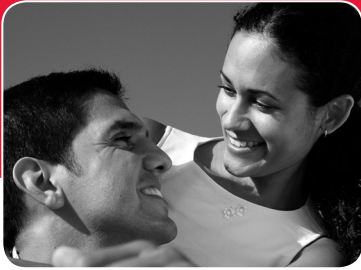


HOW IT WORKS:



The HPHC Insurance Company HDHP with HSA – *Massachusetts*

The **HDHP with HSA plan** may help you save money on your annual premium. It has significant annual deductibles, but offers extensive freedom of choice and allows you to set up a Health Savings Account to help offset your medical costs.

- ▶ You can receive in-network services from participating providers and out-of-network services from non-participating providers.
- ▶ You are not required to have a primary care provider or get referrals for care.
- ▶ Most services are subject to separate in-network and out-of-network annual deductibles.
- ▶ Many preventive tests and services are covered at no charge in-network.

How services are covered

These are examples of covered services. The Schedule of Benefits has more details on benefits and cost sharing. It governs in the event that the information in this document is different. See the next page for an example of the out-of-pocket costs that you may have with an in-network doctor’s visit.

HDHP with HSA covered services	What you pay: In-network ¹	What you pay: Out-of-network ²
<ul style="list-style-type: none"> • Preventive tests and services, including: <ul style="list-style-type: none"> - Adult annual visits - Well child visits - Annual gynecological visits - Immunizations, including flu shots (for children and adults as appropriate) 	No charge	20% coinsurance
<ul style="list-style-type: none"> • Exams for illness or injuries • Lab tests and diagnostic procedures • Treatments and procedures, including chemotherapy, surgical procedures, allergy treatments and dialysis • Inpatient and outpatient hospital services • Therapeutic procedures, including physical, speech and occupational therapy 	In-network deductible, (\$1,500 individual, \$3,000 double/family) then in-network coinsurance (10%)	Out-of-network deductible, (\$3,000 individual, \$6,000 double/family) then out-of-network coinsurance (30%)

Important Notice: If you have family coverage, the out-of-pocket maximum may be met by any combination of covered family members. The individual out-of-pocket maximum does not apply. Once the out-of-pocket maximum has been reached, no additional member cost sharing will be applied for the remainder of the calendar year.

¹Out-of-pocket maximum, in-network: \$3,000 for individual coverage per calendar year, \$6,000 for double/family coverage per calendar year.

²Out-of-pocket maximum, out-of-network: \$6,000 for individual coverage per calendar year, \$12,000 for double/family coverage per calendar year.

Continued on next page ▶

EXAMPLE: You visit an in-network doctor because you are sick, and the doctor gives you an immunization as part of the exam.

- Exams for illness or injuries are subject to the in-network deductible and coinsurance.
- If you have not yet paid the full, yearly in-network deductible, you will receive a bill from your doctor and pay all charges for the exam up to the in-network deductible amount.
- If you have already paid the full, annual in-network deductible amount, you will pay 10% coinsurance.
- There is no charge for in-network immunizations, so you would not be billed for the immunization.

In-network services

In-network services are covered services you receive from **participating providers**.

Most often, receiving in-network services means paying **lower out-of-pocket costs**. Your yearly **in-network deductible** amount is lower, and charges are based on our negotiated rates with participating providers. There is no charge for certain preventive services.

With thousands of participating doctors and hospitals across the country, chances are very good that you can find one near your home or work.

- To locate participating providers, use our online directory at harvardpilgrim.org/providerdirectory and choose “PPO.”
- If you don’t have Internet access, call Member Services for a list of nearby providers and hospitals. (The call and the list are free.)

Out-of-network services

Out-of-network services are covered services you receive from non-participating providers.

Receiving out-of-network services typically means paying **higher out-of-pocket costs**. All services you receive are subject to a separate **out-of-network deductible** that is higher than your in-network deductible. After you satisfy your yearly out-of-network deductible, you will need to pay coinsurance. You may need to send us claim forms to be reimbursed for covered services. In addition, a non-participating provider may bill you for the difference between his or her charges and the amount we pay for the service.

GLOSSARY

DEDUCTIBLE: A dollar amount you must pay annually before services are covered under your health plan. This means you may be required to pay all or part of a bill for services, until you have met your total deductible amount. Some plans may require you to pay copayments or coinsurance after you pay your annual deductible.

COINSURANCE: A percentage of the cost of services that you must pay for certain services.

COPAYMENT: A dollar amount you pay for certain in-network services. The copayment is due at the time of the visit or when the provider bills you. Copayments are always fixed dollar amounts.

PARTICIPATING PROVIDERS: Doctors, other health professionals and hospitals that have agreements to care for our members and belong to our provider network.

NON-PARTICIPATING PROVIDERS: Doctors, other health professionals and hospitals that do not belong to our provider network.

The *Schedule of Benefits* has more details on benefits and cost sharing. It governs in the event that the information in this document is different.

Going to the hospital

When you're going to be admitted to the hospital, services are covered according to what combination of providers you use. Suppose that you are being sent to a participating hospital by a non-participating doctor. In this case your hospital visit is covered at the in-network benefit level, and the doctor's services are covered at the out-of-network benefit level.

Except in an emergency, you must notify us before a hospital admission when non-participating providers are involved.



Coverage when you're traveling

If you seek care for covered services while traveling, they will be covered at the in-network benefit level when you visit participating providers, and at the out-of-network level

when you visit non-participating providers. Emergency services are subject to your in-network deductible no matter where you're traveling.

Coverage in an emergency

In an emergency (e.g., heart attack, stroke, choking, seizure or loss of consciousness), go to the nearest emergency facility or call 911 or another local emergency number. Once you are out of the hospital, please follow up with your primary care provider, if you have one, for any additional care you may need.

Your plan covers all medical emergencies at the in-network benefit level. Emergency services are subject to the in-network deductible plus any additional cost sharing that may apply. Check the Schedule of Benefits to see what kind of cost sharing you have to pay.

Prescription Drug Coverage

Prescription drug coverage is available through Optum Rx. Please call Optum Rx customer service for details at (888) 374-8127.

Deductible not a separate deductible from medical services.

IN-NETWORK AND OUT-OF-NETWORK

Retail:

- \$10 for generic drugs after deductible
- \$30 for preferred brand name drugs after deductible
- \$50 for non-preferred brand name drugs after deductible

Pharmacy network: all participating pharmacies

Mail Order (90-day supply for two co-payments):

- \$20 for generic drugs after deductible
- \$60 for preferred brand name drugs after deductible
- \$100 for non-preferred brand name drugs after deductible

Be well, save money and more

Learn about different health topics and ways to be well. Keep more money in your wallet with discounts on eyewear and fitness and nutrition programs. Look up your plan details and find out about typical costs for tests and procedures. Visit harvardpilgrim.org to learn more.

Questions?

If you're already a member, call Member Services with questions at (888) 333-4742. For TTY service, call 711.

If you're not yet a member, call (800) 848-9995.

To learn more about us in general, visit harvardpilgrim.org.

What is a Health Savings Account?

A Health Savings Account is a fund you can establish to pay for medical expenses associated with a High Deductible Health Plan or invest for your future health care needs. Under federal guidelines, you need to enroll in a High Deductible Health Plan to be able to set up a Health Savings Account (HSA). Your HSA is administered by HealthEquity.

Why set up a Health Savings Account?

Tax savings

- You can contribute to your Health Savings Account through pre-tax payroll deductions, which lowers your taxable income.
- Your interest earnings and withdrawals for qualified health care expenses are tax-free as well.

No “use-it-or-lose-it”

- Any unused amounts in your Health Savings Account carry over from year to year.
- You don’t have to worry about forfeiting your contributions at the end of the year.

It’s yours

- You own your Health Savings Account. When you change jobs or retire, your money stays with you.
- The funds in your account are yours to spend on medical expenses associated with your High Deductible Health Plan or save for future health care needs.

It’s flexible

- Smith College contributes to your HSA and you can too.
- You can use Health Savings Account funds for non-medical expenses, but withdrawals are subject to a penalty and will be taxed as ordinary income.

Use it for the future

- Health Savings Accounts may be an effective way to invest for future health care needs, including those in retirement.