FAQs

Frequently Asked Questions

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Benefits

2018

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How do I log into Benefits Central?

You can access Benefits Central at https://PhilipsBenefitsCentral.ehr.com.

You can also access it by clicking on the Benefits Central icon in the Application Launcher in the Philips Portal. If you have already registered, the Application Launcher should log you into Benefits Central automatically.

If you are logging in for the first time, select Register to gain access. Enter your Username, the last four digits of your Social Security Number and your birth date. You will then create a Password. Your Username is your 8 digit employee ID 10XXXXXX. If you forgot your password, you may reset your password by selecting Forgot Password?

If you have questions about navigating the site, please contact Health Advocate Benefits Gateway at **888-367-7223**; Option #1 (8:00 a.m. to 9:00 p.m. Eastern time, Monday through Friday).

National Blue Cross Blue Shield (BCBS) Medical Plans

1 **Do all the BCBS national medical plans provide the same level of coverage?**

Yes. All medical plans administered by BCBS have the same networks, cover the same medical services, and have the same negotiated fees for services. The differences are the amounts of the deductibles, payroll premiums or contributions and out-of-pocket maximums.

2 **Is preventive care covered by the BCBS national medical plans? What is considered preventive care?**

Yes. Preventive care is covered at 100%. Some examples of preventive care services include annual physical exams and any associated tests and screenings, such as mammograms, routine gynecological exams, well-baby care, and blood pressure screenings. Certain types of preventive medications are also covered at 100% with a doctor's prescription.

3 **Will coverage be denied to those with pre-existing conditions?**

No, the Affordable Care Act prohibits the medical plans from denying coverage to those with pre-existing conditions.

4 **Why are employees encouraged to enroll in one of the Account Based Health Plans (ABHPs)?**

Philips believes that the ABHPs provide the best opportunity to control medical costs for both employees and the company while offering a tax-efficient savings vehicle (the Health Savings Account) to accumulate funds for future health care expenses.

5 **Does Philips plan to cancel the PPO plan in the future?**

The PPO plan was closed in 2015 to new enrollees. However, the PPO plan will remain available in 2018 for employees enrolled in the PPO for 2017. It has not yet been determined when the PPO plan will be canceled or eliminated.

6 **Are there any changes to the ABHP and PPO plans in 2018?**

Yes. The coinsurance, your share of the costs of a health care service after you have satisfied the deductible, is changing from 20% to 25% for in-network services. The coinsurance percentage is higher for out-of-network.

7 If my provider currently accepts the PPO, will they accept the ABHPs?

Yes. The networks for the PPO and ABHPs are the same.

8 Why is there such a big difference in employee paycheck contributions between the ABHPs and PPO?

The ABHPs have lower employee contributions than the PPO plan because the plans have higher annual deductibles.

9 Why are employee premiums increasing?

Each year we evaluate the claims experience and estimate the total expected costs for the following year. We then make decisions regarding the sharing of those costs based on market trends. This year, premiums will increase an average of 4.5% for the ABHPs and PPO.

10 What companies does Philips benchmark its medical plans against?

We benchmark against similar sized companies in similar industries to Philips.

11 What percentage of the total cost does Philips pay for each plan?

Philips pays 72% of the BCBS PPO premiums, 80% of the BCBS ABHP 1 premiums, and 86% of the BCBS ABHP 2 premiums, on average.

12 Are bonuses, overtime pay or any additional pay added to my base salary for purposes of determining my salary tier for medical premiums?

The salary tier used to determine your employee paycheck contribution for 2018 represents your annual earnings, which is your base pay as of August 1, 2017. Your annual earnings do not include bonuses, overtime pay or any other additional compensation. For commissioned salespeople, annual earnings include your base pay on August 1, 2017 plus an average of sales commissions paid in 2015 and 2016. If your base pay changes after August 1, 2017, your 2018 contribution amount will NOT change.

13 Can I choose my own doctor in the ABHPs?

Yes, you can choose any physician. However, you will pay considerably less out-of-pocket if you choose a doctor who is in BCBS's network.

14 Does the annual deductible work the same for the PPO plan and ABHPs?

Not exactly. Under the PPO plan, if you elect Employee plus Spouse, Employee plus Child(ren), or Family coverage, the annual in-network deductible is $750 for an Individual and $1,500 for a Family. If any covered member of the family reaches the Individual deductible of $750, co-insurance begins for that individual. Co-insurance will also begin for all covered family members once the family deductible of $1,500 is reached.

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 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. Once a combination of medical and prescription drug expenses for you and any covered dependent(s) hit the annual deductible, coinsurance begins for all covered family members.

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

There are some similarities, but also some important differences. The annual OOP maximum for the medical plans includes what you spend on medical and prescription drugs. However, how you reach the annual OOP maximum differs.

- Under the PPO plan, 100% coverage will begin for an individual once he or she reaches the Individual OOP maximum, **OR** 100% coverage will begin for anyone covered under the PPO plan once the Family OOP maximum is reached.
- Under the ABHP 1, if you elect Employee plus Spouse, Employee plus Child(ren) or Family coverage, you must meet the entire Family OOP maximum before 100% coverage will begin for anyone covered under the ABHP 1.
- Under the ABHP 2, if you elect Employee plus Spouse, Employee plus Child(ren) or Family coverage, there is an Individual out-of-pocket maximum. This means if an individual's eligible expenses reach the Individual OOP, the plan will begin paying 100% for that individual's eligible expenses for the rest of the year (even if the Family out-of-pocket maximum has not yet been reached) **OR** 100% coverage will begin for anyone covered under the ABHP 2 plan once the Family OOP maximum is reached.

16 Where can I easily view my year-to-date medical expenses and find out if my deductible has been met?

BCBS – Go to www.bluecrossma.com and click on "Member" and then log into your secure account to access your claims information.

UPMC – Go to http://www.upmchealthplan.com/ and click on Member Login on the right hand side of the screen. Once registered, you can enter your user name and log into your secure account to access your claims information.

17 I understand that I am only allowed to change my benefit election during the plan year if I have experienced a qualified life event. What events can be considered qualified life events?

A qualified life event is an event that results in a gain, loss or change in benefits eligibility for you, your spouse and/or other dependents. Examples include marriage, divorce, loss of coverage on spouse's/dependent's plan, or birth/adoption of a child. If you experience a qualified life event, you can change your benefit elections, as long as the changes you make correspond with the gain, loss or change of eligibility for coverage. You have 45 calendar days from the date of the event to make changes to your benefits through the Benefits Central website, unless the event is the birth/adoption of a child, in which case you have six months from the date of birth or adoption to make changes to your benefits.

For more information on qualified life events, refer to the Summary Plan Descriptions (SPD) on the Philips Portal.

18 If I have a qualified life event during the year that requires me to move from Employee Only coverage to Employee plus Spouse, Employee plus Child(ren), or Family coverage, what happens to my deductible?

If you are enrolled in the PPO plan, your new dependent will have to satisfy his or her individual deductible of $750 (see question 14) unless you have already satisfied the entire family deductible.

If you are enrolled in the ABHPs, your year-to-date costs incurred prior to the date of your qualified life event will be applied to your new deductible level.

19 How are eligible dependents defined?

Eligible dependents for the 2018 Philips benefits plans are:

- Your legally married spouse or your same or opposite sex domestic partner. Domestic partners must meet the requirements included in the Summary Plan Description
- Your or your spouse's children up to age 26 including: your own children, stepchildren, adopted children, foster children (any child who is placed with you by an authorized placement agency or by the order of a court), and any child for whom you or your spouse has court-appointed, legal guardianship and your domestic partner's children. Coverage for enrolled children continues until the end of the month in which they turn age 26
- Handicapped children who meet the requirements included in the Summary Plan Description

NOTE: From time to time, Philips will conduct dependent eligibility audits. You are responsible for enrolling only eligible dependents on your benefits plans. Different eligibility rules may apply to life and AD&D benefits.

20 Can my eligible dependent be added to my healthcare plan if they do not have a social security number?

You may add eligible dependents even if they do not have a social security number. However, you must call Health Advocate Benefits Gateway to add your dependent. Call 888-367-7223 (option 1) between 8:00 a.m. and 9:00 p.m. Eastern time, Monday through Friday. Once your dependent's social security number has been obtained, you must call again to add that number to your dependent's record.

21 How do I find an in-network doctor or hospital?

BCBS – Go to www.bluecrossma.com, click "Member" and then "Find a Doctor." Select the Member tab and enter Philips member code, which is PAE.

UPMC – Go to http://www.upmchealthplan.com/ and click Doctor(s). Then login to MyHealth OnLine with your user ID and password. For new users, you must first register by clicking New User Registration.

22 Does BCBS have a vision plan?

BCBS does not have a vision plan for Philips employees. Philips's vision benefits are provided by VSP.

23 Where can I find information about the vision plan benefits?

You can find a summary of the vision coverage on the Philips Open Enrollment Site. Information is also included in the 2018 Open Enrollment Decision Guide.

Local Medical Plans

24 Are any local medical plans available to me?

If a local medical plan is available to you, it will be listed on your medical plan enrollment page in Benefits Central.

Prescription Drug Coverage through CVS Caremark

NOTE: If you enroll in a BCBS or UPMC plan, you are automatically covered by the CVS/Caremark Prescription Drug Plan.

25 If I enroll in one of the ABHPs, how does my prescription drug coverage work?

Under both ABHPs, most prescription drug expenses are subject to the annual deductible.

Once you meet the deductible, you and Philips 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 or non-preferred brand) and the supply of the drug (30 or 90 days).

There are a few exceptions you should be aware of. These are summarized in the chart below:

Applies to . . .	Drug Type . . .	How it's covered . . .	Notes . . .	Where to find a complete list / more information
PPO and ABHPs	Generic drugs for certain chronic conditions	Covered at 100%	Includes certain drugs for conditions such as Diabetes, Asthma, Cholesterol and Hypertension	Contact CVS Caremark at **800-388-2055** or visit the CVS Caremark Prescription Cost Tool at www.caremark.com/philips/
PPO and ABHPs	Certain prescribed preventive medications (defined by Affordable Care Act)	Covered at 100%	Examples: • Iron supplements • Aspirin • Oral fluorides • Folic acid (Need prescription for 100% coverage)	Contact CVS Caremark at **800-388-2055** or visit the CVS Caremark Prescription Cost Tool at www.caremark.com/philips/
Just the ABHPs	Certain prescription medications deemed to be preventive in nature	No deductible, subject to co-insurance based on type/supply	Drug class examples: • Anti-depressants • Anti-coagulants	Contact CVS Caremark at **800-388-2055** or visit the CVS Caremark Prescription Cost Tool at www.caremark.com/philips/

26 Do I need to show my CVS Caremark card every time I get my prescription filled?

Yes. This will ensure that you pay the negotiated cost, and that the amount you pay out-of-pocket will be applied appropriately to your deductible.

NOTE: If a prescription drug is not on the Prescription Drug Program's formulary, the cost of that drug will not be applied to your deductible.

27 Do I have to fill my prescription at a CVS pharmacy?

No, but the pharmacy must be a participating pharmacy in CVS's network.

28 Where can I find the list of participating pharmacies?

Go to CVS Caremark's website at www.caremark.com/philips and click on "Locate a Pharmacy" at the bottom left hand side of the page to start the search engine.

29 What is the difference between Retail & Maintenance Choice?

Retail is your local pharmacy and Maintenance Choice is the mail order program through CVS. Maintenance Choice provides further discounts for purchasing larger quantities of prescription drugs. In addition to the mail, the Maintenance Choice prescriptions can also be picked up at your local CVS while still providing the same discounted rates.

30 Am I required to use the mail order program for my maintenance medications?

No, but it will cost you more. You may refill your maintenance medication at your local pharmacy twice, for a total of three times. After that, you must order your prescriptions through the Maintenance Choice program or your coinsurance on a 30-day supply will increase to 50%, unless you fill your maintenance prescriptions at a CVS pharmacy.

31 Am I required to have my prescriptions filled as a generic when a generic is available?

No, but it will cost you more if your prescription is not filled with a generic drug. When a prescription is filled under the Prescription Drug Program (retail and mail order), generic drugs are used to fill prescriptions rather than more expensive brand name drugs, whenever that option exists. If a generic equivalent drug is available and you choose to have the prescription filled with a brand name drug, you will pay the difference in cost between the brand name and generic drug, in addition to the coinsurance. This is true even if your physician has indicated "dispense as written" or "no substitutions" on your prescription. If it is medically necessary for you to take the brand name drug, your physician may file for an exception with CVS Caremark, which they will review and make the final determination. Call CVS Caremark Customer Care at 800-388-2055 to request an exception form.

32 If a brand name drug does not have a generic equivalent, is the treatment of the brand cost more favorable?

If no generic drug is available, you will pay the normal coinsurance for the designated drug tier.

33 Why are brand name drugs for chronic conditions not covered at 100%?

Only generic drugs qualify for 100% coverage for certain chronic conditions. To determine the drugs that are covered at 100%, visit the CVS Prescription Cost tool at www.caremark.com/philips.

34 Are over-the-counter drugs for chronic conditions paid at 100%?

Certain over-the-counter medications are covered at 100%. You must obtain a written prescription from your physician for over-the-counter drugs and then present the prescription to the pharmacist. This will ensure that it's covered at 100%. Go to CVS Caremark's website at www.caremark.com/philips for more information.

35 Where can I get a list of brand name drugs that have 100% equivalent generics available? Is that available on the Caremark website?

Log on to the CVS Prescription Cost tool at www.caremark.com/philips to determine generic equivalents and the cost of the drug.

36 My prescription is considered a "compound medication." Why do I need to obtain a preauthorization if the cost is over $300?

A compound medication is made by combining, mixing or altering ingredients to create a custom-

ized medication that is not otherwise commercially available. Due to the lack of U.S. Food and Drug Administration (FDA) approval for many ingredients included in compounds and the high cost of these compound medications, prescriptions for compound medications exceeding $300 will not be covered by the Prescription Drug Program unless you first receive a preauthorization from Caremark. If Caremark does not authorize the prescription drug, you could be responsible for the full cost of some or all of the ingredients used in the compound medication that was prescribed for you. To request a preauthorization, ask your doctor to call CVS/Caremark at 1-800-294-5979 to request a preauthorization.

37 Does the Caremark Prescription Cost tool provide the generic version drug and its cost even if the brand drug name drug is entered?

Yes, the online tool shows generic alternatives, both in the drug search results and when coinsurance pricing is provided.

Dental Plans

38 Does the dental plan cover preventive care at 100%?

Yes.

Both Preferred Provider Dental Plans administered by Cigna and Delta Dental of Massachusetts cover preventive care in full when you use an in-network provider. We want to encourage you to get regular preventive dental check-ups. Early diagnosis and treatment can help you avoid more costly dental problems that may develop or be worsened by lack of basic preventive care.

39 Do Cigna and Delta Dental of Massachusetts cover the same dentists?

Maybe. There are different provider networks for each plan. Go to the Cigna website at www.cignadental.com and the Delta Dental website at www.deltadentalma.com to find the dental providers under each plan and then decide which network is best for you. **Please note**, Delta Dental has two levels of providers – PPO providers and Premier providers. The PPO provider network of dentists offers the greatest benefit level on services, which means the least out-of-pocket costs for you. The Premier network of providers are paid at the out-of-network benefit level and don't balance bill, but your out-of-pocket costs, including for preventive care, will be more. Check the Delta Dental website to determine your provider's network status.

40 My dentist isn't in either the Cigna or Delta Dental of Massachusetts network. Do I have any coverage if I want to continue seeing my dentist?

If you see a dentist that is not in-network, they are considered an **out-of-network provider**. Services provided by out-of-network providers will be reimbursed according to the following:

- **Cigna –** Out-of-network providers: 90% of Reasonable and Customary allowances; providers may balance bill the member up to their usual fees.
- **Delta Dental –** Delta Dental has two levels of out-of-network providers:
  - **Delta Dental Premier:** Premier providers will be paid at the out-of-network level. However, members benefit from lower fees negotiated by Delta Dental for coinsurance purposes and providers will not balance bill the member.
  - **Out-of-Network providers:** 90% of Reasonable and Customary allowances; providers may balance bill the member up to their usual fees.

Comparing the Healthcare and Day Care FSAs

41 How do the Healthcare and Day Care FSAs compare?

There are some important differences between Healthcare and Day Care FSAs. The following chart summarizes how both FSAs compare.

	Healthcare FSA	Day Care FSA
How much can be contributed	$2,650	$5,000 per household
Can be used for	Certain medical, dental, and vision expenses for you and your eligible dependents that are NOT paid for by your healthcare plans, including deductibles, coinsurance, and copayments.	Reimbursement of eligible expenses related to the care and supervision of your child(ren) (under age 13) or your dependent adult so that you and your spouse, if filing jointly, can work or look for work; CANNOT be used for healthcare expenses.
Examples	• Major dental work, dentures, orthodontia, • Eyeglasses/contact lenses and supplies, • Laser eye surgery, • Deductibles, coinsurance, and copayments for your healthcare plans, and • Prescription drugs.	• Care or services for child(ren) under 13 years, including before or after school are or day camp. • Care for dependents who can't take care of themselves. • Housekeepers who primarily care for eligible dependents.
When funds are available in your account	Full amount that you elect to contribute is available for your use starting January 1, 2018.	Funds are available for your use as they are deducted from your paycheck.
Deadlines	• You can use your 2018 Healthcare FSA to cover eligible expenses you incur from January 1, 2018 through December 31, 2018. • All 2018 Healthcare FSA claims must be filed by March 31, 2019. If you miss either deadline and have a remaining FSA balance, you will forfeit the money.	• You can use your 2018 Day Care FSA to cover eligible expenses you incur from January 1, 2018 through December 31, 2018. • All 2018 Day Care FSA claims must be filed by March 31, 2019. If you miss either deadline and have a remaining FSA balance, you will forfeit the money.
Submitting Claims	You do NOT need to submit a claim for: • Prescription drugs and FSA-eligible over-the-counter products – if you use your Healthcare FSA card for these purchases. • FSA-eligible expenses you incur through the BCBS or UPMC PPO medical plan, the Cigna Dental or Delta Dental plans, and the Vision Service Plan – these expenses are automatically submitted for reimbursement from your FSA so that you can pay the bill from your provider. You must manually submit a claim form to WageWorks for any FSA-eligible expenses not listed above	You must manually submit claim forms to WageWorks.
Direct Deposits	• The FSAs feature direct deposit, which means any claims you submit for eligible expenses can be reimbursed directly into your bank account • You can sign up for direct deposit by registering at http://myspendingaccount.wageworks.com	

42 I can use the FSA debit card to buy prescriptions but am unable to use it at the dentist's office. Why?

At Philips, the FSA debit card is set up to be used to purchase prescription drugs only in order to reduce the number of unsubstantiated FSA claims. However, the Healthcare FSA has an auto-reimbursement feature that allows eligible expenses to be automatically reimbursed from your FSA upon receipt by WageWorks of the claim information. If you do not wish to use the auto-reimbursement feature, you have the ability to opt-out of this feature during Open Enrollment.

Affordable Care Act

43 If I am enrolled in Philips medical coverage, will I be subject to the individual mandate penalty or fee?

No. Philips medical coverage provides minimum essential coverage (MEC) under the Affordable Care Act, which means you will not be subject to the individual mandate penalty or fee for 2018. For more details, please see the Health Insurance Marketplace notice, which is available on the Medical Benefits page of the Philips Portal.

44 Is there a website where employees could go to compare prices of the plans available through the Health Insurance Marketplace or "exchanges" to the Philips plan?

There is no website that compares the Philips medical plans to the Health Insurance Marketplace plans. Since there are multiple plans in each state and employees in nearly every state, this would be virtually impossible. However, employees can go on the state exchange websites to review the plans that are offered under the Health Insurance Marketplace and then compare those to the plans provided by Philips.

45 If Philips offers coverage, can an employee opt out and get coverage through the Health Insurance Marketplace?

Yes, anyone can receive coverage through the Health Insurance Marketplace but not everyone is eligible to receive tax credits. The affordability of the Philips' plans makes it unlikely that an employee will qualify for the credit. Employees should refer to the state exchange websites to determine if they qualify for a tax credit.

2018 Open Enrollment

46 I'm currently enrolled in medical, dental, vision and pharmacy. What happens if I do nothing during open enrollment? Will I have coverage for 2018?

Yes. You will have the same benefit elections in 2018 that you currently have for medical, dental and vision. For Healthcare and/or Day Care Flexible Spending Account, you **must** designate an annual 2018 contribution amount. If you don't make an FSA election you will not be enrolled in an FSA for 2018.

47 If I am on a short term disability leave of absence during the 2018 Benefits Enrollment period (October 25 to November 8), am I still eligible to go through the Benefits Enrollment period?

Yes. The Benefits Enrollment period of October 25 to November 8 is your only chance to elect certain benefits for 2018 (unless you experience a qualified life event during the year).

48 I am currently on my spouse's employer plan and my spouse's Open Enrollment will be held in December. If I drop my coverage under my spouse's plan, will I have the ability to enroll in a Philips plan after the Philips Benefits Enrollment ends?

Yes. This would be considered a qualified life event due to the loss of coverage under your spouse's plan.

49 Do I need to make changes during Open Enrollment to my other coverages, such as optional life insurance, AD&D, or long term disability buy up?

No. These benefits are not impacted by Open Enrollment.

Tobacco User Surcharge

50 What is the Tobacco User Surcharge? To whom does it apply?

If you enroll in a Philips medical plan, you will need to verify if you use tobacco or nicotine products (cigars, cigarettes, e-cigarettes and chewing tobacco). If you say yes, you will pay an additional $20 per month as a surcharge on your Philips medical coverage. The surcharge does not apply to your covered dependents who may use tobacco or nicotine products.

To help you kick the habit, you are encouraged to participate in a Tobacco Cessation Program available at no cost to you. If you stop using tobacco or commit to participating in the cessation program, the surcharge will no longer apply.

51 If I am not making any changes to my benefit elections this year, do I need to go into Benefits Central to update my tobacco status?

If you are not making any changes to your benefit elections this year, your prior tobacco user status on Benefits Central will remain intact.


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