a felony or other serious crime or assault
- travel in an aircraft for the purpose of parachuting or otherwise exiting from an aircraft while it is in flight
- parachuting, except when the insured has to make a parachute jump for self-preservation
- poison, gas or fumes, voluntarily taken, administered or absorbed.

Payment of Benefits and Your Beneficiary

If you have not designated a beneficiary at the time of your death or if your beneficiary dies before you, your Personal Accident Insurance will be paid in the following order of priority:

- your spouse or domestic partner
- your child(ren)
- your parent(s)

- your sibling(s); or
- your estate.

You are automatically the beneficiary for Personal Accident Insurance for your eligible family members. To change your beneficiary, visit the YBR website at http://resources.hewitt.com/siemens or call the SBSC at **800-392-7495**. The change will be effective as of the processing date. The Hartford is not liable for any additional payments, if a payment has been made before the beneficiary change has been processed.

Claiming Benefits

Immediately after a loss, you, your beneficiary or a family member should call the SBSC at **800-392-7495**. Claim forms and other assistance will be provided. No benefits may be paid until the forms and necessary proof of loss have been submitted to the insurance company.

When Coverage Ends

Personal Accident Insurance ends when:

- you or your dependents are no longer eligible
- the policy is canceled
- you stop making the required contributions; or
- your active service ends for any reason, including retirement.

Coverage for your spouse or domestic partner ends when yours does or when he or she reaches age 70, whichever occurs first.

Right of Conversion

If you leave the company or you, your spouse or domestic partner or child(ren) otherwise become ineligible for Personal Accident Insurance coverage under the Healthineers program, you may convert coverage for yourself and your spouse or domestic partner and child(ren), without providing Evidence of Insurability, by paying the premium directly to The Hartford. Different group rates and plan provisions will apply. Conversion coverage will provide benefits for Accidental Death and Dismemberment only. The amount of your conversion coverage will be (a) the amount of your Personal Accident Insurance coverage on the date of conversion, rounded to the nearest $1,000, with a minimum of $25,000 and a maximum of $250,000 if you are under age 70, or (b) $25,000 if you are age 70 or older but under age 75, or (c) $12,500 if you are age 75 or older. The amount of coverage that will be offered to your spouse or domestic partner or to each child will be depend on the amounts being offered by The Hartford in your state of residence as of the date that coverage under the Healthineers program is terminating. You must apply for conversion coverage and the required premium payment must be made within 31 days from the date you receive notice from The Hartford. Portable coverage is not available for Personal Accident Insurance.

The process and timelines for converting Personal Accident Insurance is the same as the process for converting supplemental life insurance (see Supplemental Life Portability and Conversion Privilege above).

YOUR BENEFITS WHILE YOU ARE DISABLED

Except where specifically noted, this document describes provisions relating to eligibility and Long-Term Disability (LTD) income options and LTD health and welfare coverages for employees who become eligible for LTD benefits under a disability that began or begins on or after May 1, 2018.

Disability Income Benefits. As a participant in the Healthineers Benefits Program, you are eligible to receive monthly Long-Term Disability ***income*** benefits ("LTD benefits") if you continue to be Disabled or Partially Disabled due to an Injury or Sickness after 180 days or, if later, after your Short-Term Disability benefits have ended. If you are receiving Workers' Compensation or benefits from a state disability plan, you may also be eligible to receive LTD benefits after satisfying the LTD Elimination Period. If you are under 60 years of age when your Disability begins and depending on the nature and duration of your Disability, as detailed below, your LTD benefits may continue to age 65. If you are age 60 or older when your Disability begins, then your eligibility to receive LTD benefits may continue past age 65.

Other Benefits While You Are Disabled. During the first 12 months that you are Disabled or Partially Disabled, which generally includes the first six months that you receive LTD benefits, you and your family members enrolled in ***health and welfare*** benefits on the day that you were last Actively at Work before your Disability began are eligible to continue to receive the same coverages that were available while you were an "active" employee. These "active" health and welfare benefits include medical (including prescription drug), vision, and dental coverage; employee life insurance; employee and dependent supplemental life insurance; personal and family accident insurance coverage; and services provided through the employee assistance program. During the first 12 months that you are Disabled or Partially Disabled, the Program offers some flexibility to change your benefit elections as your need for coverage changes, but your ability to make changes during a Plan year may be limited. Once you have been absent from work due to Disability or Partial Disability for 12 months, your eligibility for most "active" health and welfare benefits will terminate and you will be eligible for medical coverage and employee life insurance for an additional period of up to 17 months, as described in more detail below.

If you became disabled prior to May 1, 2018, please refer to the applicable Siemens Corporation Group Insurance and Flexible Benefits Program Summary Plan Description in effect at that time.

YOUR LONG-TERM DISABILITY INCOME BENEFITS

LTD Coverage Options

The Long-Term Disability Income coverage options are insured and administered by Liberty Life Assurance Company of Boston ("Liberty"). Except for employees covered under certain collective bargaining agreements, participants in the Healthineers Benefits Program are able to elect coverage under either of two LTD coverage options:

Long-Term Disability Income Coverage Options and Benefits		
Option	**Percentage of Your Monthly Pay* That Continues**	**Maximum Monthly Income**
1	**Company-Paid** (Class 1) –Healthineers pays 100% of the cost of your coverage. Subject to the monthly maximum, LTD benefits in combination with other sources of disability income equal 60% of Pay. LTD benefits are subject to federal taxation. This is the default coverage if you do not make another election.	$15,000
2	**Employee-Paid** (Class 2) – You pay 100% of the cost of your coverage with after-tax dollars. Subject to the monthly maximum, LTD plan benefits in combination with other sources of disability income equal 60% of Pay. LTD benefits are exempt from federal taxation.	$15,000
* For the purpose of the LTD coverage options, ***Pay*** is defined as the greater of **Frozen Pay**, calculated on a monthly basis, or of **pre-disability Basic Monthly Earnings**.		

Table 40 – Long-Term Disability Coverage Options

As you can see, both of these options provide a benefit equal to 60% of your monthly pay, up to a limit of $15,000 (if less). The difference is who pays for the coverage (Healthineers or you) and whether your benefit is taxable when you receive it. With the Company-Paid 60% LTD option, Healthineers pays the entire premium for your LTD coverage, and the benefit is subject to federal income and employment taxes when you receive it, which will reduce your disability income. With the Employee-Paid LTD option, you pay for your coverage with after-tax contributions, and the benefit will be paid free of federal income and employment taxes. State tax rules may vary.

You will be automatically enrolled in the Company-Paid 60% LTD option until you elect to participate in the Employee-Paid 60% LTD option and your enrollment becomes effective. If you are a newly hired or newly eligible employee and you make an election to participate in the Employee-Paid 60% LTD option, your enrollment in the Employee-Paid option becomes effective as of the date of your first after-tax payroll deduction for LTD coverage, generally one or two payroll periods following the date you make your election. If you become **Disabled** or **Partially Disabled** before your enrollment in the Employee-Paid option becomes effective, any benefit will be paid according to your prior automatic enrollment in the Company-Paid option.

If you were and continue to be Disabled or Partially Disabled as the result of an Injury or Sickness that began before January 1, 2014, or you became disabled while you were the employee of a company that was subsequently acquired by Siemens Medical Solutions USA, Inc., these LTD coverage options are not available to you and your LTD benefits (if any) will be administered by MetLife or other previous LTD claims administrator.

Liberty must find that you are **Disabled** or **Partially Disabled** (as described below) as of the date you are first absent from work in order for you to qualify for LTD benefits. Except as described below, the

maximum total amount of your monthly LTD benefit plus your income from certain other benefits and earnings will be $15,000 or 60% of your pre-disability Basic Monthly Earnings, whichever is less. The minimum LTD benefit is $50 a month. The minimum monthly benefit will not apply if you are in an overpayment situation or decline to fully participate in an approved Rehabilitation Program recommended by Liberty.

Your Eligibility for Long-Term Disability Income Benefits

LTD benefits replace a portion of your pre-disability **Basic Monthly Earnings** if, as a result of an ***Injury*** or ***Sickness***, you are and continue to be **Disabled** or **Partially Disabled** after the end of the **LTD Elimination Period** and you require and are receiving **Appropriate Available Treatment** from a ***Doctor (or Physician)*** on a continuing basis.

"Basic Monthly Earnings" is the greater of (i) your gross Pay from Healthineers in effect on the day before your disability began or (ii) one-twelfth (1/12) of your Frozen Pay as of June 30th of the year preceding the year you become Disabled or Partially Disabled (see the Glossary for additional details).

LTD "Elimination Period" means a period of consecutive days of **Disability** or **Partial Disability** for which no LTD benefit is payable. The Elimination Period or ***waiting period*** for the LTD coverage options begins on the date of Disability or Partial Disability and ends on the later of 180 days or the date your Short-Term Disability benefits end. You may be eligible for LTD benefits even if you are receiving Workers' Compensation or other state disability plan benefits. For information about how a temporary return to work during the LTD Elimination Period may affect your LTD benefits, see **When LTD Benefit Payments Begin**.

"Disabled" or **"Disability"** means that, as the result of Injury or Sickness, during the LTD Elimination Period and the next 24 months of Disability, you are unable to perform the Material and Substantial Duties of your Own Occupation; and thereafter, you are unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

"Partially Disabled" or **"Partial Disability"** means that, as the result of Injury or Sickness, you are ***able*** to perform, with reasonable continuity, on a part-time or full-time basis, one, some or all of the Material and Substantial Duties of your Own Occupation or of Any Occupation and are ***able*** to earn at least 20% but not more than 80% of your pre-disability Basic Monthly Earnings (during the LTD Elimination Period and the next 12 months of Disability or Partial Disability) or at least 20% but not more than 80% of your Indexed Basic Monthly Earnings (thereafter).

"Own Occupation" means your occupation that you were performing when your Disability or Partial Disability began. For the purpose of determining Disability under the LTD policy, Liberty will consider your occupation as it is normally performed in the local economy.

"Any Occupation" means any occupation that you are or become reasonably fitted by training, education, experience, age, physical and mental capacity.

"Indexed Basic Monthly Earnings" is the amount of your pre-disability Basic Monthly Earnings increased by 7% beginning when you have received LTD benefit payments for 12 months and, on a cumulative basis, once each year thereafter. Your Indexed Basic Monthly Earnings are one measure used to assess whether you continue to be Disabled or Partially Disabled under the provisions of the LTD plan. If you are Partially Disabled and are working and receiving a Partial Disability Work Incentive Benefit, an increase in your Indexed Basic Monthly Earnings may result in an increase in your monthly LTD benefit (see Glossary for additional details).

"Appropriate Available Treatment" means care or services which are:

1. generally acknowledged by Physicians to cure, correct, limit, treat or manage the disabling condition;

2. accessible within your geographical region;
3. provided by a Physician who is licensed and qualified in a discipline suitable to treat the disabling Injury or Sickness;
4. in accordance with generally accepted medical standards of practice.

Exclusions

The LTD options and the Liberty LTD policy do not cover any disability that results directly or indirectly from:

1. war (declared or undeclared) or any act of war or service in the armed forces of any country, government body or international authority;
2. intentionally self-inflicted injuries, while sane or insane;
3. active participation in a riot;
4. the committing of or attempting to commit a felony or misdemeanor;
5. cosmetic surgery unless such surgery is in connection with an Injury or Sickness sustained while you are a Covered Person; or
6. a gender change, including but not limited to any operation, drug therapy or any other procedure related to a gender change unless it is covered under the Medical Plan.

No benefit will be payable during any period of incarceration.

With respect to this provision, “participation” includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but does not include actions taken in defense of public or private property, or actions taken in self-defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and fire fighters.

With respect to this provision, “riot” includes all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Claiming Benefits

If you become disabled, you must call Liberty at **877-294-3423** as soon as possible to begin the disability claims process.

> If your illness or injury is work-related, then you need to file a claim for disability benefits under Workers' Compensation. Your Human Resources representative can advise you on this process, which varies by state.

If your disability is not work-related, your Liberty STD case manager will generally suggest that you apply for benefits under the LTD plan if you have been receiving STD benefits for three to five months and it seems likely that you will be unable to return to work before you reach your maximum eligibility for STD benefits or 180 days (whichever is greater). The maximum STD period generally corresponds to the LTD Elimination Period.

If you have been receiving Workers' Compensation benefits and it seems likely that you will be unable to return to work before the end of the 26-week LTD Elimination Period, Healthineers will notify Liberty at least 60 days prior to the projected LTD benefit start date to consider your application for LTD benefits. You will not need to initiate this process but may call Liberty at **877-294-3423** if you have questions or need to follow-up on your application for LTD benefits. Even if you continue to receive Workers' Compensation benefits, you will generally be eligible to receive at least the minimum LTD benefit of $50/month. More importantly, Liberty will be responsible for certifying your (and your family's) eligibility for medical coverage and employee life insurance if your disability continues for 12 or more months.

In order to receive benefits under the LTD plan, you must provide Liberty, at your expense and subject to Liberty's satisfaction, with all of the following documents:

- *Proof of Disability*, including a claim form that you have completed and signed (or otherwise formally submitted) and a statement from attending physician that the physician has completed and signed (or otherwise formally submitted). *Proof of Disability* includes, but is not limited to:
  1. the date your Disability started;
  2. the cause of your Disability; and
  3. the prognosis of your Disability
- proof that you are under the appropriate care and treatment of a physician throughout your Disability.
- evidence of continuing Disability received from your attending physician, including standard diagnosis, chart notes, lab findings, test results, x-rays and/or other forms of objective medical evidence in support of a claim for benefits.
- information about other income benefits.
- any other material information related to your Disability that may be requested by Liberty.

You may file a claim for LTD benefits up to three months prior to the date you will first become eligible to receive your first benefits payment (at the end of the LTD Elimination Period). However, you must provide notice to Liberty of a claim for LTD benefits within 20 days after the end of your LTD Elimination Period or, if that is not possible, as soon as it is reasonably possible to do so. Proof of Disability must be given to Liberty within 90 days after the end of your LTD Elimination Period unless it is not reasonably possible to do so.

No LTD benefits are payable for claims submitted more than one year after the date of disability. However, you can request that benefits be paid for late claims if you can show that it was not reasonably possible to submit your LTD claim during the one-year period and the claim was submitted to Liberty as soon as was reasonably possible.

When LTD Benefit Payments Begin

If your claim is approved, LTD benefits begin after you have completed the **LTD Elimination Period**. You complete the LTD Elimination Period when you have been continuously **Disabled** or **Partially Disabled** due to an Injury or Sickness for 180 days or you have reached the end of your short-term disability income benefits (whichever is greater). You must be found by Liberty to be **Disabled** or **Partially Disabled** as of the date your disability began or the date of your first absence from work. The fact that your condition may have worsened after the date your disability began or the date of your first absence from work does not affect the requirement that you must be **Disabled** or **Partially Disabled** as of the date your disability began in order to be eligible for LTD benefits. Separate periods of **Disability** or **Partial Disability** resulting from unrelated causes (for instance, an Injury followed by a Sickness) will be considered part of the same LTD Elimination Period unless you returned to work for at least one full day between the end of one such period and the beginning of the next.

Trial Work Periods, Non-Continuous Periods of Disability or Partial Disability

If you temporarily return to work during the LTD Elimination Period, in one or more attempts, each such attempt will be called a ***Trial Work Period***. Depending on the number of days you temporarily returned to work, your LTD Elimination Period will be longer than 180 days (taking into account the cumulative total of days you are **Disabled** or **Partially Disabled** and days of your return to work) or a new LTD Elimination Period will begin.

If you temporarily return to work for a cumulative total of 90 calendar days or less, the LTD Elimination Period will be extended by the number of days you temporarily returned to work. If you return to work for more than 90 calendar days, a new LTD Elimination Period will begin. If a new LTD Elimination begins, there may be a period of time during which you are no longer eligible to receive STD benefits and are not yet eligible to receive LTD benefits (see the example below showing how return to work can affect your LTD Elimination Period).

LTD Trial Work Days Example
(with cumulative maximum Trial Work Period of 90 days)

STD Claim Status	From	Through	STD Benefit Calendar Days	Trial Work Period Calendar Days	Trial Work Period Effect on LTD Elimination Period
Disabled (STD benefits begin)	3/22/2018	5/15/2018	54		
Full-time return to work	5/16/2018	6/26/2018		40	Used 40 out of 90 trial work days
Disabled (receiving STD benefits)	6/27/2018	7/10/2018	14		
Full-time return to work	7/11/2018	8/31/2018		52	Hit 91st trial work day on 8/30/2018
Disabled (reaching end of STD benefits)	9/1/2018	12/23/2018	114		New LTD Elimination Period starts on 9/1/2018
Maximum duration of STD benefits		12/23/2018	182		New LTD Elimination Period ends on 2/28/2019

Table 41 — LTD Trial Work Days Example

In terms of this example, you reach Maximum Duration of STD benefits on 12/23/2018. The "benefits gap" (the period of time when you are not eligible to receive any further STD benefits and are not yet eligible to receive LTD benefits) runs from 12/24/2018 through 2/28/2019. The new LTD Elimination Period ends on 2/28/2019. If your claim is approved, LTD benefits begin on 3/1/2019.

How Long LTD Benefits Continued

The following table shows how long monthly LTD income continues:

Age When Disability Begins	LTD Benefits Continue Until Recovery Or …
Under age 60	Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	The date 12 payments have been made

Table 42 – Long-Term Disability Continuation

NOTE: While you are **Disabled or Partially Disabled**, Liberty has the right to require proof at any time of your Disability and require its own physician to examine you. If you do not agree to the examinations requested by the claims administrator, you will no longer be eligible for LTD benefits under the Healthineers Benefits Program.

Concurrent Disability

If a new Disability occurs while you are receiving LTD benefits, it will be treated as part of the same period of Disability. Monthly benefits will continue while you remain Disabled or Partially Disabled. They will be subject to the maximum benefit duration and limitations and exclusions that apply to the new cause of the Disability.

Pre-Existing Condition Limitation

The LTD plan will not cover any Disability or Partial Disability:

1. which is caused by, or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 12 months immediately following your effective date of coverage under the LTD plan option.

"Pre-Existing Condition" means a condition resulting from an Injury or Sickness for which you were diagnosed or received treatment or had medications prescribed within three months prior to your effective date of coverage (the date you first enrolled in an LTD plan option provided under the Healthineers Benefits Program or, if you were an employee of a company acquired by, the effective date of your enrollment in the acquired company's LTD plan, if such a plan existed).

If you change your LTD coverage option from Company-Paid to Employee-Paid during an Annual Enrollment period, upon your return from a leave of absence, or as the result of a change in family status, any benefit related to a Pre-Existing Condition will be paid according to your prior coverage election unless the new option was in effect for at least 12 months before you became disabled. In addition, if you are not actively at work or are out on a leave of absence when the new coverage option was to become effective, the change in coverage will not apply until you are actively at work.

Other Income Benefits and Earnings That Reduce LTD Benefits

A description of the benefits provided under the LTD options, including a description of the other sources of benefits or income that reduce LTD benefits under the Plan (listed below), is provided in the Liberty LTD Plan Certificate. However, no matter how much you receive from these other sources, the LTD benefit will never be less than $50 a month unless you are in an overpayment situation.

Sources of **Other Income Benefits** and **Other Income Earnings** provided to you, your spouse, child or children because of your Disability that reduce LTD benefits include the following:

- Federal, Social Security Act, Railroad Retirement Act, Canada Pension Plan, or any provincial pension or disability plan, or the Canada Old Age Security Act ()
- Disability benefits under any other Healthineers Group Insurance Policy
- Work Earnings and Rehabilitation Incentives (except as described in Rehabilitation Incentive Benefit or Partial Disability Work Incentive Benefit in this Summary Plan Description)
- Employer's Retirement Plan (other than a 401(k), profit-sharing or other similar plan)
- No-Fault Auto Law
- Other programs or plans
- Workers' Compensation or a similar law
- Occupational Disease law
- Maritime Maintenance & Cure
- Third Party recovery
- Unemployment Insurance law or program

You can request a copy of the Liberty LTD Plan Certificate by writing to the Healthineers Benefits Service Center, 4 Overlook Point, P.O. Box 1426, Lincolnshire, IL 60069-1426, or by calling toll-free at **800-392-7495** (or **847-883-0676**), between 10 a.m. and 6 p.m., Eastern Time, Monday through Friday. The Liberty LTD Plan Certificate is also available online on the Your Benefits Resources™ website at http://resources.hewitt.com/siemens (select *Health and Insurance*, *Plan Information*).

If you elect to receive payments from a Healthineers Pension Plan while you are collecting LTD benefit payments, Liberty will reduce your monthly LTD payments by the monthly value of your pension payment over the expected period of your LTD payments. This will apply to both lump-sum and annuity payments from the pension plan. However, your LTD benefit payments will not be reduced by or adjusted for the amount of any severance pay or distributions you receive from the Healthineers Savings Plan or other retirement savings plan that you may receive.

If your spouse or dependents receive benefits from Social Security due to your disability, Liberty will reduce your monthly LTD payments by the monthly value of their Social Security Disability benefits.

Estimation of Other Income Benefits

Liberty will use an estimate of your **Other Income Benefits** to reduce your LTD benefits unless:

1. you provide proof that you have applied for **Other Income Benefits**, including Social Security Disability Income benefits;
2. you have signed the Reimbursement Agreement which confirms that you will repay all overpayments; and
3. if applicable, you submit proof that all appeals for **Other Income Benefits** have been made on a timely basis to the highest administrative level (unless Liberty determines that further appeals are not likely to succeed); and

4. if applicable, you submit proof that **Other Income Benefits** have been denied at the highest administrative level (unless Liberty determines that further appeals are not likely to succeed).

If you do not provide and sign the documents indicated above, your LTD benefits will be reduced by an estimate of your or your spouse's or dependent's **Other Income Benefits**, including Social Security Disability Income benefits. Liberty will assist you in applying for Social Security Disability Income benefits if Liberty determines that assistance will be beneficial.

When you receive approval or final denial of your claim for **Other Income Benefits** from the Social Security Administration or other administrator, you will need to submit written proof of the amount of **Other Income Benefits** awarded in order for your monthly LTD benefit to be adjusted. If Liberty has overestimated the amount of **Other Income Benefits**, you will be reimbursed. If you have received an overpayment, you must promptly refund Liberty an amount equal to all overpayments. If you do not promptly remit any overpayment due to Liberty, Liberty will reduce or offset any future LTD benefits payable to you, including the minimum benefit, by the overpayment amount.

Once your final LTD benefit is determined, it will not be reduced by future increases in Social Security benefits.

Limitation for LTD Benefits Due to Particular Conditions

If your Disability is due to:

1. **Mental Illness**,
2. **Non-Verifiable Symptoms**, and/or
3. Alcohol, drug or substance abuse, addiction or dependency,

there is a combined lifetime limit on the number of months you can receive LTD benefits under the LTD plan. This combined lifetime limit is the lesser of 24 months after your waiting period, or the length of your Disability related to these conditions, or the end of your maximum duration period. However, you can qualify for more than 24 months of LTD benefits for a Mental Illness if your Disability is the result of schizophrenia, bipolar disorder, dementia or organic brain disease.

If you are in a hospital or institution for Mental Illness and/or substance abuse at the end of the combined period of 24 months, LTD benefits will be payable during the confinement. If you are not confined in a hospital or institution for Mental Illness and/or substance abuse but are fully participating in an Extended Treatment Plan for the condition that caused the Disability, LTD benefits will be payable to you for up to a combined period of 36 months. However, in no event will LTD benefits be paid beyond the end of your maximum duration period.

"Mental Illness" means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, Liberty and the Claims Administrators of the Medical Plan options will use the replacement chosen or published by the American Psychiatric Association. You must be receiving *appropriate care and treatment* for your condition by a mental health *Doctor (or Physician)*.

"Non-Verifiable Symptoms" means your subjective complaints to a physician that cannot be diagnosed using tests, procedures or clinical examinations typically accepted in the practice of medicine. Such symptoms may include, but are not limited to, dizziness, fatigue, headache, loss of energy, numbness, pain, ringing in the ear, and stiffness.

"Extended Treatment Plan" means continued care that is consistent with the American Psychiatric Association's standard principles of Treatment and is in lieu of confinement in a hospital or institution for Mental Illness and/or substance abuse. It must be approved in writing by a physician.

Rehabilitation Incentive Benefit

If you participate in a Rehabilitation Program, Liberty will pay an increased weekly Rehabilitation Incentive Benefit while you are fully participating in the Rehabilitation Program. Before you can be considered for this benefit, Liberty must first give written approval of the Rehabilitation Program. If Liberty approves the Rehabilitation Program and you continue to be Disabled under the terms of the Liberty LTD policy and you fully participate in the Rehabilitation Program, your LTD benefit in combination with other sources of disability income will be increased on a weekly basis from 60% to 70% of your pre-disability Basic Monthly Earnings. If Liberty does not approve a Rehabilitation Program and provided you continue to be Disabled and eligible to receive LTD benefits under the terms of the Liberty LTD policy, your regular LTD benefit will be payable.

If you decline to fully participate in an approved Rehabilitation Program recommended by Liberty, your Disability benefits will terminate on the first day of the month following your declination to fully participate. If Liberty recommends rehabilitation, no benefit will be paid from the date the recommendation is made until Liberty receives your written agreement to fully participate in the Rehabilitation Program.

If you are eligible for a Rehabilitation Incentive Benefit, the increased benefit will begin on the first day of the month after Liberty receives written proof of your full participation in the Rehabilitation Program. For the purpose of this provision, "Rehabilitation Program" means a comprehensive, individually tailored, goal-oriented program to return a Disabled Covered Person to gainful employment. The services offered may include, but are not limited to, the following:

1. physical therapy;
2. occupational therapy;
3. work-hardening programs;
4. functional capacity evaluations;
5. psychological and vocational counseling;
6. rehabilitative employment; and
7. vocational rehabilitation services.

Partial Disability Work Incentive Benefit

If you are Partially Disabled under the provisions of the Liberty LTD plan and are receiving LTD benefits, for the first 24 months your LTD benefits will equal 60% of your pre-disability Basic Monthly Earnings without reduction for your earnings; provided, however, that the sum of your LTD benefits and your part-time earnings cannot exceed 100% of your Basic Monthly Earnings. During this 24-month period, your monthly LTD benefit will be reduced if and only by the amount that the combined total of your LTD benefits and your earnings would exceed 100% of your Basic Monthly Earnings. Thereafter, your monthly LTD benefit will be reduced by 50% of the amount of your earnings received while you are Partially Disabled. The Monthly Benefit will be further reduced if and to the extent that the total amount you receive including Other Income Benefits exceeds or would exceed 100% of your Indexed Basic Monthly Earnings.

On the first anniversary of your LTD benefit payments and each anniversary thereafter, for the purpose of calculating your monthly LTD benefit while you continue to be Partially Disabled, the term "Monthly Basic Earnings" is:

1. replaced by "Indexed Basic Monthly Earnings"; and
2. increased annually by 7%.

Your monthly LTD benefit will not be less than the $50 Minimum Monthly Benefit. However, if an overpayment is due to Liberty, the Minimum Monthly Benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

When LTD Benefit Payments End

Monthly LTD benefits will end on the earliest of the following dates:

- the end of the maximum benefit duration;
- the end of the period specified in the Limitation for Disabilities Due to Particular Conditions;
- the date you are no longer Disabled or Partially Disabled;
- the day you die;
- the date you fail to provide Liberty with any of the information listed in Claiming Benefits;
- the date you fail to attend a medical examination requested by Liberty as described in Claiming Benefits;
- the date you refuse to receive Appropriate Available Treatment;
- on the first day of the month following the date you cease or refuse to fully participate in a Rehabilitation Program recommended by Liberty as described in Rehabilitation Incentive Benefit;
- the date you are able to work in your Own Occupation on a part-time basis, but choose not to;
- the date you refuse a job with your Employer where workplace modification or accommodations were made to allow you to perform the Material and Substantial Duties of the job;
- the date your Partial Disability earnings averaged over three consecutive months in which you are receiving a Partial Disability Work Incentive Benefit exceeds 80% of your Indexed Basic Monthly Earnings; and
- The date you refuse to be examined or evaluated at reasonable intervals.

Successive Periods of Disability

With respect to your LTD benefits, **"Successive Periods of Disability"** means a Disability or Partial Disability that is related or due to the same cause or causes as a prior Disability for which you received a monthly LTD benefit paid by Liberty under the provisions of the LTD policy. A Successive Period of Disability will be treated as part of the prior Disability if, after you have received an LTD benefit under this policy, you:

1. return to your Own Occupation on an Active Employment basis for less than six continuous months; and
2. perform all the Material and Substantial Duties of your Own Occupation.

To qualify for a Successive Periods of Disability benefit, you must experience a loss of greater than 20% of Basic Monthly Earnings. If you qualify for a Successive Periods of Disability benefit, LTD benefits for your second or successive disability will begin immediately and will be calculated under the same terms as applied to the first or prior Disability. The second or successive Disability will be considered a continuation of the first. Benefits will not be increased, even if your Pay increased between the two periods of disability. You will not have to satisfy the LTD Elimination Period. If you

are eligible for a Successive Periods of Disability benefit, you are not eligible to receive benefits from any Healthineers Short-Term Disability plan.

If you return to your Own Occupation on an Active Employment basis for six continuous months or longer, the Successive Period of Disability will be treated as a new period of Disability and you will need to qualify first for Short-Term Disability or Workers' Compensation benefits and complete another LTD Elimination Period before you will be eligible to receive an LTD benefit.

If a new Disability occurs while you are receiving LTD benefits, it will be treated as part of the same period of Disability (see section labeled "Concurrent Disability").

How Your Pay Is Determined

Your Pay for purposes of the LTD plan is the ***greater*** of

(a) one-twelfth (1/12) of your Frozen Pay calculated as of June 30th of the calendar year preceding the year in which your Disability begins; or

(b) your pre-disability **Basic Monthly Earnings**.

Pre-disability ***Basic Monthly Earnings*** is the amount of your gross salary from Healthineers as of the day before your Disability began, calculated on a monthly basis. This may include:

- The monthly average of your actual sales commissions for the three calendar years preceding your Date of Disability. If you earn commissions, then Basic Monthly Earnings does not include bonuses.
  - If you have between two and three years of service, pay is your monthly base salary plus the monthly average of your last two calendar years of paid commissions.
  - If you have less than two years of service, pay is your monthly base salary plus the average of your monthly commissions determined by dividing the total of all commissions paid since your hire date by the number of your full months of service.
- The monthly average of your actual short-term annual bonus paid within the last 12 months preceding your Date of Disability; or
- Contributions you make through a salary reduction agreement with Healthineers to any of the following:
  - An Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
  - An executive nonqualified deferred compensation arrangement; and
  - Amounts contributed for your Healthineers Benefits Program benefit elections according to a salary reduction agreement under an IRC Section 125 plan.

Pre-disability Basic Monthly Earnings does not include:

- awards or special bonuses;
- overtime pay;
- retention bonuses;
- Healthineers' contributions on your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation.

If you do not have regular work hours, your pre-disability Basic Monthly Earnings will be based on the average number of hours you worked per month during the preceding 12 calendar months (or during

your period of employment if less than 12 months) multiplied by the hourly pay rate you were paid as of the day before your Disability began. In no event will the number of hours be more than 173 hours.

If an amount equal to one-twelfth (1/12) of your Frozen Pay, as calculated for the last plan year in which you are actively at work, is greater than the amount of your pre-disability Basic Monthly Earnings, then the Frozen Pay amount will be substituted for "Basic Monthly Earnings" in the calculation of your LTD benefit and any calculation of Indexed Basic Monthly Earnings.

If You Change LTD Plan Options

If during Annual Enrollment or upon your return to work from a leave of absence or as the result of another Qualified Life Event you change your LTD coverage from Company-Paid to Employee-Paid, the new election will be subject to pre-existing condition limitations. Any change in plan option that you request during Annual Enrollment will not become effective until your first day actively at work on or after the January 1 the change was to become effective. Any change from Company-Paid to Employee-Paid LTD coverage that you request upon your return to work from a leave of absence or as the result of another Qualified Life Event will not become effective until you receive your first after-tax payroll deduction.

Recovery of Overpayment

If your monthly LTD benefit is overpaid resulting from retroactive awards received from sources shown in the list of Other Income Benefits, fraud or any error that Liberty makes in processing your claim, Liberty has the right to recover the excess amount. The overpayment will be deducted from your benefits or you may have to make a lump-sum repayment to Liberty.

Subrogation and Reimbursement

If your Injury or Sickness appears to be the fault of someone else, your LTD benefits will not be paid unless you or your legal representative agree (i) to repay Liberty for any amount of such benefits that are compensated to you by or on behalf of the person at fault, and (ii) to allow Liberty a lien on such compensation and to hold such compensation in trust for Liberty, and (iii) to execute and give to Liberty any legal instruments needed to secure these rights. In addition, you must execute and deliver to Liberty any instruments needed to grant to Liberty the subrogation rights to recover any amount that Liberty has paid to you.

Survivor Benefit

If you die after completing the LTD Elimination Period and you were eligible to receive a monthly LTD benefit at the time of your death, the LTD option will pay a survivor benefit to:

- your spouse or domestic partner, if any, or
- your unmarried children or your spouse's or domestic partner's unmarried children under age 25 (in equal shares), or, if none, to your estate.

The survivor benefit is a lump-sum amount equal to three times your last monthly benefit. Proof of death must be provided to Liberty in order to initiate survivor benefits.

Termination of Coverage

LTD coverage stops if:

- you no longer meet the eligibility requirements for enrollment in the LTD options of the Healthineers Benefits Program, or
- you leave Healthineers for any reason except a disability for which benefits are paid, or
- the LTD options are terminated, or
- you are not actively at work at the time the Disability or Partial Disability began;
- your employment terminates; or
- required premiums are not paid; or
- the LTD policy terminates.

NOTE: After Liberty determines that you are Disabled or Partially Disabled, your monthly benefits will not be affected by termination of the LTD plan options, termination of your coverage, termination of your employment, or any change to the LTD plan option that is effective after the date you became Disabled or Partially Disabled.

YOUR OTHER BENEFITS DURING DISABILITY

IMPORTANT!

The provisions described below apply to Healthineers employees whose disabilities began on or after January 1, 2014. The rules that generally apply if you became disabled or partially disabled on or after January 1, 1997, but before January 1, 2014, are described in the Siemens Corporation Summary Plan Description effective January 1, 2013, except that you will now be permitted to change your Medical Plan option during Annual Enrollment each year by calling the SBSC. Different rules may apply if you became disabled before January 1, 1997, or if your disability began while you were an employee of a company that has since been acquired by Siemens Medical Solutions USA, Inc. Contact the SBSC at **800-392-7495** for more information.

Your Health and Welfare Benefits Eligibility Status While You Are Disabled

While you are absent from work due to Disability or Partial Disability, you must be receiving disability income benefits in order to be eligible for continuation of other health and welfare insurance benefits available under the Healthineers Benefits Program. If and whenever your disability income benefits are not paid through Healthineers payroll, the SBSC will bill you for your benefit contributions at monthly rates corresponding to payroll deduction amounts; and your continuing eligibility for medical and other coverages will depend on timely payment of your bills.

Your eligibility for continuation of benefits while you are Disabled or Partially Disabled falls into three stages:

- **STD Benefits Status.** During the period that you are receiving income benefits under a Healthineers Short-Term Disability Plan option or during the first six months that you are receiving income benefits under a state disability plan or Workers' Compensation, you have ***STD benefits status*** and are eligible for continuation of coverage under the same "active employee" plan options and at the same levels as you were enrolled in on the last day you were Actively at Work before your disability began. The period of your STD benefits status generally corresponds to the LTD Elimination Period, which is the greater of 180 days or the end of your STD income benefits. If your STD income benefits are not paid through Healthineers payroll, then the SBSC will bill you directly for your coverage.

- **LTD Benefits Status.** During the period following the end of your STD benefits status and until you have been absent from work due to Disability or Partial Disability for 12 months, which generally includes the first six months that you receive LTD income benefits, you have ***LTD benefits status*** and are eligible for continuation of coverage under the same "active employee" plan options and at the same levels as you were enrolled in on the last day you were Actively at Work before your disability began. The Healthineers Benefits Service Center will bill you directly for your coverage. However, you will not pay for your LTD income benefit coverage while you are receiving an LTD benefit. If you do not make required payments, your "active employee" coverage will be dropped and cannot be reinstated.

  NOTE: **Annual Enrollment**. While you have STD benefits status or LTD benefits status, you are eligible to make new benefits elections during Annual Enrollment. You may not have access to the *Your Benefits Resources*™ website while you are on leave and will need to call the SBSC at **800-392-7495** in order to make your elections. New Long-Term Disability, Employee Supplemental Life Insurance, Spouse or Domestic Partner Supplemental Life, or Child Supplemental Life coverage elections will not take effect until the first day after the corresponding January 1 that you are Actively at Work following the end of your Disability or Partial Disability or as otherwise provided in this Summary Plan Description.

  Qualified Life Events. While you have STD benefits status or LTD benefits status, you may decide that you need to increase, reduce or drop certain coverages. You may modify your coverage during the 30-day period that ***begins*** with the occurrence of an IRS-defined Qualified Life Event (QLE) as long as the requested change is permitted under the QLE. Examples of QLEs that occur during disability include the beginning or end of FMLA Leave, a significant change in the cost of coverage, and the loss or gain of coverage by a family member under another employer's benefits plan or a government-sponsored plan. If you are able to return to work, you may not be able to reinstate or re-enroll in coverage that you reduced or terminated while you were disabled. The full list of QLEs and the changes permitted under each may be found elsewhere in this Summary Plan Description or on the *Your Benefits Resources*™ (*YBR*) website (http://resources.hewitt.com/siemens) under the heading "Life Events", or you may call the SBSC at **800-392-7495** for further information.

- **Post-12 LTD Benefits Status.** If you are still Disabled or Partially Disabled after you have been absent from work due to Disability or Partial Disability for 12 months and you have received disability income benefits for 12 months, you will have ***Post-12 LTD benefits status***. When you reach Post-12 LTD benefits status, your eligibility for certain coverages will terminate, as described below. You will continue to be enrolled in your company-paid Employee Basic Life Insurance, the Employee Assistance Program (EAP), any dependent supplemental life coverage already in force on the last day you were Actively at Work before your Disability began (unless coverage has already been terminated), and your Medical Plan option (unless coverage has already been terminated). You will be eligible to elect a new Medical Plan option for the next plan year by calling the SBSC during Annual Enrollment. Your maximum eligibility for continuation of your Post-12 LTD Employee Basic Life, EAP, dependent supplemental life, and Medical coverage will end when you have been absent from work due to Disability or Partial Disability for 29 months or you no longer receive LTD income benefits (if sooner). If you do not make required payments for your dependent supplemental life insurance or Medical coverage, your coverage will be dropped and cannot be reinstated. If you do not wish to continue your dependent supplemental life or Medical coverage, call the SBSC at **800-392-7495**.

Employee Basic Life (STD, LTD and Post-12 LTD Benefits Status)

Your company-paid Employee Basic Life Insurance coverage in effect as of your last day Actively at Work (less any Accelerated Benefit that is paid) will continue for a maximum of 29 months (measured from the date your Disability began, as long as you remain Disabled or Partially Disabled and you continue to receive disability income benefits — or up to the last day of the month in which you retire (if earlier) — at no cost to you. If your company-paid Employee Basic Life Insurance coverage is in effect on or after the January 1st following the date you reach age 65, the benefit amount is reduced to 65% (and if you reach age 70, reduced to 50%) of the amount that previously would have been payable.

You have a one-time option to request an Accelerated Benefit of up to 80% of the value of your Employee Basic Life Insurance coverage if you have coverage of at least $10,000, are under the Social Security retirement age at the time you make the request, and have a terminal illness with a life expectancy of 24 months or less. This option is combined with your one-time option to request an Accelerated Benefit payable from your Employee Supplemental Life coverage (if any) — that is, you can make a simultaneous request for payment of an Accelerated Benefit from both plans but you cannot make two separate requests.

Once your eligibility for company-paid Employee Basic Life Insurance ends, you may continue your coverage or a portion of your coverage, without providing Evidence of Insurability, by exercising your right to portability and/or conversion and then paying premiums directly to The Hartford. Further information about your Employee Basic Life Insurance is provided elsewhere in this Summary Plan Description, or you may call the SBSC at **800-392-7495**.

Employee Assistance Program (STD, LTD and Post-12 LTD Benefits Status)

While you remain eligible for company-paid Employee Basic Life Insurance, you and the members of your household will also continue to be eligible to obtain services from the EAP. For a description of EAP services, see elsewhere in this Summary Plan Description. You can access the EAP 24 hours a day, seven days a week, by calling Cigna Behavioral Health at **800-547-5589**. In order to receive the support and information you need, you must identify yourself as a Healthineers employee, dependent or household member.

Dependent Life Insurance (STD, LTD and Post-12 LTD Benefits Status)

If you have dependent supplemental life insurance for your spouse or domestic partner and/or your dependent children, coverage may continue for a maximum of 29 months, measured from the date your Disability began, as long as you remain Disabled or Partially Disabled and you continue to receive disability income benefits (including STD, Workers' Compensation or LTD benefits) or until the family member ceases to be eligible for such coverage (if earlier) provided that you pay the required premium in timely manner. The SBSC will bill you directly for your dependent supplemental life insurance. The amount billed will be equal to the monthly premium amount payable by "active" employees with similar coverage, which may change from year to year. No refund of premiums will be payable if you fail to notify the SBSC that a covered dependent (spouse, domestic partner or dependent child) ceases to be eligible for such coverage. No benefit will be payable if the dependent was not eligible at the date of claim. You may discontinue dependent supplemental life coverage at any time by calling the SBSC at **800-392-7495**.

Your spouse or domestic partner who has dependent supplemental life insurance coverage of at least $10,000 has a one-time option to request an Accelerated Benefit of up to 80% of the value of the amount of this dependent supplemental life insurance coverage if he or she is under the Social Security retirement age at the time of making the request and has a terminal illness with a life

expectancy of 24 months or less. This Accelerated Benefit option is not available for any dependent child who may have dependent supplemental life coverage.

When supplemental dependent life coverage ends, you may continue coverage or a portion of coverage, without providing Evidence of Insurability, for your spouse or domestic partner and/or children by exercising your right to portability and/or conversion and then paying premiums directly to The Hartford. For more information, see the section captioned "Supplemental Life Portability and Conversion Privilege" elsewhere in this Summary Plan Description.

Medical Coverage (STD, LTD and Post-12 LTD Benefits Status)

During the 12-month period that includes the periods you have STD benefits status and LTD benefits status, the Medical and other benefits plan options available to "active" employees will continue to be available to you. Once you transition to Post-12 LTD benefits status, you may continue your coverage under the "active" Medical Plan option in which you and any eligible family members are enrolled (unless coverage has already been terminated) for up to 17 more months for a maximum total of 29 months of medical coverage measured from your Disability begin date) or until you cease to qualify for LTD income benefits (if sooner). You may change your Medical Plan option for the next plan year by calling the SBSC during Annual Enrollment. You may select among the Health Savings Medical Plan option administered by UnitedHealthcare or the Health Reimbursement or PPO Medical Plan options administered by UnitedHealthcare and Anthem BCBS. If you are eligible for Medicare and you elect to enroll in the Health Savings (HSA) Medical Plan option, you will not be eligible to make contributions to an HSA and will not receive HSA contributions from Siemens Medical Solutions USA, Inc.

While you have Post-12 LTD benefits status, your contribution for Medical coverage will equal the employee and dependent (if applicable) "active employee" rate established each plan year for the Medical Plan option in which you are enrolled. If you do not make required payments, your Post-12 LTD Medical coverage will be dropped and cannot be reinstated.

Important!

If you are disabled and receive Social Security Disability benefits for 24 months, or if your employment is terminated and you are or attain age 65, you qualify for Medicare. You may become eligible for Medicare under certain other circumstances. **When you become eligible for Medicare, Medicare will be considered your primary payer unless you are enrolled in a fully insured HMO Medical Plan option.** If you are or become eligible for Medicare, your claims under your Healthineers medical coverage will be processed and paid as if you are participating in Medicare Part A and Part B coverages regardless of whether you are actually enrolled in those coverages. Therefore, you should enroll in Medicare Part A and Part B as soon as you are eligible. The Healthineers Medical Plan will pay benefits for covered expenses that Medicare may not fully cover — to bring your total benefit up to the amount the Healthineers medical plan would pay if it were the only plan. **This provision will also apply to any family member who is or becomes eligible for Medicare.** It is your responsibility to notify the SBSC whenever you or a family member becomes eligible for Medicare. If a claim is paid for you or a family member and it is later determined that the claim was overpaid because you or your family member was eligible for Medicare on the date of service, the Claims Administrator of your Medical Plan option will be assigned to recover any overpayment from you or the service provider, as may be appropriate.

Your maximum eligibility for continuation of Medical coverage for you and any family members who may be enrolled while you receive disability income benefits is 29 months measured from the date your Disability began or until you no longer receive LTD income benefits (if sooner). After 29 months,

or following the termination of your Post-12 LTD Medical coverage (if sooner), you and/or your covered family members, together or individually, may elect to continue your medical coverage through COBRA for up to 18 months. However, if you became eligible for Medicare before your employment was terminated, your covered family members may be eligible for continuation of coverage under COBRA for up to 36 months counting from the date of your entitlement for Medicare. You need to be aware that Medicare is considered the primary payer under COBRA regulations and that COBRA benefits under the Healthineers medical plan for any Medicare-eligible participant will be administered as if the individual is enrolled in Medicare Part A and Part B coverages regardless of whether the individual is actually enrolled in coverage under either part.

Coverage That Ends When You Reach Post-12 LTD Benefits Status

Except for Flexible Spending Accounts, during the first 12 months that you are Disabled or Partially Disabled and you have STD benefits status or LTD benefits status, you are eligible to continue coverage under the same benefits plans and plan options that you were enrolled in on the last day you were Actively at Work before your disability began. Your eligibility for certain benefits that are available to you while you have STD benefits status or LTD benefits status ends when you reach Post-12 LTD benefits status –

- **Flexible Spending Accounts.** For the plan year in which you become disabled, you can continue to submit eligible expenses to the Health Care or Limited-Use Health Care FSA.
- **Vision.** The vision plan options available to active employees will continue for the first 12 months of your Disability. After 12 months, you may elect to continue vision coverage through COBRA.
- **Dental.** The dental options available to active employees will continue for the first 12 months of your Disability. After 12 months, you may elect to continue dental coverage through COBRA.
- **Employee Supplemental Life Insurance and Waiver of Premium.** If you are under 65 years of age at the commencement of your Disability and you become Disabled or Partially Disabled as defined in this SPD, your Employee Supplemental Life Insurance coverage in effect on the last day that you were Actively at Work before your Disability began (less any Accelerated Benefit that is paid) may continue for as long as you remain Disabled or Partially Disabled — up to age 65 if you become Disabled or Partially Disabled before age 60; or up to the maximum duration of your LTD benefits if you become Disabled or Partially Disabled after age 60 (see the section captioned, ***"How Long LTD Benefits Continue"***) — at no cost to you. However, for this to apply you must be approved for a "premium waiver."

  Once you have been absent from work due to a Disability or Partial Disability for nine consecutive months (but less than 12 months), you will need to call The Hartford at **888-563-1124** to inquire about proof of Disability that is required to apply for a premium waiver. If you are approved for a premium waiver, you will not pay for coverage.

  If you do not apply for a premium waiver or you are denied for a premium waiver, your Employee Supplemental Life coverage will terminate effective as of the date that you have been absent from work due to a Disability or Partial Disability for 12 months (unless coverage has already been terminated). You will be offered the opportunity to port or convert all or a portion of your supplemental life coverage (see the section captioned "*Supplemental Life Portability and Conversion Privilege*" elsewhere in this Summary Plan Description). Conversion is not available for any amount of Employee Supplemental Life coverage that has been approved for a waiver of premium. If you apply and are approved for conversion coverage and are subsequently approved for a waiver of premium for the same coverage, you will receive a refund of premiums.

  You have a one-time option to request an Accelerated Benefit of up to 80% of the value of your Employee Supplemental Life Insurance coverage if you have coverage of at least $10,000, are

under the Social Security retirement age at the time you make the request, and have a terminal illness with a life expectancy of 12 months or less. This option is combined with your one-time option to request an Accelerated Benefit payable from your Employee Basic Life coverage – that is, you can make a simultaneous request for payment of an Accelerated Benefit from both plans but you cannot make two separate requests.

- **Personal Accident Insurance (PAI).** The options available to active employees will continue to be available to you for the first 12 months of your Disability or Partial Disability (including the period of short-term disability).

  After you have been absent from work for 12 months due to Disability or Partial Disability, you may continue all or a portion of your PAI as Accidental Death & Dismemberment conversion coverage subject to a minimum of $25,000 and a maximum of $250,000 if you are under 70 years of age (or *limited to $25,000 if you are* at least 70 but less than 75 years of age, or limited to $12,500 if you are age 75 or older) by paying the premium directly to The Hartford. Different premium rates and plan provisions will apply. The amount of coverage that will be offered to your spouse or domestic partner or to each child will be dependent on the amounts being offered by The Hartford in your state of residence as of the date that coverage under the Healthineers Benefits Program is terminating. The process and timelines for converting personal accident insurance are the same as the process for converting supplemental life insurance (see the section captioned "Supplemental Life Portability and Conversion Privilege" elsewhere in this Summary Plan Description).

- **Long-Term Care (Employee or Spouse or Domestic Partner).** If you elected and wish to continue this coverage, you must make payments directly to MetLife. If you have questions about your Long-Term Care coverage, call MetLife at **800-GET-MET8** (**800-438-6388**).

- **Financial Planning.** If you elected the financial planning program with The Ayco Company, you can continue to participate by paying Ayco directly. Call Ayco's Customer Service Center at **800-437-6383** and speak with a service representative to continue the program.

OVERVIEW OF YOUR BUSINESS TRAVEL ACCIDENT INSURANCE

Business Travel Accident (BTA) insurance pays a benefit if you are seriously injured or die in a covered accident while on a business trip. BTA insurance is provided automatically to all employees.

While you are an active employee, your BTA insurance equals five times your **pay** (see *Claiming Benefits* in this section of the Summary Plan Description for a definition of pay) up to a maximum benefit of $500,000. This amount is rounded to the next highest $1,000, unless it is already a multiple of $1,000. If you die within one year of a business travel accident as the result of an injury from that covered accident, BTA benefits are paid in addition to any other life or accident insurance benefits.

Coverage begins when you start a business trip, whether you leave from home or work. Coverage ends when you return to your home or office, whichever comes first, or if you make a *personal deviation*. Effective January 1, 2018, personal deviations will be allowed for a maximum of three days per business trip.

> "**Personal deviations**" are activities that are not reasonably related to business and not incidental to your business trip.

The BTA benefit is insured and administered by Life Insurance of North America (LINA), a Cigna company.

Plan Benefits

The plan pays a benefit to you or your beneficiary, as applicable, if:

- you die as the result of a covered accident while on a business trip;
- you become a quadriplegic, paraplegic, hemiplegic, or uniplegic (100% for quadriplegia; 75% for paraplegia; 50% for hemiplegia and 25% for uniplegia)
- you lose sight, limb, speech and/or hearing while on a business trip as shown in the table below.

If Within One Year of a Covered Accident You Lose	You Receive
Life	100% of the principal sum of your BTA insurance
Two hands or feet, or sight in both eyes, or speech and hearing	100% of the principal sum of your BTA insurance
One hand, one foot, or sight in one eye, or speech or hearing	50% of the principal sum of your BTA insurance
Thumb and index finger of the same hand	25% of the principal sum of your BTA insurance

Table 43 – Business Travel Accident Insurance Benefit Payable

The plan provides additional benefits as follows:

- seatbelt and airbag benefit
  - Seatbelt: 10% of the Principal Sum to a maximum of $25,000
  - Airbag: 5% of the Principal Sum to a maximum of $10,000
- Child Care Center, Spouse and Child Education Benefits
  - Child Care Center: 10% of the Principal Sum to a maximum of $10,000 per year for up to 4 years

- Spouse Education: 10% of Principal Sum to a maximum of $25,000 per year for up to 3 years
- Child Education: 20% of Principal Sum to a maximum of $25,000 per year for up to 4 years

- Coma and Rehabilitation Benefits
  - Coma: 1% of Principal Sum for 11 months
  - Rehabilitation Benefits: 10% of Principal Sum to a maximum of $25,000

Definitions of Covered Losses

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. In South Carolina, loss of four whole fingers of one hand is considered the loss of a hand.

Loss of sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means..

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Important!

If you travel to another city and are expected to remain there for more than 60 days, this is considered a permanent assignment and not a business trip.

If you sustain more than one covered loss in the same covered accident, you will receive payment for the covered loss that provides the higher benefit.

The maximum amount payable for all insured individuals injured in the same covered accident is $10,000,000. All covered losses incurred as a result of war, or acts of war during any 72-consecutive-hour period are also limited to a total of $10,000,000. This payment is pro-rated among the employees or their beneficiaries involved in the common covered accident or incident.

If Your Pay Changes

The amount of your coverage automatically changes on your first day actively at work after your pay changes.

Exclusions

Business travel accident coverage does not cover losses that are the result of:

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:

a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
c. being used for:
    i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    ii. ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
d. an ultra-light or glider;
e. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
f. being used for the purpose of parachuting or skydiving;
g. designed for flight above or beyond the earth's atmosphere;

6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

Payment of Benefits/Beneficiary

If you have not designated a beneficiary at the time of your death or if your beneficiary dies before you, your Business Travel Accident Insurance benefit will be paid to the beneficiary you designated for your Employee Basic Life Insurance benefit. If you have not designated a beneficiary for your Employee Basic Life Insurance benefit, or the beneficiary dies before you, your Business Travel Accident Insurance benefit will be paid in the following order of priority:

- your spouse
- your child(ren)
- your parent(s)
- your sibling(s); or
- your estate

To designate or change your beneficiary, call the Siemens Benefits Service Center at **800-392-7495**. The change will be effective as of the processing date.

Claiming Benefits

You or your beneficiary should contact the Siemens Benefits Service Center (SBSC) at **800-392-7495** immediately after a covered loss. Claim forms and other assistance will be provided.

For the purposes of Business Travel Accident Insurance coverage, the benefit is calculated using **Pay** defined as follows:

- **Salaried or Hourly Employee** – your base salary in effect as of the date of the Covered Accident plus your actual short-term annual bonus paid within the last 12 months preceding the date of the Covered Accident. It does not include any overtime, long-term incentive bonuses, retention bonuses, or any special bonuses. *This definition of pay applies to sales employees who are not paid commission based on products sold.*
- **Sales or Commission Employee** – your base salary in effect as of the date of the Covered Accident plus the average of your actual sales commissions for the last three calendar years. It does not include bonuses, overtime pay, or extra compensation.
    - If you have between two and three years of service, pay is your base salary plus the average of your last two calendar years of paid commissions.
    - If you have less than two years of service, pay is your base salary plus all commissions paid since your hire date, divided by the number of your full months of service, multiplied by 12.

LINA has the right to examine the person claiming benefits as often as is reasonably necessary while the claim is pending. This includes requesting an autopsy in case of death where it is not forbidden by law.

When Coverage Ends

Business travel accident coverage stops on the date:

- the Plan is terminated
- you are no longer eligible
- you enter full-time active duty in any Armed Forces (this does not include Reserve or National Guard duty for training)
- your employment ends (including retirement).

Conversion

If you leave the Company or become ineligible for coverage and you are under age 70, you may convert your BTA coverage to individual Accidental Death & Dismemberment coverage subject to a minimum of $25,000 and a maximum of $250,000 by paying the premium directly to LINA. Conversion to an individual policy may not be available in every state of residence. Different group rates and plan provisions may apply. You must apply for conversion coverage and the required premium payment must be made within 31 days after your Healthineers BTA coverage ended.

OVERVIEW OF YOUR LONG-TERM CARE INSURANCE

New enrollment in LTC insurance was closed effective December 31, 2011. Active employees and their spouses and domestic partners who had been enrolled in LTC on December 31, 2011, are able to continue such coverage and continue to be able to pay for coverage for themselves and their spouses or domestic partners through payroll deductions.

Changing Long-Term Care Coverage

If you elected Long-Term Care insurance coverage, the option you selected will remain in effect until you submit a request to MetLife to increase or decrease your coverage or you stop paying the premium. Increases in coverage are subject to evidence of insurability rules. Decreases in coverage are processed based on a telephone request.

You may decrease or cancel LTC coverage at any time. All you need to do is to contact MetLife customer service at **800-438-6388**. Your coverage will end the last day of the month you notify MetLife that you want to cancel your coverage.

Cost of Coverage

Each individual enrolled has a separate certificate of insurance with MetLife. The premium is based on the coverage option(s) and the covered person's age on the coverage effective date. Rates may also change in the future but will continue to reflect the person's age on the coverage effective date unless you increase your coverage. Long-Term Care insurance coverage is paid with after-tax dollars.

The cost of LTC coverage for you and/or your spouse/domestic partner (same or opposite sex) is paid for with deductions from your paycheck. However, if the full premium due is not collected from your paycheck, MetLife will bill you at home for the unpaid amount.

Claiming Benefits

You or your authorized representative must call MetLife at **800-438-6388** to begin the process of determining your eligibility for benefits. MetLife has the right to have you examined, at their expense, by a healthcare provider and to conduct an on-site assessment of your condition. MetLife also has the right to review your continuing eligibility for benefits at least once every 12 months, but not more frequently than every 60 days.

If Your Claim Is Denied

MetLife has sole discretion to resolve any dispute regarding eligibility or payment of benefits for Long-Term Care. If your claim for benefits is denied, in full or in part, you may obtain information on procedures for resolving your dispute by calling MetLife at **800-438-6388** or send your written appeal by fax to **866-314-5904** or by email to LTD_BA_Appeals@metlife.com.

If Your Employment Terminates

If you leave the Company, you may take your LTC coverage with you by making premium payments directly to MetLife.

PLAN ADMINISTRATION

Plan Sponsor

The sponsor of each of the benefit programs under the Healthineers Benefits Program described in this Summary Plan Description is:

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard
Malvern, PA 19355

By making a written request to the Plan Sponsor, you may request information whether or not a specific employer affiliated with Siemens Medical Solutions USA, Inc. has elected to participate in the Healthineers Benefits Program.

Employer Identification Number

The employer identification number (EIN) assigned by the Internal Revenue Service (IRS) to Siemens Medical Solutions USA, Inc. Healthineers is 22-241778

Plan Administrator

The Plan Administrator for each of the benefit programs under the Healthineers Benefits Program described in this Summary Plan Description is the same as the Plan Sponsor (see above). Communications to the Plan Administrator should be addressed as follows:

Plan Administrator
c/o Siemens Corporate Benefits Department
4800 North Point Parkway, Suite 300
Alpharetta, GA 30022
(770) 369-8280

Claiming Benefits

You must file a written claim to receive benefits within 12 months of the date on which the claim was incurred under any of the benefit programs described in this Summary Plan Description except for the Flexible Spending Accounts, the Health Reimbursement Account, and the Health Savings Account. For the Flexible Spending Accounts, you have 2-1/2 months beyond the end of the calendar year — until March 15 — to incur eligible health care and dependent day care expenses, and until the end of May of that year to submit claims to the Claims Administrator (see the "Flexible Spending Accounts" section of this Summary Plan Description for information on claiming benefits). For the Health Reimbursement Account, claims must be submitted for processing within 90 days of the end of the plan year in which the claim was incurred or within 90 days of the termination of your participation in a Health Reimbursement Medical Plan option, if sooner. For the Health Savings Account, claims must be submitted for processing within six months of the date of purchase or service. No benefits will be paid for claims filed after these deadlines unless regulatory requirements dictate other timeframes or there are certain extenuating circumstances that caused the late filing. A claim for benefits should be submitted to, and will be approved or denied by, the Claims Administrator for the applicable program option. The Claims Administrator for each Healthineers Benefits Program option is identified in the Table labeled *Administrative Information* below in this section of the Summary Plan Description.

CLAIM AND APPEAL PROCEDURES FOR GROUP HEALTH PLANS

(MEDICAL, PRESCRIPTION, DENTAL AND VISION)

NOTE: Any claim for benefits you may have under certain Indemnity Plans, Preferred Provider Organizations, and Health Maintenance Organizations that are considered "insured" must be made to the applicable Indemnity Plan, PPO, HMO in accordance with its particular claims review procedure. These insured Indemnity Plans, PPOs, and HMOs are: *Cigna International, Hawaii Medical Services Association (HMSA), and Kaiser Foundation Health Plans..* In addition, the insured HMOs provide prescription drug services through their own pharmacy program. Therefore, pharmacy claims under the insured HMOs are handled through the applicable insured HMO option in the same manner as a medical claim.

Claims made under any of the Medical, Dental or Vision options that are considered "self-insured" by your employer are made in accordance with the provisions set forth below. These self-insured options include the *Health Savings Medical Plan option administered by UnitedHealthcare, Health Reimbursement Medical Plan options and PPO Medical Plan options administered by UnitedHealthcare and Anthem BCBS,* together with prescription drug services provided by *CVS/caremark* under these medical plan options; and the Delta Dental plan. The *EyeMed Vision Care "Basic," "Enhanced"* and *"Premier"* plan options are "fully insured"; however, claims made under these options also follow the provisions set forth below.

A claim for medical or dental benefits should be made in writing to the Claims Administrator of the appropriate medical or dental coverage option. Prescription drug claims for any medical plan option that offers pharmacy services through CVS/caremark must be submitted for processing within 12 months of the date of purchase to CVS/caremark, the Pharmacy Claims Administrator for the self-insured Health Savings, Health Reimbursement and PPO Medical Plan options (.

You or your covered dependent may designate in writing an authorized representative to pursue your group health (medical, prescription drug, dental or vision) claim. In the case of an urgent health care claim, a health care professional with knowledge of your medical condition may act as your authorized representative.

Procedures for CVS/caremark

There are two types of claims under the Prescription Drug Program, pre-service claims and post-service claims. Under pre-service claims, there are urgent care claims (defined below) and non-urgent care claims, and each is handled differently, as described below. If you have submitted a claim for benefits and your claim is denied in whole or in part, you will be notified in writing of the denial by CVS/caremark.

If you are not satisfied with CVS/caremark's decision on the initial claim, you, or your representative, can request that the claim be reviewed on appeal. The request for an appeal on claim decisions is made in writing to CVS/caremark Inc., Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084. Appeals may be sent by fax to (866) 443-1172, Attn: Appeals Department. The appeal must be submitted within 180 days after a denial. Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial. Copies of any materials or records that support your claim should be sent with the appeal. However, if you are requesting review of an urgent care claim, you may also request review orally, and all communications may be done by telephone, facsimile, or other similar method.

Second-Level Appeal Procedure for *CVS/caremark* in Certain Instances

If the reason your appeal to CVS was denied is due to your not obtaining prior authorization from CVS for the use of one of the drugs contained on the list of drugs requiring such prior authorization under the Healthineers Prescription Drug Program (see www.caremark.com or contact **866-478-5802**), you have the right to request and receive a second-level appeal as to whether your usage of that drug should be covered for reasons of medical necessity. The second-level appeal must be submitted in writing within 180 days after your receipt of the prior appeal denial. The second-level appeal should be sent to CVS/caremark, Attn: Appeals Department MC 109, P.O. Box 52084, Phoenix, AZ 85072-2084, or by fax to (866) 443-1172, Attn: Appeals Department. Your second-level appeal will be forwarded by CVS/caremark to an Independent Medical Review Organization that CVS/caremark has retained for review and determination. Currently, that Independent Review Organization is Medical Review Institute of America. Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the dates of the initial notice of denial and the first-level appeal denial, and the reason(s) for disputing the denials, particularly as to why that drug should be covered for reasons of medical necessity. Copies of any materials or records that support your claim should be sent with the second-level appeal.

If your second-level appeal is denied upon review, the written notice will contain the following information: (a) the specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; (c) a statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial; (d) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you upon request and free of charge; and (e) an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided upon request and free of charge.

Please note that a second appeal will be permitted only if the reason for the denial of your first appeal is due to your not obtaining prior authorization from CVS/caremark for the use of one of the drugs contained on the list of drugs for which prior authorization is required under the Healthineers Prescription Drug Program and for no other reason. You will be notified by CVS/caremark at the time you receive a decision of your first appeal as to whether you have a right to receive a second appeal.

CVS/caremark has full and exclusive discretionary authority to interpret all provisions of the Healthineers Prescription Drug Program, to determine material facts and eligibility for benefits, and to construe the terms of the Healthineers Prescription Drug Program with respect to claim adjudication and appeals. Interpretations and determinations made by CVS/caremark will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

External Review Program, Independent Third-Party Review for CVS/caremark

If your Prescription Drug claim is denied in whole or in part upon appeal by CVS/caremark and, if applicable, by the Independent Medical Review Organization retained by CVS for second-level appeals in certain instances, the notice of denial will include instructions for submitting your claim for additional review by an independent review organization (IRO). You have a right to submit your claim to the IRO even if your claim has been denied by the Independent Medical Review Organization retained by CVS for second-level appeals. Your written request for review by an IRO, together with all accompanying medical documentation, will be forwarded to the IRO by CVS/caremark. The IRO will be selected using a random algorithm that currently distributes cases among MCMC Ltd., Network Medical Review Co. Ltd., MES Peer Review Services, and MRI of America. The IRO will have full and

exclusive discretionary authority to interpret all provisions of the Prescription Drug Program, to determine material facts and eligibility for benefits, and to construe the terms of the Healthineers Prescription Drug Program. Interpretations and determinations made by the IRO will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

Appeal of Prior Benefit Determination for Delta Dental

Delta Dental will notify you and your healthcare provider if Benefits are denied, in whole or in part, for services submitted on a Claim Form, stating the reason(s) for denial. If your request for prior authorization of a dental service or treatment or your request for payment of Benefits submitted on a Claim Form is denied by Delta Dental, in whole or in part, you or your representative or your healthcare provider have at least 180 days after receiving a notice of denial to request a written appeal or grievance that gives reasons why you believe the denial was wrong. You or your representative or your healthcare provider may also ask Delta Dental to examine any additional information that may support the appeal or grievance. You or your representative or your healthcare provider may submit your appeal by mail to Delta Dental, One Delta Drive, Mechanicsburg, PA 17055-6999.

Delta Dental will send you a written acknowledgment within five days upon receipt of the appeal or grievance. Delta Dental will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially.

If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment, or clinical judgment in applying the terms of the Delta Dental Plan or Delta Dental's contract with your healthcare provider, Delta Dental will consult with a dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review nor the subordinate of such individual. Delta Dental will send you or your representative or your healthcare provider a decision within 30 days after receipt of the appeal or grievance.

Procedures for EyeMed Vision Care

There are two types of claims under the Vision Plan options, In-Network claims and Out-of-Network claims. First American Administrators, Inc. ("FAA"), a third-party administrator and wholly owned subsidiary of EyeMed, will decide claims within 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

All In-Network claims will be processed by a participating EyeMed Network Provider directly through FAA/EyeMed. You will need to pay the cost of any services or eyewear that exceeds any allowances, any applicable co-payments, and state tax, if applicable. You will also need to pay the cost of any non-covered expenses (for example, vision perception training). If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at ***844-378-9360*** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may mail or fax a formal complaint to FAA/EyeMed Vision Care LLC, Attn: Quality Assurance

Department, 4000 Luxottica Place, Mason, OH 45040 (Fax: 1-513-492-3259). You may also include written comments or supporting documentation. The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

If you receive services from an Out-of-Network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. An Out-of-Network claim form is available at www.eyemed.com or by calling the EyeMed Customer Care Center at ***844-378-9360***. To receive your Out-of-Network reimbursement, complete and sign an Out-of-Network claim form, attach your itemized receipts and send to FAA/EyeMed Vision Care LLC, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111.

If you are not satisfied with EyeMed's decision on the initial claim, In-Network or Out-of-Network, you, your representative, or your vision care Provider may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an Explanation of Benefits ("EOB") within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that you feel was misinterpreted or inaccurately applied.
- Additional information from your eye care Provider that will assist FAA in completing its review of the first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to FAA/EyeMed Vision Care LLC, Attn: Quality Assurance Department., 4000 Luxottica Place, Mason, OH 45040 (Fax: 1-513-492-3259). FAA/EyeMed will review your first-level appeal and notify you in writing of its decision.

Procedures for Group Health Claims

To understand the claims procedures for the medical (including prescription drug) and dental plan options, you need to know the following terms:

- **Urgent Care Claim.** A special type of pre-service claim where following the normal pre-service claims procedures: (i) could seriously jeopardize your life or health or your ability to regain maximum function; or (ii) in the opinion of a qualified physician with knowledge of your condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The applicable Claims Administrator will determine whether a claim is an urgent care claim by applying a prudent layperson standard, unless an attending provider with knowledge of your condition determines that the claim is an urgent care claim.
- **Pre-Service Claim**. Any claim for a benefit for which the health plan option requires pre-approval or pre-authorization before you may obtain the services requested.
- **Post-Service Claim.** Any claim that is not a pre-service claim. In other words, any claim for a benefit for care that has already been received. Claims and appeals with respect to the Health Care Flexible Spending Account are all post-service claims.

If you have tried to file a pre-service claim under a health plan option (including an urgent care claim) but have not properly followed the plan option's procedures for doing so, you will be notified of the failure and of the proper procedures for filing a pre-service claim. You will receive such notification,

orally or in writing, no later than five days after your initial attempt to file a claim (or 24 hours in the case of an urgent care claim). You will be considered to have attempted to file a pre-service claim if you have communicated with the appropriate person within the applicable Claims Administrator who normally handles group health benefit matters and if you have named a specific medical condition, symptom, treatment, service, or product for which you are seeking approval.

If you have submitted a claim for health plan option benefits and your claim is denied in whole or in part, you will be notified by phone or in writing of the denial in accordance with the rules described below. If you have submitted a claim for benefits and your claim is denied in whole or in part, you may call the Claims Administrator for your medical plan option at the number shown on your medical or dental plan ID card before requesting a formal appeal. If the Claims Administrator is unable to resolve the matter over the phone to your satisfaction, you have the right to request a formal appeal.

A formal appeal is a written request for review of a denial of a health plan option claim and should include all of the following:

- a specific request for a review (internal, expedited, external, as may apply);
- the covered person's name, address and member ID number;
- your designated representative's name and address (when applicable);
- a description of the service that was denied; and
- any new, relevant information that was not provided previously.

Urgent Care Claims

This section applies if you are submitting a claim for benefits involving urgent care. You will be notified by the applicable Claims Administrator of any determination on your claim (whether favorable or unfavorable) as soon as possible, but not later than 72 hours after your claim is received. However, if you do not provide sufficient information to determine whether benefits are payable under the health plan option, the applicable Claims Administrator will notify you as soon as possible, but no later than 24 hours after receipt of the claim. You will have at least 48 hours to provide the necessary information. The applicable Claims Administrator will notify you of its determination (whether favorable or unfavorable) as soon as possible, but no later than 48 hours after the Claims Administrator receives the additional information required (or, if earlier, the date by which the Claims Administrator required you to submit the additional information). The initial notice of denial of your urgent care claim may be provided orally by the applicable Claims Administrator if written notification is provided to you within three days after the oral notification.

Concurrent Care Decisions

This section applies if you have already received approval from the applicable Claims Administrator for an ongoing course of treatment to be provided over a period of time or a specified number of treatments.

- **Benefit Reduction or Termination in Course of Treatment.** Any decision to reduce or terminate benefits for a previously approved course of treatment (unless the health plan option is being terminated altogether) will be considered a denial of a claim for benefits. You will receive sufficient advance written notice of the benefit reduction or termination to allow you to obtain a review of the decision before benefits for the course of treatment are reduced or eliminated.
- **Requesting an Extension on a Course of Treatment.** If you wish to request an extension of a course of treatment beyond the initial period of time or number of treatments for which you previously received approval from the applicable Claims Administrator, and if the request involves

urgent care, you must make such request at least 24 hours prior to the expiration of the previously approved course of treatment. You will be notified in writing of the decision whether to extend your course of treatment as soon as possible, but no later than 24 hours after receipt of your request. If your request does not involve urgent care, your claim will be treated as a regular pre-service claim.

Pre-Service Claims

You will be notified by the applicable Claims Administrator of the denial within a reasonable period appropriate to the medical circumstances, but no later than 15 days after your claim is received. If special circumstances require an extension of time to review your claim, a 15-day extension will be permitted. You will be notified by the applicable Claims Administrator of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 15-day period. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from you, you will have at least 45 days to provide such information. The deadline for making a decision on your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

Post-Service Claims

You will be notified by the applicable Claims Administrator of the determination of your claim no later than 30 days after your claim is received. If special circumstances require an extension of time to review your claim, a 15-day extension will be permitted. You will be notified by the applicable Claims Administrator of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 30-day period. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from you, you will have at least 45 days to provide such information. The deadline for making a decision on your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

A written notice of denial by the applicable Claims Administrator will contain the following: (a) information sufficient to identify the claim involved; (b) the specific reason or reasons for denial; (c) a reference to specific Plan provisions on which the denial is based; (d) a description of any additional material or information necessary to perfect your claim, with an explanation of why the material or information is necessary; (e) an explanation of the claims review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial upon review of the claim; (f) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request; (g) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided free of charge, upon request; and (h) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

Procedures for Appeal

An appeal on claim decisions — except those involving eligibility to participate in the medical, dental or vision coverage options or a particular medical (including prescription drug coverage), dental or vision coverage option — **is made in writing to the applicable Claims Administrator**. The appeal must be within 180 days after a denial, by writing to the applicable Claims Administrator. Except where procedures specific to CVS/caremark, Delta Dental, and EyeMed Vision Care apply, the appeal procedures described below also apply to these Claims Administrators. In addition to a first level of appeal, the applicable Claims Administrator will offer a second level of appeal.

Your written appeal should include:

- your name and address,
- the fact that you are disputing the denial of a claim,
- the date of the initial notice of denial, and
- the reason(s) for disputing the denial.

Copies of any materials or records that support your claim should be sent with the appeal. However, if you are requesting review of an urgent care claim, you may also request review orally, and all communications may be done by telephone, facsimile, or other similar method.

Eligibility to Participate — If your appeal only involves whether or not you or a claimed dependent is eligible to enroll or participate in the Medical (including Prescription Drug coverage), Dental or Vision Plan or a particular Medical (including Prescription Drug coverage), Dental or Vision Plan option, your appeal must be made within 180 days after a denial by writing to the Administrative Committee for the Healthineers Benefits Program. The address for the Administrative Committee is c/o Siemens Corporate Benefits Department, 4800 North Point Parkway, Suite 300, Alpharetta, Georgia 30022. The telephone number is (866) 270-9913.

The Claims Administrator or Administrative Committee, as applicable will: (a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; (b) permit you to submit written comments, documents, records and other information relating to the claim; (c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination; (d) provide a review that does not afford deference to the initial claim determination and that is conducted by a plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person); (e) if the decision is based on a medical judgment, consult with a health care professional with experience in the appropriate field; (f) provide you with the identity of those medical experts whose advice was obtained in connection with the claim; and (g) ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person).

The applicable Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. Also, before you receive an adverse benefit determination on review based on a new or additional rationale, the applicable Claims Administrator will provide you, free of charge, with such rationale to give you a reasonable opportunity to respond.

The Claims Administrator or Administrative Committee, as applicable, has full and exclusive discretionary authority to interpret all provisions of the Plans for which it is designated with

responsibility for determining appeals, to determine material facts and eligibility for benefits, and to construe the terms of the applicable Plan option. Interpretations and determinations made by the Claims Administrator or Administrative Committee, as applicable, with respect to the Plan option for which it is designated responsibility for determining appeals, will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

Time for Decision on Review

- **Urgent Care Claims.** You will be notified by the applicable Claims Administrator of the decision on review (whether favorable or unfavorable) as soon as possible, taking into account medical exigencies, but no later than 72 hours after receipt of your request for review.
- **Pre-Service Claims.** You will be notified by the applicable Claims Administrator of the decision on review (whether favorable or unfavorable) within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of your written petition for review.
- **Post-Service Claims.** You will be notified by the applicable Claims Administrator of the decision on review (whether favorable or unfavorable) no later than 30 days after receipt of your written petition for review.

Other extensions of time will not be made unless there is an agreement in writing that good cause exists for the extension.

Notification of Determination on Review

If your health plan option claim is denied upon review, in whole or in part, the written notice will contain: (a) the specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; (c) a statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial, subject to the three-year limit in the Healthineers Benefits Program for such actions following your receipt of your final decision on your appeal; (d) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request; and (e) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided free of charge, upon request.

External Review Program, Independent Third-Party Review for Medical Plan Options

Under the External Review Program, if your claim for benefits under the medical plan options (including prescription drug coverage) is denied upon review by the applicable Claims Administrator for the medical option in which you are enrolled (including prescription drug coverage), in whole or in part, and you have exhausted your internal appeals, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may elect to participate in the External Review Program, which is available to you at no charge. You may request an independent review of the denial of a requested service or procedure or the denial of payment for a service or procedure. This provision does not apply to a claim submitted under the Dental options or the Vision options.

For Pre-Service Claims involving Urgent or Concurrent Care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal with your Claims Administrator. You or your authorized representative may request an Expedited

External Review orally or in writing to the applicable Claims Administrator. All information can be sent between you and the applicable Claims Administrator by telephone, facsimile or other similar method.

For a claim submitted under a medical coverage option (including prescription drug coverage), the External Review Program applies only if the adverse benefit determination is based on:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the medical plan Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card or as instructed in the letter of determination.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the applicable medical coverage option. The Independent Review Organization (IRO) has been contracted by the applicable Claims Administrator but has no material affiliation or interest with Healthineers or any medical plan Claims Administrator. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of receipt by the Claims Administrator of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by the Claims Administrator in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to the Claims Administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the applicable Claims Administrator will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Healthineers Benefits Program. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator of your medical plan option at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

CLAIM AND APPEAL PROCEDURES FOR FLEXIBLE SPENDING ACCOUNTS (WAGEWORKS®)

WageWorks® is the Claims Administrator for the benefits under the Health Care, Limited-Use Health Care and Dependent Care Flexible Spending Accounts. If you have submitted a claim for reimbursement from your Flexible Spending Account and your claim is denied in whole or in part, you will be notified in writing of the denial by WageWorks. The notice will contain the following: (a) the specific reason or reasons for denial; (b) a reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect your claim, with an explanation of why the material or information is necessary; and (d) an explanation of the claims review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial upon review of the claim, subject to the three-year limit in the Healthineers Benefits Program for such actions following your receipt of your final decision on your appeal.

If you are not satisfied with WageWorks' decision on the initial claim, you (or your representative or your healthcare provider) can request that the claim be reviewed on appeal by WageWorks. The request for a first-level appeal on claim decisions is made in writing to WageWorks and must be sent within 180 days after receiving notice of the denial. The address for WageWorks is Claims Appeals Board, P.O. Box 991, Mequon, WI 55032. WageWorks suggests that you call customer service at 877-924-3967 (877-WageWorks) to provide notice that you are sending an appeal. The WageWorks customer service representative will advise you on the appeal process. Your written appeal should include your name, address and WageWorks identification number as the member, the name of the patient or eligible dependent and relationship to the member, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, the name of the health care professional or facility that provided the service(s), the date and description of the service(s) provided and the charge(s), and the reason(s) for disputing the denial. Copies of any materials or records that support your claim should be sent with the appeal.

Unless special circumstances require an extension of time, a decision on an appeal will be made by WageWorks within 60 days of the date the written appeal is received. Special cases can require 120 days. You will receive a notice of the special circumstances that require an extension before the end of the 60-day period. The notice will indicate the circumstances requiring the extension and the date by which WageWorks expects to render a decision. The extension may be for up to 60 additional days. Other extensions of time will not be made unless there is an agreement in writing that good cause exists for the extension.

WageWorks will: (a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; (b) permit you to submit written comments, documents, records and other information relating to the claim; (c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination; and (d) provide a review that does not afford deference to the initial claim determination (or a subordinate of that person).

Second-Level Appeal Procedure for the Flexible Spending Accounts

If you are not satisfied with WageWorks' decision on the first level of appeal, you (or your representative) are entitled to request and receive a second-level appeal, which will be decided by the Administrative Committee for the Healthineers Benefits Program. Your written second-level appeal must be mailed within 60 business days of receiving the denial of the first-level appeal from

WageWorks. The address for the Administrative Committee for the Healthineers Benefits Program is c/o Siemens Benefits Department, 4800 North Point Parkway, Suite 300, Alpharetta, GA 30022. The telephone number is (866) 270-9913. Your second-level appeal should include your name, address, the fact that you are disputing the denial of the claim and the first-level appeal, the dates of the initial notice of denial and the denial of the first-level appeal, and the reason(s) for disputing the denials. Copies of any materials or records that support your claim should be sent with the second-level appeal.

If your second-level appeal is denied upon review, the written notice will contain the following information: (a) the specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; and (c) a statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial, subject to the three-year limit in the Healthineers Benefits Program for such actions following your receipt of your final decision on your appeal.

The Administrative Committee for the Healthineers Benefits Program has full and exclusive discretionary authority to interpret all provisions of the Flexible Spending Account programs, to determine material facts and eligibility for benefits, and to construe the terms of the Flexible Spending Account programs. Interpretations and determinations made by the Administrative Committee will be final, conclusive and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious.

CLAIM AND PROCEDURE FOR THE LONG-TERM DISABILITY PLAN

A claim for long-term disability benefits should be made in writing to Liberty. You may designate in writing an authorized representative to act on your behalf in pursuing your disability claim.

If you have submitted a claim for benefits and your claim is denied in whole or in part, you will be notified of the denial within 45 days after your claim is received. If special circumstances require an extension of time to review your claim, a maximum of two 30-day extensions will be permitted. You will be notified of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, before the end of the initial 45-day period. You will be sent notice of any second extension before the expiration of the first 30-day extension period. The notice(s) of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required from you, you will have 45 days to provide such information. The deadline for making a decision on your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

If your claim is denied, you will receive a written notice containing: (a) the specific reason or reasons for denial; (b) a reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect your claim, with an explanation of why the material or information is necessary; (d) an explanation of the claims review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial upon review of the claim; (e) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request; and (f) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided free of charge, upon request.

An appeal on LTD claim decisions is made to Liberty. The appeal must be submitted within 180 days after a denial, by writing to Liberty. The address is The Liberty Life Assurance Company of Boston Disability Claims, P.O. Box 7211, London, KY 40742-7211. The telephone number is **877-294-3423**. Your written appeal should state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial. Copies of any materials or records that support your claim should be sent with the appeal.

Liberty will: (a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; (b) permit you to submit written comments, documents, records and other information relating to the claim; (c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination; (d) provide a review that does not afford deference to the initial claim determination and that is conducted by a Plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person); (e) if the decision is based on a medical judgment, consult with a health care professional with experience in the appropriate field; (f) provide you with the identity of those medical experts whose advice was obtained in connection with the claim; and (g) ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person).

Unless special circumstances require an extension of time, you will be notified of the decision on review within 45 days after receipt of your written petition for review. If an extension is necessary due to special circumstances, you will be given a written notice of the required extension before the expiration of the initial 45-day period. The notice will indicate the circumstances requiring the

extension and the date by which Liberty expects to render a decision. The extension may be for up to 45 additional days. Other extensions of time will not be made unless you and Liberty agree in writing that good cause exists for the extension.

Liberty has full and exclusive discretionary authority to interpret all provisions of the Long-Term Disability Plan options, to determine material facts and eligibility for benefits, and to construe the terms of these LTD Plan options. Interpretations and determinations made by Liberty will be final, conclusive, and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious. Liberty's decision on an appeal is final.

If your appeal is denied upon review, the written notice will contain the following information: (a) the specific reason for the decision and specific reference to the provisions of the LTD Plan option on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; (c) a statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial, subject to the three-year limit in the Healthineers Benefits Program for such actions following your receipt of your final decision on your appeal; (d) if any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request; and (e) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided free of charge, upon request.

CLAIM AND APPEAL PROCEDURES FOR EMPLOYEE AND SUPPLEMENTAL LIFE, PERSONAL ACCIDENT AND BUSINESS TRAVEL ACCIDENT INSURANCE

The claims procedures discussed in this section apply to Employee and Supplemental Life Insurance, Personal Accident Insurance and Business Travel Accident Insurance benefit claims. If you believe you are entitled to a benefit under one of these plan options and have not been notified that one is payable, or if you disagree with the amount of the benefit that is payable, you may file a written claim with the appropriate plan option's Claims Administrator. You or your beneficiary may designate in writing an authorized representative to pursue the claim and any appeal.

A decision on a claim will be given to you or your beneficiary as soon as possible, but no later than 90 days after receipt of your properly filed claim, or 180 days in special cases, if a decision on a claim cannot be made within 90 days. You will be notified in writing before the end of this 90-day period of the special circumstances that require an extended period of consideration of your claim, and the approximate date *when* a decision is *expected* on your claim.

If a claim is denied in part or in whole, you, your dependent, or your beneficiary will receive written notification from the applicable Claims Administrator. The notification will contain: (a) the specific reason or reasons for denial; (b) a reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary; and (d) an explanation of the claims review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial upon review of the claim, subject to the three-year limit in the Healthineers Benefits Program for such actions following your receipt of your final decision on your appeal.

An appeal on a claims decision under the Employee and Supplemental Life Insurance, Personal Accident Insurance or Business Travel Accident plan options must be submitted to the applicable Claims Administrator which made the claims determination within 60 days after the date you receive a denial. The address for The Hartford is The Hartford Life Insurance Company, Attn: Group Life Claims Appeals Unit, P.O. Box 14299, Lexington, KY 40512-4299. The telephone number for The Hartford is 888-563-1124. The address for the Life Insurance Company of North America (LINA) is Cigna Claims, 1600 West Carson Street, Pittsburgh, PA 15219. Your written appeal should include your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial. Copies of any materials or records that support the claim should be sent with the appeal.

The applicable Claims Administrator will: (a) provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; (b) permit you to submit written comments, documents, records and other information relating to the claim; and (c) provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination.

Unless special circumstances require an extension of time, a decision on an appeal will be made within 60 days of the date the written appeal is received. Special cases can require 120 days. You will receive a notice of the special circumstances that require an extension before the end of the 60-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Appeal Administrator expects to render a decision. The extension may be for up to 60 additional days. Other extensions of time will not be made unless there is an agreement in writing that good cause exists for the extension.

The applicable Claims Administrator has full and exclusive authority to interpret all provisions of the Life, Personal Accident and Business Travel Accident plan options and to determine material facts and eligibility for benefits. Interpretations and determinations made by the Claims Administrator will be final, conclusive, and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious. The decision on an appeal is final.

If your appeal is denied upon review, depending on the Plan option involved, the applicable Claims Administrator will give a written notice containing: (a) the specific reason(s) for the decision and specific reference to the provisions of the Plan option on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits; and (c) a statement that you have the right to bring a civil action under Section 502(a) of ERISA if you or your beneficiary believes the claim is improperly denied, subject to the three-year limit in the Healthineers Benefits Program for such actions following your or your beneficiary's receipt of a final decision on your appeal.

TIME LIMIT FOR BRINGING LEGAL ACTIONS FOR DENIED BENEFIT CLAIMS UNDER PLANS THAT ARE PART OF THE HEALTHINEERS BENEFITS PROGRAM

You cannot bring any legal action against the Healthineers Benefits Program, any of its Claims Administrators or Insurers until you have first completed all the steps set forth in the claims review and appeals process set forth in this Summary Plan Description. If you want to bring a legal action against the Healthineers Benefits Program, any of its Claims Administrators or Insurers, the Plan Sponsor, the Plan Administrator or, if applicable, the Administrative Committee for the Healthineers Benefits Program with respect to the denial of your claim for benefits or any other claim relating to your benefits, you must do so within three years of the date you or your beneficiary, as applicable, are notified in writing of the final decision on your appeal on your claim (except with respect to Life Insurance, insured by The Hartford, and Long-Term Disability Insurance, insured by Liberty Mutual), or you or your beneficiary, as applicable, lose any rights to bring any such legal action. If you want to bring a legal action with respect to a Life Insurance or Personal Accident Insurance claim, insured by The Hartford, or a Long-Term Disability claim, insured by Liberty Mutual, the three-year limitation period begins on the last date you were required to provide proof of a claim or loss under such programs.

LEGAL SERVICE

Legal process may be served on the Plan Sponsor.

Non-Assignment of Benefits

Generally, your benefit from any Plan may not be assigned, sold, transferred, or pledged to anyone else.

Administrative Information and Claims Administrators

Plan Name	*Plan Number*	*Plan Type*	*Plan Funding*	*Claims Administrator or Insurer*
Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program (Group Life[1], Medical, Dental, Vision, Long-Term Disability Income, Personal Accident Insurance, and Business Travel Accident Insurance, Long-Term Care Insurance, Flexible Spending Accounts)	565	Welfare	Employee and Company Contribution	Employee Basic Life, Employee Supplemental Life, Dependent Life, Personal Accident Insurance: **The Hartford** is claims administrator and insurer for claims The applicable claims administrator for the medical plan options depends on the employee's election: **UnitedHealthcare** is the administrator for Health Savings, Health Reimbursement and PPO medical plan options (including mental health and substance abuse); and **Anthem Blue Cross Blue Shield** is the administrator for Health Reimbursement and PPO medical plan options (including mental health and substance abuse) **CVS/caremark** is claims administrator for prescription drug benefits available to employees covered under the Health Savings, Health Reimbursement and PPO medical plan options **Kaiser Permanente of Northern California**, and **Kaiser Permanente of Southern California** are claims administrators and insurers for their respective HMO coverage options **HMSA** is the claims administrator and insurer for the PPO medical plan option available to Hawaii residents **Cigna International** is the claims administrator and insurer for the Cigna International expatriate medical and dental plan options

Plan Name	Plan Number	Plan Type	Plan Funding	Claims Administrator or Insurer
				First American Administrators Inc. is claims administrator for the **EyeMed Vision Care** vision benefits program, which is underwritten by Fidelity Security Life Insurance Company **Delta Dental** is the dental claims administrator **Liberty Mutual** is the claims administrator and insurer for Long-Term Disability **Life Insurance Company of North America (LINA)** is the claims administrator and insurer for Business Travel Accident Insurance benefits **MetLife** is the claims administrator and insurer for Long-Term Care Insurance; enrollment closed 12/31/2011 ***WageWorks®*** is claims administrator for Flexible Spending Accounts
[1] Includes Dependent Life Insurance				

Table 44 – Administrative Information

Plan Records

All plan records are kept on a calendar-year basis beginning January 1 and ending December 31 of each year.

Plan Documents

The Plan Documents include this Part 1 of the Summary Plan Description covering health and welfare benefits for “active” employees, Part 2 of the Summary Plan Description covering retiree benefits, the Healthineers Flexible Benefits Program document and the applicable insurance company contracts, which legally govern the plans and are controlling in the event of a conflict with Parts 1 and 2 of the Summary Plan Description. These documents, as well as the annual report of each Plan’s operation and each Plan’s description, as filed with the U.S. Department of Labor, are available for review upon written request to the Plan Administrator. Copies of any of these documents will be furnished to a plan member or beneficiary within 30 days at a nominal cost.

Plan Amendment and Termination

Siemens Medical Solutions USA, Inc. reserves the right to change, modify or terminate the Healthineers Benefit Program, any of the coverages contained in the Healthineers Benefit Program and/or any provisions of any of the coverages described in this Summary Plan Description in whole or in part at any time.

Siemens Medical Solutions USA, Inc. also reserves the right to change the amount of contributions an employee may have to make for any type of coverage, including requiring employee contributions in instances where no such requirement existed.

YOUR RIGHTS UNDER ERISA

(Employee Retirement Income Security Act of 1974)

The benefits listed on the table in the Plan Administration section of the Summary Plan Description for the Healthineers Benefits Program are covered by ERISA. The law does not require employers to provide benefits. However, it does require that you be given an opportunity to learn what those benefits are and your rights to them under the law. As a participant in these plans, you are entitled to certain rights under ERISA.

ERISA provides that all plan participants shall be entitled to:

1. Receive Information About Your Plans and Benefits

- Examine, without charge, at your participating Employer's, Plan Administrator's, or Claims Administrator's office, all documents governing the plans, including, insurance contracts, collective bargaining agreements and copies of the latest annual reports (Form 5500 Series) filed by the Plans with the U.S. Department of Labor; and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

2. Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or domestic partner (same or opposite sex) or dependents if there is a loss of coverage under the health plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plans on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer, when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plans, called "Fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. Although these rights are in no way a guarantee or contract of employment, no one, including your participating Employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from a plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored in part or in whole, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If it should happen that plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about these plans, you should contact the Plan Administrator. If you have any questions about this statement or about Your Rights Under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or at http://www.dol.gov/dol/location.htm, or call the U.S. Department of Labor National Toll-Free Contact Center at 866-4-USA-DOL (866-487-2365) or TTY 877-889-5627, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration.

GLOSSARY

Actively at Work

You are ***Actively at Work*** if you are performing all of the usual and customary duties of your job at:

i. your employer's place of business;

ii. an alternate place approved by your employer; or

iii. a place to which your employer's business requires you to travel.

You will be deemed to be Actively at Work after normal business hours, during weekends or during approved vacations, holidays, business closures, and approved Family Medical Leave where you were Actively at Work on your last scheduled work day preceding such time off. .

Balance Billing

When an Out-of-Network provider bills you for the difference between the provider's charge and the maximum amount that will be covered under the plan (Reasonable and Customary, Maximum Allowed Amount or Maximum Reimbursable Charge) as determined by the Claims Administrator of your medical or dental plan option. The maximum amount that will be covered under the plan for a defined Covered Health Service takes into account any amount applied to your annual deductible and any coinsurance paid by you or the plan. For example, if the provider's charge is $100 and the maximum amount that will be covered by the plan is $70, the provider may balance bill you for the remaining $30. Balance billing is not covered or applied to your annual out-of-pocket limit under any medical or dental plan option. Balance billing cannot be reimbursed from your Health Reimbursement Account but is generally eligible for reimbursement through your Health Care Flexible Spending Account or Health Savings Account. An In-Network provider may not balance bill you for a Covered Health Service.

Beneficiary

The person or persons you name to receive your insurance benefits. Subject to certain state legal requirements, you may name anyone as your beneficiary and may change your choice at any time and for any reason. To designate your beneficiaries, visit the YBR website at http://resources.hewitt.com/siemens or call the SBSC at **800-392-7495**. Beneficiaries for Business Travel Accident insurance can be designated only by calling the SBSC.

Chiropractic Care

The term ***chiropractic care*** means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Coinsurance

Coinsurance, also known as *percentage participation*, means that the Claims Administrator for your Medical, Dental or Vision Plan option pays a certain percentage of your health care bills, while you pay the remaining percentage. The percentage you pay is your coinsurance. You may be responsible for paying the annual Deductible before your Plan Administrator is responsible for paying a percentage. The percentage paid by your Medical, Dental or Vision plan option may vary according

to the type of expense and whether the provider was In-Network or Out-of-Network. In some cases, you may not be expected to pay any coinsurance. Also, there is usually an annual Maximum Out-of-Pocket limit, which includes coinsurance that you have to pay before your Medical, Dental or Vision plan option starts paying 100% of your Covered Health Services. If you use an Out-of-Network provider who charges more than the maximum amount that will be covered by the Plan, as determined by the Claims Administrator of your Medical Plan option, you may also be responsible for paying balance billing in addition to your coinsurance.

Copayment (Copay)
Copayment or Copay is a pre-determined dollar amount that you pay directly to a pharmacy or health care provider. For example, you pay a $20 minimum copay for a 30-day supply of a preferred brand drug purchased at a CVS/caremark Network Pharmacy. You pay a $10 copay for an eye exam with an EyeMed Network provider. You pay a $25 copay for an In-Network doctor's office visit under the Health Reimbursement Medical Plan option. You pay a $250 Hospital Copay for inpatient care In- or Out-of-Network under the PPO Medical Plan option. A Copay sometimes covers the full cost of the service. Other times, further charges are payable. Copay amounts are included in the annual Out-of-Pocket Maximum.

Covered Health Service

Benefits for any Covered Health Service depend on the type of expense, the option you elect, and whether care is incurred In-Network or Out-of-Network. In all cases, plan reimbursements – including any portion of the billed amount that is applied to the deductible or annual out-of-pocket maximum – are based on the ***Reasonable and Customary (R&C)*** charge (or the ***Maximum Allowed Amount***) and whether the service or supply is ***medically appropriate*** as determined by the Claims Administrator of the plan option you elect. Covered expenses for Covered Health Services, incurred while the Plan coverage is in effect, are determined as stated below.

For ***In-Network*** benefits, covered expenses are based on either of the following:

- When Covered Health Services are received from In-Network providers, covered expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, covered expenses are the fee(s) that are negotiated with the non-Network provider.

For ***Out-of-Network*** benefits administered by UnitedHealthcare and MetLife, covered expenses are determined by either:

- Calculating covered expenses based on available data resources of competitive fees in that geographic area, or
- Applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

For ***Out-of-Network*** benefits administered by Anthem BCBS, covered expenses are limited to the ***Maximum Allowed Amount***.

Covered expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to another appropriate source or determination that the Claims Administrator accepts.

Custodial Care

Services that do not require the skills of professionally trained medical personnel and are of a sheltering, protective or safeguarding nature (including a stay in an institutional setting, at-home care or nursing services to care for you because of age or mental or physical condition) or to assist with the activities essential to daily living (such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing food, or taking medications that can be self-administered). Custodial care is not meant to be curative or to provide medical treatment.

Deductible

Deductible is the amount of covered medical expenses you pay each year before benefits are paid by the plan. Deductible amounts are included in the annual Out-of-Pocket Maximums.

The annual deductible for an individual or family depends on the medical plan option you elect and whether expenses are incurred In-Network or Out-of-Network. The family deductible is met once the expenses applied toward the deductible for each covered individual in your family equals the family deductible amount.

Dentist

An individual holding a degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

Disabled or Partially Disabled

For purposes of the Short-Term Disability Plan, you are ***Disabled*** if a physical or mental condition prevents you from performing all the essential functions of your Own Position, with or without reasonable accommodations, as determined by the appropriate Claims Administrator.

After LTD benefits have been paid for 24 months, you are considered Disabled if you are unable to perform with reasonable continuity the Material and Substantial Duties of Any Occupation for which you are reasonably qualified, taking into account your training, education, experience and pre-disability earnings. For purposes of the Long-Term Disability Plan and during the LTD Elimination Period and the next 24 months of Disability (i.e., the first 24 months of LTD benefit payments), you are ***Disabled*** if, as the result of an Injury or Sickness, you are unable to perform the Material and Substantial Duties of your *Own Occupation*, as determined by Liberty

at your Own Occupation for any employer in your local economy. In determining whether you are ***Disabled***, Liberty will not consider employment factors that include, but are not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job-sharing, or loss of a professional or occupational license or certification.

After LTD benefits have been paid for 24 months, you are considered Disabled if you are unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation for which you are reasonably qualified, taking into account your training, education, experience and Pre-disability Earnings.

For purposes of the Long-Term Disability Plan, you are ***Partially Disabled*** if, as the result of an Injury or Sickness, you are ***able*** to perform one, some or all of the Material and Substantial Duties of your ***Own Occupation*** or ***Any Occupation*** on a part-time basis, as determined by Liberty, and are able to earn at least 20% but no more than 80% of your *Basic Monthly Earnings* (during the first 12 months of LTD benefit payments) or *Indexed Basic Monthly Earnings* (thereafter).

Doctor (or Physician)

An individual holding a degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.D.M.), Doctor of Podiatry Medicine (D.P.M.) or Doctor of Chiropractic (D.C.), practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided. Under certain circumstances, this term may be applied to a licensed healthcare professional, such as a Physician's Assistant, Nurse Practitioner, Nurse Midwife, or Registered Nurse, who is permitted under the laws of the state or jurisdiction to provide services, including the right to prescribe medication, under the supervision of a doctor or physician. The term "Doctor" or "Physician" does not include you or any family member or domestic partner.

Emergency

A serious medical condition or symptom resulting from injury, sickness or mental illness which:

- Arises suddenly; *and*
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Health Maintenance Organization (HMO)

An HMO medical plan option provides benefits for most health care needs. Services are provided through a network or select group of doctors, hospitals and other providers, who are under contract to the HMO. You need to choose a primary care physician (PCP) at enrollment to direct your care and treatment. A referral is generally required for treatment outside your PCP's office. If you receive medical services outside your carrier's network, you usually will not receive any benefits coverage.

Home Health Care Agency

A public or private agency or organization licensed and operated according to law, which provides medical care and treatment in the patient's home. The agency must be supervised by at least one licensed doctor and Registered Nurse (R.N.) and be based on policies established by a professional group.

Hospice Care Program

A program that provides:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual, and social needs of terminally ill persons and their families;

- palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness;
- a program for persons who have a *terminal illness* and a life expectancy of fewer than six months and for the families of those persons.

Hospice Care Services

Any services provided by a hospital, skilled nursing care facility (or a similar institution), a home health care agency, a hospice facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

A facility, unit of a facility, public or private agency or subdivision of a public or private agency that meets federal certification requirements as a Hospice, or is comparably licensed under applicable state laws to provide care or management of the *Terminally Ill*.

Hospital

A public or private facility, licensed and operated according to law, which provides care and treatment by licensed physicians and nurses of ill or injured people with facilities for diagnosis and major surgery. The facility must be under the supervision of licensed doctors with a Registered Nurse on duty at all times. A hospital does not include an institution, or part of one, which is mainly a place for rest, the aged or convalescent care. A hospital includes tuberculosis facilities, substance abuse treatment facilities and mental/nervous treatment facilities.

Indexed Basic Monthly Earnings

Your pre-disability Basic Monthly Earnings increased by 7%. The first increase is calculated and takes effect on the date the 13th monthly long-term disability (LTD) benefit is payable. Subsequent increases take effect on each anniversary of the first increase. An increase in your Indexed Basic Monthly Earnings results in an increase in your monthly LTD benefit only if you are considered to be Partially Disabled and are receiving a *Partial Disability Work Incentive Benefit*, and the amount of any such increase will depend on the ratio of your current earnings to your Indexed Basic Monthly Earnings. You must have been continually receiving monthly benefits under the LTD plan to qualify for this increase in your LTD benefits. Your eligibility to receive a Partial Disability Work Incentive Benefit will end and your LTD benefits will terminate when the three-month average of your part-time earnings exceeds 80% of your pre-disability Basic Monthly Earnings or exceeds 80% of your Indexed Basic Monthly Earnings (depending on the number of months that you have been receiving LTD benefits).

Injury

A bodily impairment resulting directly from an accident and independently of all other causes. For the purposes of determining LTD benefits, any Disability that begins more than 60 days after an Injury will be considered a Sickness; and any Injury that occurred before you were covered under the Liberty LTD policy but accounts for a medical condition that arises while you are covered under the Liberty LTD policy will be treated as a Sickness.

Long-Term Care

A range of personal care, health care and social services for people who suffer from chronic diseases or long-lasting disabilities. These services may be provided in a nursing care facility, hospice facility, assisted living facility, a licensed adult day care center, or at home from a nurse, therapist, or home health aide.

Maximum Allowed Amount ("MAA")

Anthem BCBS determines the Maximum Allowed Amount ("MAA") that will be covered under your Medical Plan option for a Covered Health Service provided by an ***Out-of-Network*** provider. The Covered Health Service must be medically appropriate, not excluded from coverage, and provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan; and must be billed with accurate and appropriate procedure and diagnosis codes. The MAA includes any amount that you may be required to pay as deductible, copayment or coinsurance. Also, you may be responsible for paying the difference between the total amount the Out-of-Network provider bills and the payment based on MAA that Anthem makes ("balance billing").

The MAA will be one of the following:

- An amount based on Anthem BCBS's out-of-network fee schedule, which it has established in its discretion and which it reserves the right to modify from time to time, after considering one or more of the following:
  - Reimbursement amounts accepted by similar providers contracted with the Plan
  - Reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies; and
  - Other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the MAA upon the level or method of reimbursement based on CMS, Anthem BCBS will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third-party vendor to Anthem BCBS, which may reflect one or more of the following factors:
  - The complexity or severity of treatment;
  - Level of skill and experience required for the treatment; or
  - Comparable providers' fees and costs to deliver care; or
- An amount negotiated by Anthem BCBS or a third-party vendor, which has been agreed to by the Out-of-Network provider. This may include rates for services coordinated through case management; or
- An amount based on or derived from the total charges billed by the Out-of-Network provider; or
- When Covered Health Services are provided outside of Anthem's Service Area by non-participating providers, Anthem may determine benefits and make payment based on pricing from either the local Blue Cross or Blue Shield plan or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment and coinsurance will be based on that MAA. Please refer to the Inter-Plan program details that can be found at www.anthem.com once you have registered as a user.

Member services for Anthem BCBS (phone **855-869-8137**) can assist you in estimating the MAA and your responsibility for a particular service from an Out-of-Network provider. You will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) and charge for the service.

Although member services can assist with this information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the provider.

Maximum Reimbursable Charge

Cigna determines the Maximum Reimbursable Charge for U.S. Out-of-Network claims based on the lesser of (a) the provider's normal charge for a similar service or supply or (b) a percentile of charges made by providers of such service or supply in the geographic area where the service is received as compiled in a third-party database selected by Cigna. U.S. Out-of-Network services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area. The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge ("balance billing") in addition to any deductibles and coinsurance that may apply.

Medically Appropriate or Medically Necessary

Any generally accepted medical service or supply provided by, or under the supervision of, a licensed doctor that is required to diagnose or treat an illness or injury.

Mental Health and Substance Abuse Program

Mental Health and Substance Abuse benefits are administered by the Claims Administrator for your Medical Plan option and are described in the section entitled **"Mental Health and Substance Abuse Program."** For questions regarding your mental health and substance abuse benefits, visit the Anthem BCBS Behavioral Health website at www.anthem.com or call **855-869-8137**; or visit the United Behavioral Health website at www.myuhc.com or call **866-221-5901**.

Neuromusculoskeletal and Soft Tissue Disorders

Any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles.

Nursing Care

Services requiring the profession skills of a Nurse, provided by a Nurse, under the orders of a physician, for the purpose of improving or maintaining the covered person's health.

Out-of-Pocket Maximum

The annual out-of-pocket maximum limits the amount of coinsurance you have to pay each year. Once your annual deductible, copay (if applicable), and coinsurance payments have reached the corresponding In-Network or Out-of-Network annual out-of-pocket maximum, your Medical Plan option pays 100% of your Covered Health Services for the rest of the calendar year.

Pay

The definition of "pay" used in determining benefits under the Employee Basic Life, Employee Supplemental Life, Personal Accident and Business Travel Accident insurance plans differs depending on your employee classification, as follows:

- **Frozen Pay —** for the purpose of calculating benefit premium contributions and estimated coverage amounts for each plan year, frozen pay means your base salary on June 30 of the last preceding calendar year plus the total amount of short-term bonuses (if applicable) or commissions (if applicable) paid during the 12 months preceding the same June 30. For instance, frozen pay as calculated on June 30, 2017, will be used to estimate premium contributions and coverage for the plan year beginning January 1, 2018. If you are hired or become an active employee after June 30, then your frozen pay is equal to your base pay. Your frozen pay, as calculated for the last plan year in which you are actively at work, is also used as an alternative benefit amount.
- **Salaried and Hourly Employees** — for BTA, your base salary in effect as of the date of your death plus your actual short-term annual bonus paid within the last 12 months preceding your date of death (or for other coverages, the greater of frozen pay **or** the sum of your base salary in effect as of the date of your death plus your actual short-term annual bonus paid within the last 12 months preceding your date of death). It does not include any overtime, long-term incentive bonuses, retention bonuses, or special bonuses. *This definition of pay also applies to sales employees who are not paid commissions based on products sold.*
- **Sales and Commission Employees** — for BTA, your base salary in effect as of the date of your death plus the average of your actual sales commissions for the last three calendar years (or for other coverages, the greater of frozen pay **or** the sum of your base salary in effect as of the date of your death plus the average of your actual sales commissions for the last three calendar years). It does not include bonuses, overtime pay, or extra compensation.
  - If you have between two and three years of service, pay is your base salary plus the average of your last two calendar years of paid commissions.
  - If you have less than two years of service, pay is your base salary plus all commissions paid since your hire date, divided by the number of your full months of service, multiplied by 12.

The definitions of "pay" used in determining LTD benefits are modeled on the definitions used to determine life insurance premiums and coverage under the Healthineers Benefits Program and differ depending on your employee classification, as follows:

- **Frozen Pay —** for the purpose of calculating Employee-Paid LTD benefit premium contributions and estimated coverage amounts for each plan year, Frozen Pay means your annual base salary on June 30 of the last preceding calendar year in which you were an "active" employee plus the total amount of short-term bonuses (if applicable) or commissions (if applicable) paid during the 12 months preceding the same June 30. For instance, Frozen Pay as calculated on June 30, 2016, will be used to estimate premium contributions and coverage for the plan year beginning January 1, 2017. If you are hired or become an active employee after June 30, then your Frozen Pay is equal to your annual base pay.

The amount of "pay" used to calculate your LTD benefit will be equal to one-twelfth (1/12) of your Frozen Pay, as calculated for the last plan year in which you are actively at work, or the amount of your pre-disability Basic Monthly Earnings, whichever is ***greater***. The amount of your Frozen Pay, as calculated for the last plan year in which you are actively at work, does not change even if your actual expected compensation for the year is reduced or increased by a change in scheduled hours or rate of pay that preceded your Disability or Partial Disability.

- **Salaried and Hourly Employees** — the greater of one-twelfth (1/12) of your Frozen Pay **or** the sum of your monthly base salary in effect as of the day immediately preceding your Date of Disability plus the monthly average of your actual short-term annual bonus paid within the last 12 months preceding your Date of Disability. "Pay" does not include any overtime, long-term incentive bonuses, retention bonuses, special bonuses or awards. *This definition of pay also applies to sales employees who are not paid commissions based on products sold.*

- **Sales and Commission Employees** — the greater of one-twelfth (1/12) of your Frozen Pay **or** the sum of your monthly base salary in effect as of day immediately preceding your Date of Disability plus the monthly average of your actual sales commissions for the three calendar years preceding your Date of Disability. It does not include bonuses, overtime pay, extra compensation or awards.
  - If you have between two and three years of service, pay is your monthly base salary plus the monthly average of your last two calendar years of paid commissions.
  - If you have less than two years of service, pay is your monthly base salary plus the average of your monthly commissions determined by dividing the total of all commissions paid since your hire date by the number of your full months of service.

Pre-Existing Condition (for Long-Term Disability)

An illness, injury or medical condition for which you incurred expenses, received medical treatment, took prescribed drugs or consulted a physician during the three months before you became covered by a specific option in this plan. However, a condition is not considered pre-existing if you become disabled after you have been covered by a specific option in this plan for 12 consecutive months.

For example, a requested change in your LTD coverage from the Company-Paid to the Employee-Paid option effective January 1, 2016, would not apply until January 1, 2017, if the disability:

- occurred after January 1, 2016, and
- resulted from an illness treated after September 30, 2015 (which is within three months of the effective date of the new coverage level).

Any benefit payable would be under the terms of the Company-Paid option. Remember, any change requested during Annual Enrollment is not effective until your first day of work on or after January 1.

Preferred Provider Organization (PPO)

Like a *Health Maintenance Organization (HMO)*, a PPO is composed of a network of doctors and health care providers who have agreed to provide services at negotiated rates. Unlike an HMO, you can choose to get care from either In-Network or Out-of-Network providers under the PPO Plan. The PPO does not require you to choose a Primary Care Physician, but you will pay less for care provided In-Network.

Reasonable and Customary ("R&C")

The prevailing rate or normal range of fees charged by physicians, dentists, and other health care providers of similar standing in a given locality for a covered service or supply, as determined by the Claims Administrator. Out-of-Network claims administered by UnitedHealthcare and MetLife are paid on the basis of an R&C rate. Out-of-Network claims administered by Anthem BCBS are paid on the basis of a *Maximum Allowed Amount*. Out-of-Network charges in excess of R&C or the Maximum Allowed amount ("balance billing") are not covered by any of the Medical Plan options and cannot be reimbursed from your Health Reimbursement Account but are generally eligible for reimbursement through your Health Care Flexible Spending Account or Health Savings Account.

Member services for United Healthcare (phone **866-221-5901**) can assist you in estimating the R&C rate and your responsibility for a particular service from an Out-of-Network provider. You will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) and charge for the service. Although member services can assist with this information, the final R&C amount for your claim will be based on the actual claim submitted by the provider.

Rehabilitative Employment

A return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume productive employment or service in an occupation for which you are reasonably qualified, taking into account your training, education, experience and past earnings; or participation in vocational training or physical therapy. A Liberty Mutual vocational rehabilitation counselor must consider this appropriate.

Sickness

An illness, disease, pregnancy or complications of pregnancy.

Skilled Nursing Care Facility

A Skilled Nursing Care Facility is a licensed institution (other than a hospital) which specializes in physical rehabilitation on an inpatient basis, or skilled nursing and medical care on an inpatient basis. The institution must maintain on its premises all facilities necessary for medical treatment, provide such treatment (for compensation) under the supervision of doctors, and provide nursing services. The facility must be approved as an extended care facility by the Joint Committee on Accreditation of Hospitals or Medicine.

Terminally Ill

For the purposes of eligibility for hospice care under any Medical Plan option, you are ***terminally ill*** if you have an illness or injury that is determined by a physician to be likely to result in your death within six months. For the purposes of the employee life insurance plan, you are ***terminally ill*** if you have an illness or injury that is determined by a physician to be likely to result in your death within 24 months.