

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 January 1, 2024, was modified by, and includes the Summaries of Material Modifications dated January 1, 2026 and January 1, 2025 as follows:

- Summary of Material Modifications and Benefits **Enrollment Guide** for Plan Year 2026 – beginning on Page 2
- Summary of Material Modifications and **Benefits Enrollment Guide** for Plan Year 2025 – beginning on Page 35
- **Summary Plan Description** dated January 1, 2024 – beginning on Page 72

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

2026 Benefits Enrollment Guide

Personalized Benefits That Work for You





Your health and well-being matter to us. That's why Siemens Healthineers offers benefits to help you and your family live well.

Personalized Benefits That Work for You

Your Siemens Healthineers benefits offer you options that give you flexibility, value, and support.

Your next steps:



**Explore your
benefit options.**



**Use the tools and
resources available
to decide the right
coverage for you and
those you care about.**



**Enroll in your
benefits for 2026.**

Resources to Help you Enroll

Your health matters to us, and we want to be sure you get the most from your benefits. As you prepare to enroll, take advantage of the resources we've provided to explore your options and understand all the programs available to you.

Alight Benefits Guidance

When you need added assistance for enrollment, schedule an appointment with 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.myenrollmentinfo.com.



Siemens Healthineers Benefits Center (SHBC)

Get answers to your 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 by phone on weekdays between 10am and 6pm Eastern Time.

Estimate your medical expenses

During the enrollment process on mySHSBenefits.com, enter your estimated medical and prescription drug usage assumptions, and let the tool do the rest.



BenefitsatSHS.com

Want to explore all your benefit options in one place? Visit BenefitsatSHS.com for details on your health, wealth, and wellness options.

Alight Health Pro

Connect with your Alight 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 and click **Health Pro Connection** to securely message your Health Pro, or call **833-935-3328**.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Enrolling in Your Benefits

Steps to Enroll

Be sure to register on mySHSBenefits.com to enroll in and view your benefits.

As a first-time user, you must register on mySHSBenefits.com. You generally have access within two business days of your date of hire.

Go to mySHSBenefits.com.

Create a User ID and Password, as well as a Siemens Healthineers Benefits Center (SHBC) phone PIN by selecting **New User?**

Enter the last four digits of your Social Security Number, your date of birth, and your zip code.

When prompted, create a User ID, Password, and phone PIN:

- Your User ID and Password will give you access to the site in the future. You'll be asked to provide a Password hint as well as select and answer five security questions.
- Your phone PIN will give you access to your information through the SHBC. You'll be asked to provide a PIN hint.

Once you complete these steps, you will be able to view your benefit options and enroll.

1.

Register as a new user on mySHSBenefits.com. Click **New User** to create your login.

Once you've registered for the first time, for future logins you can quickly access the site via Single Sign-On by visiting the Siemens Healthineers Employee Service Portal and selecting the mySHSBenefits.com tile.
2.

Review information, consider your choices, and make your elections.
3.

Click **Complete Enrollment** to submit your choices—once you see “Completed Successfully,” you're all set.
4.

Check your confirmation by email or mail.

Enroll within the first 30 days at Siemens Healthineers or you won't have coverage.

You must enroll for benefits within your first 30 days at Siemens Healthineers, or you won't be eligible again until the next annual enrollment period (unless you experience a qualified life event during the year).

During the year, if you experience a life event such as marriage, birth, or divorce, call the SHBC at **833-935-3328** within **30 days** to update your coverage.*

*For more information about dependents, review the [Summary Plan Description \(SPD\)](#).

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Medical Plans

Health Reimbursement Copay Advantage Plan

The Health Reimbursement Copay Advantage Plan is administered through Anthem Blue Cross Blue Shield (BCBS) or UnitedHealthcare (UHC). With Anthem BCBS and UHC national provider networks, in-network care is available almost anywhere in the USA.

How the Plan Works

- You'll pay fixed costs for things like doctor visits, specialist appointments, and urgent care, which can help you budget your healthcare expenses. Copays are for in-network providers and are not applied to your deductible.
Primary care visit: \$30 **Specialist visit:** \$45 **Urgent care:** \$60
- For more complex care, like hospital stays or surgeries, you cover the full cost of care until you reach your deductible—\$1,500 for individuals or \$3,000 for families if you stay in-network.
- Then we share costs: After the deductible, you pay 10% coinsurance and Siemens Healthineers pays 90% until you hit your out-of-pocket max—\$3,700 for individuals or \$7,400 for families.
- After that, it's covered: Once you reach the out-of-pocket max, the plan pays 100% of eligible costs for the rest of the year.
- Out-of-network costs are higher: You pay more out of pocket, and the deductible is \$2,250 for individuals or \$5,550 for families. After that, you pay 35% and Siemens Healthineers pays 65%, up to a higher out-of-pocket max.
- Annual checkups and recommended screenings are covered at no cost when you stay in-network.

The Copay Advantage plan automatically comes with an HRA to help with costs. Siemens Healthineers gives you money in a **Health Reimbursement Account (HRA)**: \$500 for individual coverage or \$1,000 if you cover dependents. You can earn more by completing wellness activities. If you join after January 1, the amount is adjusted based on when you enroll.

Please note: Only Siemens Healthineers can contribute to this account.

Resources to Help you Enroll1

Enrolling in Your Benefits2

Health Reimbursement Copay Advantage Plan3

What you Need to Know About your HRA4

Health Savings Medical Plan5

What you Need to Know About your HSA6

Kaiser HMO Plan8

Comparison of Medical Plans (Highlights)9

Prescription Drug Benefits11

Dental Plan13

Vision Plan14

How Plan Costs Compare15

Healthcare and Dependent Day Care Flexible Spending Accounts16

Life & Work Assistance Program18

Wellness Programs19

Life Insurance22

Voluntary Benefits25

Disability Programs27

Commuter Benefits Program28

Additional Information and Notices29



What you Need to Know About your HRA



You can use your HRA to help pay medical costs for you and your covered family members.



You can either pay the bill yourself and ask for reimbursement or choose to have the HRA pay automatically.



You can't pay for everything with your HRA—things like dental, vision, prescription drugs, and payroll contributions don't count. Check the [Summary Plan Description \(SPD\)](#) to confirm before using your funds.



You'll need to send in documents to get reimbursed, unless you set up automatic payments on the HRA website of your claims administrator (Anthem BCBS or UHC).



If you don't use all your HRA funds, you can carry over up to \$4,000 to use next year—as long as you stay enrolled.



If you enroll mid-year, your company contribution is prorated based on the month of the year you join.

Resources to Help you Enroll **1**

Enrolling in Your Benefits **2**

Health Reimbursement Copay Advantage Plan **3**

What you Need to Know About your HRA **4**

Health Savings Medical Plan **5**

What you Need to Know About your HSA **6**

Kaiser HMO Plan **8**

Comparison of Medical Plans (Highlights) **9**

Prescription Drug Benefits **11**

Dental Plan **13**

Vision Plan **14**

How Plan Costs Compare **15**

Healthcare and Dependent Day Care Flexible Spending Accounts **16**

Life & Work Assistance Program **18**

Wellness Programs **19**

Life Insurance **22**

Voluntary Benefits **25**

Disability Programs **27**

Commuter Benefits Program **28**

Additional Information and Notices **29**

Medical Plans

Health Savings Medical Plan

The Health Savings Medical Plan is administered through Anthem Blue Cross Blue Shield (BCBS) or UnitedHealthcare (UHC) and offers you more control over your healthcare costs. With Anthem BCBS and UHC national provider networks, in-network care is available almost anywhere in the USA.

How the Plan Works

You'll pay more upfront for care, but you get extra support through a Health Savings Account (HSA)—a tax-free account that Siemens Healthineers helps fund.

- You pay first: You cover the full cost of care (including prescriptions) until you meet your deductible—\$2,000 for individuals or \$4,000 for families.
- Then you share costs: After the deductible, you pay coinsurance of 15% and Siemens Healthineers pays 85% for in-network care, until you reach your out-of-pocket max—\$4,500 for individuals or \$9,000 for families.
- After that, it's covered: Once you hit the out-of-pocket max, the plan pays 100% of eligible costs for the rest of the year.
- Preventive care is free: Annual checkups and recommended screenings are covered at no cost when you stay in-network.
- Out-of-network costs are higher: You pay more out of pocket, and the deductible is \$3,000 for individuals or \$6,000 for families. After that, you pay 35% and Siemens Healthineers pays 65%, up to a higher out-of-pocket max.



Resources to Help you Enroll 1

Enrolling in Your Benefits 2

Health Reimbursement Copay Advantage Plan 3

What you Need to Know About your HRA 4

Health Savings Medical Plan 5

What you Need to Know About your HSA 6

Kaiser HMO Plan 8

Comparison of Medical Plans (Highlights) 9

Prescription Drug Benefits 11

Dental Plan 13

Vision Plan 14

How Plan Costs Compare 15

Healthcare and Dependent Day Care Flexible Spending Accounts 16

Life & Work Assistance Program 18

Wellness Programs 19

Life Insurance 22

Voluntary Benefits 25

Disability Programs 27

Commuter Benefits Program 28

Additional Information and Notices 29



What you Need to Know About your HSA

-  You can open an HSA only if you're enrolled in the Health Savings Medical Plan and have no other medical coverage.
-  Siemens Healthineers deposits \$400 into your HSA (or \$800 if you cover dependents).
-  You can also add your own money tax-free.
-  You can earn more dollars for your HSA by completing wellness activities in the Healthy Rewards Program.
-  The total contribution limit for 2026 (including company contributions) is \$4,400 for individual coverage or \$8,750 for family coverage.
-  If you enroll mid-year, your company contribution is prorated based on the month of the year you join.

Want to grow your savings?

Once your HSA balance is over \$2,000, you can invest in mutual funds through Optum Bank.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

More About your Health Reimbursement Copay Advantage and Health Savings Medical Plan Options

What doctors can I use?

You can see any doctor—no referral or primary care physician needed. In-network providers usually cost less, offer better coverage, and fully cover most preventive care.

Extra protection—at no cost to you

You automatically receive company-paid* Critical Illness coverage through Voya—no action needed.

- \$5,000 benefit for you and your covered spouse
- 50% benefit for covered children
- Coverage for serious conditions like heart attack, stroke, cancer, organ transplant, and more
- \$50 wellness reward each year when you or your dependents complete a qualified health screening
- For more information or to file a claim, visit [Voya’s website](#)

* Siemens Healthineers will pay the full cost of the premiums for this coverage—employees will be taxed on the value of the premiums paid on their behalf via an imputed income charge through payroll.



This added coverage helps protect your finances during unexpected health events—and rewards you for staying proactive about your health.



You can learn more about these plans and other benefit programs at [BenefitsatSHS.com](#).

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Kaiser Health Maintenance Organization (HMO) Medical Plan

The Kaiser HMO option may be available if you live in California, based on your home address.

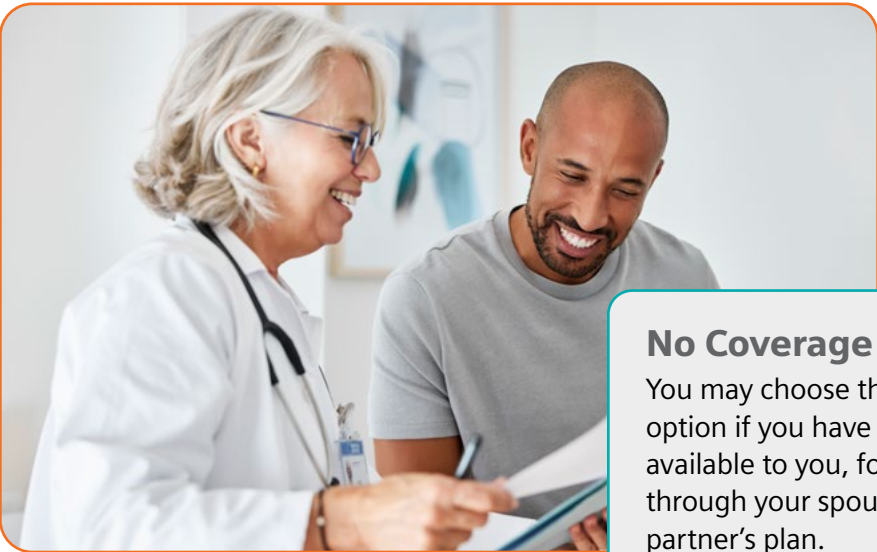
How the Plan Works

- You pay a set fee (called a copay) when you visit the doctor, urgent care or the emergency room.
- These copays count toward your yearly limit on how much you'll spend.
- There's no deductible, so you don't have to pay a big amount before the plan starts contributing.
- If you have a real emergency and need care outside the Kaiser network, the plan will still help—as long as you let them know as soon as you can.
- Your out-of-pocket max for medical and prescription drug expenses is \$1,500 for individual coverage, or \$3,000 if you're covering family. Once you hit the out-of-pocket max, the plan pays 100% of eligible costs for the rest of the year.
- Annual checkups and recommended screenings are covered at no cost when you stay in-network.

What doctors can I use?

With an HMO plan, you must stay in-network for coverage.

You'll need to choose a primary care provider (PCP) from the HMO network to manage your care. If you need to see a specialist, your PCP will give you a referral. Without a referral or if you go outside the network, the plan won't cover the cost.



No Coverage Option

You may choose the "No Coverage" option if you have other coverage available to you, for example, through your spouse's or domestic partner's plan.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Comparison of Medical Plans (Highlights)

	Health Reimbursement Copay Advantage Plan	Health Savings Medical Plan*	Kaiser HMO Medical Plan
What doctors or providers can I use?	See any doctor or specialist of your choice		PCP required
	No PCP or referral required to see a specialist		Need PCP referral to see a specialist
	Higher benefit level for in-network care than out-of-network care		No coverage for out-of-network care, unless it's a true emergency
Company contribution	Includes a Siemens Healthineers-funded HRA; with contributions of: \$500 employee \$1,000 employee + dependents You cannot make contributions to the HRA	Includes access to a HSA with employee before-tax contributions and Siemens Healthineers contributions of: \$400 employee \$800 employee + dependents Maximum amount you and Siemens Healthineers can contribute to your HSA: \$4,400 individual \$8,750 family	None
Annual deductible	In-network medical only: \$1,500 individual \$3,000 family Out-of-network medical only: \$2,250 individual \$5,550 family	In-network medical and prescription drug combined: \$2,000 individual \$4,000 family Out-of-network medical and prescription drug combined: \$3,000 individual \$6,000 family	In-network medical and prescription drug combined: - No deductible Out-of-network: - No coverage for out-of-network care, unless it's a true emergency
Copays	In-network - Primary care visit: \$30 - Specialist visit: \$45 - Urgent Care: \$60	N/A	- Primary care visit: \$25 - Specialist visit: \$45 - Urgent care: \$25 - Emergency Room care: \$150
Coinsurance	In-network preventive care: - Plan pays 100% for most services; not subject to deductible Other services: - You pay 10% Out-of-network:** - You pay 35%	In-network preventive care: - Plan pays 100% for most services; not subject to deductible Other services: - You pay 15% Out-of-network:** - You pay 35%	In-network preventive care: - Plan pays 100% for most services Out-of-network: - No coverage for out-of-network care, unless it's a true emergency

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

(continued)

(continued)

	Health Reimbursement Copay Advantage Plan	Health Savings Medical Plan*	Kaiser HMO Medical Plan
Out-of-pocket maximum	In-network medical and prescription drug combined: • \$3,700 individual • \$7,400 family Out-of-network medical and prescription drug combined: • \$4,700 individual • \$14,000 family	In-network medical and prescription drug combined: • \$4,500 individual • \$9,000 family Out-of-network medical and prescription drug combined: • \$7,000 individual • \$14,000 family	In-network medical and prescription drug combined: • \$1,500 individual • \$3,000 family Out-of-network: • No coverage for out-of-network care, unless it's a true emergency
Lifetime maximum	None	None	None

*If an employee covers more than one individual under the Health Savings Medical Plan, 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.

For **Anthem Blue Cross Blue Shield members, plan reimbursement for covered services for out-of-network providers is limited to the Maximum Allowed Amount as determined by **Anthem Blue Cross Blue Shield**. Effective 1/1/25 for **UnitedHealthcare** members, plan reimbursement for covered services for out-of-network providers is limited based on reference-based pricing as determined by **UnitedHealthcare**. This methodology uses a fixed rate often based on Medicare or other benchmarks.

You're not alone—your benefits include support for mental health and substance use challenges.

Whether you're facing stress, depression, anxiety, or substance-related concerns, care is available to help you feel better. Coverage includes diagnosis and treatment for emotional health needs, including alcohol and drug dependency. These services are provided through the claim's administrator of your chosen medical plan, so you can access care that fits your situation and needs.



- Resources to Help you Enroll 1
- Enrolling in Your Benefits 2
- Health Reimbursement Copay Advantage Plan 3
- What you Need to Know About your HRA 4
- Health Savings Medical Plan 5
- What you Need to Know About your HSA 6
- Kaiser HMO Plan 8
- Comparison of Medical Plans (Highlights) 9
- Prescription Drug Benefits 11
- Dental Plan 13
- Vision Plan 14
- How Plan Costs Compare 15
- Healthcare and Dependent Day Care Flexible Spending Accounts 16
- Life & Work Assistance Program 18
- Wellness Programs 19
- Life Insurance 22
- Voluntary Benefits 25
- Disability Programs 27
- Commuter Benefits Program 28
- Additional Information and Notices 29

Prescription Drug Benefits

Siemens Healthineers provides prescription drug coverage through CVS/caremark® for the Health Reimbursement Copay Advantage Plan and Health Savings Medical Plan. If you are enrolled in an HMO Medical Plan, check with your carrier for specifics.

Filling Prescriptions Made Easy

You have flexible options to get your medications, whether you need them right away or on a regular basis.

1.

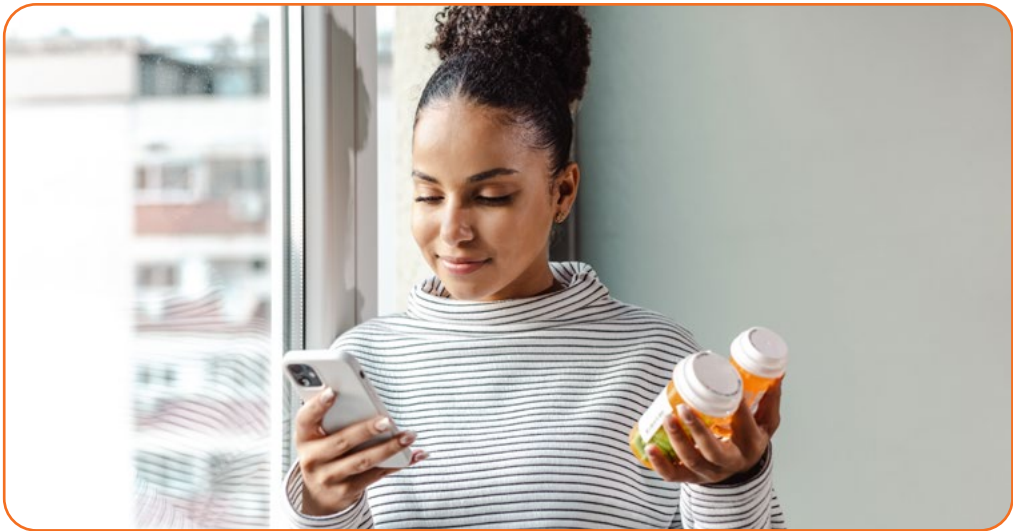
Quick fills: Pick up 30-day prescriptions at major retail pharmacies like CVS, Walgreens, Walmart, and many local options.

2.

Convenient refills: For ongoing medications, use mail order or your local CVS pharmacy to get a 90-day supply at the discounted mail order price.

3.

Get started fast:
Ask your doctor for two prescriptions: one for a 30-day supply to fill immediately, and one for a 90-day supply with refills to use through mail order or CVS. That way, you won't have to wait to begin treatment.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Prescription Drug Benefits

	Health Reimbursement Copay Advantage Plan	Health Savings Medical Plan*	Kaiser HMO Medical Plan
Annual deductible	None	Combined medical and prescription drug expenses: \$2,000 individual \$4,000 family	None
Retail (30-day supply)	- Generic: \$10** - Preferred brand: \$50 - Non-preferred brand: \$100	- Generic: 10% (\$5 minimum; \$25 maximum)** - Preferred brand: 30% (\$20 minimum; \$100 maximum) - Non-preferred brand: 45% (\$35 minimum; \$150 maximum)	- Generic: \$15 - Preferred brand: \$30 - Non-preferred brand: \$30
Mail order service or CVS pharmacy (90-day supply)	- Generic: \$20** - Preferred brand: \$100 - Non-preferred brand: \$200	- Generic: 10% (\$10 minimum; 50 maximum)** - Preferred brand: 30% (\$40 minimum; \$200 maximum) - Non-preferred brand: 45% (\$70 minimum; \$300 maximum)	- Generic: \$30 - Preferred brand: \$60 - Non-preferred brand: \$60
Specialty† pharmacy medication	30%; no minimum copay; \$300 maximum (excludes drugs eligible for PrudentRX program)	30% after deductible is met; no minimum copay; \$300 maximum (excludes drugs eligible for PrudentRX program)	\$30 per prescription (up to a 30-day retail supply and subject to formulary guidelines)

* If an employee covers more than one individual under the Health Savings Medical Plan, 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.

** If the total cost of the drug is less than the flat copay or minimum amount, you'll pay only the full cost of the drug.

† 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). 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 after deductible, for their prescriptions covered under the PrudentRx Copay Program.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Dental Plan

With the Delta Dental PPO High and Low Plan options, you have access to both the Delta Dental Premier® and the Delta Dental PPO networks. While the Delta Dental Premier network provides access to a larger number of dental providers, the Delta Dental PPO network offers greater discounts and lower out-of-pocket costs, allowing you to save more on dental services. However, you may use any in- or out-of-network dental provider you choose. The DeltaCare DHMO Plan is also available. If you enroll in this option, you will only receive coverage when you use in-network providers. There is no out-of-network coverage.

	DeltaCare DHMO Plan	Delta PPO High Plan	Delta PPO Low Plan
Annual deductible	None	\$50 individual \$150 family	\$75 individual \$225 family
Preventive Services (cleanings, oral exams, X-rays)	\$0	Plan pays 100%	Plan pays 100%
Basic Services (extractions, fillings)	Per schedule of benefits	Plan pays 80% after deductible	Plan pays 70% after deductible
Major Services (inlays, bridges, crowns, surgery)	Per schedule of benefits	Plan pays 50% after deductible	Plan pays 50% after deductible
Annual Benefit Maximum	N/A	\$2,000 per covered person	\$1,000 per covered person
Orthodontia	Per schedule of benefits	Plan pays 50% after deductible	None
Orthodontia Lifetime Maximum	N/A	\$2,000 per covered person	N/A
Out-of-Network Benefits	None	Plan pays 100% preventive; Plan pays 60% Basic; Plan pays 50% Major	Plan pays 80% preventive; Plan pays 50% Basic/Major

For more details, access the schedule of benefits at [BenefitsatSHS.com](https://www.BenefitsatSHS.com).



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Vision Plan

You're automatically enrolled in the Basic Vision Plan through EyeMed—no extra steps required.

Vision Coverage That Works for You

You'll get:

- 100% coverage for your annual eye exam after a \$10 copay
- Access to a wide network of providers, including LensCrafters, Pearle Vision, Target Optical, and more
- Hassle-free enrollment so you can focus on your health, not paperwork

Want more coverage?

Upgrade to the Enhanced Vision Plan or Premier Vision Plan for added benefits like contact lenses, frames, and lenses—or choose to waive coverage. Visit [BenefitsatSHS.com](https://www.benefitsatshs.com) for a comparison of the three plans available.

Flexible coverage levels

Just like medical and dental, the vision plans allow you to choose the coverage that fits your needs:

- Employee only
- Employee + spouse or domestic partner
- Employee + child(ren)
- Employee + family

It's all about giving you options that support your vision and your lifestyle.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

How Plan Costs Compare

2026 Bi-Weekly Contributions for Full-time Employees

Plan	Employee	Employee + Spouse/Domestic Partner	Employee + Child(ren)	Family
Medical				
Health Savings Medical Plan	\$32.74	\$103.25	\$93.75	\$182.65
Health Reimbursement Copay Advantage Plan	\$63.23	\$192.31	\$167.55	\$296.64
Kaiser HMO (California)	\$63.00	\$168.00	\$151.00	\$235.00
Dental				
Delta Dental PPO High Plan	\$10.48	\$20.89	\$21.35	\$29.64
Delta Dental PPO Low Plan	\$8.07	\$16.09	\$16.44	\$22.83
Delta Dental DeltaCare DHMO Plan	\$4.66	\$9.31	\$10.66	\$16.62
Vision				
EyeMed Basic Vision Plan	\$0.00			
EyeMed Enhanced Vision Plan	\$2.30	\$4.59	\$4.13	\$6.89
EyeMed Premier Vision Plan	\$3.54	\$7.10	\$6.36	\$10.60

Note: If you are a part-time employee, or eligible for the Cigna International or HMSA plans, please visit [mySHSbenefits.com](#) to view your 2026 contribution amounts.

- Resources to Help you Enroll **1**
- Enrolling in Your Benefits **2**
- Health Reimbursement Copay Advantage Plan **3**
- What you Need to Know About your HRA **4**
- Health Savings Medical Plan **5**
- What you Need to Know About your HSA **6**
- Kaiser HMO Plan **8**
- Comparison of Medical Plans (Highlights) **9**
- Prescription Drug Benefits **11**
- Dental Plan **13**
- Vision Plan **14**
- How Plan Costs Compare **15**
- Healthcare and Dependent Day Care Flexible Spending Accounts **16**
- Life & Work Assistance Program **18**
- Wellness Programs **19**
- Life Insurance **22**
- Voluntary Benefits **25**
- Disability Programs **27**
- Commuter Benefits Program **28**
- Additional Information and Notices **29**

Healthcare and Dependent Day Care Flexible Spending Accounts

Flexible Spending Accounts (FSAs) let you use before-tax dollars to pay for healthcare and dependent day care expenses. Siemens Healthineers offers two options—Healthcare FSA and Dependent Day Care FSA—and you can enroll in one or both.

How the FSAs Work

You elect an annual amount to contribute to an FSA. The amount is deducted from your paycheck (before taxes) in equal installments over the course of the year.



Keep in mind

- If you're enrolled in the Health Savings Medical Plan, you can't contribute to a regular Healthcare FSA, but you can use a Limited-Use FSA to help cover dental and vision costs.
- If you're enrolled in the Health Reimbursement Copay Advantage Plan, use your HRA first for eligible medical costs like your copay, deductible, and coinsurance. Once your HRA is used up, you can use your Healthcare FSA for the remaining medical expenses. You can also use your FSA anytime for things the HRA doesn't cover—like prescriptions, dental costs, and vision costs.

Account Type	Contributions	Eligible Expenses for your Funds
Healthcare FSA	\$120 – \$3,400 per year	Medical plan expenses (including prescriptions) Dental plan expenses Vision care expenses Expenses over reasonable and customary amounts that are not reimbursed by medical or dental insurance Over-the-counter medications
Dependent Day Care FSA (helps pay for the care of eligible children up to age 13, parents, grandparents, or a disabled spouse)	\$120 – \$7,500* per year \$3,750 if you are married and file separate income tax returns	Fees for day care provided by individuals or a day care center inside or outside your home Costs for a housekeeper if a portion of the services provided are for dependent day care Costs for a pre-school or summer day camp

*Amount may be limited for highly compensated employees in compliance with IRS nondiscrimination requirements.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Healthcare and Dependent Day Care Flexible Spending Accounts

How to Use Your FSA Funds

- When you enroll in the Healthcare FSA, HealthEquity sends you a debit card automatically.
- You can request extra cards for family members at no cost.
- Manage your account anytime at healthequity.com/wageworks.
- Keep your receipts! The IRS requires HealthEquity to confirm that your purchases are eligible.
- If a purchase needs verification, you'll see a notice in your account.
- You'll have 90 days to verify the expense—otherwise, your card may be suspended.

How to Use Your DCFSA Funds

- For a complete list of reimbursable expenses under the Dependent Day Care FSAs, call: **800-TAX-FORM (800-829-3676)** or visit the IRS website (irs.gov).
- Keep your receipts! You'll need them for your claim form.

	Healthcare FSA	Dependent Day Care FSA
Using your funds	Use your HealthEquity debit card to pay for eligible healthcare expenses or submit a claim form and receive reimbursement.	Submit a claim form, along with your receipts.
Maximum reimbursement	The amount you chose to contribute for the year, minus any reimbursements you've already received.	When you submit a claim, you'll be reimbursed up to your current FSA balance. If your claim is more than what's in your account, you'll get reimbursed as more funds are added throughout the year.
Deadlines	You can use your 2026 FSA funds for expenses through December 31, 2026. Up to \$680 will roll over into 2027—anything over that is forfeited. You have until May 31, 2027, to submit claims for 2026 expenses.	You can use your 2026 FSA for eligible expenses through March 15, 2027. Any unused funds after that date are forfeited. You have until May 31, 2027, to submit your claims to HealthEquity.



Check your receipts!

To be valid for FSA reimbursement, your receipt must include:

- Patient's name
- Provider's name
- Date of service
- Description of service
- Amount you paid

If you're submitting an Explanation of Benefits (EOB) or provider invoice, it helps to include your healthcare card receipt showing the exact amount paid.

- [Resources to Help you Enroll](#) **1**
- [Enrolling in Your Benefits](#) **2**
- [Health Reimbursement Copay Advantage Plan](#) **3**
- [What you Need to Know About your HRA](#) **4**
- [Health Savings Medical Plan](#) **5**
- [What you Need to Know About your HSA](#) **6**
- [Kaiser HMO Plan](#) **8**
- [Comparison of Medical Plans \(Highlights\)](#) **9**
- [Prescription Drug Benefits](#) **11**
- [Dental Plan](#) **13**
- [Vision Plan](#) **14**
- [How Plan Costs Compare](#) **15**
- [Healthcare and Dependent Day Care Flexible Spending Accounts](#) **16**
- [Life & Work Assistance Program](#) **18**
- [Wellness Programs](#) **19**
- [Life Insurance](#) **22**
- [Voluntary Benefits](#) **25**
- [Disability Programs](#) **27**
- [Commuter Benefits Program](#) **28**
- [Additional Information and Notices](#) **29**

Life & Work Assistance Program

Support When You Need it—at No Cost to You

As a Siemens Healthineers employee, you and your eligible family members have free access to the Healthineers Life & Work Assistance program, powered by TelusHealth—even if you waive Siemens Healthineers healthcare coverage.

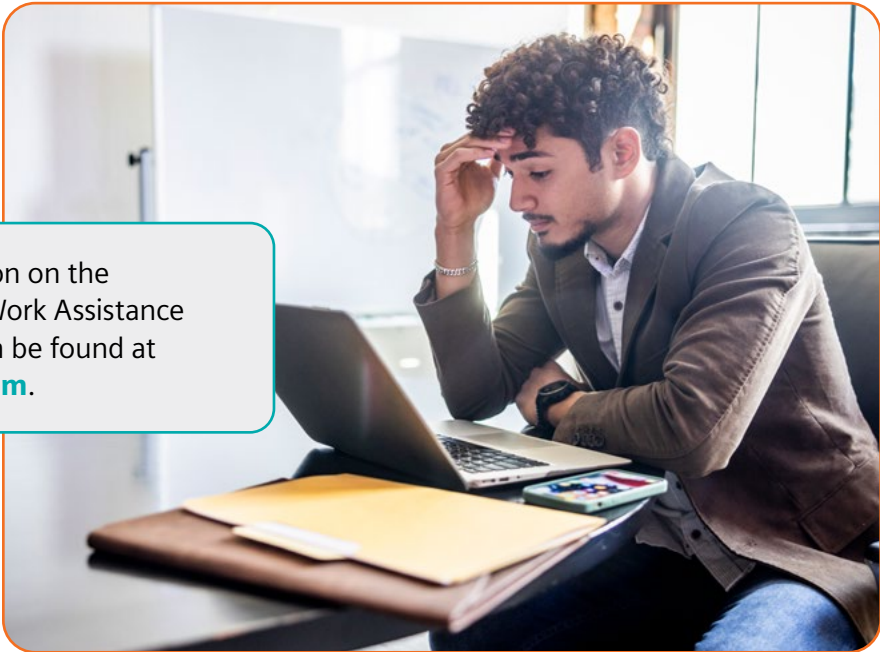
This confidential program offers:

- Free short-term counseling—up to six sessions per issue, per year
- Help with personal, family, and financial challenges
- 24/7 access to professionally trained counselors

Getting started is easy:

Call **800-433-7916** and identify yourself as a Siemens Healthineers employee or family member.
Expert, caring support—whenever life gets complicated.

Additional information on the Healthineers Life & Work Assistance program services can be found at one.telushealth.com.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Wellness Programs

Get rewarded for taking care of yourself! Siemens Healthineers wellness programs offer reimbursements and support for your physical and emotional health.

Earn Healthy Rewards



When you enroll in the Health Reimbursement Copay Advantage Plan or Health Savings Medical Plan, you can earn extra company contributions to your healthcare account—just by completing wellness activities throughout the year. You and your covered spouse or partner may earn even more by joining eligible programs that support your health and well-being.

Healthy Rewards Activity	Company contribution to your HRA or HSA
Get your annual physical or well woman exam	\$150
Complete a Health Risk Assessment on your medical claims administrator website (Anthem Blue Cross Blue Shield or UnitedHealthcare)	\$100
Get an eye exam	\$50
Get a mammogram	\$50
Get a colon cancer screening	\$50
Get a skin cancer screening	\$50
Get a prostate cancer screening (PSA test)	\$50
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



Resources to Help you Enroll 1

Enrolling in Your Benefits 2

Health Reimbursement Copay Advantage Plan 3

What you Need to Know About your HRA 4

Health Savings Medical Plan 5

What you Need to Know About your HSA 6

Kaiser HMO Plan 8

Comparison of Medical Plans (Highlights) 9

Prescription Drug Benefits 11

Dental Plan 13

Vision Plan 14

How Plan Costs Compare 15

Healthcare and Dependent Day Care Flexible Spending Accounts 16

Life & Work Assistance Program 18

Wellness Programs 19

Life Insurance 22

Voluntary Benefits 25

Disability Programs 27

Commuter Benefits Program 28

Additional Information and Notices 29

Wellness Programs

Be Well Reimbursement Program

Support your physical and emotional well-being with a program designed to fit your lifestyle. Whether you're into fitness, mindfulness, or wellness tech, this benefit helps you invest in yourself with up to \$300 in reimbursements per year towards eligible health and wellness products and services.*

What's covered:

-  **Exercise classes (e.g., yoga, Pilates)**
-  **Meditation and mindfulness sessions**
-  **Wearable fitness devices**
-  **Other eligible wellness expenses**

Eligibility:

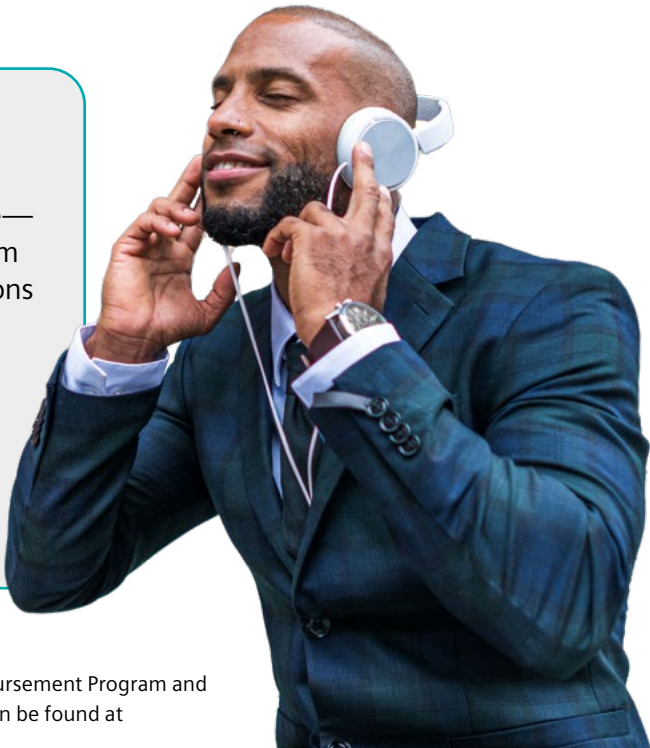
- No need to be enrolled in a Siemens Healthineers medical plan
- Dependents (spouse, partner, children) are not eligible
- If both you and your spouse work at Siemens Healthineers in participating companies, you're both eligible



headspace

Recharge your mind with Headspace—free for all employees! Enjoy premium access to bite-sized guided meditations and mindfulness tools that can help you sleep better, stress less, and stay focused.

Plus, you can share the calm: invite two friends or family members to join for free.



*A full list of eligible expenses for the Be Well Reimbursement Program and for information on how to sign up for Headspace can be found at [BenefitsatSHS.com](https://www.BenefitsatSHS.com).

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Wellness Programs

AccessHope



AccessHope provides leading-edge cancer expertise at no cost for all USA-based employees and dependents, as well as parents and parents-in-law, grandparents and grandparents-in-law, and siblings.

Expert advisory review

Request a review of your cancer diagnosis and treatment plan from AccessHope’s world-class specialists. The specialists then provide expert clinical recommendations while offering peer-to-peer discussions with your local doctor.

The specialists may share the latest cancer research findings and identify new medications, tests, or clinical trials relevant to your care as your doctor continues to manage your treatment plan.

Cancer support team

Connect with experienced, compassionate oncology nurses for appointment details, treatment information, or emotional support, wherever you are in your cancer journey and whether you’ve received a cancer diagnosis or are caring for someone who has.

To learn more, call **833-693-4673** or visit myaccesshope.org/siemenshealthineers.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Life Insurance

Siemens Healthineers' Basic and Supplemental life insurance coverages are administered by The Hartford. Whole Life insurance is made available through Allstate.

Basic Employee Life Insurance*

You automatically get Basic Employee Life Insurance equal to one times your pay, up to \$1 million. If your coverage is over \$50,000, the IRS requires the company to report some of it as taxable income (called "imputed income") on your W-2. This amount is based on IRS rules and how much coverage you have over \$50,000.

Spouse or Domestic Partner Life Insurance*

You can buy life insurance for your spouse or partner if they're age 70 or younger and not seriously ill or receiving disability benefits. You are automatically listed as the beneficiary, but you can change that if you'd like. Coverage ranges from \$10,000 to \$250,000, in \$10,000 increments, and is capped at 3 times your pay.

Supplemental Employee Life Insurance*

You can buy extra life insurance, up to 10 times your pay, with a limit of \$2.5 million. This is on top of your basic coverage and paid with after-tax dollars. Pay includes your base salary, bonus, and commissions, rounded up to the next \$1,000.

If your pay goes up during the year, your coverage increases too. If it goes down, your coverage stays the same until next year. You can name anyone as your beneficiary and change it anytime.

Child Life Insurance

You can buy life insurance for your unmarried children if they're at least 15 days old. Coverage options range from \$5,000 to \$25,000, and a single premium covers all eligible kids. Coverage ends when your child turns 19, or 25 if they're a full-time student. You're automatically the beneficiary.

*Accelerated death benefit

If you're diagnosed with a terminal illness and have less than 24 months to live, you can receive 80% of your life insurance early (up to \$500,000); the rest goes to your beneficiary after your death.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Life Insurance



Evidence of insurability

You will be required to provide evidence of insurability (proof of good health) in these cases:

- You or your spouse/domestic partner have coverage and wish to increase the amount.
- You or your spouse/domestic partner waive coverage and decide to purchase at a later date.
- For Supplemental Employee Life Insurance—if you are newly hired and elect coverage greater than three times your pay, or coverage exceeds \$300,000.
- For Spouse Life Insurance—you elect coverage that exceeds \$10,000 for your spouse or domestic partner.

Business Travel Accident Insurance

Siemens Healthineers automatically provides you with company-paid Business Travel Accident Insurance that pays benefits to you (if you sustain certain injuries) or your beneficiary (if you die) as a result of an accident while on a business trip.

Personal Accident Insurance (PAI)

PAI gives financial protection if you're seriously hurt or die in an accident. You can get coverage up to 12 times your pay.

Company-paid coverage:

- If you choose employee-only coverage, you get 2x your pay.
- If you choose coverage for your family, you get 1x your pay.

Extra coverage:

You can buy more (up to 12x your pay).

Beneficiaries:

- You must name someone to receive the benefit when you enroll.
- If you choose family coverage, you are the beneficiary for your spouse/partner and children.
- If you choose employee-only coverage, your beneficiary gets 100% of the benefit if you die or are injured.

Family coverage payouts:

If a family member dies or is injured, the amount you receive depends on who is covered, for example your spouse/partner, children, or both.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29



Life Insurance

Allstate Whole Life Insurance with Long-term Care

One policy that gives you two types of protection:

- 1. Life Insurance: Pays money to someone you choose (a beneficiary) after you die.
- 2. Long-term Care Insurance: Helps pay for care if you can't do everyday tasks on your own, like bathing or dressing.

Why it's beneficial

As people get older, they're more likely to need long-term care. But younger people might need it too, because of accidents or serious illnesses.

Key features:

- You can get coverage if you're between 18 and 70 years old.
- Life insurance pays up to \$150,000 for employees and up to \$30,000 for spouses or partners.
- If you need long-term care, you can use part of your life insurance money while you're still alive. You can get monthly payments for up to 50 months if:
 - You can't do at least two daily activities for 90 days, and
 - You're getting professional long-term care.
- The cost of the policy stays the same for the whole term.
- If you leave Siemens Healthineers or retire, you can keep your coverage.
- You can sign up when you're hired or during Annual Enrollment.
- You pay for the coverage through after-tax paycheck deductions.
- You must be actively working to enroll.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Voluntary Benefits

Voluntary benefits give you extra coverage and flexibility to choose options that fit your personal needs—all at group rates that are often lower than buying on your own. Your options include:

- Accident Insurance (through Voya)
- Critical Illness Insurance (through Voya)
- Hospital Indemnity Insurance (through Voya)
- Legal Insurance (through LegalEASE)
- Identity Theft Protection (through Norton LifeLock)
- Pet Insurance (through Nationwide)
- Auto and Home Insurance (through Mercer)



Accident Insurance

Out-of-pocket medical expenses due to an accident can add up quickly. Accident Insurance, offered through Voya, will pay a benefit based on the type of injury sustained and the type of treatment you receive.



Critical Illness Insurance

Critical Illness Insurance, offered through Voya, offers peace of mind if you are facing a serious diagnosis or illness such as a heart attack, stroke, or cancer. This plan will pay a lump sum if you or a covered dependent is diagnosed with a covered critical illness.



Hospital Indemnity Insurance

A hospital stay can place a sudden and unexpected strain on your household budget. Hospital Indemnity Insurance, through Voya, provides a benefit if you or a covered dependent are admitted or confined to a hospital because of pregnancy, an accident, or sickness.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29



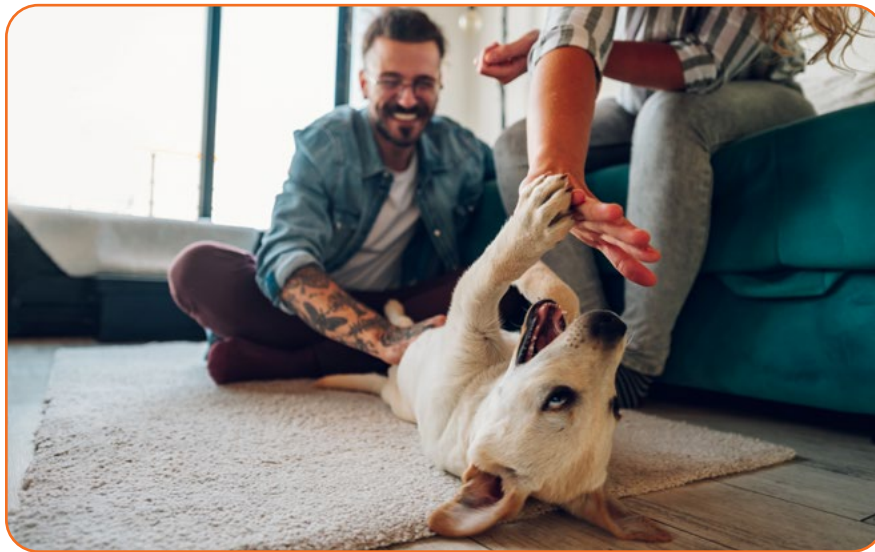
Legal Insurance

LegalEASE's legal insurance plan provides support and protection for unexpected personal legal issues. As a Siemens Healthineers employee, you can enroll in this plan at a discounted rate.



Identity Theft Protection

Norton LifeLock's Benefit Premier Plus plan can help safeguard you and your family's identity, privacy, and security with all-in-one protection. As a Siemens Healthineers employee, you have access to this plan at a discounted rate.



Pet Insurance*

Similar to health insurance for you and your family, pet insurance offers coverage for your pets that can help you to be prepared for unexpected vet costs. As an employee of Siemens Healthineers, you have the ability to enroll in Siemens Corporation's Pet Insurance benefits through Nationwide.

To learn more about this benefit and enroll, visit petinsurance.com/affiliates/siemens.



Auto and Home Insurance*

Mercer's CHOICE Auto and Home Program could help you avoid over-paying for your auto and homeowners' insurance by ensuring you are taking advantage of every discount available to you.

Contact the Mercer Call Center at **800-782-3603** to learn more about Auto and Home Insurance programs.

*Please note: Pet and Auto/Home Insurance will only be offered on a direct pay basis, not through payroll deductions and will not be viewable on the enrollment platform.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Disability Programs

Short-Term Disability (STD)

Siemens Healthineers gives you short-term disability coverage for up to 26 weeks to help replace income during the first 6 months of a disability.

Long-Term Disability (LTD)

Long-Term Disability (LTD) Insurance helps replace part of your income if you can't work for a long time due to a physical or mental disability.

Here's how it works

- ✓ You get paid a percentage of your monthly salary after being disabled for 180 days.
- ✓ To qualify, you must be totally and permanently disabled and under a doctor's care.
- ✓ For the first 24 months, you're considered disabled if you can't do your job.
- ✓ After 24 months, you're considered disabled if you can't do any job you're qualified for, based on your skills and experience.
- ✓ Your LTD benefit may be reduced if you get other disability payments (like Social Security or Workers' Comp).
- ✓ If you choose the company-paid plan, your benefit is taxable.
- ✓ You can choose to buy your own LTD coverage with after-tax dollars, which gives you a non-taxable benefit equal to 60% of your salary.
- ✓ If your pay goes up during the year, your coverage will increase too (up to \$15,000/month), but your cost won't change until the next annual enrollment period.
- ✓ If your pay goes down, your coverage won't change until the next calendar year.



Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Commuter Benefits Program

Manage your commuting costs easily with online access and flexible payment options.

How It Works

Choose how much to contribute: up to \$340/month before tax for transit, vanpools, and parking (IRS limits apply). You can also contribute up to \$500/month after tax.

Contributions are deducted from your last paycheck each month. You can start, stop, or change your contributions anytime—just make your change prior to the first Thursday of the month for it to take effect the next month.

Ways to Pay



Commuter Card: Use it like a credit card to buy transit and parking passes. Funds are available on the 20th of the month before use.



Home Pass Delivery: Get your transit passes delivered to your home automatically each month.



Pay My Parking: HealthEquity pays your parking provider directly—ideal for monthly permits.



Pay Me Back: Submit a claim to get reimbursed for eligible commuting expenses you paid out of pocket.



Parking benefits must be used for commuting to work or public transit. If you leave the company, you can still submit paper claims for up to 180 days for expenses incurred while you were employed.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Additional Information and Notices

Summary of Material Modifications

This document serves as a Summary of Material Modifications (SMM) for benefit changes effective January 1, 2026. 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 2024 Siemens Medical Solutions USA, Inc. Group Insurance and Flexible Benefits Program.

If you have any questions about this SMM or want a complete copy of the SPD, 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 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 10am to 6pm 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 viewing our *Notice of Nondiscrimination* at BenefitsatSHS.com.

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.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Additional Information and Notices

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.

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Resources to Help you Enroll	1
Enrolling in Your Benefits	2
Health Reimbursement Copay Advantage Plan	3
What you Need to Know About your HRA	4
Health Savings Medical Plan	5
What you Need to Know About your HSA	6
Kaiser HMO Plan	8
Comparison of Medical Plans (Highlights)	9
Prescription Drug Benefits	11
Dental Plan	13
Vision Plan	14
How Plan Costs Compare	15
Healthcare and Dependent Day Care Flexible Spending Accounts	16
Life & Work Assistance Program	18
Wellness Programs	19
Life Insurance	22
Voluntary Benefits	25
Disability Programs	27
Commuter Benefits Program	28
Additional Information and Notices	29

Siemens Healthineers 2025

Siemens Healthineers pioneers breakthroughs in healthcare. For everyone. Everywhere. Sustainably. The company is a global provider of healthcare equipment, solutions and services, with activities in more than 180 countries and direct representation in more than 70. The group comprises Siemens Healthineers AG, listed as SHL in Frankfurt, Germany, and its subsidiaries. As a leading medical technology company, Siemens Healthineers is committed to improving access to healthcare for underserved communities worldwide and is striving to overcome the most threatening diseases. The company is principally active in the areas of imaging, diagnostics, cancer care and minimally invasive therapies, augmented by digital technology and artificial intelligence. In fiscal 2024, which ended on September 30, 2024, Siemens Healthineers had approximately 72,000 employees worldwide and generated revenue of around €22.4 billion. Further information is available at [siemens-healthineers.com](https://www.siemens-healthineers.com).



Programs to support you and your family

2025 Benefits Enrollment Guide

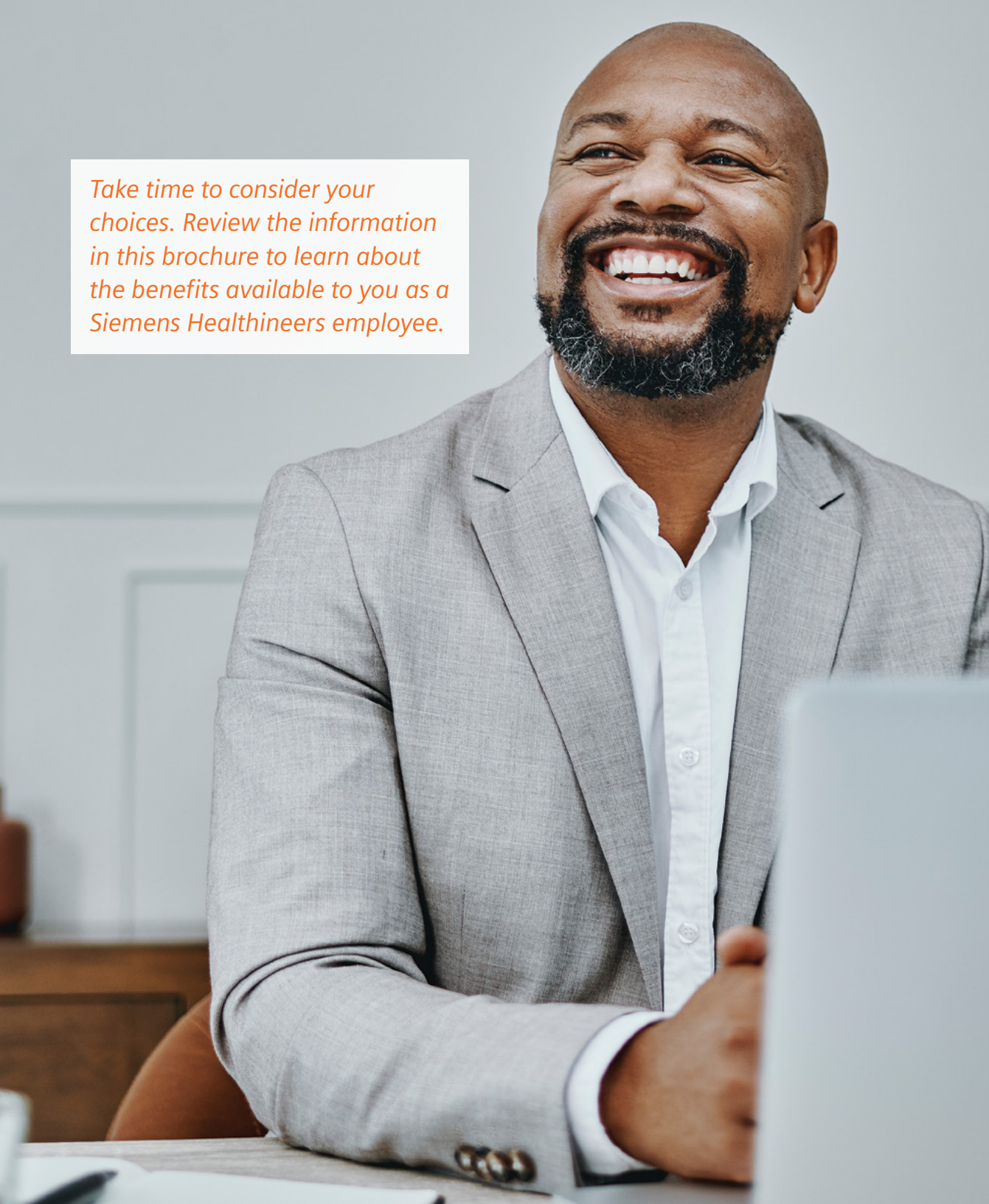
For active employees

 BenefitsAtSHS.com



Contents

4	Resources to Help You Decide	19	Prescription Drug Benefits	29	Life and Accident Insurance
5	Enrolling	21	Dental Plan	29	Basic Employee Life Insurance
6	Flexible Benefits Program	21	Vision Plan	29	Supplemental Employee Life Insurance
11	Medical Plans	22	2025 Siemens Healthineers Contact Information	29	Spouse Life Insurance
12	Health Reimbursement Medical Plan	23	Healthcare and Dependent Day Care Flexible Spending Accounts	29	Child Life Insurance
14	Health Savings Medical Plan	26	How Plan Costs Compare	30	Evidence of Insurability
16	Health Maintenance Organization (HMO) Medical Plan (available in limited locations)	27	Life & Work Assistance/Wellness Programs	31	Personal Accident Insurance
17	Comparison of Medical Plans	27	Healthy Rewards	33	Business Travel Accident Insurance
18	Mental Healthcare and Substance Abuse Treatment	28	Be Well Reimbursement Program	33	Allstate Whole Life Insurance with Long-Term Care
		28	Headspace		
		28	AccessHope	34	Disability Programs
				35	Commuter Benefits Program
				36	Additional Information and Notices



Take time to consider your choices. Review the information in this brochure to learn about the benefits available to you as a Siemens Healthineers employee.

Providing you and your family with the benefits to help you live well is essential. To help you make choices that meet your needs in 2025, Siemens Healthineers offers several resources allowing you to explore your options.

Flexible Benefits Program for Active Employees

Siemens Healthineers is committed to ensuring you have access to benefits that truly support your needs and priorities. That's why we maintain an ongoing effort to provide flexibility, value, and support within your benefits options. 2025's benefits package includes several enhancements, reflecting our continued investment in your well-being and our commitment to listening to your feedback.

These enhancements are just a part of our broader priority to create an environment where every Healthineer can thrive personally and professionally. By investing in the benefits that matter most to you, we aim to help you feel supported and empowered to choose the plan and options that are right for you.

We encourage you to play an active role in your health by taking time to review the offerings so you can get the most out of your benefits. Prepare to enroll by exploring your options and the many resources available to help you choose the coverage that's right for you.

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, the Company encourages you to use the resources provided, including visiting [BenefitsAtSHS.com](https://www.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.

The Siemens Healthineers Benefits Center (SHBC) is also a great way to get answers to your enrollment questions through web chat, available on [mySHSBenefits.com](https://www.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.

Align Benefits Guidance

When you need added assistance for enrollment, schedule an appointment with an Align 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.myenrollmentinfo.com.

Estimate your medical expenses

When you log on to [mySHSBenefits.com](https://www.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.

Enrolling

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 7–10 business days to receive it by mail.
2. **Make your elections.** Review the information on the enrollment page, consider your choices, 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** and review it carefully. After enrollment closes, you can review your elections anytime by selecting **Your Current 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.
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.myenrollmentinfo.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.

When to Enroll

You can enroll in the Flexible Benefits Program:

- When you are newly hired
- During the Annual Enrollment period that occurs each fall
- During the year if you experience a major life event (as defined by the Internal Revenue Service), such as marriage, divorce, or the birth or adoption of a child

-
- ! **To receive important benefits information via email, provide a preferred personal email address on mySHSBenefits.com.**
 - **To sign up, simply log on to mySHSBenefits.com, choose your communication preference by selecting the person icon in the upper right-hand corner of the home page, then select 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.**
-

Flexible Benefits Program for active employees

Through the Flexible Benefits Program, Siemens Healthineers offers employees a wide variety of high-quality, affordable healthcare and insurance benefits to meet your unique needs.

Medical Plans (including Prescription Drug)

Siemens Healthineers provides the flexibility you need by offering a choice of medical plans. The medical plans cover similar expenses—the differences include insurance administrator, provider access, and how much you pay for care. Your medical options include:

- Health Reimbursement Medical Plan
 - Health Savings Medical Plan
 - Health Maintenance Organization (HMO) Medical Plan (available in limited locations based on home zip code)
 - Cigna International (available to delegates from the United States to another country)
-

Dental Plan

With the Delta Dental PPO Plan, you have access to receive care from providers who are part of the Delta Dental Premier® and Delta Dental PPO networks or from a dental provider outside the network. However, you receive a higher level of benefits and typically pay less for care received in-network because providers have agreed to charge discounted rates.

Siemens Healthineers also offers the DeltaCare Plan. If you enroll in the DeltaCare DHMO Plan, you'll receive coverage when you use in-network providers. There is no out-of-network coverage.

Vision Plan

As a Siemens Healthineers employee, you will be automatically enrolled in the Basic Vision Plan through EyeMed. If you prefer more comprehensive coverage, you can elect to enroll in one of two additional buy-up programs—the Enhanced Plan or the Premier Plan—to meet your eye care needs.

Flexible Spending Accounts (FSAs)

Siemens Healthineers offers two Flexible Spending Accounts, or FSAs—the Healthcare FSA and the Dependent Day Care FSA. You can choose to enroll in both accounts or just one.

The FSAs allow you to contribute money from your paycheck on a before-tax basis and use it toward certain healthcare and dependent care expenses. You do not need to be enrolled in the medical plan to enroll in either FSA.

Healthineers Life & Work Assistance Program

The Healthineers Life & Work Assistance Program provides confidential, immediate, and free support to help you cope with:

- Work-related issues
- Childcare
- Anxiety/depression
- Elder care
- Financial concerns
- Any personal crisis
- Legal issues

The program is automatically available to all active Siemens Healthineers employees, including family members residing with you.

Flexible Benefits Program for active employees

Wellness Programs

Siemens Healthineers understands how important overall well-being is to you and your family. The Company offers Healthy Rewards, Be Well Reimbursement, Headspace, and AccessHope to eligible employees.

The **Healthy Rewards Program** provides employees enrolled in either the Health Reimbursement Medical Plan or the Health Savings Medical Plan the opportunity to earn additional company contributions to their healthcare accounts.

The **Be Well Reimbursement Program** helps eligible employees maintain or improve their physical and emotional health. The program provides flexibility to fit one's lifestyle and reimburses employees for eligible expenses, such as gym memberships, yoga classes, home gym equipment, and more.

A free, premium membership to **Headspace**, your app for mental well-being, is available to all employees.

AccessHope provides access to leading-edge cancer expertise for all U.S.-based employees and dependents, as well as parents and parents-in-law, grandparents and grandparents-in-law, and siblings at no cost.

Life and Accident Insurance

Siemens Healthineers helps you protect the ones you love by offering several life insurance plans:

- **Basic Employee Life:** Siemens Healthineers automatically provides a benefit of 1x your pay (up to \$1,000,000).
 - **Supplemental Employee Life:** You can choose this coverage in addition to your Basic Employee Life Insurance coverage.
 - **Spouse Life:** You can purchase insurance for your spouse or domestic partner (certain restrictions apply).
 - **Child Life:** You can purchase insurance for your unmarried dependent children under age 19 (or age 25 if a full-time student).
 - **Personal Accident Insurance (PAI):** Siemens Healthineers automatically provides a benefit equal to 2x your pay for employee only coverage or 1x your pay for family coverage. Additional coverage is available up to 12x your pay for employee or family coverage.
 - **Global Business Travel Insurance:** Siemens Healthineers provides you with a Company-paid benefit.
 - **Whole Life with Long-Term Care:** Employees and spouses/domestic partners can purchase this coverage which provides a guaranteed financial benefit after death, as well as value through Long-Term Care Insurance that employees can rely on as life needs change.
-

Flexible Benefits Program for active employees



Disability Program

Short-term disability (STD) benefits help protect you against the loss of income during the first six months of a disability. Siemens Healthineers provides this coverage at no cost to you.

Long-term disability (LTD) coverage helps protect you against loss of income when you cannot work for an extended period (six months or longer) because of a disability. You automatically receive this benefit from Siemens Healthineers, which provides a taxable benefit equal to 60% of your pay if you are disabled. You have the option to replace Company-paid LTD by purchasing an after-tax benefit that pays a tax-free benefit equal to 60% of your pay if you are disabled.

Commuter Benefits Program

The Commuter Benefits Program allows you to contribute to an account that you can use to pay for public transit, including train, subway, bus and ferry, eligible vanpool, and qualified parking expenses you pay as part of your commute to work.

Decide how much to contribute—up to the monthly before-tax limit set by the IRS—and your contribution will be deducted in full from your last paycheck of the month on a before-tax and/or after-tax basis, based on your preference.

Alight Health Pro

When you need help navigating your healthcare journey, you have your Alight Health Pro to back you up.

Connect with your Alight Health Pro for assistance with finding highly-rated in-network providers, scheduling doctor's appointments, reviewing medical bills for accuracy, and more.

Visit HealthPro Connection at mySHSBenefits.com and click Health Pro Connection to securely message your Health Pro, or call **833-935-3328**.

Flexible Benefits Program for active employees

Paying for Coverage

Offering choice is important to Siemens Healthineers. Balancing options and costs while ensuring we all have access to affordable, high-quality healthcare is a priority for the Company. Siemens Healthineers pays the majority of the cost of benefits for you and your dependent(s). When you enroll in coverage, your portion of the cost will be made through automatic before-tax and/or after-tax payroll contributions. Different federal and state tax rules may apply with respect to the cost of benefits provided to your domestic partner, state-registered partner, or civil union partner, and children of these relationships.

Who's Eligible

Dependents eligible for coverage under the Flexible Benefits Program include:

- Your spouse or domestic partner, state-registered partner, or civil union partner
- Medical, dental, and vision coverage—Dependent children up to age 26 or unmarried children over age 26 who are certified as disabled.
- Child Life and Personal Accident Insurance—Dependent children who are:
 - At least 15 days old and under age 19 (or under age 25 if in full-time attendance at an accredited institution of learning).
 - Age 19 or older if incapable of self care and dependent on you for support due to a physical or mental disability that began before age 19.

Dependent children include your natural children, legally adopted children, stepchildren who live with you, and any other children for whom you are the legal guardian as defined by a court order.

Dependent Verification Process

Benefits are expensive—for you and for Siemens Healthineers. Each of us is responsible for ensuring that the Company is spending money on programs and plans that comply with the rules and benefit all of us. One way to do this is through verifying that only eligible dependents are covered under the Siemens Healthineers Plans.

If you enroll dependents in a medical, dental, vision, spouse life, and/or Personal Accident Insurance plan, you will be asked to provide copies of a marriage certificate, birth certificates, and/or proof of common residence to verify the eligibility of your dependent(s). It's important that you provide the required documentation by the communicated deadline to ensure your newly enrolled dependent(s) are covered.

Flexible Benefits Program for active employees



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.

Domestic Partner, State-Registered Partner, or Civil Union Partner Coverage

To qualify as domestic partners (same or opposite gender):

- Both you and your partner must be at least 18 years of age, have lived together for at least 12 months, have a serious, committed relationship; and
- Your partner is financially interdependent with you, is not related to you in a way that would prohibit legal marriage, and is not legally married to anyone else.

To qualify as state-registered partners or civil union partners:

- You and your partner (same or opposite gender) must be part of a civil union or registered domestic partnership per the definition of the state in which the employee lives.

Employers are required to report as compensation the value of health insurance coverage provided to domestic partners, state-registered or civil union partners, and the children of these relationships covered under their health programs, and to withhold taxes on that amount. The value of the health insurance coverage provided to these dependent relationships is referred to as "imputed income."

Different rules may apply for state tax purposes. For more information, please contact the SHBC at **833-935-3328**.

Medical Plans for active employees

Siemens Healthineers provides the flexibility you need by offering a choice of medical plans. The medical plans have similar services—the differences include provider access and how much you pay for care. Your medical plans include:

Health Reimbursement Medical Plan	With the Health Reimbursement Medical Plan, you can receive care from providers both in-network and out-of-network; however, your costs will generally be lower when you go to in-network providers. This plan comes with a Health Reimbursement Account (HRA), to which Siemens Healthineers makes contributions that you can use to pay for out-of-pocket medical expenses.
Health Savings Medical Plan	With the Health Savings Medical Plan, you have a higher deductible, but lower payroll contributions. You can receive care from providers both in-network and out-of-network; however, your costs will generally be lower when you go to in-network providers. This plan comes with a Health Savings Account (HSA), which is a tax-advantaged account that you can use to pay for out-of-pocket healthcare expenses. Siemens Healthineers contributes to this account, and you can also make tax-free contributions to help pay for your healthcare expenses.
HMO Medical Plan (available in limited locations)	An HMO Medical Plan may be available if you live in California, based on your home address. Only in-network care is covered under an HMO. In addition, an HMO requires you to select a Primary Care Physician (PCP) to coordinate your care and provide referrals to specialists, if necessary.

Please note: Hawaii Medical Service Association (HMSA) is available to employees who live in Hawaii, while the Cigna International Medical Plan is available to outbound delegates (also known as expatriates).

You can also elect to waive medical coverage through Siemens Healthineers. For example, the coverage available through your spouse's or domestic partner's employer might better meet your needs.

Coverage Categories

The medical plans allow you to choose one of four coverage categories:

- Employee only
- Employee plus spouse or domestic partner
- Employee plus child(ren) (no spouse or domestic partner)
- Employee plus family

Before choosing a medical plan, you should consider the number of eligible family members you'll need to cover, the costs of your selected coverage, and whether you can receive coverage under another family member's plan.

Medical Plans

Health Reimbursement Medical Plan

The Health Reimbursement Medical Plan is administered through Blue Cross Blue Shield (BCBS) or UnitedHealthcare (UHC). With BCBS and UHC national provider networks, in-network care is available almost anywhere in the U.S.

Provider Choice You may use any provider you want—whether in-network or out-of-network—and you do not need to select a PCP. Using an in-network provider is generally more cost-effective, as you will receive discounted rates, a higher level of benefit, and will not be subject to balance billing. Generally, most in-network preventive care is covered at 100%.

How the Plan Works

Deductible, coinsurance, and out-of-pocket maximum: You pay for the cost of care until you satisfy your deductible. Then coinsurance begins—meaning you and Siemens Healthineers share in the cost of care until you meet the out-of-pocket maximum (individual or family). Once the out-of-pocket maximum is met, the plan pays 100% of eligible medical expenses for the remainder of the year.

- In-network costs: You pay a \$1,500 individual or \$3,700 family annual deductible. You pay 15% coinsurance for eligible expenses and Siemens Healthineers pays 85% after the deductible has been satisfied. Your out-of-pocket maximum for the year is \$3,700 individual or \$10,000 family. The deductible and coinsurance count toward your annual out-of-pocket maximum.
- Out-of-network costs: After you meet the \$2,250 individual or \$5,550 family annual deductible, Siemens Healthineers pays 65% of eligible expenses and you pay 35%, up to the annual out-of-pocket maximum of \$4,700 individual or \$14,000 family.

Health Reimbursement Account (HRA): The HRA is a reimbursement account that you can use to pay for eligible medical expenses. Only Siemens Healthineers contributes to this account—\$500 for individual coverage or \$1,000 if you enroll your dependents. You and your covered spouse or domestic partner can also earn additional company contributions to your HRA by completing certain wellness activities under the Healthy Rewards Program. Please note: Employees or newly covered dependents enrolling after January 1 will receive a prorated contribution based on the number of months enrolled in the plan.

What You Need to Know About the HRA

- Your HRA can be used to pay your eligible medical expenses and those of your dependents who are covered under the Health Reimbursement Medical Plan.
- You have the option of paying for an eligible medical expense out-of-pocket or submitting it for reimbursement under the HRA.
- For eligible medical expenses, refer to the Summary Plan Description (SPD). Keep in mind that expenses not eligible under your medical plan; amounts above the reasonable and customary charges; prescription drug, dental, and vision expenses; as well as payroll contributions are not eligible for reimbursement under the HRA.
- You are responsible for requesting reimbursement from your HRA, unless you elect to have your claims automatically paid from your HRA. This election can be made on the HRA website of your claims administrator (BCBS or UHC).
- You can carry over up to \$4,000 of unused HRA funds to the next year, for as long as you remain enrolled in this option.

Medical Plans Health Reimbursement Medical Plan

Employees and dependents who are covered under the Health Reimbursement or Health Savings Medical plans are also provided a company-paid Critical Illness benefit through Aflac.

Coverage includes:

- Coverage for critical conditions including Heart Attack, Stroke, Coronary Artery Bypass, Invasive Cancer, End Stage Renal Failure and Major Organ Transplant, among others.
- \$5,000 benefit amount for employees and covered spouses; 50% benefit for covered children.
- \$50 Wellness benefit per year for employees and/or dependents who complete a qualified health screening test.

You can learn more about the HRA and the Health Reimbursement Medical Plan at: BenefitsAtSHS.com



Medical Plans

Health Savings Medical Plan

The Health Savings Medical Plan is administered through Blue Cross Blue Shield (BCBS) or UnitedHealthcare (UHC) and offers you more control over your healthcare costs. With BCBS and UHC national provider networks, in-network care is available almost anywhere in the U.S.

Provider Choice You may use any provider you want—whether in-network or out-of-network—and you do not need to select a PCP. Using an in-network provider is generally more cost-effective, as you will receive discounted rates, a higher level of benefit, and will not be subject to balance billing. And don't forget that most in-network preventive care is covered at 100%.

How the Plan Works The plan requires you to pay a higher deductible; however, to offset the higher deductible, you can take advantage of a Health Savings Account (HSA), which is a tax-advantaged health account that Siemens Healthineers helps you fund.

Deductible, coinsurance, and out-of-pocket maximum: With the Health Savings Medical Plan, you'll pay for the full cost of care, including your prescription drug costs, until you satisfy your deductible. If you have family coverage, you must meet the entire family deductible before the plan begins paying benefits (even if a family member has met the individual deductible). Then coinsurance begins—meaning Siemens Healthineers and you share in the cost of care. The deductible and coinsurance count toward your out-of-pocket maximum. Once the combined medical and prescription drug out-of-pocket maximum is met, the plan pays for all eligible services for the remainder of the year.

In-network: In-network preventive care, such as annual physicals and health screenings, is generally covered at no cost to you. You pay a \$2,000 individual or \$4,000 family annual deductible. After you meet the deductible, you pay 15% coinsurance for in-network eligible expenses, and Siemens Healthineers pays 85%. You are protected with an annual out-of-pocket maximum of \$4,500 for individual coverage or \$9,000 if you cover a dependent. If an employee covers more than one individual under the Health Savings Medical Plan, 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.

Out-of-network: After you meet the \$3,000 individual or \$6,000 family deductible, Siemens Healthineers pays 65% of eligible expenses and you pay the other 35%, up to the annual out-of-pocket maximum of \$7,000 individual or \$14,000 family. If you have family coverage, the entire family out-of-pocket maximum must be met.

Health Savings Account (HSA): You can participate in an HSA, a tax-advantaged account that lets you set aside tax-free money to pay for healthcare.

- **Siemens Healthineers contribution:** Siemens Healthineers will automatically contribute \$400 to your HSA as well as an additional \$400 if you cover your dependents. You and your covered spouse or domestic partner can also earn additional company contributions to your HSA by completing certain wellness activities under the Healthy Rewards Program. Please note: Employees or newly covered dependents enrolling after January 1 will receive a prorated contribution based on the quarter in which they are hired. New enrollees from January through March receive the full amount (100%), April to June receive 75%, July to September receive 50%, and October or November receive 25% of the full amount.
- **Your contribution:** You can make contributions to the HSA on a before-tax basis, which lowers your taxable income. The maximum contribution amount—from you and Siemens Healthineers combined—is \$4,300 if you have employee-only coverage or \$8,550 if you have family coverage.

Please note: Your automatic company contributions and any Healthy Rewards you earn will count toward the limit.

Medical Plans

Health Savings Medical Plan

What You Need to Know About an HSA

You can open an HSA only if you have no other medical coverage.

- To receive Siemens Healthineers contributions or make your own contributions to your HSA, you must first establish your account with Optum Bank. If you choose to enroll in the Health Savings Medical Plan, you must accept the terms and conditions for an HSA after you enroll in the plan.
 - Once your balance is greater than \$2,000, you can grow your HSA by investing in mutual funds available through Optum Bank.
-

Employees and dependents who are covered under the Health Reimbursement or Health Savings Medical Plans are also provided a company-paid Critical Illness benefit through Aflac.

Coverage includes:

- Coverage for critical conditions including Heart Attack, Stroke, Coronary Artery Bypass, Invasive Cancer, End Stage Renal Failure and Major Organ Transplant, among others.
- \$5,000 benefit amount for employees and covered spouses; 50% benefit for covered children.
- \$50 Wellness benefit per year for employees and/or dependents who complete a qualified health screening test.

You can learn more about the HSA and the Health Savings Medical Plan at: [BenefitsAtSHS.com](https://www.BenefitsAtSHS.com)

Medical Plans Kaiser Health Maintenance Organization (HMO) Medical Plan



HMO option may be available if you live in California, based on your home address.

Provider Choice There is no coverage if you go outside an HMO provider network. In addition, an HMO requires you to select a PCP to coordinate your care and provide referrals to specialists, if necessary. You can choose your PCP from a wide selection of providers in the HMO network. If you get care without a referral from your PCP, there is no coverage under the HMO.

How the Plan Works

- You pay copayments for doctors' visits, ambulance service, and emergency room service. Medical copayments count toward your annual out-of-pocket maximum.
- There is no annual deductible.
- In the event of a true emergency, Kaiser HMO will provide benefits if you need to use an out-of-network provider—provided that you notify the plan provider as soon as possible.
- The annual out-of-pocket maximum is \$1,500 individual or \$3,000 family.

Comparison of Medical Plans Highlights

	Health Reimbursement Medical Plan*	Health Savings Medical Plan**	Kaiser HMO Medical Plan
Provider Choice	See any doctor or specialist of your choice		PCP required
	No Primary Care Physician (PCP) or referral required to see a specialist		Need PCP referral to see a specialist
	Higher benefit level for in-network care than out-of-network care		No coverage for out-of-network care, unless it's a true medical emergency
Company Contribution	Includes a Siemens Healthineers-funded Health Reimbursement Account (HRA) Siemens Healthineers contribution to your HRA: • \$500 employee • \$1,000 employee + dependents • You cannot make contributions to the HRA	Includes access to a Health Savings Account (HSA) with employee before-tax contributions and Siemens Healthineers contributions Siemens Healthineers contribution to your HSA: • \$400 employee • \$800 employee + dependents Maximum amount you and Siemens Healthineers can contribute to your HSA: • \$4,300 individual • \$8,550 family	None
Annual Deductible	In-network Medical • \$1,500 individual • \$3,700 family Out-of-network Medical • \$2,250 individual • \$5,550 family	In-network Medical and Prescription Drug Combined • \$2,000 individual • \$4,000 family Out-of-network Medical and Prescription Drug Combined • \$3,000 individual • \$6,000 family	In-network Medical and Prescription Drug Combined No deductible Out-of-network No coverage for out-of-network care, unless it's a true medical emergency

* Plan reimbursement for covered services is limited to the Maximum Allowed Amount as determined by Blue Cross Blue Shield, or Reasonable and Customary (R&C) charges as determined by UnitedHealthcare, depending on which claims administrator you select.

** If an employee covers more than one individual under the Health Savings Medical Plan, 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.

No Coverage Option

You may choose the "No Coverage" option if you have other coverage available to you, for example, through your spouse's or domestic partner's plan.

Comparison of Medical Plans Highlights

	Health Reimbursement Medical Plan*	Health Savings Medical Plan**	Kaiser HMO Medical Plan
Coinsurance	In-network - Preventive care: Plan pays 100% for most services; not subject to deductible - Other services: You pay 15% Out-of-network You pay 35%	In-network - Preventive care: Plan pays 100% for most services; not subject to deductible - Other services: You pay 15% Out-of-network You pay 35%	In-network - Preventive care: Plan pays 100% for most services - Office visits: You pay a \$25 copayment - Specialist office visits: You pay a \$45 copayment - Other services: You pay 20% Out-of-network No coverage for out-of-network care, unless it's a true medical emergency
Out-of-Pocket Maximum	In-network Medical \$3,700 individual \$10,000 family Out-of-network Medical \$4,700 individual \$14,000 family	In-network Medical and Prescription Drug Combined \$4,500 individual \$9,000 family** Out-of-network Medical and Prescription Drug Combined \$7,000 individual \$14,000 family	In-network Medical and Prescription Drug Combined \$1,500 individual \$3,000 family
Lifetime Maximum	None	None	None

* Plan reimbursement for covered services is limited to the Maximum Allowed Amount as determined by Blue Cross Blue Shield, or Reasonable and Customary (R&C) charges as determined by UnitedHealthcare, depending on which claims administrator you select.

** If an employee covers more than one individual under the Health Savings Medical Plan, 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.

Mental Healthcare and Substance Abuse Treatment

Benefits for mental healthcare and substance abuse treatment generally cover the diagnosis and treatment of mental illness, depression and nervous disorders, and care for other emotional health needs, as well as for alcohol and drug abuse, and chemical dependency. Benefits for mental health and substance abuse are provided through the claims administrator for the medical plan you select.

Prescription Drug Benefits

Siemens Healthineers provides prescription drug coverage through CVS/ caremark for the Health Reimbursement and Health Savings Medical Plans. If you are enrolled in an HMO Medical Plan, check with your carrier for specifics.

Convenient ways to fill your prescriptions

You can fill your prescription drugs at a retail pharmacy or through the mail order service. You also have the option to fill maintenance medications through your local CVS pharmacy at the discounted mail order service price.

30-day prescriptions: You can purchase prescription drugs (a 30-day supply or less) at a local retail pharmacy. Most major chains, including CVS, Eckerd, Osco, RiteAid, Walgreens, and Walmart, are included in the network, along with some local pharmacies.

Maintenance medications: If you take maintenance medications, you must fill your prescription:

- Through the mail order service, or
- At a CVS pharmacy

When your doctor first prescribes a medication, ask him/ her to write two prescriptions: one 30-day supply to be filled immediately at a pharmacy and one 90-day supply (plus refills) to submit through the mail order service. This approach will enable you to start taking your medication without waiting to receive your first order in the mail.

Protect Your Health

You may receive vaccinations through the CVS network of pharmacies. Learn more at [BenefitsAtSHS.com](https://www.benefitsatshs.com).



Prescription Drug Benefits

	Health Reimbursement Medical Plan	Health Savings Medical Plan**
Annual Deductible	None	Combined with medical deductible
Out-of-Pocket maximum	Prescription drug expenses: • \$2,300 individual • \$3,500 family	Combined medical and prescription drug expenses: • \$4,500 individual • \$9,000 family**
Retail (30-day supply)	Generic: You pay 10%; \$5 minimum*; \$25 maximum Preferred brand: You pay 30%; \$20 minimum; \$100 maximum Non-preferred brand: You pay 45%; \$35 minimum; \$150 maximum	
Mail order service or CVS pharmacy (90-day supply)	Generic: You pay 10%; \$10 minimum*; \$50 maximum Preferred brand: You pay 30%; \$40 minimum; \$200 maximum Non-preferred brand: You pay 45%; \$70 minimum; \$300 maximum	
Specialty†	You pay 30%; no minimum copay; \$300 maximum (excludes drugs eligible for PrudentRx program)	You pay 30% after deductible is met; no minimum copay; \$300 maximum (excludes drugs eligible for PrudentRx program)

* If the total cost of the drug is less than the \$5 or \$10 minimum, you'll pay only the full cost of the drug.

** If an employee covers more than one individual under the Health Savings Medical Plan, 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.

† **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.

Dental Plan

Siemens Healthineers PPO dental benefits cover the full cost of most preventive care and help you pay for a wide range of other dental services through Delta Dental.

Delta Dental provides enhanced coverage for in-network dental care, including a lower deductible for non-preventive care and a higher coinsurance for basic services.

You have access to both the Delta Dental Premier® and Delta Dental PPO networks. While the Delta Dental Premier network provides access to a larger number of dental providers, the Delta Dental PPO network offers greater discounts and lower out-of-pocket costs—allowing you to save more on dental services. However, you may use any dental provider—in or out of network—that you choose.

Keep in mind that if you use in-network providers, dental services will most likely cost you less because these providers have agreed to charge reduced fees. Other advantages of staying within the network include:

- The credentials of the dental providers have been checked.
- The fees they charge have already been determined to be “reasonable and customary.”
- They file claims with Delta Dental, so you don’t have to.

The DeltaCare DHMO Plan is also available. If you enroll in this option, you will only receive coverage when you use in-network providers. There is no out-of-network coverage.



Vision Plan

As a Siemens Healthineers employee, you will be automatically enrolled in the Basic Vision Plan offered through EyeMed. The Basic Vision Plan pays 100% for an annual eye exam, after a \$10 copayment.

If you prefer additional coverage for contact lenses, frames, and lenses, you can choose to enroll in and pay for one of two comprehensive options: the Enhanced Vision Plan or the Premier Vision Plan. You can also waive vision coverage.

With EyeMed, you have access to independent, national, and regional retail providers, plus online options. This includes trusted names like LensCrafters, Pearle Vision, Target Optical, and many more.

About Coverage Levels

Just like medical, the dental and vision plans allow you to choose one of four coverage categories:

- Employee only
- Employee plus spouse or domestic partner
- Employee plus child(ren) (no spouse or domestic partner)
- Employee plus family



2025 Siemens Healthineers Contact Information



Carrier contact information can be found in the chart below. Each health plan’s website allows you to see if your providers are currently in that plan’s network.* You’ll also find tools and resources, including smartphone apps, to help you get the most out of your medical, dental, and vision plans once enrolled.

Carrier	Member Services Phone Number	Website
Anthem Blue Cross Blue Shield	833-969-3997	anthem.com
CVS Caremark	844-757-0414	caremark.com
Delta Dental (PPO, Premier, and DeltaCare Networks)	800-592-0145	www1.deltadentalins.com/shs
EyeMed Vision Care (Insight Network)	866-800-5457	member.eyemedvisioncare.com/SHS
Kaiser Permanente	800-464-4000	kp.org
UnitedHealthcare	866-238-2637	myuhc.com

**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.*

More Resources

Siemens Healthineers understands that you may need some help deciding which plans and coverage are right for you. Siemens Healthineers offers this online resource:

mySHSBenefits.com

Healthcare and Dependent Day Care Flexible Spending Accounts

Flexible Spending Accounts, or FSAs, allow you to use before-tax dollars to pay for certain healthcare and dependent day care expenses. Siemens Healthineers offers two separate accounts—the Healthcare FSA and the Dependent Day Care FSA. You can choose to enroll in one or both accounts.

How the FSAs Work

You elect an annual amount to contribute to an FSA. The amount is deducted from your paycheck (before taxes), in equal installments, over the course of the year.

Account	Contributions	Eligible Expenses Include
Healthcare FSA	\$120 to \$3,300 per year	• Medical plan expenses (including prescription drug) • Dental plan expenses • Vision care expenses • Expenses over reasonable and customary amounts that are not reimbursed by medical or dental insurance • Over-the-counter medications
Dependent Day Care FSA (helps pay for the care of eligible children up to age 13, parents, grandparents, or a disabled spouse)	• \$120 to \$5,000* per year • \$2,500 if you are married and file separate income tax returns	• Fees for day care provided by individuals or a day care center inside or outside your home • Costs for a housekeeper if a portion of the services provided are for dependent day care • Costs for a pre-school or summer day camp

**Amount may be limited for highly compensated employees in compliance with IRS nondiscrimination requirements.*

Healthcare and Dependent Day Care Flexible Spending Accounts

Claims for Reimbursement

This table describes how you can use the funds you contribute to an FSA.

	Healthcare Spending Account	Dependent Day Care Account
Using Your Funds	You will receive a spending account card that you can use to pay for eligible healthcare expenses. The card works just like a debit card at valid locations and eliminates the need to submit claim forms for reimbursement. You can also submit a claim form and receive reimbursement.	You can submit a claim form, along with your receipts.
Maximum Reimbursements	The amount you elected to deposit for the year, less any reimbursements you’ve already received from the FSA.	The amount deposited to your FSA when you make your claim. If your claim is higher than your account balance, you will be reimbursed as you make additional deposits during the year.
Deadlines	You have until December 31, 2025, to incur expenses for the 2025 plan year. Any remaining funds up to \$660 will roll over into the new plan year (remaining balances over \$660 are forfeited). You have until May 31, 2026, to submit claims for the 2025 plan year.	You can receive reimbursement for eligible expenses you incur through March 15, 2026. Funds remaining in your account after that deadline are forfeited. You will have until May 31, 2026, to submit claims to HealthEquity.

HRA and Healthcare FSA

If you enroll in the Health Reimbursement Medical Plan, expenses that are eligible for reimbursement under both the HRA and the Healthcare FSA must be submitted to your HRA first. This includes out-of-pocket medical expenses such as your deductible and coinsurance. After your HRA balance has been used, future medical expenses may be submitted directly to your Healthcare FSA. Expenses that are not eligible for reimbursement under the HRA (e.g., prescription drug, vision, and dental claims) may be paid from the Healthcare FSA.

Health Savings Medical Plan and Limited-Use Healthcare FSA

If you participate in the Health Savings Medical Plan, you cannot also contribute to a Healthcare FSA. Instead, you can contribute to a Limited-Use Healthcare FSA. You can use this limited FSA to pay for dental and vision expenses.

Healthcare and Dependent Day Care Flexible Spending Accounts

About Your Healthcare Flexible Spending Account Card

Please note: HealthEquity and WageWorks have partnered.

You may see co-branding on the member portal and other materials.

When you enroll for the Healthcare FSA, HealthEquity will automatically send you a debit card. You may also request additional cards for your family at no additional cost. You will have access to your personalized account at healthequity.com/wageworks.

The IRS requires HealthEquity to verify that all purchases made using your Healthcare 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 HealthEquity account page.

If an expense requires verification, you must verify the transaction within 90 days, or your Healthcare Card will be suspended. For more information, including details on when a receipt is required, please go to wageworks.com/card.

Check Your Receipts Before Submitting!

Your receipt must include the following five criteria in order to be considered a valid FSA 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 (e.g., your deductible, copayment amount, or the portion not covered by your insurance [your 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 healthcare card receipt (must include provider name), which provides the exact amount paid.

For employees hired during October, November, or December, this benefit is not available until the next calendar year.

For a complete list of reimbursable expenses under the Healthcare and Dependent Day Care FSAs, call: 800-TAX-FORM (800-829-3676) or visit the IRS website (irs.gov).

You can learn more about the various types of healthcare accounts available to you at: BenefitsAtSHS.com

How Plan Costs Compare

2025 Bi-Weekly Contributions for Full-Time Employees

Plan	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)	Family
Medical				
Health Savings Medical Plan (Anthem BCBS or UnitedHealthcare)	\$31.32	\$98.80	\$89.71	\$174.79
Health Reimbursement Medical Plan (Anthem BCBS or UnitedHealthcare)	\$59.09	\$179.73	\$156.58	\$277.23
Kaiser HMO—California	\$58.62	\$155.82	\$140.42	\$217.97
Dental				
Delta Dental PPO Plan	\$10.36	\$20.65	\$21.11	\$29.31
Delta Dental DeltaCare DHMO Plan	\$4.54	\$9.08	\$10.38	\$16.23
Vision				
EyeMed Basic Vision Plan	\$0.00	\$0.00	\$0.00	\$0.00
EyeMed Enhanced Vision Plan	\$2.30	\$4.59	\$4.13	\$6.89
EyeMed Premier Vision Plan	\$3.54	\$7.10	\$6.36	\$10.60

Note: If you are a part-time employee, or eligible for the Cigna International or HMSA plans, please visit mySHSbenefits.com to view your 2025 contribution amounts.

Life & Work Assistance/Wellness Programs

Life & Work Assistance Program

You and your eligible family members are automatically covered by the Healthineers Life & Work Assistance program, in partnership with TelusHealth, at no cost to you, even if you waive Siemens Healthineers healthcare coverage. This program provides free, confidential counseling and referrals in times of personal, family, and financial need. Each year, you and your eligible family members are eligible for short-term counseling up to a maximum of six free sessions per incident. You can reach a professionally trained counselor by calling the Healthineers Life & Work Assistance program toll-free at **800-433-7916** and identifying yourself as a Siemens Healthineers employee or family member.

Additional information on the Healthineers Life & Work Assistance program services can be found on one.telushealth.com.

Siemens Healthineers offers wellness programs to meet your needs and support your physical and emotional health. Whether it's the Healthy Rewards Program, Healthy Focus Program, Be Well Reimbursement Program, Headspace, or AccessHope, Siemens Healthineers empowers you to maintain and improve your overall well-being.

Earn Healthy Rewards

If you enroll in the Health Reimbursement Medical Plan or Health Savings Medical Plan, you can earn additional company credits to your healthcare account, which we call Healthy Rewards.

Because it's important for you to understand any health risks you may have, Siemens Healthineers will reward you for completing wellness activities between January 1 and December 31 (the plan year). You and your covered spouse or domestic partner can earn even more Healthy Rewards if you are eligible for, and participate in specific programs.

For more information go to: BenefitsAtSHS.com

Healthy Rewards Activity	Contribution to Your HRA or HSA
You And Covered Spouse Or Domestic Partner	
Get your annual physical or well woman exam	\$150
Complete a Health Risk Assessment on your medical claims administrator web site (Blue Cross Blue Shield or UnitedHealthcare)	\$100
Get an eye exam	\$50
Get a mammogram	\$50
Get a colon cancer screening	\$50
Get a skin cancer screening	\$50
Get a prostate cancer screening (PSA test)	\$50
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

Wellness Programs

Be Well Reimbursement Program

Siemens Healthineers offers the Be Well Reimbursement Program for employees of participating companies.* This program helps you maintain or improve your physical and emotional health by providing flexibility to fit your lifestyle. You'll receive reimbursement for eligible expenses, from exercise classes and wearable fitness devices to meditation classes and more. You do not need to be enrolled in a Siemens Healthineers sponsored medical plan to be eligible to participate. The Be Well Reimbursement Program, administered by HealthEquity, is designed to empower and support you to be your best self.

Your dependents (i.e., spouse, domestic partner, children) are not eligible to participate in the program. If you and your spouse are Siemens Healthineers employees and work in a participating company, both of you are eligible for benefits under this program.

**Participating Siemens Healthineers Company; Corindus, Inc., Dedicated2Imaging LLC, PETNET Solutions, Inc., Siemens Healthcare Diagnostics, Inc., Siemens Healthcare Laboratory LLC, Siemens Medical Solutions USA, Inc. Varian Medical Systems, Inc., D3 Oncology*

Headspace

Headspace is a smartphone app that provides bite-sized guided meditations and mindfulness programs to help you reduce stress, sleep better, increase focus, and manage anxiety.

A free, premium membership to Headspace is available to all employees. With the Family & Friends Option, employees who have signed up can nominate up to two people from outside the organization to use Headspace for free.

AccessHope

AccessHope provide access to leading-edge cancer expertise for all U.S.-based employees and dependents, as well as parents and parents-in-law, grandparents and grandparents-in-law, and siblings at no cost. Services include:

Expert Advisory Review

Request a review of your cancer diagnosis and treatment plan from AccessHope's world-class specialists. The specialists then provide expert clinical recommendations while offering peer-to-peer discussions with your local doctor.

The specialists may share the latest cancer research findings and identify new medications, tests, or clinical trials relevant to your care as your doctor continues to manage your treatment plan.

Cancer Support Team

Connect with experienced, compassionate oncology nurses for appointment details, treatment information, or emotional support—wherever you are in your cancer journey and whether you've received a cancer diagnosis or are caring for someone who has.

To learn more, visit myaccesshope.org/siemenshealthineers.

For more information go to:
BenefitsAtSHS.com

Life and Accident Insurance

Siemens Healthineers' Basic and Supplemental life insurance coverages are administered by The Hartford. Whole Life insurance is made available through Allstate.

Basic Employee Life Insurance

Basic Employee Life Insurance coverage is automatically provided at 1x pay (up to \$1,000,000).

Imputed Income

If you have Basic Employee Life coverage of more than \$50,000, your W-2 form at the end of the year will show additional taxable income in the form of "imputed income" for premiums paid on your behalf by the Company. Imputed income is a calculated value based on a table supplied by the IRS and the amount of coverage you have that exceeds \$50,000.

Supplemental Employee Life Insurance

You can choose this coverage (paid with after-tax dollars) in addition to your Basic Employee Life Insurance coverage. You can choose coverage from one to 10x your pay; however, your supplemental coverage cannot exceed \$2,500,000.

Please note: For Basic Employee Life and Supplemental Life, pay includes base pay plus short-term annual bonus and commissions. Pay is rounded to the next-highest \$1,000, unless it already is a multiple of \$1,000.

If your pay increases during the year, your coverage will also automatically increase. If your pay decreases, your coverage will remain the same until the next calendar year. You may name anyone as beneficiary, and you can change your beneficiary at any time.

Spouse Life Insurance

You can also elect Spouse Life Insurance coverage (paid with after-tax dollars) if your spouse or domestic partner is age 70 or younger and is not a patient in a hospital, confined at home under the care of a doctor, or receiving disability benefits. You are automatically the beneficiary under your spouse's or domestic partner's coverage. However, you can change the beneficiary if you so choose.

You may choose between \$10,000 and \$250,000 in increments of \$10,000, not to exceed 3x your pay.

Child Life Insurance

You can purchase life insurance for your unmarried dependent children (paid with after-tax dollars) in amounts of \$5,000, \$10,000, \$15,000, \$20,000, or \$25,000. Your cost for this benefit covers all eligible dependent children. To be eligible, your child must be at least 15 days old and must be unmarried. Coverage ends on the child's 19th birthday (25th birthday if a full-time student). You are automatically the beneficiary under your dependent child's coverage.

Allstate Whole Life Insurance with Long-Term Care

Allstate Whole Life Insurance with Long-Term Care is one policy with two benefits. It provides a guaranteed financial benefit after death, as well as value through Long-Term Care Insurance that you can rely on as life needs change.

Accelerated Death Benefit

The Basic Employee Life, Supplemental Life, and Spouse Life plans feature an accelerated death benefit that pays you 80% of the coverage amount (up to \$500,000) after medical certification of a terminal illness and a life expectancy of 24 or fewer months. This 80% benefit amount is paid in a lump sum, with the remaining 20% paid to your beneficiary after your death.

Life and Accident Insurance Evidence of Insurability



You will be required to provide evidence of insurability—or proof of good health—if any of the situations below apply.

Type of Coverage	Situation
Supplemental Employee Life Insurance	If you are a newly hired employee and you elect coverage greater than three times your pay, or your coverage exceeds \$300,000.
	If you have Supplemental Life Insurance and wish to increase your coverage.
	If you waive Supplemental Life Insurance and then wish to purchase this coverage at a later date.
Spouse Life Insurance	If you elect coverage for your spouse or domestic partner that exceeds \$10,000.
	If you have coverage for your spouse or domestic partner and wish to increase his or her coverage.
	If you waive life insurance coverage for your spouse or domestic partner and then wish to purchase this coverage at a later date.

Life and Accident Insurance

Personal Accident Insurance (PAI)

PAI helps protect you and your family against financial loss if you are seriously injured in an accident or die from accidental death. Coverage is available up to 12x pay for employees or their family. The plan automatically provides a benefit of 2x your pay for employee only coverage or 1x your pay for family coverage. Additional coverage above 2x your pay is paid for with before-tax dollars. You must designate a beneficiary when you enroll. If you choose employee plus family coverage, you are the beneficiary for your spouse or domestic partner and/or child(ren).

If you choose employee-only coverage, and you die or are injured as the result of an accident, your beneficiary would receive 100% of the benefit. (The benefit is a certain multiple of your pay, depending on the option you choose.)

If you choose employee plus family coverage, the amount that you, as beneficiary, would receive if there's an accidental death or injury of a family member depends on whether your family consists of your spouse or domestic partner and children; spouse or domestic partner only; or children only. If you die or are injured in an accident, your beneficiary would receive 100% of the coverage amount (the same as if you choose employee-only coverage).

Employee-Only Coverage*

Coverage Amounts	Amount Beneficiary Receives if Accidental Death or Injury of Employee
One to 12x your pay	100%

Employee Plus Family Coverage*

Coverage Amounts	Amount Employee Receives if Accidental Death or Injury of Family Member		
	If Your Family Consists of:		
One to 12x your pay	Spouse or Domestic Partner and Children: 50% spouse or domestic partner/ 10% child	Spouse or Domestic Partner Only: 60%	Children Only: 15%
Coverage Amounts	Amount Beneficiary Receives if Accidental Death or Injury of Employee		
One to 12x your pay	100%		

*Coverage maximum is \$1,000,000.

Life and Accident Insurance

The following chart shows how the benefits paid would be a percentage of the amount shown in the previous chart. The percentage depends on the type of loss resulting from the accident.

Loss	Percentage of the Coverage Amount
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 arm or one 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 on same side of body)	100%
One hand, or one foot, or the 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 fifth day of the coma, for the duration of the coma, to a maximum of 50 months

Life and Accident Insurance

Business Travel Accident Insurance

Siemens Healthineers automatically provides you with Company-paid Business Travel Accident Insurance that pays benefits to you (if you sustain certain injuries) or your beneficiary (if you die) as a result of an accident while on a business trip.

Allstate Whole Life Insurance with Long-Term Care

Allstate Whole Life Insurance with Long-Term Care is one policy with two benefits. It provides a guaranteed financial benefit after death, as well as value through Long-Term Care Insurance that you can rely on as life needs change.

While the Whole Life portion of the policy provides a sum of money to a beneficiary if you die, the Accelerated Death Benefit for Long-Term Care portion of the policy pays for services to care for you when you can no longer perform activities of daily living on your own. As we age, the likelihood of needing long-term care increases; however, age is not the only determining factor. An accident or prolonged illness means the need for long-term care services can happen to anyone at any age.

- **Guaranteed-issue coverage** for employees and spouses/domestic partners who are between the ages of 18 and 70 when coverage becomes effective.
- **A lifetime level death benefit**, which provides a fixed benefit amount for the duration of the policy in the amount of up to \$150,000 for employees and up to \$30,000 for spouses/domestic partners.
- **An accelerated death benefit for long-term care** provides a monthly benefit for up to 50 months that allows the insured to use some or all of the life insurance policy's death benefit for long-term care expenses while the insured is alive. The benefit is payable if the insured is:
 - Unable to perform at least two activities of daily living for at least 90 days; and
 - Receiving professional long-term care.
- **Guaranteed-level premiums**, which means the cost of the policy will not change for the duration of the selected term of coverage.
- **Coverage portability**, allowing an employee to continue their life insurance and long-term care coverage if they leave Siemens Healthineers or retire.

Coverage may be elected upon hire or during annual enrollment. If coverage is elected, you will pay the full cost of coverage with after-tax contributions deducted per paycheck. You must be actively at work to enroll in coverage.



Disability Programs



Short-Term Disability

Siemens Healthineers provides you with short-term disability (STD) coverage for up to 26 weeks. STD helps protect you against loss of income during the first six months of a disability.

Long-Term Disability

Long-term disability (LTD) coverage helps protect you against loss of income when you cannot work for an extended period because of a physical or mental disability. If you become disabled, the benefit you receive is a certain percentage of the monthly pay you were receiving before you became disabled. Benefits are payable after 180 days of continuous disability.

To be eligible, you must be considered totally and permanently disabled and under the care of a licensed physician. For the first 24 months of coverage, you are considered totally and permanently disabled if you cannot perform all the essential duties of your occupation. 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.

The following conditions could affect your LTD benefits:

- Any benefit you receive will be reduced by any other disability benefits you are eligible for, such as Social Security or Workers Compensation.
- If you choose the Company-paid option, the total amount of your benefit will be subject to income tax.
- You also have the option to replace your Company-provided LTD coverage with an LTD benefit that you purchase on an after-tax basis. If you become disabled, you will be covered with a benefit equal to 60% of your salary. Your benefit will not be taxable, since it was purchased on an after-tax basis. This means you would receive a higher LTD benefit at the time you need it most.

Under most circumstances, your LTD coverage will automatically increase if your pay increases during the year—subject to a maximum monthly benefit of \$15,000 (for either employee-paid or Company-paid LTD coverage). The increase in coverage will begin on your first day at work after your pay increase, but your contributions will remain unchanged until the next enrollment period. If your pay decreases during the year, your LTD coverage will not change until the following calendar year.

Commuter Benefits Program

With the Commuter Benefits Program, you may contribute before-tax and after-tax dollars to an account that you can use to pay for public transit—including train, subway, bus, ferry, and eligible vanpool—and qualified parking expenses incurred as part of your daily commute to work. By paying your commuting expenses with before-tax dollars, you reduce your taxable income and experience financial savings.

The Commuter Benefits Program is convenient, and you can manage your account online. Here is how it works:

- Simply decide how much to contribute up to the monthly before-tax limit (\$325 for transit, eligible vanpools, and qualified parking—these limits are determined by the IRS and are subject to change). The maximum after-tax contribution is \$500 for mass transit, vanpool, and parking.
- If you enroll in the program, your contribution will be deducted in full from your last paycheck of the month on a before-tax and/or after-tax basis. You can start, pause, or cancel contributions to your account at any time, provided it is done by the fourth day of the month for the first day of the following month.

You can choose to pay your commuting expenses in a variety of ways:

- **Commuter Card.** Buy transit and parking passes and vouchers by using the WageWorks Commuter Card. The Commuter Card is a stored-value card that works like a credit card at transit agency ticket-vending machines and ticket windows. Funds from each month that you make a contribution will become available through your card on the 20th of the month before the benefit month (for example, June 20 for the July benefit month).
- **Home Pass Delivery.** Order your monthly passes or tickets for public transportation and have them automatically delivered to your home each month.
- **Pay My Parking.** HealthEquity will pay your parking provider directly on your behalf in time for the start of each order month, either by check or by automatically loading your parking card (if one is offered by your provider). This works well if you pay for a monthly parking space or permit. Upon termination of your employment, you will no longer be able to use the funds on your parking card. If you pay cash for parking or park at different places during the month, you can file a claim for reimbursement. The IRS is very clear that the parking benefit is to be used to park near public transportation or at the place of work.
- **Pay Me Back.** Get reimbursed for eligible commuting expenses you pay out of pocket. You simply file an electronic claim or paper claim to be reimbursed. Please note: An electronic claim does not require a receipt, so if you use daily parking or parking meters, this may be an option for you. Upon termination of your employment, paper claims can be submitted up to 180 days after the expense was incurred for the period that you were employed.

Know What Commuter Expenses Are Eligible and Not Eligible

What's Eligible

- Bus, light rail, regional rail, streetcar, trolley, subway, or ferry
- Vanpool
- Parking at or near work
- Parking at or near public transportation for your commute

What's Not Eligible

- Parking costs that are not work-related
- Mileage and tolls
- Taxis and limousines
- Parking at an airport for air travel

You can learn more at healthequity.com or by calling HealthEquity at: 877-924-3967.



Please note: HealthEquity and WageWorks have partnered. You may see co-branding on the member portal and other materials.

Additional Information and Notices



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 viewing our *Notice of Nondiscrimination* at BenefitsAtSHS.com.

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.

Siemens Healthineers 2024

Siemens Healthineers pioneers breakthroughs in healthcare. For everyone. Everywhere. Sustainably. The Company is a global provider of healthcare equipment, solutions, and services, with activities in more than 180 countries and direct representation in more than 70. The group comprises Siemens Healthineers AG, listed as SHL in Frankfurt, Germany, and its subsidiaries. As a leading medical technology company, Siemens Healthineers is committed to improving access to healthcare for underserved communities worldwide and is striving to overcome the most threatening diseases. The Company is principally active in the areas of imaging, diagnostics, cancer care, and minimally invasive therapies, augmented by digital technology and artificial intelligence. In fiscal 2023, which ended on September 30, 2023, Siemens Healthineers had approximately 71,000 employees worldwide and generated revenue of around €21.7 billion. Further information is available at www.siemens-healthineers.com.

Complete details of the various benefits offered under the Siemens 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 Medical Solutions, USA, Inc., as the plan sponsor of the Siemens Healthineers benefit plans, reserves the right to amend or terminate the plans or any part of the plans it sponsors at any time and for any reason.

Siemens Healthineers Headquarters - USA

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard
Malvern, PA 19355-9998, USA
siemens-healthineers.us

Summary Plan Description

Siemens Healthineers Benefits Program Active Employee Coverage

Effective: January 1, 2024

Search by key words or use the .PDF bookmarks or the [“Table of Contents”](#) or [hyperlinked text](#) to navigate this document

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 \(PAI\)](#), [Short-Term Disability \(STD\)](#), [Long-Term Disability \(LTD\)](#), [Business Travel Accident Insurance \(BTA\)](#), [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 Benefits Program or the “Plan.”

If you have questions about this document, call the Siemens Healthineers Benefits Center (SHBC) at **1-833-935-3328**.

[PAGE INTENTIONALLY LEFT BLANK]

Table of Contents

YOUR HEALTHINEERS BENEFITS PROGRAM	1
Here is how it works:	1
OVERVIEW OF YOUR HEALTHINEERS GROUP INSURANCE AND FLEXIBLE BENEFITS PROGRAM (HEALTHINEERS BENEFITS PROGRAM)	2
ELIGIBILITY AND ENROLLMENT	5
Who Is Not Eligible	6
Enrollment Restrictions	7
How to Enroll.....	7
Summary of Benefits and Coverage.....	8
Evidence of Insurability	8
Medical Plan Enrollment Restriction for Delegates.....	8
The Cost of Coverage	9
Pre-Tax Dollars	9
Post-Tax Dollars	10
WHEN COVERAGE BEGINS	10
New Employees	10
If You Do Not Enroll.....	11
Annual Enrollment.....	11
Changing Your Elections.....	12
Mid-Year Benefit Plan Changes You May Request	15
Special Enrollment Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009	20
Changing Your Medical Coverage Election.....	21
If You Change from Full-Time to Part-Time Employment Status Mid-Year	21
MAKING YOUR CHOICES.....	22
Medical.....	22
Choosing a Coverage Category.....	22
Dental	23
Vision.....	23
Flexible Spending Accounts	23
All Other Coverages.....	23
Retiree Coverages	23
OVERVIEW OF YOUR MEDICAL OPTIONS.....	24
Healthineers’ Self-Funded Medical Plan Options.....	24

Fully Insured Medical Plan Options	27
Delegates	28
PROVISIONS OF COVERAGE UNDER HEALTHINEERS' SELF-FUNDED MEDICAL PLAN	
OPTIONS	30
The Annual Deductible	30
The Annual Deductible for the Health Reimbursement Medical Plan Option	31
Coinsurance (Percentage Paid by Plan)	31
Maximum Out-of-Pocket Limits	32
HSA or HRA — Which Is Best for You?	34
Earn Healthy Rewards	35
NOTICE REGARDING WELLNESS PROGRAM	36
PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION	37
THE PRE-ADMISSION OR PRIOR AUTHORIZATION REVIEW PROGRAM	38
Prior Authorization	39
CONSOLIDATED APPROPRIATIONS ACT OF 2021 NOTICE	41
Consolidated Appropriations Act of 2021 (CAA)	41
Protections Against Surprise Medical Bills	41
Transparency Requirements	42
Continuity of Care	43
SUMMARY OF YOUR MEDICAL PLAN BENEFITS	44
Physician Expenses	44
Second Surgical Opinions	44
Hospital Expenses	44
Outpatient Medical Care and Physician Expenses	46
Dental Care and Surgery	47
Preventive Care Expenses	48
Guidelines and Coverage Information	50
Other Covered Services	50
Hyperhidrosi	58
Additional Services Available	63
Clinical Trials	64
Telemedicine	65
When to Use a Virtual Doctor	65
Know Your Virtual Doctors	66
Common Conditions Virtual Doctors Treat	66

Know Who Your Virtual Provider Is	66
Breast Reconstruction Benefits	67
Expenses Not Covered	67
Claiming Benefits – When and How to Use Claim Forms	72
Hospital Benefits	72
Other Benefits.....	72
THE PRESCRIPTION DRUG PROGRAM	74
Prescription Deductible for Health Savings Medical Plan	75
Prescription Drug Maximum Out-of-Pocket.....	75
Preventive Drugs.....	75
Non-ACA Preventive Drugs Subject to Coinsurance before Deductible	76
The Retail Pharmacy Program – Up to 30-Day Supply – Coinsurance	77
CVS Caremark Retail and Mail Service Pharmacy Program (Maintenance Choice®) – Up to 90-Day Supply – Coinsurance	78
Generic, Preferred Brand Name, and Non-Preferred Brand Name Coinsurance	79
Formulary and Preferred Drug List (PDL)	80
Pharmacy Prescription Contraceptives for Females	80
Compound Drugs and Topical Analgesics	81
CVS Specialty Pharmacy	81
Specialty Medications Require Prior Authorization	82
Specialty Pharmacy Coinsurance.....	82
Clinical Prior Authorization Process.....	83
Exceptions Process	84
Expenses Not Covered	84
MENTAL HEALTH AND SUBSTANCE USE PROGRAM.....	87
Covered Expenses	88
Neurobiological Disorders – Autism Spectrum Disorder Services.....	88
How the Program Works.....	89
Preauthorization Requirements for Inpatient and Out-of-Network Services.....	90
In-Network Services.....	90
Treatment for Substance Abuse (Substance Use Disorder).....	91
Expenses Not Covered	91
Claiming Benefits.....	93
If You Are Enrolled in a Fully Insured Plan Option.....	93
AN OVERVIEW OF THE HEALTH SAVINGS ACCOUNT (HSA) AND HEALTH REIMBURSEMENT ACCOUNT (HRA) FEATURES.....	94

Health Savings Medical Plan Option — HSA Feature	94
Health Reimbursement Medical Plan Option — HRA Feature	97
OVERVIEW OF YOUR DENTAL OPTIONS	99
DeltaCare Plan Option	99
Enrollment Restriction.....	99
THE DELTA DENTAL PLAN OPTION	100
The Deductible	100
Annual Maximum	101
Covered Expenses	101
Diagnostic and Preventive Care (Type A Services)	101
Definitions of Covered Diagnostic and Preventive Care	102
Basic Restorative Care (Type B Services).....	103
Definitions of Covered Basic Restorative Care	104
Major Restorative Care (Type C Services).....	104
Definitions of Covered Major Restorative Care	105
Orthodontic Services	106
Alternate Benefits	106
Pretreatment Estimate of Benefits	107
Claiming Benefits.....	107
Expenses Not Covered	108
Dental Benefits Extension	109
Dental Plan Enrollment Restriction for Outbound Delegates.....	110
OVERVIEW OF YOUR VISION PROGRAM.....	112
Eyeglass Benefits	113
Contact Lens Benefits	115
Medically Necessary Contact Lenses.....	116
Additional Discounts	117
Savings on Laser Vision Correction	117
Expenses Not Covered	117
Claiming Benefits.....	118
Using In-Network Providers.....	118
Using Out-of-Network Providers.....	118
OVERVIEW OF YOUR EMPLOYEE ASSISTANCE PROGRAM.....	120
EAP Services for Managers and Supervisors	120
Accessing EAP Services	120

When Benefits End	121
OTHER MEDICAL, DENTAL, VISION AND EAP PLAN PROVISIONS.....	122
Qualified Medical Child Support Orders	122
Compliance with HIPAA Privacy and Security Regulations	122
The Genetic Information Nondiscrimination Act (GINA)	122
If You Become Disabled	123
If You, Your Spouse and/or Your Domestic Partner Are Eligible for Medicare.....	123
If You Die	124
When Coverage Ends	125
Conversion Privileges.....	126
Extensions of Coverage (COBRA)	126
Your legal rights to continuation coverage under COBRA:.....	126
COBRA Continuation Period	128
Cost for COBRA Coverage	130
Are there other coverage options besides COBRA Continuation Coverage?	130
Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?.....	130
If You Have Questions	131
Keep Your Plan Informed of Address Changes	131
Plan Contact Information	131
Military Leave.....	131
FMLA Leave	132
Overpayments.....	132
Coordination of Benefits	133
Right of Subrogation and Reimbursement	135
Rescission	137
AN OVERVIEW OF YOUR FLEXIBLE SPENDING ACCOUNTS.....	139
Your Flexible Spending Accounts.....	139
Flexible Spending Accounts and the Health Savings Medical Plan Option.....	140
Flexible Spending Accounts and the Health Reimbursement Medical Plan Option.....	141
Your Contributions	141
Special Rules to Consider	142
Eligible Health Care Expenses	142
Health Care Expenses <i>Not</i> Eligible.....	145
Eligible Dependent Care Expenses	146
Dependent Care Expenses Not Eligible	146

Claiming Benefits.....	147
Health Care Expenses Spending Account Card.....	147
Using Your HealthEquity Health Care Card.....	148
Check Your Receipts Before Submitting	149
Dependent Care Expenses	150
Dependent Care Reporting Requirements	150
Claim Forms for Reimbursement.....	150
Termination of Employment.....	151
In Case of Your Death.....	152
OVERVIEW OF YOUR EMPLOYEE LIFE INSURANCE OPTIONS	153
Pay and Frozen Pay.....	153
If Your Pay Changes	154
Employee Basic Life Insurance.....	154
Imputed Income	154
If You Continue Working or Receive Benefits on an Approved STD or LTD Claim After Age 65	154
Accelerated Benefit.....	155
If You Become Disabled	155
Your Beneficiary and Claiming Benefits.....	155
When Coverage Ends	155
Portability and Conversion Privilege	155
OVERVIEW OF YOUR SUPPLEMENTAL LIFE INSURANCE OPTIONS.....	156
Employee Supplemental Life Coverage	156
Special Limited Option to Increase Employee Supplemental Life Coverage	157
Dependent Coverage	157
Coverage for Your Spouse or Domestic Partner	158
Coverage for Your Children	159
Cost of Coverage.....	159
Choosing Coverage in the Future.....	159
Accelerated Benefit.....	160
If You Become Disabled	161
Payment of Benefits and Your Beneficiary.....	161
When Benefits Are Not Paid	162
Claiming Benefits.....	162
When Coverage Ends	162
Portability and Conversion Privilege	163

OVERVIEW OF YOUR PERSONAL ACCIDENT INSURANCE OPTIONS	166
Choosing Coverage in the Future.....	167
Plan Benefits.....	167
Definitions of Covered Losses	168
Other Plan Benefits	168
Exclusions.....	169
Payment of Benefits and Your Beneficiary.....	170
Claiming Benefits.....	170
When Coverage Ends	171
Right of Conversion	171
YOUR BENEFITS WHILE YOU ARE DISABLED.....	171
YOUR SHORT-TERM DISABILITY BENEFITS.....	173
STD Coverage.....	173
Eligibility	173
Enrollment	173
Cost.....	173
Summary of Benefits.....	173
How Benefits are Paid	173
How STD Benefits are Calculated.....	175
STD Benefit Calculation:.....	175
Determining Your Rate of Pay	176
Commission Paid Employees	176
Reduction of Benefit Payments	176
State Mandated Disability Benefits.....	177
Applying for Disability Benefits.....	177
Work Incentive/ Transitional Duty Program	178
Light Duty	179
Successive Disabilities	179
Impact On Other Benefits While On Short Term Disability	179
Exclusions.....	180
Workers' Compensation Claims	180
Example:	180
When Coverage Ends	181
When Benefits End	181
OTHER IMPORTANT PROVISIONS OF THE PLAN.....	182
Right of Recovery.....	182

Recovery of Overpayment	182
YOUR LONG-TERM DISABILITY INCOME BENEFITS	183
LTD Coverage Options	183
Your Eligibility for Long-Term Disability Income Benefits	184
Exclusions	185
Claiming Benefits	186
When LTD Benefit Payments Begin	187
Trial Work Periods, Non-Continuous Periods of Disability or Partial Disability	187
How Long LTD Benefits Continue	188
Concurrent Disability	189
Pre-Existing Condition Limitation	189
Other Income Benefits and Earnings That Reduce LTD Benefits	189
Estimation of Other Income Benefits	191
Limitation for LTD Benefits Due to Particular Conditions	191
Rehabilitation Incentive Benefit	192
Partial Disability Work Incentive Benefit	193
When LTD Benefit Payments End	193
Successive Periods of Disability	194
How Your Pay Is Determined	195
If You Change LTD Plan Options	196
Recovery of Overpayment	196
Subrogation and Reimbursement	196
Survivor Benefit	196
Termination of Coverage	197
YOUR OTHER BENEFITS DURING DISABILITY	198
Your Health and Welfare Benefits Eligibility Status While You Are Disabled	198
Employee Basic Life (STD, LTD and Post-12 LTD Benefits Status)	199
Employee Assistance Program (STD, LTD and Post-12 LTD Benefits Status)	200
Dependent Life Insurance (STD, LTD and Post-12 LTD Benefits Status)	200
Medical Coverage (STD, LTD and Post-12 LTD Benefits Status)	201
Coverage That Ends When You Reach Post-12 LTD Benefits Status	202
OVERVIEW OF YOUR BUSINESS TRAVEL ACCIDENT INSURANCE	204
Plan Benefits	204
Definitions of Covered Losses	205
If Your Pay Changes	206
Exclusions	206

Payment of Benefits/Beneficiary	207
Claiming Benefits.....	207
When Coverage Ends	208
Conversion.....	208
PLAN ADMINISTRATION.....	209
Plan Sponsor	209
Employer Identification Number	209
Plan Administrator.....	209
Claiming Benefits.....	209
CLAIM AND APPEAL PROCEDURES FOR GROUP HEALTH PLANS (MEDICAL, PRESCRIPTION, DENTAL AND VISION)	211
Procedures for CVS Caremark.....	211
Second-Level Appeal Procedure for CVS Caremark in Certain Instances.....	212
External Review Program, Independent Third-Party Review for CVS Caremark	213
Appeal of Prior Benefit Determination for Delta Dental	213
Procedures for EyeMed Vision Care	214
Procedures for Group Health Claims	215
Urgent Care Claims.....	216
Concurrent Care Decisions	216
Pre-Service Claims.....	217
Post-Service Claims.....	217
Procedures for Appeal.....	218
Time for Decision on Review	219
Notification of Determination on Review	219
External Review Program, Independent Third-Party Review for Medical Plan Options	220
CLAIM AND APPEAL PROCEDURES FOR FLEXIBLE SPENDING ACCOUNTS (HEALTH EQUITY)	222
Second-Level Appeal Procedure for the Flexible Spending Accounts.....	223
CLAIM AND APPEAL PROCEDURE FOR THE SHORT-TERM DISABILITY PLAN	224
CLAIM AND PROCEDURE FOR THE LONG-TERM DISABILITY PLAN	226
CLAIM AND APPEAL PROCEDURES FOR EMPLOYEE AND SUPPLEMENTAL LIFE, PERSONAL ACCIDENT AND BUSINESS TRAVEL ACCIDENT INSURANCE	228
TIME LIMIT FOR BRINGING LEGAL ACTIONS FOR DENIED BENEFIT CLAIMS UNDER PLANS THAT ARE PART OF THE HEALTHINEERS BENEFITS PROGRAM	230
LEGAL SERVICE	231

Non-Assignment of Benefits.....	231
ADMINISTRATIVE INFORMATION AND CLAIMS ADMINISTRATORS.....	232
Plan Records.....	233
Plan Documents	233
Plan Amendment and Termination.....	233
YOUR RIGHTS UNDER ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974).....	234
Receive Information About Your Plans and Benefits	234
Continue Group Health Plan Coverage.....	234
Prudent Actions by Plan Fiduciaries	234
Enforce Your Rights.....	235
Assistance with Your Questions.....	235
GLOSSARY	236

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, Short-Term Disability, 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. 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, and Child Life 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 Healthineers Benefits Center (SHBC) at **833-935-3328**.

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 - 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
Short-Term Disability	Percentage of pay for up to 25 weeks of disability, based on plan option available to you
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, \$1,000,000 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, \$20,000, or \$25,000 (subject to certain limits)

In This Benefit Area	You May Choose
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
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. You may elect a Health Care Account even if you do not enroll in a Healthineers medical option. 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 is available to all Healthineers employees. The 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. Important Points to Keep in Mind - You choose the amount, if any, that you want to contribute to either or both types of account (up to certain annual 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.

In This Benefit Area	You May Choose
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 January 1, 2024, 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 <u>actively at work</u> 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 Healthineers Benefits Center and must be approved by Siemens Healthineers Benefits Center before coverage will go into effect.	
Options and Plan Provisions in effect as of January 1, 2024	

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; <i>and</i> • Your partner has lived with you for at least 12 months and you and your domestic partner have a serious, committed relationship; <i>and</i> • Your partner is financially interdependent with you; <i>and</i> • 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 SHBC at 1-833-935-3328. 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 (<u><i>or</i></u>, 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 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 Healthineers Benefits Center and must be approved by the Siemens Healthineers Benefits 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](#);

- Any employee covered by a collective bargaining agreement (including any applicable side agreements or memoranda of understanding) that does not provide for participation in the Plan;
- Any individual classified by the Company as a leased employee or independent contractor, even if there is a subsequent contrary determination of this classification by a court or government agency;
- Any employee of another employer even if working on Company premises or providing services to the Company;
- Any “intern,” “temporary,” or “seasonal” employee; or
- Any individual employed by the Company who is regularly or normally scheduled to work less than twenty (20) hours per week.

Healthineers uses a dependent verification procedure for benefit eligibility purposes. If you have a question regarding eligibility, contact the SHBC at **1-833-935-3328**.

You are responsible for notifying the SHBC 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 mySHSBenefits.com, which can be accessed from any computer or mobile device with an Internet connection. The website is your primary source for enrolling or obtaining information about your benefits. If you are unable to enroll or complete your enrollment at mySHSBenefits.com, you can enroll by calling the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328**. Representatives are available weekdays from 10 a.m. to 6 p.m. Eastern Time.

At mySHSBenefits.com, you will find 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. Visit BenefitsAtSHS.com to help you fully understand the benefits available to you.

Resource	How to Access
mySHSBenefits.com website	Log onto mySHSBenefits.com and enter your User ID and password ¹
The automated voice response system, or VRS	Call 833-935-3328 and enter the last 4 digits of your SSN, your date of birth and password, then follow the system prompts.
SHBC representatives	Call 833-935-3328 weekdays from 10 a.m. to 6 p.m. Eastern Time to speak with a representative.
¹ You create your own User ID and password to access mySHSBenefits.com . When you log on to the website, click on <i>"New User?"</i> and follow the instructions. If you do not have Internet access, or if you forgot your user ID or Password and want to create a new one, call the SHBC at 833-935-3328 to for assistance.	

Table 3 — SHBC Resources

For most situations, you will want to go first to mySHSBenefits.com. The website can handle most of your enrollment and information needs and is available 24 hours a day, 7 days a week.

When you have a situation or question that cannot be handled through the website, you can talk to an SHBC representative by calling **833-935-3328** weekdays from 10 a.m. to 6 p.m. Eastern Time.

Summary of Benefits and Coverage

The SPD includes an overall summary of what the Plan covers. A Summary of Benefits and Coverage (SBC) for each medical option is also available, along with a Uniform Glossary, to help you compare your medical options. The SBCs may be found at BenefitsAtSHS.com>Resources>Benefits Documents. The SBCs summarize important information in a standard format, so you can compare across all the plan options. You may also obtain a paper copy of the SBC for each of the medical options, free of charge, by calling the Siemens Healthineers Benefits Center at **833-935-3328**.

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, you are eligible for coverage under the Anthem or UnitedHealthcare Health Reimbursement Plan. Alternatively, you may elect medical coverage for you and your eligible family members under the Globality program, sponsored by Siemens Healthineers GmdH.

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 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, Personal Accident Insurance, 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 benefits 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

New Employees

If you are a new — or newly eligible employee — you must actively enroll in your benefits online at mySHSBenefits.com or by calling the SHBC 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 SHBC in advance by calling **833-935-3328**. 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 SHBC 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 at the mySHSBenefits.com website or by calling the SHBC. **If your child does not yet have a valid U.S. Social Security Number, you will need to call the SHBC 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 SHBC 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.

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 mySHSBenefits.com, 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 \$1,000,000); 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 Annual Enrollment section of mySHSBenefits.com website, or call the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** 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 (including the health plan administrator, e.g., Anthem or United Healthcare) 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.

Changing Your Elections

The 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 [mySHSBenefits.com](#) or by calling the SHBC at **833-935-3328** 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 SHBC, 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.

Note about HRA Balances: If you and your spouse are both employees of a participating employer, have a balance in your HRA and are making a change that affects who is paying for coverage (e.g., you covered your family in 2023 and your spouse covers your family in 2024), unused money in your HRA will be forfeited.

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 SHBC at **833-935-3328** 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
- Change from full-time to part-time work schedule without loss of eligibility
- 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
- Revocation Due to Enrollment in the Marketplace of Employee and Family:
 - » A participating employee may revoke an election in order to obtain coverage through the Marketplace under the following conditions:
 - The employee is seeking to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, and
 - The employee enrolls, along with any related individuals who cease coverage due to the revocation, in a Marketplace plan effective immediately following the revocation.

The Company may rely on the reasonable representation of an employee who is enrolling in Marketplace coverage that the employee and related individuals have enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation (that is, there is no gap in coverage).

- Revocation Due to Enrollment in the Marketplace of Family Member(s):
 - » A participating employee may revoke an election of family coverage, switching to a lower tier of coverage (i.e., self-only), in order for other covered family members to obtain coverage through the Marketplace under the following conditions:

- One or more of the employee's dependents are eligible for a special or open enrollment period in the Marketplace, and
- The change to the employee's election is related to their dependent(s) intended enrollment in individual health insurance coverage through the Marketplace. The Marketplace health insurance coverage must be effective beginning no later than the day immediately following the last day they are covered under the employee's employer plan.
- The Company may rely on the reasonable representation of an employee whose family member(s) is enrolling in Marketplace coverage that the family member(s) has enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation (that is, there is no gap in coverage).
- Revocation Due to Reduction in Hours of Service:
 - » A participating employee may revoke prospectively an election of coverage under a group health plan (other than a health care FSA) provided the following conditions are met:
 - The employee changes from full-time status to part-time status and is reasonably expected to remain in part-time status, and
 - The employee enrolls, along with any related individuals who cease coverage due to the revocation, in another plan no later than the first day of the second full month following the revocation.
 - An employer may rely on the reasonable representation of an employee who is changing to part-time status that the employee and related individuals have enrolled or intend to enroll in another plan within the above timeframe.

[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 <u>Spouse</u> <u>Life</u> 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
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

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 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 <u>only</u> : Enroll Increase Decrease Drop	No changes allowed	Start Reinstate	Start Reinstate

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 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
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

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
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 plan⁴					
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
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

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
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
Marketplace Coverage					
Employee enrolls in Marketplace Plan	Drop coverage	No changes allowed	No changes allowed	No changes allowed	No changes allowed
Employee enrolls family members in Marketplace Plan	Change coverage tier	No changes allowed	No changes allowed	No changes allowed	No changes allowed
Reduction of Hours					
Reduction of employee hours	Change plan option; Drop coverage	No changes allowed	No changes allowed	No changes allowed	No changes allowed
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 Healthineers Benefits Center and must be approved by the Siemens Healthineers Benefits 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					

Qualified Life Events	Medical, Vision and Dental Coverage	Life and PAI Coverage	Long-Term Disability Coverage	Health Care Spending Account	Dependent Care Spending Account
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. ⁴ Loss of other coverage does not include a loss of coverage due to: • The failure of the employee or dependent to pay premiums on a timely basis • Voluntary disenrollment from a plan, or Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the 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 mySHSBenefits.com website or by calling the SHBC.** 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.

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 SHBC at **833-935-3328** 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 SHBC, 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 mySHSBenefits.com website or by calling the SHBC at 833-935-3328.

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.

[Four Medical Plan options](#), under two 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 two Health Savings Medical Plan options, which both offer a [Health Savings Account \(HSA\)](#) feature, are administered by UnitedHealthcare and Anthem BCBS.
- The two Health Reimbursement Medical Plan options, which both offer a [Health Reimbursement Account \(HRA\)](#) feature, 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 at [mySHSBenefits.com](#) or call the SHBC. 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, Dental and/or Vision 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. The [DeltaCare Plan](#) is also available beginning January 1, 2024. If you enroll in the DeltaCare Plan, you will only receive coverage when you use in-network providers. There is no out-of-network coverage.

Vision

You automatically receive coverage under the [EyeMed Vision Care](#) Basic vision plan option, 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 mySHSBenefits.com or by calling the SHBC at **833-935-3328**.

Overview of Your Medical Options

The Healthineers Benefits Program offers most employees a choice of two 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) and a Health Reimbursement Medical Plan option with a Health Reimbursement Account (HRA) feature (the HRA Plan).

UnitedHealthcare (UHC) and Anthem Blue Cross Blue Shield (Anthem BCBS) both administer the Health Savings Medical Plan option and Health Reimbursement Medical Plan option. When you enroll, you 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	Health Savings Health Reimbursement
Medical plan member website	www.myuhc.com	www.anthem.com
Member services phone number	866-238-2637	833-969-3997
Prescription drug vendor	CVS Caremark	CVS Caremark
Prescription drug website	www.caremark.com	www.caremark.com
Prescription drug member services phone number	844-757-0414	844-757-0414
Specialty Pharmacy program vendor	CVS/specialty	CVS/specialty
Specialty Pharmacy website	CVSspecialty.com	CVSspecialty.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 **CVSCaremark** with specialty medications through **CVS Caremark Specialty Pharmacy**.

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
Plan Type	High-Deductible Consumer-Driven Health Plan	High-Deductible Consumer-Driven Health Plan
Plan Names	UHC HSA Anthem BCBS HSA	UHC HRA Anthem BCBS HRA
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 - In-Network care is lower in cost - Health Reimbursement Account (HRA) helps offset the higher deductible
Company Contribution	Healthineers contributes to your HSA ²: \$300 for you, <i>plus</i> \$300 for your enrolled spouse or domestic partner - You can increase Healthineers' contributions by earning <i>Healthy Rewards</i> You can contribute to your HSA ² pre-tax: - Up to \$4,150 you-only - Up to \$8,300 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: \$400 for you, <i>plus</i> \$400 for your enrolled spouse or domestic partner - You can increase Healthineers' contributions by earning <i>Healthy Rewards</i> - You can carry over unused HRA funds up to \$4,000 to the next year as long as the HRA Medical Plan option continues to be offered and you remain enrolled in this option
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
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	In-Network ^{3, 4} - Preventive care: Plan pays 100% for most services; not subject to the deductible - Other services: Plan pays 85% coinsurance after deductible is met

	Health Savings ¹	Health Reimbursement ¹
	Out-of-Network ^{4, 5} - Plan pays 65% of R&C charges after deductible is met - You pay the balance of the billed amount	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
Medical Annual Maximum Out-of-Pocket (MOOP) ¹	In-Network ^{3, 4, 5} (includes deductible) \$5,500 you-only \$7,350 per year for individual on family contract \$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) \$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
Prescription Drug MOOP (Rx MOOP)	Included with Medical	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 2024, 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 areas, 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 for 2024) 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 or Summary of Benefits available at mySHSbenefits.com, use the member website provided by each carrier. 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)	Maui branch: 808-871-6295 Oahu: 808-948-6386 Toll-Free: 855-260-5256	www.hmsa.com
Kaiser Permanente	800-464-4000	http://healthy.kaiserpermanente.org

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

PRIMARY CARE PROVIDER NOTICE

The Kaiser Permanente HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Kaiser Permanent network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at **800-464-4000** or online at healthy.kaiserpermanente.org. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. 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 procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 800-464-4000 or online at healthy.kaiserpermanente.org.

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 SHBC 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 based on the lesser of (a) the provider's normal charge for a similar service or supply or (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 based on 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](#)"), subject to applicable provisions of the Consolidated Appropriations Act of 2021, 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 Health Reimbursement Plan medical option administered by UnitedHealthcare (and Delta Dental, if you had dental coverage as a delegate).

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
Annual Medical Deductible	In-Network \$2,000 you only \$4,000 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 \$3,000 you only \$6,000 you + one or more Includes 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

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 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 Medical Plan Option

To help limit the number of Deductibles you and your covered family members need to pay, the Health Reimbursement Medical Plan option includes 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 Deductible. 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
Coinsurance Percentage	In-Network Plan pays 85% until In-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 charge until Out-of-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

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.

Important: 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. If your provider charges more than the R&C or MAA, you may be responsible for any excess amount, even if your MOOP limit has been reached.

	Health Savings	Health Reimbursement
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 ; 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
* Under the Prudent Rx program, certain eligible specialty medications do not qualify as “essential health benefits” and member cost-share payments for these medications do not count toward the plan’s prescription drug out-of-pocket maximum.		

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 an IRS out-of-pocket maximum (subject to change each year, \$7,350 in 2024 for in-network care will

have met the out-of-pocket maximum for themselves; while the remaining family members must continue to pool their expenses to meet the annual out-of-pocket maximum). This applies only to in-network services.

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 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 or HRA — Which Is Best for You?

	Health Savings Account	Health Reimbursement Account
Healthineers’ automatic annual contribution		
You only	\$300 ^a	\$400
You + child(ren)	\$300 ^a	\$400
You + spouse or domestic partner	\$600 ^a	\$800
You + family	\$600 ^a	\$800
Additional Healthineers’ contributions		
Earn Healthy Rewards	Yes	Yes
Maximum total annual tax-free contributions (Healthineers’ plus your own) ^b		
You only	\$4,150 ^{a, b}	No
You + child(ren)	\$8,300 ^{a, b}	
You + spouse or domestic partner	\$8,300 ^{a, b}	
You + family	\$8,300 ^{a, b}	
Can you increase tax savings with a Flexible Spending Account (FSA)?		
Health Care FSA (HCFSA)	No	Yes ^d
Limited-Use Health Care FSA	Yes ^c	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 2024 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 and 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 HCFSAs](#), 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. A covered medical expense will generally include any type of expense that is managed through the UnitedHealthcare or Anthem BCBS claims process (excluding out-of-network amounts in excess of R&C or MAA). This specifically excludes prescription drug expenses, which are administered under the CVS Caremark Prescription Drug Program, as well as dental and vision expenses. You can also elect to contribute to an [HCFSAs](#). The IRS has rules that govern the order in which [medical expenses](#) must be submitted by individuals who have both an HRA and an HCFSAs —
 - » 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 HCFSAs.
 - » Expenses that are eligible for reimbursement from both the HRA and the HCFSAs 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 HCFSAs 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 HCFSAs.
 - » Your HCFSAs 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 2024, 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
Receive a mammogram	\$50
Receive a colon cancer screening	\$50
Receive a prostate cancer screening	\$50
Receive a skin cancer screening	\$50
<i>Healthy Focus Maternity Program</i>	
Complete a pre-delivery screening or planning call	\$100
Complete a post-delivery call	\$100
<i>Healthy Focus Program</i>	
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.

Notice Regarding Wellness Program

Healthy Rewards is a voluntary wellness program available to all employees. Employees who choose to participate in the wellness program can receive an incentive of up to \$1,200 per family as described above. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be eligible to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA in order to be eligible for other Healthy Rewards incentives.

Additional incentives may be available for employees who participate in certain Healthy Focus Maternity or Disease Management activities. If you are unable to participate in any of the health-related activities to earn an incentive, you may be entitled to a reasonable

accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Siemens Healthineers Benefits Center at **833-935-3328**.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as disease management programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Siemens Healthineers may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Rewards will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are your doctor," or "a Healthy Focus registered nurse coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Plan Administrator.

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.

Going Out-of-Network?

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

Member services for UHC (866-238-2637) and Anthem BCBS (833-969-3997) 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.

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. In-network, your provider will handle pre-certification of inpatient medical care for you. Out-of-network, 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 **866-238-2637** or Anthem BCBS at **833-969-3997**). 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.

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 or Health Reimbursement Medical Plan options, if you fail to precertify, in addition to satisfying your deductible, you will pay \$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 services that may be subject to pre-certification. You must contact your Claims Administrator to obtain pre-certification (or confirmation pre-certification is not required) for the following services:

- Accidental dental services
- Congenital heart disease services
- Durable medical equipment over \$1,000 (purchase or cumulative rental)
- Home health care
- Hospice care (must have a life expectancy of six months or less)
- 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.

Prior Authorization

Both Anthem BCBS and UnitedHealthcare require prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide these services to you.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Services for which you are required to obtain prior authorization are identified in *Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a Federal law that includes the No Surprises Billing Act as well as the provider transparency requirements that are described below. You may request a paper copy of the Notice from your health plan by calling the number on your ID card. Information is also posted at the www.myuhc.com and www.anthem.com.

Protections Against Surprise Medical Bills

Under federal law (the No Surprises Act of the Consolidated Appropriations Act, 2021), you will be protected from “surprise medical billing” or “[balance billing](#)” when you receive emergency care or treatment from an Out-of-Network health care provider at an In-Network hospital or ambulatory surgical center. Surprise medical billing is when you receive services at an In-Network facility from an Out-of-Network provider and the member later receives a bill for Out-of-Network services. Balance billing is when you receive care from an Out-of-Network provider who bills you for the difference between the provider’s normal charge and the allowable amount under the Plan. This applies in addition to the cost sharing you must pay (such as a deductible, copayment or coinsurance) under the Plan.

Under the federal law, you are protected from balance billing for the following services. These services will be referred to as “protected services.”

- *Emergency services:* If you have an emergency medical condition and receive emergency services from an Out-of-Network provider or facility, the most the provider or facility may bill you is the Plan’s In-Network cost-sharing amount (such as deductibles, copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may receive after you are in stable condition, unless you provide written consent to give up protections not to be balance billed for these post-stabilization services.
- *Certain services at an In-Network hospital or ambulatory surgical center:* When you receive services from an In-Network hospital or ambulatory surgical center, certain providers may be Out-of-Network. In these cases, the most those providers may bill you is the Plan’s In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up protections not to be balance billed.
- *Air ambulance:* If you have an emergency medical condition and receive emergency transport through an Out-of-Network air ambulance service, the most the provider may bill you is the Plan’s In-Network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency air ambulance services.

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was In-Network). The Plan will pay Out-of-Network providers and facilities directly the “Out-of-Network rate” as required by section 2799A-1 of the Public Health Service Act. You’re never required to give up your

protections from balance billing. You also aren't required to receive care Out-of-Network. You can choose a provider or facility in the Plan's network.

If you receive a balance bill for a protected service, you will need to contact the Claims Administrator at the customer service telephone number listed on your ID card. Upon such notification, the Claims Administrator will resolve the balance billing. For questions, contact your Claims Administrator.

Additionally, for the protected services listed above, the Plan will:

- Cover emergency services without requiring prior authorization and without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition), an affiliation or waiting period, or applicable cost sharing,
- Base the amount you pay for the provider or facility on the In-Network cost-sharing amount (regardless if the provider or facility is Out-of-Network), and
- Count any amount you pay for the Out-of-Network services towards your In-Network deductible and out-of-pocket maximum.

Transparency Requirements

The Plan provides the following information through its Claims Administrators' websites at www.anthem.com and www.myuhc.com:

- Protections with respect to Surprise Billing claims by providers;
- Estimates on what Out-of-Network providers may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements.

Upon request, the Plan Administrator or the Claims Administrator will provide you with a paper copy of the type of information you request from the above list.

The Claims Administrator, either through its price comparison tool on www.myuhc.com or www.anthem.com or through Member Services at the phone number on the back of your ID card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific network provider;
- A list of all Network Providers, updated at least every 90 days;
- Cost sharing information on an Out-of-Network provider's services based on the Claims Administrators reasonable estimate based on what the health plan would pay an Out-of-Network provider for the service.

In addition, the Claims Administrator will provide access through its website to the following information:

- Network negotiated rates;
- Historical Out-of-Network rates; and
- Drug pricing information.

Continuity of Care

In certain circumstances, if you are receiving continued care from an In-Network provider or facility, and that provider's network status changes from In-Network to Out-of-Network, you can continue to receive care from the provider at the In-Network cost-sharing amount for up to 90 days from the date you are notified of your Provider's termination, unless otherwise indicated below. This will apply if you are: (1) undergoing treatment for a serious and complex condition, (2) pregnant and undergoing treatment for the pregnancy, through your first postpartum visit, (3) receiving inpatient care, (4) scheduled to undergo urgent or emergent surgery, including postoperative or (5) terminally ill (having a life expectancy of 6 months or less) and receiving treatment for the illness from the provider. Please contact your health plan if you need transitional care.

Summary of Your Medical Plan Benefits

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 and Anthem BCBS administer the Health Savings as well as the Health Reimbursement 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
Inpatient Care		
Hospital 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
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
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
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
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; non-emergency not covered	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
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

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.

	Health Savings	Health Reimbursement
Outpatient Medical Care		
Primary doctor office visit	In-Network 85% covered after deductible is met	In Network 85% after deductible is met
	Out-of-Network 65% covered after deductible is met	Out-of-Network 65% covered after deductible is met
Specialist office visit	In-Network 85% covered after deductible is met	In Network 85% after deductible is met
	Out-of-Network 65% covered after deductible is met	Out-of-Network 65% 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	In-Network 85% covered after deductible is met
	Out-of-Network 65% covered after deductible is met	Out-of-Network 65% covered after deductible is met
Second surgical opinion	In-Network 85% covered after deductible is met	In Network 85% covered after deductible is met
	Out-of-Network 65% covered after deductible is met	Out-of-Network 65% covered after deductible is met
Urgent care clinic visit	In-Network 85% covered after deductible is met	In-Network 85% 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 , if applicable under provisions of the Consolidated Appropriations Act of 2021.		

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.
- Surgical and non-surgical treatment for temporomandibular joint dysfunction (TMJ) including splints and appliances

	Health Savings	Health Reimbursement
Dental Care		
Dental implants	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; 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
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

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 both of the self-funded Medical Plan options. Under the Health Reimbursement Medical Plan option, 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
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 deductible Out-of-Network 65% 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 deductible Out-of-Network 65% covered; not subject to deductible
Well-woman exam (includes pap); Mammogram (preventive)¹; Women’s preventive and maternity services 100% covered <i>in- network</i> 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
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 deductible Out-of-Network 65% covered; not subject to deductible

	Health Savings	Health Reimbursement
¹ 3-D mammography is covered 100% under preventive care when received in-network 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% <i>In-Network</i> 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 CVSCaremark 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), iron supplements (for children at risk of iron deficiency) and human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) medications (restrictions on specific products or quantities may apply). 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 https://www.uhc.com/health-and-wellness/preventive-care
Anthem BCBS – Health Savings, Health Reimbursement https://www.anthem.com/preventive-care/

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
Family Planning/Maternity Care		
Prenatal services 100% covered <i>in-network</i> 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
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 85% covered after deductible is met Out-of-Network 65% covered after deductible is met

	Health Savings	Health Reimbursement
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
Newborn medical and nursery services – preauthorization required for newborn remaining inpatient after mother is discharged	In-Network 85% covered after deductible is met	In-Network 85% covered after deductible is met
	You must enroll your newborn within 30 days of the date of birth by calling the SHBC at 833-935-3328. No Social Security Number is required.	
	Out-of-Network 65% covered after deductible is met	Out-of-Network 65% covered after deductible is met
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 deductible; for details on federal guidelines and plan option coverage, see Table 15 above Out-of-Network 65% 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
Fertility services – subject to certain limits, 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

	Health Savings	Health Reimbursement
In-vitro fertilization; Artificial insemination — subject to certain limits, 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
Family Planning and services and items not included in ACA guidelines — subject to certain limits, 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
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 85% covered after deductible is met Out-of-Network 65% covered after deductible is met
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
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 85% covered after deductible Out-of-Network 65% 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

	Health Savings	Health Reimbursement
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
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
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
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
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
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

	Health Savings	Health Reimbursement
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
Durable medical equipment —subject to medical review (except breast pumps covered <i>In-Network</i> 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
NOTE: Prenatal services covered <i>In-Network</i> 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 <u>not</u> 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. There are no limits on the number of visits for outpatient occupational/physical/speech therapy and nutritional counseling provided for a mental health or substance use disorder diagnosis.		

	Health Savings	Health Reimbursement
NOTE: Fertility and Family Planning: 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 • Assisted reproductive technologies (ART) including 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 are 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 which cover the cost for storing frozen eggs, embryos, and sperm to use in covered procedures for up to 12 months • Pre-implantation genetic testing, including testing for a monogenic disorder (PGT-M), chromosomal abnormality (PGT-A) or structural rearrangement (PGT-SR) of the embryo • Fertility preservation for medical reasons, including 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 the medical plan's deductible, coinsurance and out-of-pocket maximums. Maximum Benefits: Fertility services are limited to a lifetime maximum of \$15,000 (in- and out-of-network combined) for medical benefits and \$10,000 lifetime for prescription drug benefits. Services for the diagnosis and treatment of an underlying cause of infertility are not subject to the fertility lifetime maximum benefit. Contact your health plan in order to use these services. You must enroll with Fertility Solutions (UHC) or WINFertility (BCBS) to access these benefits. You may contact WINFertility for information and to enroll at 855-556-9869 or online at managed.winfertility.com/siemens-healthineers/. Certain services are excluded from coverage. See the section "Expenses Not Covered" for information. 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 **866-238-2637** or Anthem BCBS at **833-969-3997**.

Other Services Covered under the Self-Funded Medical Plan Options
Allergy tests and treatment • 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 <i>To enroll, contact Anthem BCBS at 1-855-869-8137 or UnitedHealthcare at 1-866-221-5901.</i>
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
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 <i>not</i> 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)
- Voice modification surgery
- Voice modification therapy
- Facial feminization procedures
- Lipoplasty or body-contouring surgery
- Hair removal, including when required as part of reconstructive surgery

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

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

Other Services Covered under the Self-Funded Medical Plan Options

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.
- Nutritional counseling for mental health and substance use disorders (e.g., anorexia, bulimia) is covered as described above

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
- BMI of 35 to 39 for at least 2 years with evidence of co-morbid conditions attributable to obesity: such as 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

Prior authorization 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 Plan members, covered at 100% with no Deductible or inpatient copay
- Otherwise, covered with In- or Out-of-Network Coinsurance after the Deductible 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:

Other Services Covered under the Self-Funded Medical Plan Options

- 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 and lodging benefits may be available. See “[Travel and Lodging Benefit](#)” for more information.
- » **Outpatient care:** if a Center of Excellence is not used, covered In- or Out-of-Network with In-Network Coinsurance

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

Other Services Covered under the Self-Funded Medical Plan Options

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.

Other Services Covered under the Self-Funded Medical Plan Options

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

- Per diem rate, up to \$50 per day, for the caregiver if the patient is in the hospital
- Per diem rate, up to \$50 per day, for the patient if the patient is not in the hospital
- 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.

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: **866-238-2637**
- » Anthem Blue Cross and Blue Shield: **833-969-3997**

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: **866-238-2637**
 - Anthem Blue Cross and Blue Shield: **833-969-3997**

Participation in the Healthy Focus program is voluntary.

- **BeWell Reimbursement Program.** Siemens Healthineers offers the Be Well Reimbursement Program to help you maintain or improve your physical health and emotional health. You'll receive reimbursement for eligible expenses from exercise classes and wearable fitness devices to meditation classes and more. You do not need to be enrolled in a Siemens Healthineers sponsored medical plan to be eligible to participate. Your dependents are not eligible to participate. Reimbursement of eligible expenses is administered by HealthEquity.

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 15% after deductible
Health Savings Medical Plan Option	You pay 15% 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 [™] , Doctor on Demand [™] , Optum Virtual Care and Teladoc

If your medical plan administrator is...	Anthem Blue Cross Blue Shield	UnitedHealthcare*
How to access virtual doctor visits	Download the Sydney Health app at the AppStore SM or Google Play TM .	Go to myuhc.com or the UnitedHealthcare 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 SM or Google Play TM .
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.

Breast Reconstruction Benefits

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under The Women's Health and Cancer Rights Act of 1998.

If you (or a covered dependent) are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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 (not to transport between facilities when there is no true emergency)

- 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](#)" if applicable based on provisions of the Consolidated Appropriations Act of 2021 — 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 HCFA
- 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
- Fertility services including:
 - » 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
- 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 as 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.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.

- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Gluteal augmentation.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- 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.
- Minoxidil

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 [mySHSBenefits.com](#) 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 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 CaremarkSpecialty** Pharmacy for participants in the Health Savings and Health Reimbursement 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
Prescription Drug Coverage		
Prescription drug vendor	<i>CVS Caremark</i>	<i>CVS Caremark</i>
Prescription drug website	www.caremark.com	www.caremark.com
Prescription drug member services phone number	844-757-0414	844-757-0414
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	Covered up to \$10,000 lifetime maximum	Covered up to \$10,000 lifetime maximum
Diabetic Equipment	Coverage includes insulin pumps and diabetic supplies, retail and mail service	Coverage includes insulin pumps and diabetic supplies, retail and mail service
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. A three-day limit applies for new opioid users age 19 or younger. 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.

If you are enrolled in the PrudentRx program and obtain an eligible specialty medication that 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.

- Health Reimbursement 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.

Preventive Drugs

The following Preventive drugs covered at 100% in compliance with the Patient Protection and Affordable Care Act (ACA)*:

- Aspirin (generic only), for adults 50-59 years old (over-the-counter requires a prescription)
- Contraceptive drugs and devices with a doctor’s prescription
- Oral fluorides (brand and generic), for children age 5 or younger (does not cover over-the-counter)

- Folic acid (generic only), for women age 55 and younger (over the counter requires a prescription)
- Tobacco cessation products (if on CVS Caremark's list), for individuals age 18 and older to quit smoking
- Human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) medications (restrictions on specific products and/or quantities may apply)
- Vaccines, including COVID-19 Vaccines and booster shots authorized through an Emergency Use Authorization (EUA) or fully approved by the Food and Drug Administration (FDA) and recommended by the Advisory Committee on Immunization Practices (ACIP)
- Bowel prep products used to prepare for colonoscopy
- Risk reducing breast cancer medication
- Statins to prevent serious heart disease in adults age 40-75
- Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum
- Prediabetes – *Generic only*

Non-ACA Preventive Drugs Subject to Coinsurance before Deductible

Certain (non-ACA) drugs required to treat ongoing health conditions are considered preventive, and subject to the plan's cost sharing **before** meeting the deductible. The following are some examples of non-ACA preventive drugs (but not the full list) for specified conditions that may apply to your plan:

Preventive Care for Specified Conditions	For Individuals Diagnosed With
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ration (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression

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, 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 **844-757-0414**.

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
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
Specialty	70% covered after medical deductible is met; no minimum Copay ¹	70% covered; no minimum Copay ¹

¹ **PrudentRx Copay Program** – Effective 1/1/24, 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.

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.

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, and do not utilize the CVS maintenance choice program, you will pay the full cost of the medication.

You can also access the CVS network of retail pharmacies to receive vaccines, including Hepatitis A and B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Tetanus, Chicken Pox (Varicella), Diphtheria, and Zoster (Shingles). Vaccines are covered in full under the Affordable Care Act at no cost sharing.

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 52136, Phoenix, AZ 85072-2136.

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 retail CVS pharmacy or through the mail.

	Health Savings	Health Reimbursement
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 retail CVS pharmacy 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: **844-757-0414**

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 **844-757-0414**, 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 Medical Plan option and you have a Health Care Flexible Spending Account (HCFSAs), you may be able to obtain reimbursement of the “product selection cost” amount from your HCFSAs.

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 **844-757-0414**.

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 Pharmacy

The **CVS Specialty Pharmacy** 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, only 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.CVSSpecialty.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 30% [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). If you are enrolled in the PrudentRx program and obtain an eligible specialty medication that 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. To request an exception/appeal, submit a request to CVS via fax or mail. Exception requests/appeals can also be submitted verbally by physician only. Once an appeal is received, the appeal and all supporting documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal:
 - » For plans with one level of appeal: 30 days
 - » For plans with two levels of appeal: 15 days
- Post-Service Appeal: 30 days

CVS Caremark Appeals Department MC109
P.O. Box 52084
Phoenix, AZ, 85072-2084
Fax: 1-866-689-3092

Participants in the Health Reimbursement Medical Plan option will pay 30% [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 Plan 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.

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.

	Health Savings	Health Reimbursement
Specialty Pharmacy program vendor	Specialty Customer Care	Specialty Customer Care
Specialty Pharmacy website	www.CVSSpecialty.com	www.CVSSpecialty.com
Specialty Pharmacy phone number	800-237-2767	800-237-2767
Specialty Pharmacy coinsurance	70% covered for eligible drugs after medical plan deductible is met	70% covered for eligible drugs

Table 23 – CVS Caremark Specialty Pharmacy Benefits

NOTE: Most Specialty medications must be purchased through the **CVS Specialty** Pharmacy in order to qualify for the Specialty Pharmacy Coinsurance rate. Generally, if you do not use the **CVS Specialty** Pharmacy 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.

Members with hereditary angioedema and members who take Solaris are subject to enhanced specialty guideline management. Contact Specialty Customer Care at **800-237-2767** for more information.

Clinical Prior Authorization Process

Some drugs in the Healthineers Prescription Drug Program – including Specialty Pharmacy products – require Prior Authorization from **CVS Caremark**. Drugs that require Prior Authorization include, but are not limited to:

- Fentanyl products (participants receiving these drugs prior to January 1 2018 were grandfathered) and
- Two high-cost generic Metformin ER products used to treat Type 2 diabetes, as a lower-cost generic version (Glucophage) is available.
- Acthar (restricted to infantile spasm)
- Sucraid
- Sitavig
- Duobrii
- 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. Current approvals are honored until prescription expiration, enhanced criteria will be applied for continued use

- Duexis and Vimovo will only be available based on “medical necessity” as over-the-counter alternatives are 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 **844-757-0414**. **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 **844-757-0414**

- 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 or through a CVS retail pharmacy for a 90-day supply.
- 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
- Fertility medications in excess of the \$10,000 lifetime limit
- 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 Use Program

Coverage for mental health and substance use 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
Behavioral Health (Mental Health and Substance Use Treatment)		
Behavioral health provider	UnitedHealthcare Behavioral Health www.myuhc.com 866-238-2637	UnitedHealthcare Behavioral Health www.myuhc.com 866-238-2637
	Anthem BCBS Behavioral Health www.anthem.com 866-621-0554	Anthem BCBS Behavioral Health www.anthem.com 866-621-0554
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 85% covered after deductible is met Out-of-Network 65% 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
¹ Only Medically Appropriate services are covered under the Mental Health and Substance Use Program under any Medical Plan option. Plan reimbursements for Covered Health Services provided by <i>Out-of-Network</i> 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 ”), subject to applicable provisions of the Consolidated Appropriations Act, 2021. 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 Use

The amount of your mental health and substance use 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.

Covered Expenses

The Mental Health and Substance Use 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 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 health 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
In-Network 85% covered after deductible is met	In Network 85% after deductible is met
Out-of-Network 65% covered after deductible is met	Out-of-Network 65% covered after deductible is met

These Benefits describe only the behavioral health 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 Use Resources Available to You

If you or family members are experiencing mental health or substance use 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 Use Program.

The **Healthineers Work and Life Assistance Program** (EAP, **800-433-7916**) 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 <https://shs.lifeworks.com>. 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 Line](#) for your medical plan option:

UnitedHealthcare: **866-238-2637**

Anthem Blue Cross and Blue Shield Behavioral Health: **833-969-3997**

How the Program Works

To receive maximum benefits under the Mental Health and Substance Use 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: **866-238-2637**
- Anthem Blue Cross and Blue Shield Behavioral Health: **866-621-0554**

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, residential treatment facility 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 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
Substance Use Disorder		
Detox and Rehab: Outpatient coverage	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
Detox and Rehab: Inpatient coverage	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

Table 26 – Substance Use

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 Use 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
- 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*
- Wilderness therapy, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, and services provided in conjunction with (or as part of) those programs.
- 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 **866-238-2637** or Anthem Blue Cross and Blue Shield Behavioral Health at **833-969-3997**).

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)	808-948-6386 on Oahu or 855-260-5256 toll-free	www.hmsa.com
Kaiser Permanente	800-464-4000	http://healthy.kaiserpermanente.org

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 2024, Healthineers will contribute \$300 for you and \$300 for your enrolled spouse or domestic partner on an annual basis if enrolled for the full year. Individuals who enroll mid-year will receive a pro-rated amount depending on the remaining number of pay periods in the year. 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 go to [mySHSBenefits.com](#) 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 2024, the maximum combined amount you and Healthineers can contribute to the HSA is \$4,150 for single coverage or \$8,300 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 **866-234-8913**. 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 within 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 and Anthem 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 SHBC 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 \$2,000, you can start investing your balance in a selection of mutual funds. For information on the interest crediting rate and investment options, call Optum Bank at **866-234-8913**, 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 2023) 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>.

To learn more about the fees associated with your Optum account, log into your account at optumbank.com. Select “Account” on the top tab menu. Click on “Account Management,” scroll down to “Account fees,” then click on “Account Fee Schedule.”

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 2023, Healthineers will contribute \$400 to your HRA as well as an additional \$400 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 www.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 an **Anthem BlueCross BlueShield 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.
- Once your User-ID and Password have been created, you will be able to access your HRA directly from the Anthem website. From the home page, select *My Plans* at the top of the page, then *Spending Accounts*, then *Manage My Account*.
- 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.
- If you have any questions or you do not have access to a computer, contact the Anthem BCBS customer service team at **833-969-3997** 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 (HCFSAs), 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 HCFSAs 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 HCFSAs 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.

If you and your spouse are both employees of a participating employer, have a balance in your HRA and are making a change that affects who is paying for coverage (e.g., you covered your family in 2023 and your spouse covers your family in 2024), unused money in your HRA will be forfeited.

Overview of Your Dental Options

The Healthineers Benefits Program offers the Delta Dental Plan option described below. Beginning January 1, 2024, an additional option, the DeltaCare plan, has also been added. In addition to these options, you may also elect “No Coverage” (waiver of coverage).

Here is a summary of your Delta Dental Plan 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

DeltaCare Plan Option

Through Delta Dental, you also have access to a DeltaCare Plan. If you enroll in this option, you will only receive coverage when you use in-network providers. There is no out-of-network coverage. Learn about the ease and convenience of the DeltaCare Plan by reviewing this summary at [HL DCU PA14I V23 W EN 04.01.23 LTR.pdf \(benefitsatshs.com\)](#).

When considering the DeltaCare Plan option, please be sure to review Delta’s website to make sure your preferred dentist participates in this Plan. There is no out-of-network benefit for this plan, so your provider must participate in order to receive benefits.

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 Plan Option

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

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 www1.deltadentalins.com/shs.

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 www1.deltadentalins.com/shs or call Delta Dental at **1-800-592-0145** 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 network 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, except intraoral-periapical and extraoral X-rays
Cleaning of teeth (oral prophylaxis)	4 per calendar year	
Periodontal maintenance	4 times per calendar year <u>less</u> 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 (covered at 80%, no deductible)	
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	1 in 30 days, or per visit for the purpose of diagnosing an emergency condition	

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. These X-rays are covered at 80%, no deductible.

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
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 repair, 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	
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	2 within a calendar year	
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).

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)		
Anesthetics¹	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
Veneers	Limited to anterior teeth; 1 per tooth every 84 months. Pre-treatment estimate is recommended to ensure other restorative work does not limit benefit	
Crowns²	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	
Bridges²	Once every 84 months; cast gold, porcelain fused to gold, plastic processed to gold	

Services	Frequency/Limitations	Coverage
Major Restorative Care (Type C Services)		
Surgical extractions and all other oral surgery	Once per tooth/arch/quadrant per lifetime	In-Network 50% after deductible is met Out-of-Network 50% after deductible is met
Implants (including prosthetic devices) ²	Once every 84 calendar months for prosthetic devices; <i>repair</i> of implants limited to once in a 12-month period	
Gold restorations (if necessary as the result of extensive cavities or fracture <u>and</u> if restoration with amalgam, silicate, acrylic or plastic is not possible)	Once every 84 months	
Posts and cores	No limit	
Bruxism	Including 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.

Veneers are used to reshape the anatomy of an anterior (in the front of the mouth) tooth.

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 typically made in two (2) installments. The initial payment is made when braces are first installed. Thereafter, a secondary/final payment will be made at the 12-month anniversary of the installation.

Orthodontic Services	Coverage
Preliminary X-rays, diagnostic casts and treatment plan	In-Network <i>or</i> 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 www1.deltadentalins.com/shs.

When you are treated by a Delta Dental PPO 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 www1.deltadentalins.com/shs or by calling Delta Dental at **1-800-592-0145**. 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 Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055-2105

For information about a claim you have already submitted, call Delta Dental Claims Processing at **1-800-592-0145** (TTY/DD 1-888-373-3582).

You must file a claim to receive benefits within 12-months of the date of service in order for a benefit payment to be allowed. 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 **1-800-592-0145**.

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 SHBC at **833-935-3328** (or at **332-600-6270** 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)	\$2,000
Lifetime Maximum (for Class IV)	\$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%

Services	Coverage
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, and most Pearle Vision locations. You can also use your in-network benefits to purchase glasses, contacts and prescription sunglasses online. Simply visit glasses.com, contactsdirect.com, lenscrafters.com, targetoptical.com or ray-ban.com to instantly apply your eyewear benefits at checkout.

To find an EyeMed network provider, search the online directory at member.eyemedvisioncare.com/SHS and choose the **Insight Network** or call EyeMed’s Customer Care Center at **866-800-5457**. EyeMed’s Customer Care Center can be reached Monday through Saturday, 8:00 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 <i>minus</i> \$55 allowance, <i>plus</i> \$40 copay	

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
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

Healthineers Vision Plan members are eligible for benefits towards one full pair of glasses (frames and lenses) OR contacts and frames as described below. In the latter, members can receive a 20% discount on the lenses for the eyeglasses. 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

	Basic (Company-Paid)	Enhanced (Buy-Up)	Premier (Buy-Up)
In-Network Eyeglass Benefits			
• 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		\$175 copay	\$175 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		\$85 copay	\$85 copay
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	
• 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			
• Single Vision	Not available	\$25	\$25
• Bifocal		\$40	\$40
• Trifocal		\$55	\$55
• Lenticular		\$55	\$55
• Progressive Lenses		\$40	\$40
Lens Options			
• Anti-Reflective Coating	Not available	\$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
• 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 Lenses — available once per calendar year instead of spectacle lenses	Not available	Up to \$63	Up to \$90
Disposable — available once per calendar year instead of spectacle lenses		Up to \$63	Up to \$90
Medically Necessary		Up to \$300	Up to \$300

*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** (Mild/Moderate) - when keratoconus is present and the member's vision is not correctable to 20/ 25 in either or both eyes using standard spectacle lenses

- **Keratoconus** (Advanced/Ectasia) – when keratoconus is present and one or more specified conditions are met
- **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.

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, owned and operated by LCA Vision, 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

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Group number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

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 Benefits. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form and attach your itemized receipts. For your convenience, you may submit your claim form in one of the three (3) following options:

1. Online: FAA/EyeMed out-of-network claims can be completed online. To access the out-of-network form or to check the status of a claim, log in to [Member Web](#) and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included.

2. Mail: First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:
FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111
3. Email: You may also print a claim form and email it to oonclaims@eyemed.com or call the EyeMed's Customer Care Center at **866-800-5457**.

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 member.eyemedvisioncare.com/SHS and choose the *Insight* Network. You may also call EyeMed's Customer Care Center at **866-800-5457**. EyeMed's Customer Care Center can be reached Monday through Saturday, 8:00 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) called the Healthineers Life and Work Assistance Program administered by Telus 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 Healthineers Life and Work Assistance Program.

EAP Services	
Service Level	24 hours a day, 7 days a week
	Provider referrals
Participant Services	Telephone consultation
	Crisis intervention services
	Life at Work resources
	Discounts on health- and wellness-related products and services
	Emotional well-being online (assessment tools, FAQs, wellness content, online access and referrals, self-directed digital programs to help with body, work, mind and relationships)

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
- Critical incident and crisis support
- 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 **800-433-7916**. 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

You can also access online services at <https://shs.lifeworks.com>.

When Benefits End

Your EAP benefits end 30 days after your termination of employment.

If you are authorized for 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).

Compliance with HIPAA Privacy and Security Regulations

The medical options under this Plan are intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Company is required to provide notice of the ways that protected health information (PHI) may be used in accordance with HIPAA. You can find a copy of the HIPAA notice at mySHSBenefits.com or call 833-935-3328.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act prohibits health coverage discrimination and employment discrimination against employees based on their (or their family members’) genetic information.

Genetic information includes:

- You or your family member’s genetic tests
- The request for, or receipt of, genetic counseling or other genetic services by you or your family members, and
- The manifestation of a disease or disorder in an individual’s family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history will be treated as confidential, as required by HIPAA and GINA.

The plan will not discriminate on the basis of genetic information. This means that the plan will not adjust premiums for an employee or any group of similarly situated individuals under the plan, on the basis of genetic information.

The plan will not request or require you or your family member to undergo a genetic test. However, your physician may obtain and use information about the results of a genetic test.

The plan may also obtain such information to the extent required in making a determination regarding payment (for example, where payment is made only as to medically necessary treatment and the results of a genetic test are necessary to determine the medical necessity of the services provided). In some circumstances the plan may obtain or request genetic information for research purposes (if required by a state for the protection of individuals) or as part of your or your family member's voluntary participation in a research study.

The plan will not collect genetic information for underwriting purposes, which includes (1) determination of eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premiums under the plan or coverage (including discounts in return for activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. However, if the plan conditions the benefit based on its medical appropriateness, which depends on the genetic information, the plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness.

The plan will not collect genetic information with respect to any individual before that individual's effective date of coverage under that plan, nor in connection with the rules for eligibility that apply to that individual.

For more information on genetic information protection and nondiscrimination, contact Siemens Healthineers Benefits Center at **1-833-935-3328**.

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 SHBC at **833-935-3328** 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 **800-633-4227**. 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.

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 SHBC at **833-935-3328** 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 SHBC at **833-935-3328** 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.
3. 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 SHBC, and elect the extended COBRA coverage, within 60 days of the occurrence of this second qualifying event. You can notify the SHBC by calling the SHBC at **833-935-3328**. 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.
4. 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.

5. **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 SHBC 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 SHBC 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.
6. 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.
7. 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 SHBC at **833-935-3328**.

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.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up>.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights as well as the rights of your spouse and dependent children, you should keep the plan administrator informed of any address changes for your spouse and/or dependent children. You should also keep a copy for your records of any notices you send to the plan administrator.

Plan Contact Information

COBRA Administrator
Siemens Healthineers Benefits Center (SHBC)
Dept. 09408
PO Box 1590
Lincolnshire, IL 60069-1590

Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (that is, Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus any additional seniority, rights and benefits that you would have attained if employment had not been interrupted.

If an employee has military orders for over 31 days, the employee may continue his/her medical, dental and vision benefit coverages in effect before the Military Leave of absence by continuing to pay his/her share of the premiums while on leave for up to 24 months from the commencement of the leave. Thereafter, the employee and covered dependents will be

offered COBRA coverage for up to an additional 18 months at 102% of the overall (both employer and employee) premium rate. The group short-term, long-term disability and business travel accident insurance provided by the Company will end the day the employee begins his/her Military Leave.

Basic, supplemental, spouse and dependent life insurance along with personal accident insurance (PAI) will continue for a period of 24 months of Military Leave, subject to continued payment of any required employee premiums. After the 24-month period, the employee can elect to port or convert the basic, supplemental, spouse and dependent Life and PAI coverage to an individual policy.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated medical coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days, or
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

FMLA Leave

Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of unpaid leave for certain family and medical situations and continue your elected medical coverage benefits during this time. The Company is required to maintain group health plan coverage for an employee on FMLA leave a) if you had that coverage before taking the leave, and b) on the same terms as if you had continued to work. If applicable, you may need to make arrangements to pay your share of group health plan contributions while on leave. In some instances, the Company may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

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 coverage for a health service is available under two plans, COB determines which plan pays 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.

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 Healthineers, 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, Your Spouse and/or Your Domestic Partner 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.

Rescission

Your (and/or your dependent's) coverage under the medical plan may be rescinded (i.e., cancelled or discontinued with a retroactive effective date) if you (and/or your dependent) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of this plan. For example, if Healthineers determines that you have enrolled an individual who does not meet the plan's

eligibility requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such plan ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and Healthineers reserves the right to rescind your (and/or your dependent's) medical plan coverage. Your (and/or your dependent's) coverage may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances.

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 HealthEquity. If you have a question regarding the provisions of the program, call HealthEquity customer service at **877-924-3967** or visit their website at www.healthequity.com/wageworks 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 2024 and you participated in a regular HCFSA during 2023, you will need to submit claims for reimbursement from your 2023 HCFSA of any eligible **medical, dental or vision care** expenses that were incurred (but not reimbursed) on or before December 31, 2023. (You will not be able to use your HealthEquity Visa spending account card after December 31, 2023, to pay expenses from your 2023 HCFSA.) You may submit paper or online claims for reimbursement from your 2023 HCFSA for eligible **dental and vision care** expenses incurred January 1, 2024,

through March 15, 2024. Any claims for **medical** expenses incurred on or after January 1, 2024, 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 2024, your annual contribution may not be less than \$120 and not more than \$3,050.
- **Limited-Use Health Care Account:** For 2023, your annual contribution may not be less than \$120 and not more than \$3,050.
- **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 2024 plan year, an employee who in 2023 earned total compensation over \$150,000 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 \$3,000 if you have dependent care expenses for one eligible dependent; \$6,000 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 until the end of May following the plan year to submit claims to the Health Care, Limited-Use Health Care and Dependent Care accounts.
- **Carryover Rules for the HCFSA.** Any unused balance in your HCFSA or Limited-Use Health Care FSA at the end of 2023 up to \$610 will automatically be available for claims in the 2024 plan year. Any rollover amount from the 2023 Healthcare FSA plan year does not count toward the 2024 contribution limit. This is in addition to the \$3,050 maximum contribution amount for 2024. After May 31, 2024, any unused balance over \$610 will be forfeited.

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.

You may be reimbursed for eligible expenses up to the full amount of your annual contribution, even if you have not contributed that amount at the time of your request. This protects you against the high cost of a major health care expense early in the year.

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 HCFSAs for eligible dental and vision and prescription drug expenses, but you must generally exhaust the balance in your HRA before they can use the HCFSAs for medical expenses.

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 to alleviate or treat an illness or injury and menstrual supplies
- 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 [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 HealthEquity website at healthequity.com/wageworks. You may want to check with your tax advisor for further information.

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.

Eligible expenses will be reimbursed up to your account balance at the time you request reimbursement. Amounts over that will be pended for payment until further contributions are made.

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 HealthEquity website at healthequity.com/wageworks.

Claiming Benefits

As you incur eligible expenses throughout the year, you use your HealthEquity 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 until the end of May to submit claims to the Health Care, Limited-Use Health Care and Dependent Day Care accounts for the prior year balances. For plan year 2023, for example, you have until May 31, 2024, to file claims. You may carryover up to \$610 in unused 2023 Healthcare FSA expenses into 2024.

If you are enrolling in the Health Savings Medical Plan option for the first time in 2024 and you participated in a regular Health Care FSA during 2023, you will need to submit paper or online claims for reimbursement from your 2023 Health Care FSA of any eligible **medical, dental or vision care** expenses that were incurred but not reimbursed on or before December 31, 2023. (You will not be able to use your HealthEquity Visa spending account card after December 31, 2023, to pay for or gain reimbursement from your 2023 HCFSA.) You may submit paper or online claims for reimbursement from your 2023 HCFSA for eligible **dental or vision care** claims incurred January 1, 2023, through December 31, 2023, or use any carryover funds in a Limited Purpose HCFSA for dental and vision expenses incurred in 2024. Any claims for **medical** expenses incurred on or after January 1, 2024, 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 HealthEquity 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, 2024, you cannot use your spending card to pay any expense incurred in 2023 – even if you contributed to a Health Care FSA during 2023 and still have funds remaining in your 2023 account. If you have eligible expenses incurred during 2023 that have not been posted to your spending account card or otherwise reimbursed before January 1, 2024, 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 HealthEquity 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.
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 2024, 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, plus any rollover amount from the Healthcare FSA.

Using Your HealthEquity Health Care Card

When you enroll in a Health Care FSA or Limited-Use Health Care FSA, HealthEquity will automatically send you a HealthEquity debit card. You may also request additional cards for your family at no additional cost. As a reminder, the IRS requires HealthEquity 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 HealthEquity account page at www.healthequity.com/wageworks. 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.healthequity.com/wageworks.
- **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.healthequity.com/wageworks.

If the Company learns of an improper payment through use of your Health Care FSA/Limited-Use Health Care FSA debit card, federal law requires the Company to recover the money using these procedures:

- You will be notified that you need to supply additional documentation to support the charge, or you must pay back to the Health Care FSA/Limited-Use Health Care FSA the amount of the improper payment on an after-tax basis
- If payment is not made as described above, the Company may withhold the amount of the improper payment from your wages or other compensation on an after-tax basis, to the extent permissible by law
- If any portion of the improper payment remains outstanding, the Company will offset payment of any additional claims by the disputed amount in order to recoup the loss

In addition, your access to the Health Care FSA/Limited-Use Health Care FSA debit card will be frozen until you repay the amount of the improper payment. If your card is deactivated, any claims for covered health care expenses must be submitted in writing with receipts or invoices to substantiate the payment. If all of these procedures are unsuccessful, you will remain indebted to Healthineers for the amount of the improper payment and Healthineers will treat the payment as any other business indebtedness.”

For more information, including details on when a receipt is required, please go to www.healthequity.com/wageworks.

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.healthequity.com/wageworks or by using the **EZ Receipts™ HealthEquity Mobile Application**. (To learn more, go to www.healthequity.com/wageworks.) If this is not convenient, you can download and print a claim form from the HealthEquity website or you can call **877-924-3967** to request a form. You can also access the HealthEquity website through mySHSBenefits.com by selecting *Other Sites* from the *Health Insurance* page. When you fax your claims, along with documentation of your expenses, HealthEquity 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 HealthEquity at **877-924-3967** or visit their website at www.healthequity.com/wageworks.

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.

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 2023 funds by May 31, 2024.

- **What happens after May 31, 2024?** After May 31, 2024, you will no longer be able to use any remaining 2023 funds, with the exception of any eligible carryover amount in the 2023 Healthcare or Limited-Use Healthcare FSA. If you have a remaining 2023 balance in the Dependent Care FSA, and remaining amounts above the \$610 carryover amount in the Healthcare or Limited-Use Healthcare FSA will be forfeited.

Where can you get a claim form? You can submit a claim and attach documentation or download a claim form at www.healthequity.com/wageworks or request a form by calling HealthEquity at **877-924-3967**.

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 HealthEquity 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 SHBC at 833-935-3328 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 \$1,000,000. 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-715005, 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). If you are not actively at work on the date the increase would be effective, it will automatically increase as of the first day you return to active work. 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	\$1,000,000
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 up to 80% of your coverage amount, to a maximum of \$500,000, 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](#)” as defined in the Healthineers Short Term Disability (“STD”) Plan or in the [Long-Term Disability \(“LTD”\)](#) sections 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.

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 SHBC at **833-935-3328**. 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-715005.

To enroll, inquire about coverage information, make an assignment, or change your beneficiary, contact the SHBC at **833-935-3328**.

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). If you are not actively at work on the date the increase would be effective, it will automatically increase as of the first day you return to active work. 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 SHBC at **833-935-3328**.

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 age 70 or younger 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 SHBC at **833-935-3328**.

Note that if your spouse or domestic partner is a) confined in a hospital, or b) confined elsewhere (meaning your dependent is unable to perform, unaided, the normal functions of

daily living or leave home or other place of residence without assistance), coverage or any increase in coverage will not take effect until the day your spouse/domestic partner is no longer confined and has 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. See the section "[Choosing Coverage in the Future](#)" for details.

Coverage for Your Children

You may purchase portable term insurance in multiples of \$5,000 — from \$5,000 up to \$25,000 — 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 SHBC at **833-935-3328** for details on the current rates for coverage. These rates are also available on mySHSBenefits.com 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 a) confined in a hospital, or b) confined elsewhere (meaning your dependent is unable to perform, unaided, the normal functions of daily living or leave home or other place of residence without assistance), 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, to a maximum period of 29 consecutive months from the date you were last Actively at Work.

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 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. For details on the payment methods that are available and the procedure for claiming benefits, call The Hartford at **888-563-1124**.

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 mySHSBenefits.com website or call the SHBC at **833-935-3328**.

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 mySHSBenefits.com or call the SHBC at **833-935-3328**. 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.

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 SHBC at 833-935-3328**. 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 \$25,000 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 \$2,200,000 (\$1,000,000 Basic plus \$1,200,000 Supplemental):
 - » If you elect to **port** \$500,000 (the minimum amount — i.e., 50% of \$1,000,000 Basic), the maximum amount available to **convert** is \$1,700,000
 - » If you elect to **port** \$1,700,000 (the maximum amount), then the maximum amount available to **convert** is \$850,000.
- 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 SHBC at **833-935-3328** 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 SHBC 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 43786, Cleveland, OH 44143-0786. 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 5 th 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:

- Intentionally self-inflicted injuries
- Suicide or attempted suicide
- Travel in experimental aircraft or device
- 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 national 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, crewmember, 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;
- Travel in an aircraft for the purpose of parachuting or otherwise exiting from an aircraft while it is in flight
- Injury sustained while intoxicated. Intoxicated means:
 - » The blood alcohol content;
 - » The results of other means of testing blood alcohol level; or
 - » The results of other means of testing other substances;
 that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

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 mySHSBenefits.com or call the SHBC at **833-935-3328**. 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 SHBC at **833-935-3328**. 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 Short-Term Disability (STD) and Long-Term Disability (LTD) income options and STD 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 Short-Term Disability (“STD benefits”) for up to 26 weeks, and 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](#). While you are receiving STD benefits, and 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 Short-Term Disability Benefits

STD Coverage

Short-Term Disability (STD) Plan is administered by The Lincoln National Life Insurance Company ("Lincoln Financial Group"). The Plan provides a defined level of income to employees who are unable to perform their job for more than seven full consecutive calendar days as a result of a **Disability**, and assist and provide accommodation for employees who are recovering from their disability, as required by applicable law. Benefits vary based on your employer group, as shown in the chart below.

Eligibility

You are eligible to participate in the Plan if you are a regular salaried, hourly or union hourly paid U.S. employee, and inbound delegates of the Company, as described in the "Eligibility" section of this SPD. Dependents are not eligible for coverage under the Plan.

Enrollment

You may participate in the Plan starting on your first day of active work. There is no enrollment required.

Cost

Siemens Medical Solutions USA, Inc. pays the full cost of this benefit. There is no cost to you.

Summary of Benefits

To be eligible for benefits, you must complete a seven full calendar day waiting period. You may use available time off (PTO, vacation, sick days, etc.) in order to receive pay during this period. To qualify for STD benefits, you must (a) meet the definition of **disability**, (b) be **actively at work** on the date your disability begins, and (c) be under the care of an **appropriate legally licensed health care practitioner** who must certify the starting, continuing and ending dates of your disability.

How Benefits are Paid

Disability benefits are paid based on the Option available to your employer group for up to 25 weeks following completion of the seven-day waiting period. Payment options are shown below:

	Duration of Disability	Benefit Paid
Option 1 – Employees of the Following Employers:		
Siemens Healthcare Diagnostics Inc. (all salaried and hourly nonunion employees in the U.S. and Puerto Rico)	Weeks 2-9 Weeks 10-26	100% of Eligible Pay 66 2/3% of Eligible Pay
Siemens Medical Solutions USA, Inc. (all salaried and hourly nonunion employees in the U.S. and Puerto Rico)		
Siemens Medical Solutions USA, Inc. (hourly union employees who are members of IBEW Local 222, Boston)		
Siemens Medical Solutions USA, Inc. (hourly union employees who are members of the IBEW Local 48, Portland)		
Siemens Medical Solutions USA, Inc. (hourly union employees who are members of IBEW Local 3, New York Nuclear)		
Siemens Medical Solutions USA, Inc.(hourly union employees who are members of IBEW Local 3, New York Multi-Modality Bargaining Unit)		
PetNet Solutions Inc. (all salaried and hourly nonunion employees in the U.S.)		
Dedicated2Imaging LLC (all salaried employees in the U.S. employees in the U.S.)		
Corindus, Inc. (all salaried and hourly nonunion employees in the U.S.)		
Varian Medical Systems, Inc. (all salaried and hourly nonunion employees in the U.S.)		
Option 2 – Employees of the Following Employers:		
Siemens Healthcare Diagnostics, Inc. (hourly union employees who are members of Local 12273-06 (Elkhart, IN) and (all hourly union employees who are members of Local 12273-07 (Mishawaka, IN)	Weeks 2- 26	66 2/3% of Eligible Pay
*Benefits for part-time employees are prorated according to their normal work hours.		

Table 40 – How Disability Benefits Are Paid

If you remain Disabled following the 26th week period under the STD Plan, you may be eligible for long term disability benefits in accordance with the provisions of the applicable long term disability plan. See the section “Your Long-Term Disability Income Benefits” for a description of the Long-Term Disability Plan.

STD benefits paid by the Company will be offset by state disability benefits if applicable. See the section “State Mandated Disability Benefits” for information.

How STD Benefits are Calculated

STD Benefit Calculation:

The STD benefit is calculated as follows for employees on a conventional Monday-Friday work schedule:

- $\text{Pay period salary or hourly equivalent} \div \text{Number of Mon.-Fri. days in the pay period} = \text{Daily rate.}$
- $\text{Daily rate} \times \text{Number of Mon.-Fri. days on disability in the pay period} \times \text{STD percentage rate} = \text{STD pay.}$

Where employees have irregular schedules, STD benefits may be calculated on an hourly basis for normally scheduled work time missed.

For Example

Here’s how an employee’s bi-weekly STD pay would be calculated for Option 1 and Option 2.

Option 1: Bi-Weekly Pay Example

Biweekly Salary (or hourly equivalent): \$3,000

Number of work days in the pay period: 10

Work Days on Paid Disability: 45 (after waiting period)

$\$3,000 \div 10 \text{ days} = \$300$

First 40 days (weeks 2-9) after waiting period paid at 100% $\$300 \times 40 \text{ days} = \$12,000$

$\$12,000 \times 100\% = \$12,000$

Remaining 5 days paid at 66 2/3%

$\$300 \times 5 \text{ days} = \$1,500$

$\$1,500 \times 66.67\% = \$1,000.50$

Total STD Pay = \$13,000.50 (\$12,000+\$1000.50) for 45 days

Option 2: Bi-weekly Pay Example:

Biweekly Salary (or hourly equivalent): \$3,000

Number of work days in the pay period: 10

Work Days on Paid Disability: 5 (after the waiting period)

$\$3,000 \div 10 \text{ days} = \$300$

$\$300 \times 5 \text{ days} = \$1,500$

$\$1,500 \times 66.67\% = \$1,000 \text{ STD Pay}$

Determining Your Rate of Pay

The rate of pay for all short term disability payments under this Plan will be based upon the employee's base salary or base hourly rate of pay at the time the disability began, excluding any bonus, overtime, shift differential, or other contingent or incentive pay.

The starting date of your disability is determined by Lincoln as the date certified by the employee's health care practitioner and supported by medical evidence. This is contingent upon (i) the employee being continuously absent from work before seeing the health care practitioner and (ii) the first date the employee is absent from work is not more than 7 calendar days before they met with the health care practitioner.

Commission Paid Employees

An average of commissions earned over the preceding 3 years will be included in base pay for the disability calculation, if during such period commissions accounted for more than 50% of the employee's monetary compensation. If an employee has been employed for less than 3 years, and such commissions have accounted for at least 50% of the employee's mandatory compensation, an average of commissions earned during the period of employment will be included in the calculation unless the employer determines that such amount is unlikely to be representative of future employment, in which case a lesser amount may be used in the company's discretion.

Rate of pay will not change during the period the employee is receiving Plan benefits. Employees will not be eligible for wage/salary increases during the disability period. Increases will be applied when the employee returns to work and begins receiving pay for work instead of benefits from this Plan.

Please contact Lincoln at **1-800-530-6506** with questions on how your benefit will be calculated.

Reduction of Benefit Payments

Benefits under the Plan are reduced by any amounts payable for the same periods from:

- The Jones Act or similar law;
- Social Security disability Benefits (for the employee) (the insurance company will estimate the Social Security benefits used to reduce the Plan benefit unless proof is provided that it was applied for, and was denied);
- The mandatory part of any automobile insurance policy written to comply with a "no-fault" insurance law;
- Subrogation (see Right of Recovery, below);
- California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico disability benefits law (and any other state or locally required benefit under a statutory plan or state paid leave);
- Another Company-paid group insurance plan; or
- Unemployment insurance law

State Mandated Disability Benefits

Six jurisdictions, California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island have laws that require employees in those jurisdictions be covered by the state disability plan or an equal insured plan that complies with the mandated disability requirements (Rhode Island and Puerto Rico coverage is only available through the State/Commonwealth). The employee may pay for these statutory benefits through payroll deductions. Employees in these states should follow the following process:

- Hawaii, New York and New Jersey:
 - » Employee will file a disability claim with Lincoln. Lincoln will pay the statutory benefit and the Company will pay any additional amount due under this Plan.
- California:
 - » Employee will file disability claim with the State of California and with Lincoln. California will pay the statutory benefit and the Company will pay the difference between the benefit under this Plan and the State of California maximum benefit. The employee should notify their Human Resources representative if they do not receive the maximum California benefit.
- Rhode Island and Puerto Rico:
 - » Employee will file disability claim with the State/Commonwealth and with Lincoln. Rhode Island or Puerto Rico will pay the statutory benefit and the Company will pay any additional amount due under this Plan.

Under no circumstances will the combined benefits from a state disability plan and this Plan exceed 100% of the employee's base pay. If the employee is overpaid, the Company has the right to recover the overpayment from the employee.

Applying for Disability Benefits

To receive benefits under this Plan, the employee must notify Lincoln. Lincoln will forward a written application which must be completed within the time period specified by Lincoln. An employee's claim for short term disability benefits must be approved by Lincoln before any benefits can be paid. The fact that an employee presents a physician's certificate indicating disability does not, in and of itself, establish an employee's entitlement to short term disability benefits.

To file a disability claim, an employee must call Lincoln at 800-530-6506 or submit their claim online at mylincolnportal.com. If the employee knows in advance that they will be out due to pregnancy or a planned medical procedure, the employee can initiate the claim up to two weeks in advance of the disability date, without further medical justification.

Failure to comply with individual work location requirements for notification of absences or return to work procedures may result in disciplinary action up to and including termination of employment.

While reviewing an employee's claim for short term disability benefits, Lincoln may request additional information from the employee or the employee's licensed health care practitioner

and/or request the employee to obtain a second opinion from a physician of its choice (at Lincoln's expense), prior to granting approval of short term disability benefits. In addition, Lincoln may require the employee to periodically obtain a certification from his/her physician and/or obtain a second opinion from a physician of its choice (at Lincoln's expense) in order to reconfirm the employee's disability. Failure to comply with Lincoln's request for an independent medical exam may result in the termination or suspension of the short term disability benefits.

An employee may be placed on a medical leave of absence without pay while the employee's claim for short term disability benefits is under consideration. Medical leaves of absence will be governed by the company's Family and Medical Leave policy.

During the course of a Short-Term Disability, Lincoln has the right to have the employee examined at any time at reasonable intervals by medical specialists of their choice. The examination will be at Lincoln's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of the employee's benefits.

If a claim for STD benefits is denied, in whole or in part, you can file an appeal, as described in the section of this SPD entitled "[Claim and Appeal Procedure for the Short-Term Disability Plan](#)."

Work Incentive/ Transitional Duty Program

While an employee is on "Disability", the employee may be required to work or participate in a Transitional Duty Program, as approved by Lincoln. The "Transitional Duty Program" enables the employee to return to active employment with the Company (i) on a part-time/reduced schedule or (ii) under a work modification/accommodation which could last up to 90 days on a part-time or full-time basis.

When an employee works while having a "Disability" under this Plan, the employee will receive the sum of the following amounts:

- The employee's benefits under the Plan are pro-rated for the period(s) not worked; plus
- The amount of the employee's earnings for working while on "Disability."

The employee's payments under the Plan will be reduced if the total amount the employee is due to receive from the above sources exceeds 100% of the employee's base salary at the time the employee's disability began. The employee's payments under the Plan will be reduced by that portion equal to the amount that exceeds 100% of the employee's base salary at the time the employee's disability began.

The "Transitional Duty Program" is intended to assist the employee in regaining productive employment or service in an occupation for which the employee is reasonably qualified, taking into account the employee's training, education, experience and past earnings. The Transitional Duty Program may include participation in vocational training or physical therapy. The Transitional Duty Program must be mutually agreed upon by the employee's health care practitioner, the Company, and one of Lincoln's disability or vocational case

managers. Benefits under the Plan may end if the employee refuses to participate in a Lincoln recommended Transitional Duty Program.

Light Duty

If the Company offers the employee light duty or other suitable work which complies with the employee's work restrictions as determined by Lincoln (with due consideration of the report of the employee's physician), the employee's benefit under this Plan will be reduced by the amount the employee earns in such light duty or other suitable work. If the employee refuses such light duty or other suitable work which is offered, the employee's benefit under this plan will be reduced by the amount the employee would have earned if the employee had accepted and performed such light duty or other suitable work.

Successive Disabilities

If an eligible employee becomes disabled again due to the same or a related cause after returning to work for ninety (90) calendar days or less, the second period of Short Term Disability will be considered a continuation of the first. In such case, no 7-day waiting period will be required, and the maximum duration (of benefits) will be extended by the period of time the employee returned to work. Separate periods of total disability resulting from unrelated causes will be considered one period of total disability unless these periods are separated by return to active employment for at least one full day. If an employee returns to work as part of a transitional duty program, this will not be considered a return to active employment for purposes of determining if the employee has successive disabilities.

Once an employee becomes eligible for Long Term Disability benefits, a successive period of disability may be treated as part of the prior disability even if the employee returns to work for more than 90 days. In this case the Long Term Disability, rather than Short Term Disability provisions may apply. Please refer to "Successive Periods of Disability" in the Long Term Disability Section below.

Impact On Other Benefits While On Short Term Disability

An employee's health and welfare benefits in effect immediately prior to his or her "Disability," will continue at the active employee rates as long as the employee is eligible to receive benefits under this Plan. The employee will make required premium payments for these benefits through payroll deductions as long as benefits are paid under this Plan.

Any unpaid periods will require direct payments to the Siemens Healthineers Benefits Center. If the employee is eligible to participate in his or her employer provided 401(k) Plan immediately prior to his or her "Disability," that eligibility will continue as long as the employee remains employed by a participating employer and the employee's contributions will be made through payroll deduction from benefits paid under this Plan.

Paid Time Off (PTO), Vacation and Sick Days that accrue during the year will continue to accrue during the approved disability period under the Plan. All other provisions of the Paid Time Off, Vacation and Sick Days plans will apply during the disability period.

For more information about how benefits continue during a disability leave, see the [“Your Other Benefits During Disability.”](#)

Exclusions

The Plan does not cover any disability that results directly or indirectly from:

- Work-related injuries and illnesses (see Workers’ Compensation Claims below);
- War (declared or undeclared) or service in the armed forces of any country, government body or international authority;
- Intentionally self-inflicted injuries, while sane or insane;
- Active participation in a riot*;
- The committing of, or attempting to commit, a felony or misdemeanor;
- Elective treatment or procedures, such as cosmetic surgery, reversal of sterilization, liposuction, visual corrective surgery.

No benefit will be payable during any period of incarceration.

*With respect to this provision “participation” shall include promoting inciting conspiring to promote or incite aiding abetting and all forms of taking part in but shall not include actions taken in defense of public or private property or actions taken in defense of the employee 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.

“Riot” shall include 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.

Workers’ Compensation Claims

This Plan excludes benefits when you become disabled as the result of a work-related illness or injury. If you become disabled due to a work-related illness or injury and are receiving Workers’ Compensation benefits and then subsequently become disabled due to a non-work related condition, the following will occur:

- While receiving Workers’ Compensation benefits, short-term disability benefits from this Plan will not be payable
- If the Workers’ Compensation benefit period overlaps with the non-work related disability, you will only be eligible for short-term disability benefits from this Plan after Workers’ Compensation benefits end
- The Short-Term Disability Plan maximum benefit period will begin the date short-term disability benefits from this Plan begin

Example:

- Workers’ Compensation benefits begin on 2/1/2024.
- The non-work related disability absence begins 3/1/2024.
- Workers’ Compensation benefits end on 5/1/2024.
- The non-work related disability absence continues.

- Short-Term Disability benefits from this Plan are payable beginning 5/2/2024 for up to 25 weeks (the 7 full calendar day waiting period for short-term disability benefits occurred during the overlap of the work-related disability and non-work related disability), provided all other Plan provisions are met.

When Coverage Ends

Coverage under the Plan stops if:

- An employee no longer meets the Plan's eligibility requirements;
- An employee terminates employment with the Company for any reason except a disability for which benefits are paid;
- An employee retires;
- The Plan terminates; or
- An employee is on a leave other than a leave which is protected under the federal FMLA or similar state law.

When Benefits End

- An employee is paid for the maximum duration of benefits (25 Weeks after the waiting period unless extended due to successive disabilities);
- An employee is no longer disabled within the provisions of the Plan;
- An employee fails to provide Lincoln with necessary information needed to make a disability determination as defined under the provisions of the Plan;
- The date an employee ceases or refuses to participate in a Transitional Duty Program recommended by Lincoln or refuses light duty or other suitable work offered by the Company;
- The date an employee fails to attend a medical examination requested by Lincoln; or
- The day an employee dies.

Other Important Provisions of the Plan

Right of Recovery

If an employee receives benefits from this Plan for an illness or injury for which the employee also receives payments from a third party, or if the employee receives any payment from the Company for the injury or illness other than benefits under this Plan, the employee must repay the Company or Lincoln. The repayment must equal the benefits the employee received from the Plan or the amount received from the Company or the third party (less reasonable expenses to make the recovery) if less. Personal disability policies owned by the employee for whom the employee makes all premium payments are exempt from this right of recovery.

Recovery of Overpayment

If an employee's monthly disability benefit is overpaid, the Company or Lincoln has the right to recover the excess amount. The overpayment may be deducted from the employee's future disability benefits, earnings, or the employee may be required to make a lump sum payment. Overpayments may also be withheld from the employee's future wage or salary payments where permitted by State law.

Your Long-Term Disability Income Benefits

LTD Coverage Options

The Long-Term Disability Income coverage options are insured and administered by the Lincoln National Life Insurance Company ("Lincoln Financial Group"). 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, <i>Pay</i> is defined as the greater of Frozen Pay , calculated on a monthly basis, or of pre-disability Basic Monthly Earnings .		

Table 41 – 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.

Lincoln 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 Lincoln.

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, Lincoln 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 Lincoln 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. 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 Lincoln at **800-530-6506** 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 Lincoln STD case manager will escalate your claim to an LTD case manager to begin a review 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 Lincoln 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 Lincoln at **800-530-6506** 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.

In order to receive benefits under the LTD plan, you must provide Lincoln, at your expense and subject to Lincoln'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 Lincoln.

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 Lincoln 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 Lincoln 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)	3/22/2023	5/15/2023	54		
Full-time return to work	5/16/2023	6/26/2023		40	Used 40 out of 90 trial work days
Disabled (receiving STD benefits)	6/27/2023	7/10/2023	14		
Full-time return to work	7/11/2023	8/31/2023		52	Hit 91st trial work day on 8/30/2023
Disabled (reaching end of STD benefits)	9/1/2023	12/23/2023	114		New LTD Elimination Period starts on 9/1/2023
Maximum duration of STD benefits		12/23/2023	182		New LTD Elimination Period ends on 2/28/2024

Table 42 — LTD Trial Work Days Example

In terms of this example, you reach Maximum Duration of STD benefits on 12/23/2023. 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 12/24/2023 through 2/28/2024. The new LTD Elimination Period ends on 2/28/2024. If your claim is approved, LTD benefits begin on 3/1/2024.

How Long LTD Benefits Continue

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

Age When Disability Begins	LTD Benefits Continue Until Recovery Or ...
67	18 months
68	15 months
69 and over	The date 12 payments have been made

Table 43 – Long-Term Disability Continuation

NOTE: While you are [Disabled or Partially Disabled](#), Lincoln has the right to require proof at any time of your Disability and require review by an Independent Physician. 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 Lincoln 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 Lincoln LTD Plan Certificate by writing to the Siemens Healthineers Benefits Center, Dept 09408, P.O. Box 1590, Lincolnshire, IL 60069-1590, or by calling toll-free at **833-935-3328**, between 10 a.m. and 6 p.m., Eastern Time, Monday through Friday. The Lincoln LTD Plan Certificate is also available online on mySHSBenefits.com (select *Health and Insurance, Plan Information*).

If you elect to receive payments from a Healthineers Pension Plan while you are collecting LTD benefit payments, Lincoln 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. Severance payments will also be considered an offset and reduce your monthly LTD payments. However, your LTD benefit payments will not be reduced by or adjusted for the amount of any distributions you receive from the Healthineers Savings Plan or other 401(k), profit sharing or other similar plan that you may receive.

If your spouse or dependents receive benefits from Social Security due to your disability, Lincoln will reduce your monthly LTD payments by the monthly value of their Social Security Disability benefits.

Estimation of Other Income Benefits

Lincoln 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 Lincoln 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 Lincoln 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. Lincoln will assist you in applying for Social Security Disability Income benefits if Lincoln 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 Lincoln 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 Lincoln, Lincoln 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 may 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, Lincoln 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, Lincoln 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, Lincoln must first give written approval of the Rehabilitation Program. If Lincoln approves the Rehabilitation Program and you continue to be Disabled under the terms of the Lincoln 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 Lincoln does not approve a Rehabilitation Program and provided you continue to be Disabled and eligible to receive LTD benefits under the terms of the Lincoln LTD policy, your regular LTD benefit will be payable.

If you decline to fully participate in an approved Rehabilitation Program recommended by Lincoln, your Disability benefits will terminate on the first day of the month following your declination to fully participate. If Lincoln recommends rehabilitation, no benefit will be paid from the date the recommendation is made until Lincoln 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 Lincoln 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 Lincoln with any of the information listed in [Claiming Benefits](#);

- The date you fail to attend a medical examination requested by Lincoln 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 Lincoln 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 Lincoln 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 Lincoln makes in processing your claim, Lincoln 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 Lincoln.

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 Lincoln for any amount of such benefits that are compensated to you by or on behalf of the person at fault, and (ii) to allow Lincoln a lien on such compensation and to hold such compensation in trust for Lincoln, and (iii) to execute and give to Lincoln any legal instruments needed to secure these rights. In addition, you must execute and deliver to Lincoln any instruments needed to grant to Lincoln the subrogation rights to recover any amount that Lincoln 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 Lincoln 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 Lincoln 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

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 SHBC 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 SHBC 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 Siemens Healthineers Benefits 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 [mySHSBenefits.com](#) while you are on leave and will need to call the SHBC at **833-935-3328** 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 [mySHSBenefits.com](#) under the heading "Change Your Coverage," or you may call the SHBC at **833-935-3328** 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 SHBC 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 SHBC at **833-935-3328**.

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 SHBC at **833-935-3328**.

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 Telus Health at **800-433-7916**. 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 SHBC 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 SHBC 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 SHBC at **833-935-3328**.

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 SHBC during Annual Enrollment. You may select among the Health Savings Medical Plan or the Health Reimbursement 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 SHBC 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).

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*. 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 44 – 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 thereof 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. 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 Healthineers Benefits Center at **833-935-3328**. The change will be effective as of the processing date.

Claiming Benefits

You or your beneficiary should contact the Siemens Healthineers Benefits Center (SHBC) at **833-935-3328** 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.

Plan Administration

Plan Sponsor

The sponsor of the Healthineers Benefits Program described in this Summary Plan Description is:

Siemens Medical Solutions USA, Inc.
c/o Employee Health and Group Benefits
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 22-2417778

Plan Administrator

The Plan Administrator of 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:

Siemens Medical Solutions USA, Inc.
c/o Employee Health and Group Benefits
40 Liberty Boulevard
Malvern, PA 19355

800-888-7436

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 and Claims Administrators](#)" 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 an insured Medical Plan must be made to the applicable Plan in accordance with its particular claims review procedure. These insured Plans 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 and the Health Reimbursement Medical Plan option 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 and Health Reimbursement 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 Caremark was denied 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 requiring such prior authorization under the Healthineers Prescription Drug Program (see www.caremark.com or contact **844-757-0414**), 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 Caremark 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 Caremark 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 **866-800-5457** 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 **866-800-5457**. 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:

Siemens Medical Solutions USA, Inc.
c/o Employee Health and Group Benefits
40 Liberty Boulevard
Malvern, PA 19355

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 (HealthEquity)

HealthEquity 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 HealthEquity. 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 HealthEquity's decision on the initial claim, you (or your representative or your healthcare provider) can request that the claim be reviewed on appeal by HealthEquity. The request for a first-level appeal on claim decisions is made in writing to HealthEquity and must be sent within 180 days after receiving notice of the denial. The address for HealthEquity is Claims Appeals Board, P.O. Box 991, Mequon, WI 55032. HealthEquity suggests that you call customer service at 877-924-3967 to provide notice that you are sending an appeal. The HealthEquity customer service representative will advise you on the appeal process. Your written appeal should include your name, address and HealthEquity 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 HealthEquity 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 HealthEquity 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.

HealthEquity 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 HealthEquity's 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 HealthEquity. The address for the Administrative Committee for the Healthineers Benefits Program is:

Siemens Medical Solutions USA, Inc.
c/o Employee Health and Group Benefits
40 Liberty Boulevard
Malvern, PA 19355

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 Appeal Procedure for the Short-Term Disability Plan

A claim for short-term disability benefits must be made to Lincoln during the seven-day waiting period.

If Liberty denies the employee's claim for benefits under the Plan, the employee may appeal the decision by writing to the following address:

Lincoln Financial Group
Group Benefits Disability Claims
P.O. Box 7213
London, KY 40742-7211

Upon the employee's written request, Lincoln will provide the employee, free of charge, with copies of documents, records and other information relevant to the employee's claim.

Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination.

As part of the employee's appeal, the employee may submit any written comments, documents, records, or other information relating to the employee's claim.

After Lincoln receives the employee's written request appealing the initial determination, Liberty will conduct a full and fair review of the employee's claim. Deference will not be given to the initial denial, and Lincoln's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that the employee submits relating to the employee's claim without regard to whether such information was submitted or considered in the initial determination. The person who will review the employee's appeal will not be the same person that made the initial decision to deny the employee's claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny the employee's claim. If the initial denial is based in whole or in part on a medical judgment, Lincoln will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have been consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Lincoln will notify the employee in writing of its' final decision within a reasonable period of time, but no later than 45 days after Lincoln's receipt of the employee's written request for review, except that under special circumstances Lincoln may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, Lincoln will notify the employee prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an

extension is needed because the employee did not provide sufficient information, the time period from Lincoln's notice to the employee of the need for an extension to when Lincoln receives the requested information does not count toward the time Lincoln is allowed to notify the employee of its' final decision. The employee will have 45 days to provide the requested information from the date the employee receives the notice from Lincoln.

If Lincoln denies the claim on appeal, Lincoln will send the employee a final written decision which will contain the following information (a) the specific reason for its' decision and the specific reference to the provisions of the Plan on which the decision is based; (b) a statement that the employee is 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) if any internal rule, guideline, protocol or other similar criteria were relied upon in denying the employee's claim, an explanation of those criteria or a statement that such criteria will be provided to the employee free of charge, upon request.

Lincoln has full and exclusive discretionary authority to interpret all provisions of the Plan, to determine all facts and eligibility for benefits and to construe the terms of the Plan. Interpretations and determinations made by Lincoln under the Plan will be final, conclusive and binding unless it can be shown that such interpretation or determination was arbitrary and capricious. Lincoln's decision on appeal is final.

Claim and Procedure for the Long-Term Disability Plan

A claim for long-term disability benefits should be made in writing to Lincoln. 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 Lincoln. The appeal must be submitted within 180 days after a denial, by writing to Lincoln. The address is Lincoln Financial Group Benefits Disability Claims, P.O. Box 7213, London, KY 40742-7211. The telephone number is **800-530-6506**. 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.

Lincoln 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 Lincoln 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 Lincoln agree in writing that good cause exists for the extension.

Lincoln 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 Lincoln will be final, conclusive, and binding; unless it can be shown that the interpretation or determination was arbitrary and capricious. Lincoln'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 Short-Term and Long-Term Disability Insurance, insured by Lincoln Financial), 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 Short-Term or Long-Term Disability claim, insured by Lincoln Financial 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, Short-Term Disability, Long-Term Disability Income, Personal Accident Insurance, and Business Travel Accident 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 and Anthem Blue Cross Blue Shield are the administrators for Health Savings and Health Reimbursement 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 and Health Reimbursement 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 outbound expatriate medical and dental plan options; - First American Administrators Inc. is claims administrator for the EyeMed Vision Care vision benefits program, which is underwritten by Fidelity Security Life Insurance Company;

Plan Name	Plan Number	Plan Type	Plan Funding	Claims Administrator or Insurer
				• Delta Dental is the dental claims administrator • Lincoln Financial Group is the claims administrator for Short-Term Disability and 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; • HealthEquity is claims administrator for Flexible Spending Accounts
¹ Includes Dependent Life Insurance				

Table 45 – 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 Summary Plan Description covering health and welfare benefits for “active” employees, 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 the Summary Plan Descriptions. 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)

Most of 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 Dependent Care Flexible Spending Account and the Health Savings Account are not ERISA plans. Information about them is included in this SPD for your reference. 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:

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.

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.

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 or by visiting www.dol.gov/ebsa.

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.

Appropriate Legally Licensed Health Care Practitioner

For the purposes of determining a Short-Term Disability, means a person who (i) is legally licensed to practice medicine; or any other person whose services according to applicable law, must be treated as Physician's services for purposes of the Plan; (ii) is licensed in the jurisdiction where such services are performed; (iii) is not related to the employee; and (iv) the care and treatment provided by the practitioner is within the scope of his or her license.

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, you may be responsible for the difference, unless balance billing is restricted under the Consolidated Appropriations Act of 2021 for certain healthcare expenses. 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 mySHSBenefits.com or call the SHBC at **833-935-3328**. Beneficiaries for Business Travel Accident insurance can be designated only by calling the SHBC.

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. 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

Covered Health Services are those Medically Appropriate/Medically Necessary services and supplies covered under the Healthineers dental, vision, and self-funded medical, plan options as described in each applicable section of this Summary Plan Description.

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, In-Network benefits are based on contracted provider charges, and Out-of-Network benefits are based on [Reasonable and Customary \(R&C\)](#) charges, the [Maximum Allowed Amount](#), or the Maximum Reimbursable Charge as applicable as determined by the Claims Administrator of the plan option you elect.

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 Lincoln, 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 or mental health condition or symptom resulting from injury, sickness or mental health and substance use disorders 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 833-969-3997) 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, subject to provisions of the Consolidated Appropriations Act of 2021.

Medically Appropriate or Medically Necessary or Dentally Necessary

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a [Sickness](#), [Injury](#), Mental Illness, substance-related and addictive disorder, condition, disease or symptoms (or for preventing, diagnosing, ameliorating or correcting a vision or dental disorder) that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical (or Vision or Dental) Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.

- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty (or vision or dental) society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary (or Dentally Necessary). The decision to apply Physician specialty (or vision or dental) society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrators for the Medical Plan options develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice, scientific evidence, prevailing medical standards and clinical guidelines supporting their determinations regarding specific services. These clinical policies (as developed by the Claims Administrators and revised from time to time), are available to covered persons on www.myuhc.com or www.anthem.com or by calling the number on your ID card and to Physicians and other health care professionals on www.uhcprovider.com or www.anthem.com/provider/policies.

Mental Health and Substance Use Program

Mental Health and Substance Use benefits are administered by the Claims Administrator for your Medical Plan option and are described in the section entitled "[Mental Health and Substance Use Program](#)." For questions regarding your mental health and substance use benefits, visit the Anthem BCBS Behavioral Health website at www.anthem.com or call **833-969-3997**; or visit the United Behavioral Health website at www.myuhc.com or call **866-238-2637**.

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, 2023, will be used to estimate premium contributions and coverage for the plan year beginning January 1, 2024. 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, 2023, will be used to estimate premium contributions and coverage for the plan year beginning January 1, 2024. 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, 2023, would not apply until January 1, 2024, if the disability:

- Occurred after January 1, 2023, and
- Resulted from an illness treated after September 30, 2022 (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.

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 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 **866-238-2637**) 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.