

## YOUR 2024 MONTHLY COSTS FOR BENEFITS COVERAGE

Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<b>Medical</b>				
Anthem HSA Plus	\$105.31	\$250.03	\$234.06	\$379.04
Anthem HSA Core	\$30.89	\$125.72	\$117.68	\$190.58
Kaiser CDHP – Northern California	\$109.51	\$281.08	\$255.53	\$383.29
Kaiser CDHP – Southern California	\$84.43	\$216.69	\$196.99	\$295.49
<b>Dental</b>				
Plus PPO	\$18.00	\$27.00	\$35.00	\$45.00
Core PPO	\$12.00	\$24.00	\$26.00	\$38.00
<b>Vision</b>				
VSP Vision Plan	\$5.50	\$9.00	\$7.50	\$13.00

**Note:** Premium contributions are deducted from your paycheck on a pretax basis unless otherwise requested by you in writing. "Spouse" can also refer to Domestic Partner. The value of Domestic Partner coverage will be taxable to you.

## SUMMARY OF THE MEDICAL PLANS

Plan Features	Anthem HSA Plus and HSA Core	Kaiser CDHP
<b>Availability</b>	Available to all employees	Available to employees in California in the Kaiser Service area
<b>Network</b>	Anthem is both the plan administrator (they pay the claims) and the network of providers. You may use providers outside the Anthem network, but you pay more out of pocket. When you use in-network providers, you receive a higher level of benefit coverage.	You must use Kaiser providers.
<b>Deductible</b>	There is an annual deductible. See the benefit comparison on the next page for more information.	There is an annual deductible. See the benefit comparison on the following pages for more information.
<b>Managing Care</b>	You decide each time you need medical care whether you want to use in-network providers or out-of-network providers.	You have the option to choose a primary care physician who will play an important role in coordinating your healthcare needs.
<b>Paying for Services</b>	You will pay a percentage of the cost (coinsurance), including office visits and prescription drugs after the deductible. You may choose to use your HSA to pay for qualified services, HSA balance permitting.	You pay a flat fee (copay) for most services, including office visits, hospital stays and emergency care, after the annual deductible.
<b>Claim Forms</b>	You must file a claim form for reimbursement of medical expenses for services received from out-of-network providers, and you will be subject to Usual, Customary and Reasonable (UCR) charges.	No claim forms are required except for emergency claims at a non-Kaiser facility.
<b>Usual, Customary and Reasonable</b>	Applicable to out-of-network providers only. Anthem pays based on what 80% of the providers in that zip code charge for a given service.	Not applicable
<b>Out-of-Area Coverage at an In-Network Rate</b>	You are covered for medical emergencies anywhere in the world.	You are covered for medical emergencies anywhere in the world.

## ANTHEM HSA PLUS AND HSA CORE

Plan Features	Anthem HSA Plus		Anthem HSA Core	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>General Information</b>	You may select any provider you wish for your healthcare. When you obtain services from providers in-network, you will receive a higher level of coverage with lower out-of-pocket costs. <sup>1,2</sup>		You may select any provider you wish for your healthcare. When you obtain services from providers in network, you will receive a higher level of coverage with lower out-of-pocket costs. <sup>1,2</sup>	
<b>Annual Deductible</b>	\$1,600 per individual <sup>1,2</sup> \$3,200 per family	\$3,200 per individual \$6,400 per family	\$2,750 per individual <sup>1,2</sup> \$5,500 per family	\$5,500 per individual \$11,000 per family
<b>Annual Out-of-Pocket Maximum (includes deductible)</b>	\$3,750 per individual \$6,850 per individual within a family \$7,500 per family	\$7,500 per individual \$7,500 per individual within a family \$15,000 per family	\$5,950 per individual \$6,850 per individual within a family \$11,900 per family	\$11,900 per individual \$11,900 per individual within a family \$23,800 per family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Physician Office Visits</b>	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Annual Routine Physical Exam</b>	No charge (screening and lab work included)	40% coinsurance after deductible	No charge (screening and lab work included)	40% coinsurance after deductible
<b>Well-Baby or Well-Child Care</b>	No charge (screening and lab work included)	40% coinsurance after deductible	No charge (screening and lab work included)	40% coinsurance after deductible
<b>Diagnostic Lab and X-Ray</b>	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Outpatient Surgery Services</b>	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Hospitalization (room and board)</b>	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Emergency Room Services (copay waived if admitted)</b>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Chiropractic Care</b>	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Acupuncture</b>	20% coinsurance after deductible; limited to \$1,000 per calendar year in- and out-of-network combined	40% coinsurance after deductible; limited to \$1,000 per calendar year in- and out-of-network combined	20% coinsurance after deductible; limited to \$1,000 per calendar year in- and out-of-network combined	40% coinsurance after deductible; limited to \$1,000 per calendar year in- and out-of-network combined
<b>Infertility</b>	20% coinsurance after deductible; limited to \$7,500 lifetime maximum	40% coinsurance after deductible; limited to \$7,500 lifetime maximum (limited to diagnosis and treatment of underlying cause only)	20% coinsurance after deductible; limited to \$7,500 lifetime maximum	40% coinsurance after deductible; limited to \$7,500 lifetime maximum (limited to diagnosis and treatment of underlying cause only)

1. Hitachi will contribute \$1,000 single, \$2,000 employee plus dependents for employees who enroll in the Anthem HSA Plus Plan and \$750 single, \$1,500 for employees who enroll in the Anthem HSA Core Plan. To qualify for the contribution, you must establish a Health Savings Account. See the Frequently Asked Questions section of this guide for more information. When covering one or more dependents, you must satisfy the entire family deductible before the plan begins to pay claims (with the exception of preventive care. That family deductible can be satisfied by one person or it can be accumulated by several family members. For example, the employee could satisfy \$1,000 of the family deductible and their spouse could satisfy the other \$2,000.

2. You can cover your domestic partner under this plan, but you cannot use your HSA funds to pay for your domestic partner's or your domestic partner's children's expenses, unless they are your tax dependent.

## ANTHEM HSA PLUS AND HSA CORE

The Anthem HSA Plans are available to all Hitachi employees.

Plan Features	Anthem HSA Plus		Anthem HSA Core	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Prescription Drugs</b>				
Retail Pharmacies	Through CVS Caremark: 20% coinsurance after deductible. Once the out-of-pocket maximum is reached for the year, the plan pays 100% of costs for that year. The deductible is waived for certain preventive prescription drugs. <sup>3</sup>	Covered same as In-Network	Through CVS Caremark: 20% coinsurance after deductible. Once the out-of-pocket maximum is reached for the year, the plan pays 100% of costs for that year. The deductible is waived for certain preventive prescription drugs. <sup>3</sup>	Covered same as In-Network
Mail Order	20% coinsurance after deductible	Covered same as In-Network	20% coinsurance after deductible	Covered same as In-Network
<b>Mental Health</b>				
Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Substance Abuse</b>				
Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	20% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible

<sup>3</sup>. Please refer to the CVS Preventive Drug List for eligible medications.

# KAISER CDHP

The Kaiser CDHP is available to employees who live within the service area of Northern and Southern California only.

Plan Features	Kaiser CDHP
<b>General Information</b>	You must seek services through a Kaiser provider. Services obtained from nonauthorized providers will not be covered by Kaiser <sup>1</sup>
<b>Annual Deductible</b>	\$2,000 per individual \$3,200 per individual within a family \$4,000 per family <sup>2,3</sup>
<b>Annual Out-of-Pocket Maximum</b>	\$3,200 per individual \$3,200 per individual within a family \$6,000 per family
<b>Lifetime Maximum Benefit</b>	Unlimited
<b>Physician Office Visits</b>	\$30 copay, after deductible
<b>Annual Routine Physical Exam</b>	No charge
<b>Well-Baby or Well-Child Care</b>	No charge
<b>Diagnostic Lab and X-Ray</b>	\$10 copay, after deductible
<b>Outpatient Surgery Services</b>	\$150 copay per procedure, after deductible
<b>Hospitalization (room and board)</b>	\$250 copay per admission, after deductible
<b>Emergency Room Services (copay waived if admitted)</b>	\$100 copay, waived if admitted, after deductible
<b>Chiropractic Care</b>	\$15 copay after deductible; limited to 20 visits per calendar year
<b>Acupuncture</b>	Not covered unless prescribed by Kaiser for treatment of nausea or as part of a comprehensive pain management program for chronic pain
<b>Prescription Drugs</b>	
Retail Pharmacies	30-day supply After the deductible, Generic – \$10 copay   Brand – \$30 copay
Mail Order	100-day supply After the deductible, Generic – \$20 copay   Brand – \$60 copay
<b>Mental Health</b>	
Inpatient Services	\$250 per admission, after deductible
Outpatient Services	\$30 copay (\$15 copay for group therapy), after deductible
<b>Substance Abuse</b>	
Inpatient Services	\$250 per admission, after deductible for inpatient detoxification services
Outpatient Services	\$30 co-pay (\$5 co-pay for group therapy), after deductible

1. Except for emergency services or referral by Kaiser.

2. Hitachi will contribute 50% of the deductible annually: \$1,000 single; \$2,000 for employee plus dependents. To qualify for the contribution you must establish a Health Savings Account. See the Frequently Asked Questions section of this guide for more information. When covering one or more dependents, you no longer need to meet the family deductible before the Plan begins to pay claims (with the exception of preventive care) which is always covered at 100%. The Plan will begin paying claims for an individual within that family once that individual meets a \$3,200 deductible. The Plan will also begin paying claims if no single individual meets \$3,200 but the family collectively meets the family deductible of \$4,000. Likewise, the Plan will begin paying 100% of eligible charges for an individual once that individual meets the out-of-pocket maximum of \$3,200. If no individual within a family meets \$3,200, the family collectively must meet the \$6,000 family out-of-pocket maximum before the Plan begins paying 100%.

3. You can cover your domestic partner under this plan, but you cannot use your HSA funds to pay for your domestic partner's or your domestic partner's children's expenses, unless they are your tax dependent.