

HSA

Account Based
Health Plan with
Health Savings
Account Guide

PHILIPS

Benefits

2018
LEAD **THE** WAY

You're in control with an Account-Based Health Plan

Philips believes an Account-Based Health Plan (ABHP) with a Health Savings Account (HSA) provides the most effective way for you to manage healthcare costs now and in the future. Here's how:

- You have two ABHPs to choose from. The differences between the two ABHPs are the amount you pay for the premium, deductible and out-of-pocket maximum. The Blue Cross Blue Shield provider network and covered services are the same for both plans.
- You can open an HSA, which is a tax-advantaged savings account, that gives you control over how you spend your healthcare dollars. You can open an HSA only if you're enrolled in an ABHP.
- In 2018, Philips will contribute the following to your HSA.

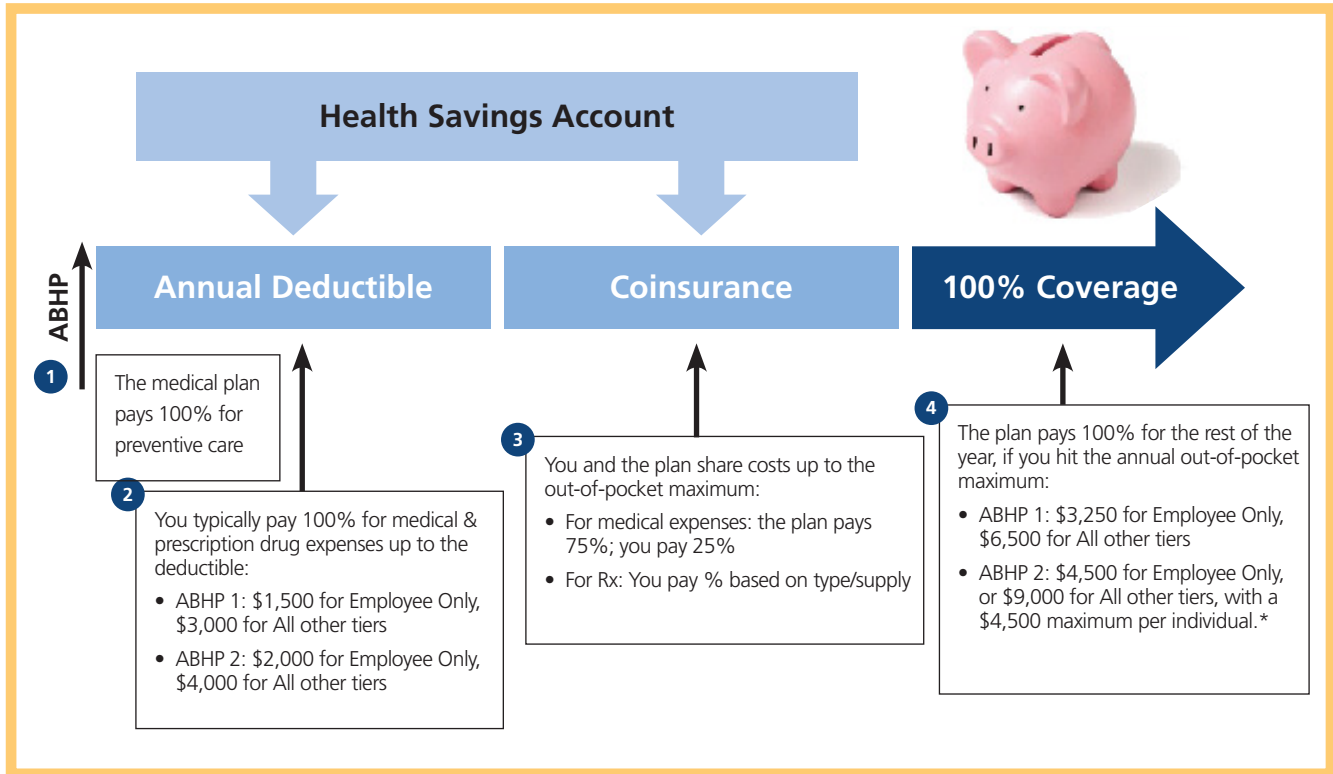
Coverage type	ABHP 1	ABHP 2
Employee only	\$620	\$370
All other tiers	\$1,200	\$700

- If you are not eligible for an HSA (due to IRS regulations), Philips will give you the money that would have been deposited to your HSA in a taxable per payroll credit over the course of the year provided you are enrolled in an ABHP for the entire year. If you enroll after January 1, the amount of the payroll credit will be pro-rated to reflect the period of time you are enrolled in the ABHP.
- You can elect to make tax-free contributions to your HSA, up to annual IRS limits, with the flexibility to change your contribution throughout the year. In 2018, the IRS allows HSA contributions up to \$3,450 for employee-only coverage and \$6,900 for all other tiers (including Philips contributions).
- The money in your HSA can be used to pay for current and future healthcare expenses, so you don't need to worry about having to spend it all in a single year.

Read on to learn more about the ABHPs with HSA.

How the ABHPs Work

There are two main components of an Account-Based Health Plan (ABHP): comprehensive medical and prescription drug coverage and the Health Savings Account (HSA). The graphic below shows you how the medical and prescription drug coverage component works.



Note: This graphic and the descriptions on page 4 assume in-network coverage.

** ABHP 2 out-of-pocket maximum: 100% coverage begins for the remainder of the year if an individual out-of-pocket maximum, or when the family out-of-pocket maximum, is reached. If an individual's eligible expenses reach \$4,500 then the plan will begin paying 100% for that individual's eligible expenses for the rest of the year (even if the \$9,000 family out-of-pocket maximum has not yet been reached).*

A key advantage of an ABHP is that you can have an HSA...

Funds in your HSA can be used to help you pay the cost of the deductible, coinsurance and other eligible healthcare expenses for you AND any eligible dependents! Philips contributes money to your HSA and you can choose to contribute your own tax-free dollars too.

1) Preventive Care

In-network preventive care services are fully covered by the ABHPs at 100% with no deductible – that means you pay nothing! Also, generic drugs for certain chronic conditions and certain prescribed preventive medications are also fully covered at 100% with no deductible.*

2) Annual Deductible

For all non-preventive care services (including the cost for most prescription drugs), you pay 100% of the costs or rates that Blue Cross Blue Shield and Caremark have negotiated with providers, up to the annual deductible of:

- **ABHP 1:** \$1,500 for employee only, \$3,000 for all other tiers**
- **ABHP 2:** \$2,000 for employee only, \$4,000 for all other tiers***

Note: The deductible is waived (you pay only coinsurance) for certain prescription medications deemed to be preventive in nature.*

3) Coinsurance

If you satisfy the deductible, you and the plan share the cost of medical services AND prescription drugs.

- For medical services, the plan pays 75% and you pay 25%.
- For prescription drugs, you pay a percentage of the cost based on the type of drug and supply amount.

4) Out-of-Pocket Maximum

If your total expenses (deductible plus coinsurance) for medical services AND prescription drugs reach the amounts listed below for 2018 coverage, the plan then covers all eligible expenses at 100% – that means you pay nothing else for the rest of the year.

- **ABHP 1:** \$3,250 for employee only, \$6,500 for all other tiers**
- **ABHP 2:** \$4,500 for employee only, or \$9,000 for all other tiers (with a maximum of \$4,500 per individual)***

* More information on these prescription drugs can be found through the CVS Caremark Prescription Cost Tool at www.caremark.com/philips or contact CVS Caremark directly at 800-388-2055 with questions.

** Under ABHP 1, you must meet the entire deductible before coinsurance will begin for the rest of the year, for any covered member. You must meet the entire out-of-pocket maximum before Philips will begin to pay 100% of remaining expenses, for the rest of the year, for any covered member.

*** Under ABHP 2, you must meet the entire deductible before coinsurance will begin for the rest of the year, for any covered member. ABHP 2 out-of-pocket maximum: 100% coverage begins for the remainder of the year if an individual out-of-pocket maximum, or when the family out-of-pocket maximum, is reached. If an individual's eligible expenses reach \$4,500 then the plan will begin paying 100% for that individual's eligible expenses, for the rest of the year (even if the \$9,000 family out-of-pocket maximum has not yet been reached).

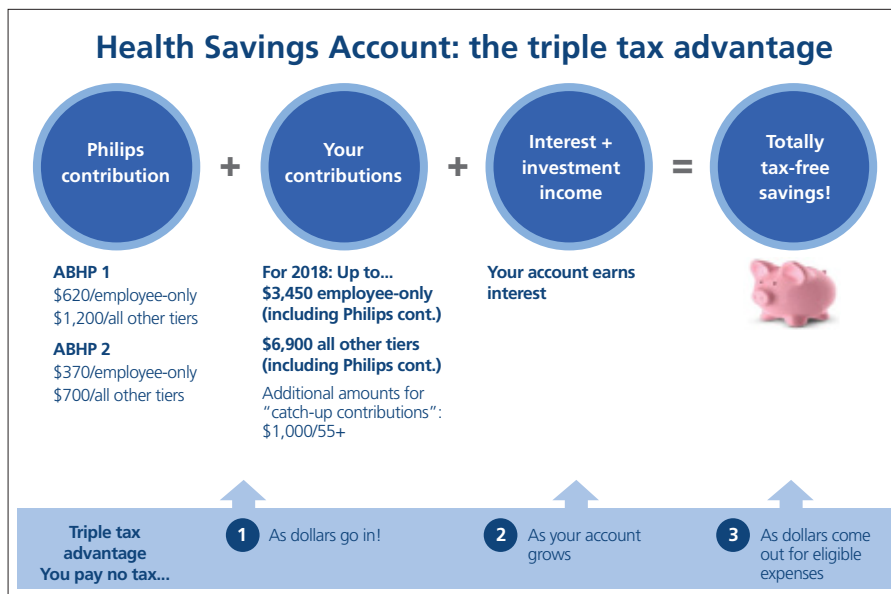
How the HSA Works

The Philips HSA, administered by HealthEquity, is a smart way to pay for current and future eligible healthcare expenses.

You must enroll in an ABHP and be eligible to open an HSA in order to receive the automatic annual HSA contribution from Philips. You can choose to contribute on your own too. Your contributions are automatically deducted on a pre-tax basis from each paycheck OR you can elect to contribute amounts outside of the payroll process entirely. You can also change your contribution amount at any time during the year.

You are eligible to open and contribute to an HSA if you meet all of the following IRS requirements:

- You are covered under a qualifying ABHP
- You are not covered under another health plan that is not a high deductible health plan
- You are not covered under a Healthcare Flexible Spending Account (including your spouse's)
- You are not enrolled in Medicare, Medicaid or Tri-Care
- You are not claimed as a dependent on someone else's tax return, and
- Except for a "service-connected disability," you have not received medical benefits (including prescription drugs) from the Veterans Administration or at one of its facilities in the last three months



Here is an example of what \$100 is worth after taxes:

After taxes

\$100 – \$36 in taxes = \$64

Wouldn't you rather have the \$100 tax-free?

Note: The example above assumes a 28% federal tax rate and a Social Security and Medicare tax rate of 7.65%. Also, some states may tax HSA contributions; however, most states do not.

Notes:

- If you are married and both you and your spouse are HSA eligible, the contribution limit above is divided equally between you (unless you agree to a different allocation).
- If you join an ABHP mid-year as a result of a special enrollment event, your 2018 IRS HSA limit is prorated on a monthly basis.

However, Philips will make its full contribution to your account if your coverage is effective prior to December 1, 2018.

Benefits of an HSA

You can use your HSA for eligible healthcare expenses for you AND your eligible dependents.

You can put your HSA dollars toward your deductible and other eligible medical, prescription, dental and vision expenses – even expenses for your eligible dependents* who are NOT covered under the ABHP. (Note: You can only be reimbursed for a child's healthcare expenses if the child is your tax dependent.)

Unlike a Flexible Spending Account (FSA), you can contribute to your HSA at any time during the year.

So, if you have unexpected healthcare costs during the year, you can contribute additional tax-free money (up to the annual IRS limits) to your HSA to pay for those expenses.

You can build savings for future eligible healthcare expenses.

You can use dollars in your HSA to pay for eligible expenses in both current and future years, even if you are no longer enrolled in an ABHP. Through HealthEquity, your balance grows with interest; once you have a balance of \$1,500 or more, HealthEquity provides you with the opportunity to invest your HSA dollars and potentially grow your account.**

You can take it with you.

The money in your HSA is always yours, so you can take your unused balance when you retire or leave Philips.

Your HSA offers significant tax advantages.

The HSA is a triple-tax advantaged account – that means you never pay taxes on your HSA dollars as you make contributions, as your account grows with interest or investment income, or when you withdraw the money to pay for eligible expenses. The money in your HSA remains tax-free as long as you use it to pay for eligible healthcare expenses.

Payment is easy and convenient.

To pay for eligible healthcare expenses with your HSA, you can use the HSA Debit Card from HealthEquity, pay providers online (just like online banking) and/or reimburse yourself for expenses you've paid out of pocket.

* Domestic partners and the children of domestic partners are not eligible dependents for purposes of the HSA.

** Philips has not reviewed any of the investment options that HealthEquity may make available for the investment of your HSA account and does not endorse or recommend any options. You should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for you.

Note: Neither Philips' arrangement for making contributions to the HSAs of eligible employees nor the HSAs themselves are welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).

Frequently Asked Questions

What are the costs for prescription drugs under the ABHPs?

Under the ABHPs, most prescription drug expenses are subject to the annual deductible. This means you must pay the FULL NEGOTIATED COST for your prescriptions until you meet the deductible. Once you meet the deductible, you and the plan begin to share in the cost through coinsurance.

The percentage you pay in coinsurance varies based on the type of prescription drugs (generic, preferred brand name or non-preferred brand name) and the supply of the drug (30 or 90 days). There are a few exceptions you should be aware of, however. The following are covered at 100% (which means you pay nothing; the annual deductible and coinsurance do not apply):

- Generic drugs for certain chronic conditions (such as asthma, diabetes, and depression).
- Certain prescribed preventive medications (as referenced under the Affordable Care Act).
- In addition, other prescription medications deemed to be preventive in nature are NOT subject to the annual deductible but ARE subject to coinsurance.

More information on these drugs can be found through the CVS Caremark Prescription Cost Tool at www.caremark.com/philips or contact CVS Caremark directly at 800-388-2055 with questions.

Keep in mind: *You can use funds from your HSA to offset the cost of prescriptions. Also, make sure you use your CVS Caremark card when you purchase prescription drugs. When you do, you will pay the negotiated price, and the amounts you pay will be applied appropriately to your ABHP deductible. Note that your drug costs are applied to the deductible only if the drug is listed on the applicable CVS Caremark formulary.*

I want to estimate how much my prescription drugs would cost under the ABHPs. Where can I find this information?

You can find the estimated cost of your prescription drugs through the CVS Caremark Prescription Cost Tool at www.caremark.com/philips. Visit the tool and click on the "Check Availability and Cost" tab.

Why are employee paycheck deductions for the ABHPs less than for the PPO?

The ABHPs have lower employee deductions (or "premiums") than the PPO Plan because they have higher annual deductibles. With these lower premiums, employees who enroll in the ABHPs can choose to use the additional money they would have spent in PPO premiums to fund their HSA.

Why can't I open an HSA if I am enrolled in the PPO?

Under federal tax law, you can open and contribute to an HSA only if you are enrolled in a qualified high-deductible health plan like the Philips ABHPs. Since the PPO doesn't meet the requirements to be considered a qualified high-deductible health plan, you cannot open and contribute to an HSA if you're enrolled in the PPO.

Do I need to report my HSA on my individual tax return?

Yes. HSA contributions and distributions are reported on IRS Form 8889, which is filed as an attachment to your Form 1040. You are responsible for determining whether your HSA distributions are taxable or whether they were used for eligible medical expenses (and therefore are not taxed by the federal government). See IRS Publication 969 for more information.

Note that you are responsible for ensuring that you do not contribute more than the applicable annual IRS limit to your HSA. Excess contributions could be subject to a 6% excise tax. Consult your personal tax advisor for more information.

Frequently Asked Questions

Does the annual deductible work the same for the PPO Plan and ABHPs?

Not exactly. Under the ABHPs, if you elect employee plus spouse, employee plus child(ren), or family coverage, you and your covered dependents must meet the entire family annual deductible (\$3,000 for ABHP 1 and \$4,000 for ABHP 2) before coinsurance will begin for any covered member of the family. This means you and your covered dependents must pay the full cost of medical and prescription drug expenses until the annual deductible is met. The deductible can be met by one individual or by a combination of covered family members. Then, coinsurance begins for the entire family.

Under the PPO, if you elect employee plus spouse, employee plus child(ren), or family coverage, the annual deductible is \$750 for each covered individual and \$1,500 for the family. This means if any individual reaches the individual deductible, coinsurance begins for that individual. And, once a combination of expenses for covered family member(s) reaches the family deductible, coinsurance begins for the entire family.

Is there a limit on how much I can accumulate in my HSA over time?

No. There is no limit on how much money you can accumulate in the HSA; there is only a limit, set by the IRS, on how much can be contributed on a tax-free basis in any given year. In 2018, the IRS limit is \$3,450 for employee only coverage and \$6,900 for all other tiers. The limit includes the automatic contribution from Philips plus any contributions you make. If you are age 55 and over, you may contribute an additional \$1,000 over the IRS annual limit. At year-end, unused money and earnings in your HSA (if any) will automatically carry forward to the next year. The money in your HSA is always yours, even if you enroll in a different plan, leave Philips or retire.

What happens if I use my HSA for ineligible expenses?

If you use your HSA to pay for ineligible expenses (such as babysitting/child care, elective cosmetic surgery, or health club dues), you will incur a 20% tax penalty and be subject to ordinary income taxes on the amount of the ineligible expense.

Does the annual out-of-pocket (OOP) maximum work the same for the PPO Plan and ABHPs?

Not exactly. Under the ABHP 1, if you elect employee plus spouse, employee plus child(ren), or family coverage, you and/or your covered dependents must meet the entire family OOP maximum of \$6,500. At that point, the plan will pay 100% of remaining eligible costs, for the rest of the calendar year, for the entire family.

The ABHP 2 OOP works the same as the PPO's. This means that under the ABHP 2 or PPO, if any individual reaches the individual OOP maximum (\$4,500 under the ABHP 2; \$5,000 under the PPO), the plan will pay 100% of remaining eligible costs, for the rest of the year, for that individual. And, once a combination of expenses for two or more covered family members reaches the family maximum (\$9,000 under the ABHP 2; \$10,000 under the PPO), the plan will pay 100% of remaining eligible costs, for the rest of the year, for the entire family.

Why does the ABHP 2 have an individual OOP maximum under employee plus spouse, employee plus child(ren), or family coverage and the ABHP 1 does not?

The "per individual" OOP maximum for the ABHP 2 was new in 2016 to comply with Affordable Care Act (ACA) rules. The individual maximum annual OOP cost cannot exceed

Frequently Asked Questions

\$6,850 regardless of whether the individual is enrolled in employee only, employee plus spouse, employee plus child(ren), or family coverage. Since the ABHP 1 OOP maximum of \$6,500 for employee plus one, employee plus child(ren), or family coverage is below the ACA limit of \$6,850 per individual, there is no individual OOP maximum required.

I enrolled in a ABHP for 2017 and want to continue coverage under the ABHP in 2018. Will Philips automatically contribute to my HSA in 2018? Will my designated contribution for 2017 continue for 2018?

If you remain enrolled in an ABHP and continue to meet the other HSA eligibility requirements, Philips will automatically contribute to your HSA in January 2018. Further, your 2017 HSA payroll deduction contribution amount will roll over to 2018, up to IRS limits. Remember, you can change your HSA contribution amount at any time by logging on to Benefits Central.



This guide contains only highlights of the Philips benefit plans. For detailed information on a benefit plan, please consult your summary plan description and the official plan document for that plan. In the event of a discrepancy between the official plan document and this guide, the official plan document will control. Receipt of this guide does not guarantee eligibility for any Philips sponsored plan or program of benefits. Eligibility for and entitlement to a benefit is governed by the terms of the official plan document. Philips reserves the right to modify, or terminate completely, any benefit plan, at any time and without notice.

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