Health Care Handbook
Making the most of your medical benefits
MassMutual offers three medical coverage options — two high deductible health plans (HDHPs), and one preferred provider organization (PPO).

The three options cover exactly the same services. The main differences are in the way your portion of the costs are broken out: the deductibles, “premiums,” copays/coinsurance, and out-of-pocket maximums — and in your ability to contribute to a health savings account.

Use this guide to make the most of the medical option you’ve chosen.

You may view this booklet online anytime on FieldNet>My Practice>Benefits (look under Health and Welfare).

As you go through this booklet, look for checkmarks at the top of the page to see if information on that page applies to your option.

**TOPICS**

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DISCLAIMER: This communication provides some basic 2019 benefits information. It has been prepared for career contract agents, sales managers, General Agents and General Managers of the Massachusetts Mutual Life Insurance Company who are enrolled in or eligible for a MassMutual’s Health Savings 1350, Health Savings 2000 or Preferred Provider Organization 750 health coverage option. It is not for agents covered under MCS or Cigna PPO Hawaii, nor is it for retired career agents, field staff or MassMutual employees. This is not a summary plan description (SPD) or summary of material modifications (SMM).

Your receipt of this material is not a promise or guarantee by the company of your eligibility for any one or all the benefits and programs described. The company reserves the right to terminate, modify, amend or suspend any or all of its benefit plans and programs at any time, and from time to time. In case of conflict between this information and the plan terms, the plan terms and official plan documents shall govern. Provisions are based on current law and regulations, which are subject to change.
Your coverage

The three medical options offered by MassMutual all cover the same services in the same ways. The main differences between them are in the “premium,” deductible, out-of-pocket maximums and your ability to contribute to a health savings account.

The **Health Savings 2000 (HSA2000)** and **Health Savings 1350 (HSA1350)** medical options are high deductible health plans (HDHPs), which are a type of health plan that comes with the opportunity to contribute to a tax-advantaged health savings account (HSA). If you elect HSA2000 or HSA1350 coverage, you will have the opportunity to contribute to a Cigna Choice Fund® Health Savings Account.

**Preferred Provider Organization 750 (PPO750)** is not a high deductible health plan, so you can’t contribute to an HSA while enrolled in this option. However, you can contribute to a tax-preferred health care flexible spending account (FSA). See page 17 for details.

To see which services are covered, read the Summary of Benefits & Coverage (SBC) for your option:

- Health Savings 2000 (HSA2000) SBC
- Health Savings 1350 (HSA1350) SBC
- Preferred Provider Organization 750 (PPO750) SBC

You may want to save or print out your SBC for easy access. If you have any questions about it, call Cigna at 1-800-548-3980.

Medical deductibles and coinsurance

MassMutual’s medical options have deductible, coinsurance, and “plan pays all” phases, as follows:

- **Deductible phase:** Before you’ve met your annual deductible:
  - If you’re enrolled in HSA2000 or HSA1350, you’ll pay 100% of Cigna’s negotiated rate for eligible in-network care, and 100% of eligible out-of-network charges.
  - If you’re enrolled in PPO750, you will pay a copay for office visits; for all other services, you will pay 100% of Cigna’s negotiated rate for eligible in-network care, and 100% of eligible out-of-network charges.

- **Coinsurance phase:** After you’ve met your deductible, you’ll pay only coinsurance for in-network care, or coinsurance plus any charges over the maximum reimbursable charge (MRC) for out-of-network care.

- **Plan-pays-all phase:** If you reach your annual out-of-pocket maximum, the plan will pay 100% of charges for eligible in-network care, or 100% of charges up to MRC for eligible out-of-network care.
Deductibles and coinsurance

Here are some important things to understand about deductibles, out-of-pocket maximums and coinsurance/copays:

Deductibles are different for individual and “family” coverage (family coverage includes all individual plus one-or-more dependent options).

All deductibles are annual and reset on January 1 each year.

In family coverage under the HSA2000 and HSA1350 options, there is no individual deductible. This means that you, and everyone you cover, will continue to be in the deductible phase until the family deductible is met. Once the family deductible is met, you and everyone you cover will transition to the coinsurance phase.

In family coverage under the PPO750 option, there is an embedded $750 individual deductible. That means an individual covered under your plan will transition to the coinsurance phase once that person’s eligible expenses reach $750, regardless of whether the family deductible has been met. Once the family deductible has been met, you and everyone you cover will transition to the coinsurance phase, regardless of whether any person you cover has met their individual deductible.

Eligible medical and prescription costs count toward the deductible and out-of-pocket maximum in all three options. (In PPO750, office visit copays do not count toward the deductible, but do count toward the out-of-pocket maximum.)

Prescription coinsurance works differently than medical coinsurance. See page 8.

The out-of-pocket maximum is the maximum amount you will pay for covered medical care in any plan year. It includes your deductible and copays/coinsurance. It does not include your “premium” (your per-commission-voucher deduction for medical coverage). Out-of-network charges over the maximum reimbursable charge, penalties, surcharges and any other charges not covered by the plan do not count toward your out-of-pocket maximum.

Each option has a different out-of-pocket maximum, and the out-of-pocket maximum varies between individual and family coverage as well.

See the chart on the next page for details.
### Deductible and Medical Coinsurance/Copay Chart

<table>
<thead>
<tr>
<th></th>
<th>HSA2000</th>
<th>HSA1350</th>
<th>PPO750</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network coinsurance</strong></td>
<td>After deductible, 20% coinsurance</td>
<td>After deductible, 10% coinsurance</td>
<td>After deductible, 20% coinsurance</td>
</tr>
<tr>
<td><strong>Out-of-network coinsurance</strong></td>
<td>After deductible, 30% coinsurance (20% for behavioral health)</td>
<td>After deductible, 30% coinsurance (20% for behavioral health)</td>
<td>After deductible, 30% coinsurance (20% for behavioral health)</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>Office visit</strong></td>
<td>Subject to deductible &amp; coinsurance</td>
<td>Subject to deductible &amp; coinsurance</td>
<td>In-network: $20 PCP copay; $60 specialist copay (not subject to deductible or coinsurance) Out-of-network: subject to deductible &amp; coinsurance</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Subject to deductible &amp; coinsurance</td>
<td>Subject to deductible &amp; coinsurance</td>
<td>Subject to deductible &amp; coinsurance</td>
</tr>
<tr>
<td><strong>Emergency room</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>In-patient hospitalization</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Out-patient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual coverage</strong></td>
<td>Deductible $2,000</td>
<td>$1,350</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket maximum $3,500</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Family coverage</strong> (includes ind. + spouse/partner, ind.+child(ren) and ind. + family)</td>
<td>Embedded individual deductible None</td>
<td>None</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>Family Deductible $4,000</td>
<td>$2,700</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td>Family out-of-pocket maximum $7,000</td>
<td>$6,000</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>Deductible type</strong></td>
<td>Aggregate — this means you and your dependents must meet the entire deductible before coinsurance begins</td>
<td>Embedded — Each individual’s expenses count toward their own deductible as well as the family deductible</td>
<td></td>
</tr>
</tbody>
</table>

Each of these options covers exactly the same services. Curious about how the costs of each option break down? See the 2019 Benefit Rates.

For definitions, see Glossary on page 25.

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1 Deductibles, coinsurance, and copays listed in these charts describes the plan participant’s responsibility. The Plan is responsible for the remainder.
Doctor visits

**Save money with in-network care**

Our Cigna network is Open Access Plus (OAP). While you may see either in-network or out-of-network providers, to make the most of your coverage, look for in-network providers under “find care” on myCigna.com.

To understand how claims work for out-of-network care (and learn about the maximum reimbursable charge), see page 23.

**HSA2000 and HSA1350**

When you call your doctor’s office to make an appointment, let the office know that you have a high deductible health plan and ask to be billed after your claim has been processed by Cigna.

**Present your Cigna ID card**

Show your Cigna ID card when you check in. This signals the doctor’s office to bill Cigna directly.

**HSA2000 and HSA1350**

If you haven’t met your deductible, even though you are responsible for the bill, an in-network provider usually will not require payment at the time of your visit. They’ll send the claim to Cigna, and you’ll be billed after Cigna has applied its negotiated rates.

**PPO750**

You will pay a copay at the time of service.

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Paying bills

**Review your Explanation of Benefits (EOB)**

Once your claim has been submitted, Cigna will send you an Explanation of Benefits (EOB). EOBs list the amount charged by the provider, explain Cigna’s discounts, detail how much the plan has paid and show the portion that’s your responsibility to pay. EOBs aren’t bills. If applicable, your doctor will send you a separate bill after Cigna has processed your claim.

**Pay your portion of the bill**

When you get the bill from the provider or facility, pay your portion.

**If you have HSA2000 or HSA1350, you may pay with funds available in your Cigna Choice Fund® HSA. See page 14 for details.**

**If you have PPO750 and a health care flexible spending account (FSA), you may pay with available FSA funds. (If you have an HSA balance, you may use that for eligible expenses, too — you simply can’t contribute to it while enrolled in PPO750.)**

Alternatively, instead of paying from your HSA or FSA, you may pay your provider as you would any other bill.
**CHOOSE IN-NETWORK CARE TO SAVE TIME AND MONEY.**

**If you use an out-of-network provider:**

- You won’t receive the advantage of Cigna’s negotiated discounts.
- Your medical coinsurance percentage is higher.
- You’ll be responsible for ensuring that your doctor has obtained any necessary pre-authorizations from Cigna.
- You’ll be responsible for paying all charges over the maximum reimbursable charge (MRC). Charges over MRC are not applied to your annual deductible or out-of-pocket maximum. They are completely your responsibility.

If an **out-of-network** provider requires you to pay at the time of service and submit the claim to Cigna yourself, download a claim form from myCigna.com or from your myBenefits website (FieldNet logon required).

**Keep track of your claims**

Monitor your claims activity and how much you’ve paid toward your annual deductible and out-of-pocket maximum. Use Cigna’s website or app, and call them with questions.

Get the myCigna App, free from the App Store or Google Play.

Questions? Call Cigna anytime, day or night, at **1-800-548-3980** or visit myCigna.com.
IF YOU’RE ASKED TO PAY AT THE TIME OF SERVICE, ASK QUESTIONS TO UNDERSTAND YOUR OPTIONS

There may be times when you’re asked to pay while you’re in the office – before you get your EOB. Asking the provider or office staff a few questions (like those below) can help you make payment arrangements that you’re comfortable with.

“Would you please use the Cigna Cost of Care Estimator to print out an Explanation of Estimate for me?”
(This tool will show your provider your estimated bill, what the plan will pay, and any charges subject to deductible or coinsurance.)

“Can you check my deductible status and my coverage for this service?”

“Can I pay a portion now and have you bill me for the rest once you’ve submitted the claim?”

Questions about payments?
Call Cigna anytime, day or night, at 1-800-548-3980.
Prescriptions
Under MassMutual medical options, prescriptions are covered by Express Scripts (not Cigna).

Show your Express Scripts ID card
When you fill a prescription, the pharmacist will check your benefits with Express Scripts, then tell you the negotiated price of your drug and how much you’ll pay.

HSA2000 and HSA1350
Before you’ve met your annual medical and prescription deductible, you’ll pay the full negotiated cost of your prescription; however, certain preventive drugs are not subject to the deductible — for most preventive drugs, you’ll only pay coinsurance; others are covered at 100%.

PPO750
The deductible will apply for certain drugs, but not for Tier 1 drugs, which are subject to a copay, but not subject to the deductible.

All options
- After you’ve met your deductible, you’ll pay only coinsurance — a percentage of the negotiated cost — or a copay, up to per-prescription maximums, if applicable (see page 8).
- If you reach your annual out-of-pocket maximum, the plan will pay 100% of eligible prescription drug charges.

Pay at point of sale
If you have HSA2000 or HSA1350, you may pay with funds available in your Cigna Choice Fund® HSA. (See page 13).

If you have PPO750 and a flexible spending account (FSA), you may pay with available FSA funds. (If you have an HSA balance, you may use that for eligible expenses too – you simply can’t contribute to it while you are enrolled in PPO750.)

You may also pay out of pocket.
### Prescription Drug Coverage

<table>
<thead>
<tr>
<th></th>
<th><strong>HSA2000 and HSA1350</strong></th>
<th><strong>PPO750</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Up to 30-day supply</strong></td>
<td>(Any in-network retail pharmacy)</td>
<td>(Any in-network retail pharmacy)</td>
</tr>
<tr>
<td><strong>90-day supply</strong> (Walgreens or Express Scripts only)</td>
<td><strong>Up to 30-day supply</strong> (Walgreens or Express Scripts only)</td>
<td></td>
</tr>
<tr>
<td><strong>Tier 1: Generic</strong></td>
<td>After deductible, $10 copay (or cost of drug, if less)</td>
<td>$10 copay (or cost of drug, if less) (not subject to the deductible)</td>
</tr>
<tr>
<td></td>
<td>After deductible, $25 copay (or cost of drug, if less)</td>
<td>$25 copay (or cost of drug, if less) (not subject to the deductible)</td>
</tr>
<tr>
<td><strong>Tier 2: Preferred Brand</strong></td>
<td>After deductible, 20% coinsurance, up to $100 max.</td>
<td>After deductible, 20% coinsurance, up to $250 max.</td>
</tr>
<tr>
<td></td>
<td>After deductible, 20% coinsurance, up to $250 max.</td>
<td>After deductible, 20% coinsurance, up to $250 max.</td>
</tr>
<tr>
<td><strong>Tier 3: Non-Preferred Brand</strong></td>
<td>After deductible, 40% coinsurance, up to $150 max.</td>
<td>After deductible, 40% coinsurance, up to $150 max.</td>
</tr>
<tr>
<td></td>
<td>After deductible, 40% coinsurance, up to $375 max.</td>
<td>After deductible, 40% coinsurance, up to $375 max.</td>
</tr>
<tr>
<td><strong>HDHP Preventive Drug list</strong></td>
<td>The deductible does not apply to certain preventive drugs; you pay only coinsurance</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Affordable Care Act preventive drug list</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
</tbody>
</table>

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2 Maintenance prescriptions must be purchased as a 90-day supply through participating Walgreens or Express Scripts Home Delivery only. Express Scripts allows you to fill a 30-day supply of a maintenance medication at a retail pharmacy just twice. After that, if you choose to purchase a 30-day supply of a maintenance medication at your local pharmacy instead of a 90-day supply, you may have to pay a surcharge.

3 For people meeting specific criteria, ACA preventive drugs include prescriptions for aspirin, fluoride, immunizations, vitamin D, colonoscopy prep, breast cancer prevention, contraceptives and statins.
Maintenance medications: Two ways to save

Long-term prescriptions, called “maintenance medications,” are prescription drugs that are generally taken on a long-term basis, often for chronic conditions. You can save money when you purchase a 90-day supply through Express Scripts’ home delivery or from a participating Walgreens.

Express Scripts offers two ways to get a 90-day supply:

• Through home delivery from the Express Scripts Pharmacy, which provides a 90-day supply of your maintenance medication delivered to your door.
• At a participating Walgreens pharmacy, where you can pick up a 90-day supply of your maintenance medication.

If you don’t fill a 90-day supply of a maintenance medication: Express Scripts will allow you to fill a new 30-day supply of a maintenance medication at a retail pharmacy just twice. After that, you must fill a 90-day supply or you may pay a surcharge.

How the surcharge works: After you’ve met your deductible, you may be subject to the 90-day per-prescription maximum charge when you get a 30-day supply of a maintenance medication at a retail pharmacy. (See 30-day vs. 90-day per-prescription maximums on page 8). The surcharge does not apply to short-term (i.e., non-maintenance) prescriptions, such as antibiotics.

Bottom line: To avoid potentially higher costs, get a 90-day supply of maintenance medications either at a participating Walgreens or through home delivery from the Express Scripts Pharmacy:

• To find out if your prescription drug is on the Maintenance Drug List, please contact Express Scripts at 1-866-219-1933.
• To set up home delivery from the Express Scripts pharmacy, call 1-866-544-2892 or log on to www.Express-Scripts.com/StartHD.
• To find a Walgreens pharmacy that participates in filling 90-day supplies, log in or register at www.Express-Scripts.com/90day, select “Manage Prescriptions,” and click “Locate a Pharmacy.” The pharmacy can tell you how to transfer your prescription or start a new one.

Get the Express Scripts app on Google Play or the App Store.
Call Express Scripts anytime, day or night, at 1-866-219-1933 and visit Express-Scripts.com. Use their web tools and expertise!
Specialty drugs
Certain specialty drugs are filled by Express Scripts’ specialty pharmacy, Accredo®. The FDA restricts how some of these drugs can be dispensed, so some may only allow for a limited fill. Contact Express Scripts for details.

Preferred drug list
Please see the Express Scripts National Preferred Formulary for a list of drugs included and excluded from Express Scripts’ formulary.

HELPFUL TOOLS YOU CAN USE ON EXPRESS-SCRIPTS.COM:

- **Prescription drug cost estimator & manager** — Under Manage Prescriptions, two tools can help you estimate and manage your drug costs:
  - With Price a Medication, you can find out costs for retail and home delivery options as well as formulary alternatives.
  - With Save With My Rx Choices, you can find annual costs for medications you take on an ongoing basis and compare them to lower-cost options. When you enter multiple prescriptions, you can also check for potential drug interactions. Or, call Express Scripts anytime, day or night, at 1-866-219-1933 to get an estimate of your prescription costs.

- **Comprehensive prescription drug coverage information to share with your (or your covered family member’s) doctor** — You can print out a copy of your prescription history, coverage details (including coinsurance and per-script maximums) and/or a home delivery fax order form to help your doctor make prescription choices that give you the best care at the best price. Under Health & Benefits Information, choose Prepare for My Doctor Visit, select the section(s) you want, then click the “print the kit” button.
Preventive care

Take care of yourself and your covered dependents and get the full benefit of your coverage. Preventive care is paid for by the plan at 100% in-network.

Preventive care (as defined by federal health care standards) is not subject to the annual deductible or coinsurance. Preventive care provided in-network is covered in full. If received out-of-network, it’s covered in full up to the MRC.

Regular preventive care helps people stay well and avoid more complicated and costly medical conditions down the road.

Preventive care includes things like routine physicals, well-child visits, certain immunizations, preventive mammograms and colorectal cancer screenings. For a schedule of preventive care based on age and gender, see the Cigna’s Preventive Health Care guide. Call Cigna with any questions at 1-800-548-3980.

Schedule a screening or an annual check-up for you or a family member today!

Tip: Talk to your provider in advance about how your preventive screening will be coded for billing.
WHY DID I GET CHARGED FOR PREVENTIVE CARE?

Sometimes you will be billed for a portion of your preventive care visit. This can happen when:

- You went to a provider for a routine physical and at that exam, your provider may also have addressed an acute condition, ordered additional tests, or performed procedures that aren’t considered preventive. Acute care, diagnostic tests and non-preventive lab services are subject to your annual deductible and coinsurance.
- You went to an out-of-network health care provider for preventive care and that provider charged more than the maximum reimbursable charge (MRC). The charge in excess of the MRC is your financial responsibility.

Be aware that you could be billed for a preventive screening, such as a colonoscopy, if it’s not coded as preventive by your doctor. See this guide to communicating with your doctor before your screening to make sure your test is billed correctly.

For help resolving claims issues, call ConsumerMedical at 1-888-361-3944, 8:30 a.m. – 11 p.m. ET. ConsumerMedical is an independent third party, unaffiliated with Cigna, and their services are free to you.

HSA2000 and HSA1350

As with preventive medical care, the preventive prescription drugs list is based on guidelines issued by the federal government. Listed drugs are covered without a deductible, so instead of paying the full price of the drug, you’ll pay only coinsurance up to per-script maximums. See page 8 for the coinsurance schedule.

The amount you pay in coinsurance for these drugs doesn’t count toward your annual deductible, but it does count toward your annual out-of-pocket maximum. Check the link above to see if your prescription is included. Contact Express Scripts any time, day or night, with questions at 1-866-219-1933.
Health savings accounts (HSAs)

A health savings account (HSA) is a tax-advantaged account that allows you to save money for qualified health expenses.

If you’re enrolled in HSA2000 or HSA1350, you have access to a Cigna Choice Fund® HSA. This is your account; it is not owned or controlled by MassMutual. You may make contributions directly or through convenient commission-voucher deductions. Only commission-voucher deductions can be made on a before-tax basis.

**Note:** If you have “other health coverage” (as defined by the IRS; i.e., TriCare, Medicare, or are receiving certain VA or Indian Health Care System benefits) you are not eligible to contribute to an HSA.

HSA contributions are taken from every commission voucher, according to your contribution election (there are 24 commission vouchers in a calendar year). You can adjust your contributions throughout the year using Workday. Monitor your HSA contributions regularly on myCigna.com. (For General Managers (GMs), contributions are deducted from their pay. They are not eligible for before-tax payroll deductions, but may make after-tax HSA contributions and may be able to claim a credit when filing their taxes.)

Be aware that contributions can only be taken if you earn enough each voucher (or pay, for GMs) to cover your designated contribution amount. If there isn’t sufficient W-2 income in any given voucher, neither a full nor partial HSA contribution will be taken. If a contribution is missed, it won’t be automatically made up in a future commission cycle as it could negatively impact the ability to take other more sensitive deductions (e.g., charge backs or health and E&O premiums).

To make up for missed deductions, you’ll need to adjust your future contributions (either within Workday or via a manual contribution).

Remember, only W-2 income (not 1099 income) is eligible for before-tax HSA deductions.

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4 If you start your Social Security benefit after age 65, you may be retroactively enrolled in Medicare coverage. Because this retroactive enrollment date can be up to six months BEFORE your actual enrollment date, and because being covered by Medicare makes you ineligible to contribute to an health savings account (HSA), consult Medicare or your tax advisor about whether you will be eligible to make HSA contributions in the months before starting Social Security.

5 If you’re receiving VA or Indian Health Care System benefits, contact Advisor Operations to discuss whether you’re eligible to contribute to an HSA.
Tax savings

As long as you use your HSA for qualified health expenses, your deposits, interest and investment earnings, and withdrawals are not subject to federal income taxes — meaning significant savings for you. (As of the date of this publication, Alabama, California and New Jersey do not offer favorable tax treatment for HSAs; consult your tax advisor for more information).

Using your account

It is up to you whether to use your HSA dollars for current qualified expenses — or to let your account balance accumulate from year to year, invest it and use it for qualified health expenses you incur in later years. Calendar-year limits apply to all contributions made to your HSA. Monitor your balance so that you don’t exceed the IRS limit — or you may owe taxes. See the HSA User Guide to learn more (requires myCigna.com logon).

PPO750 participants: If you have an HSA, you may not contribute to it while enrolled in PPO750, but you may use your existing balance to pay for eligible health expenses.

Three ways to pay for qualified health expenses with your HSA:

1. When you receive a bill from your health care provider, enter your Cigna Choice Fund® HSA debit card information in the “payment by credit/debit card” section.
2. Use your HSA debit card at pharmacies and at health care provider locations for your estimated portion of the bill (see page 4).
3. Pay online using your HSA. Choose Manage Claims & Balances on myCigna.com, then click on Health Savings Account on the left. Schedule one-time or repeating payments. You can even reimburse yourself using this feature if you paid any expenses out of pocket.

Other HSA payment options include Auto Pay (automatic claim forwarding), purchasing and using an HSA checkbook (fee applies), and reimbursing yourself through withdrawals made at an ATM. See myCigna.com for details.

Keep your receipts!

It’s your responsibility to comply with HSA spending regulations. Keep receipts with your tax files for documentation in case you’re audited.
Monitor your HSA and change your contributions, if needed

It’s your responsibility to make sure your contributions don’t exceed IRS annual maximums, which are:

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,500</td>
</tr>
<tr>
<td>Individual+</td>
<td>$7,000</td>
</tr>
<tr>
<td>Catch up</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

If your spouse makes contributions to their own HSA, the IRS maximum applies to your combined total contributions — that is, your combined maximum will be $7,000 (however, if you and/or your spouse will be age 55 or older at any time during 2019, you and/or your spouse remain eligible to make a catch-up contribution to an HSA). Make sure you keep in mind any contributions your spouse, or your spouse’s employer, may make to an HSA in determining your contribution level for the year.

Note: There’s an IRS monthly maximum for HSA contributions that comes into play if you’re eligible to contribute to an HSA for fewer than 12 months of the calendar year.

Here’s an example of how it works:
If you contribute the maximum annual amount up front, and subsequently become ineligible to contribute to an HSA (for example, if you terminate your high deductible medical coverage, become covered by a non-high deductible plan (like PPO750), receive certain VA benefits, or become covered by Medicare), any amount that exceeds the prorated monthly contribution would be included in your income and subject to a 10 percent additional tax. There are other special rules that may apply. Contact your personal tax advisor for more information.

Change your HSA contributions at any time.
Follow the instructions in this job aid:
benecontent.massmutual.com/FORMS/Workday_JobAid_HSAContribution.pdf
Keys to HSA success:

- Keep your receipts and all HSA documentation with your tax files.
- Monitor your HSA contributions on myCigna.com to ensure you do not exceed IRS limits.
- View, increase, decrease, start or stop your contributions using Workday throughout the year, if needed.
- Call Cigna with questions at 1-800-548-3980.

View your HSA anytime

Online: You can check your transactions, balance and progress toward your deductible:
- Log on to myCigna.com.

• Choose “Review My Coverage” from menu bar.
• Choose “Health Savings Account (HSA)” from the drop-down menu (view Deductible Tracker on this page).
• Click on “Manage your HSA” (view your contribution and transaction history — and set up payments to providers — from this page).
• “Payroll Deductions” are your contributions.

In the myCigna app:
• On the Home screen, choose “Account Balances” for recent transactions, or “Deductibles” to see your progress toward your deductible and out-of-pocket maximum.

WHAT ARE QUALIFIED HEALTH EXPENSES?

Qualified expenses are expenses for health care, generally as described in Section 213(d) of the Internal Revenue Code (viewable at irs.gov), for which you have not been compensated or reimbursed by insurance or otherwise. Examples of qualified health expenses include expenses incurred before meeting your deductible; coinsurance and copays at doctors’ offices, pharmacies, dentists, vision centers, and medical labs; qualified long-term care insurance premiums and much more — including many treatments and medical supplies that traditional health care plans do not cover.

• For HSA tax rules, see IRS Publication 969.
• For qualified medical expenses, see IRS Publication 502.
• See a user-friendly summary of eligible and ineligible expenses (requires myCigna.com logon).
Limited-use FSA
If you’re enrolled in HSA2000 or HSA1350 and are contributing to a health care flexible spending account (FSA), remember that it’s a limited-use FSA. This means you can only use your FSA to pay for or be reimbursed for qualified dental and vision expenses.

Full-use FSA
If you’re enrolled in PPO750 you may contribute to a full-use FSA, which can be used to pay for or be reimbursed for qualified medical, dental and vision expenses.

Under certain circumstances, a full-use FSA may be available if you’re enrolled in HSA2000 and HSA1350 and receiving Medicare or VA benefits. Contact Advisor Operations with questions.

Using your FSA
While you contribute to your FSA through commission-voucher deductions throughout the year, your total annual election is available as of January 1. You must use your total election on eligible expenses by December 31 or forfeit the balance. If you left the company during the year, you will only be able to submit expenses incurred before you left the company for reimbursement unless you elect to continue your participation through COBRA.

The 2019 health care FSA annual contribution limit is $2,700. Your FSA is administered by WageWorks®.

Confused about what kind of FSA you’re eligible for? See this FSA decision tree.
Finding a behavioral health provider, such as a licensed therapist or counselor, is sometimes challenging in certain geographic areas. To help you find quality care:

- When you call Cigna at 1-800-548-3980, your Cigna customer service representative advocate will do the legwork for you to help find an in-network behavioral health provider that best matches your needs for mental health, substance abuse or the Agent Assistance Program (AAP).
- If an in-network provider isn’t available or doesn’t suit your needs, you can see an out-of-network provider at 20% coinsurance up to the MRC after you’ve met your medical deductible (instead of the usual 30% coinsurance for out of network providers — the plan picks up the difference).
Fertility benefits

MassMutual provides two resources to support your fertility journey: Ovia Health and Progyny

**Ovia Health** is a maternity and family benefit that supports your health and parenting journey with three apps.

- **Ovia Fertility** helps women boost their chances of conceiving with cycle tracking, expert fertility information, and personalized health insights.
- **Ovia Pregnancy** supports healthy pregnancies by providing health and wellness tips, for each phase of your pregnancy, and answers to almost every pregnancy question.
- **Ovia Parenting** provides expert parenting articles, daily guidance based on your child’s age, up to age four, and the ability to share milestones with friends and family.

Download the Ovia Health app from the App Store or Google Play and identify MassMutual as your company.

**Progyny** is a fertility and family-building benefits provider. Only fertility treatment provided by Progyny is covered under HSA1350, HSA2000 and PPO750.

**Progyny’s Smart Cycle** benefit connects you to leading fertility specialists and allows them to provide the most advanced, effective treatment the first time – so you can forgo unnecessary procedures and increase your chance of pregnancy using the course of treatment that is best for you. It includes:

- Coverage for IUI, IVF, egg freezing and more.
- Unlimited guidance and personalized support from a patient-care advocate (a real, live human!) throughout your fertility journey.
- Access to the largest national network of premier fertility physicians.
Progyny has bundled individualized fertility services, tests and treatments into “Smart Cycles.” Plan participants are eligible for a lifetime maximum of two Smart Cycles.

Smart Cycle examples include, but are not limited to:

- Intrauterine insemination (IUI) = ¼ Smart Cycle
- Egg freezing, In Vitro Fertilization (IVF) Freeze All or Frozen Embryo transfer = ½ Smart Cycle each
- IVF Fresh Cycle or IVF Frozen Cycle = 1 Smart Cycle

The bundled Smart Cycle is meant to include everything you need for your treatment so you don’t exhaust your coverage mid-cycle. Each person’s Smart Cycle is individually determined by their physician’s treatment recommendations following an evaluation.

Progyny serves all kinds of parents and families, including single parents, LGBTQ individuals, and same-sex couples.

Progyny also provides information about surrogacy, adoption, and egg and sperm donor services.

Progyny services are subject to your medical option’s deductibles, coinsurance, copays, and other provisions.

To get started or to learn more, call Progyny at 1-833-505-6173.

Only fertility treatment provided by Progyny is covered under HSA1350, HSA2000 and PPO750.

What if I previously met MassMutual’s lifetime fertility benefits maximum?

As of January 1, 2019, everyone covered by a MassMutual medical option will be eligible for the maximum Progyny benefit, regardless of any fertility benefits you used before that date.
ConsumerMedical Cancer Care Program

When the diagnosis is cancer, getting quality care quickly is crucial — and getting expert guidance is key.

ConsumerMedical’s Cancer Care Program offers the following to those with a positive or possible diagnosis of cancer:

- Unlimited access to an oncology nurse who can help you navigate the health care system to get the right care including making calls and appointments on your behalf, if you wish.
- A customized support plan that helps you identify the right facilities, doctors and treatment plan for your diagnosis.
- Integration between ConsumerMedical and Cigna to help you maximize all the resources available to you.

If you or your covered dependent gets a cancer diagnosis, ConsumerMedical will reach out to you, but if you’d like to expedite the process, you can call ConsumerMedical directly.

Note: This program is voluntary — and designed to help you get the best care when you need it most. If you decide to participate and complete the Cancer Care Program, you’ll receive a $300 gift card\(^6\). There is no surcharge for not using this service. Call ConsumerMedical for more information 1-888-361-3944, 8:30 a.m.–11 p.m. ET.

Learn more about all of the services ConsumerMedical provides on page 23.

\(^6\) The $300 gift card is sent to you after you successfully complete the Cancer Quality Care Program. The gift card may be taxable for federal, state and local purposes. Consult your tax advisor about any taxes owed as a result of receipt of the gift card.
Surgery Decision Support
Get informed. Don’t pay more.

If your doctor has recommended voluntary surgery, you may wonder if there are alternatives and where you can find reliable information.

Enter ConsumerMedical. Their Surgery Decision Support program provides personalized information based on objective, peer-reviewed research about your diagnosis and available treatment options.

ConsumerMedical won’t steer you toward or away from a specific treatment. They’ll inform you about risks and benefits to help YOU make the treatment decision that’s right for you. **This information is intended to supplement, not replace, the advice of your doctor.**

You and any covered dependents over age 18 are required to participate in Surgery Decision Support before undergoing certain non-emergency procedures. If you don’t, you’ll pay a $500 surcharge at the time the surgery claim is processed. **Note:** This surcharge will not count toward your deductible or out-of-pocket maximum.

This requirement applies if you have a physician-confirmed diagnosis and a recommendation for one of these non-emergency procedures:

- Knee replacement
- Hip replacement
- Low-back surgery
- Hysterectomy
- Bariatric surgery for weight loss

To avoid the surcharge, you must begin the Surgery Decision Support program at least 30 days in advance of the scheduled surgery and complete a post-program survey.

If you complete the program, no surcharge will apply — regardless of whether or not you have the surgery. And you’ll get a **$300 gift card** from ConsumerMedical!

If you undergo one of the procedures above due to an emergency, the surcharge will not apply. Learn more about all of the services ConsumerMedical provides on page 23.

**YOU are responsible for contacting ConsumerMedical at least 30 days in advance of the surgery at 1-888-361-3944, 8:30 a.m. – 11 p.m. ET. Your doctor will not contact ConsumerMedical for you.**

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7 The $300 gift card is sent to you after you successfully complete the Surgery Decision Support program. The gift card may be taxable for federal, state and local purposes. Consult your tax advisor about any taxes owed as a result of receipt of the gift card.
Extras – With your MassMutual medical coverage

Because you’re enrolled in a MassMutual medical option, you can take advantage of some “extra” services that can add a lot of value to your coverage.

ConsumerMedical® – Your Medical Ally®

MassMutual provides ConsumerMedical services to help you and your covered dependents navigate the health care system to get the best care. ConsumerMedical’s experienced medical researchers can help you:

- Confirm whether the diagnosis you’ve been given is correct
- Understand your treatment options
- Decide if surgery is the right choice for you (see page 22)
- Find leading doctors and hospitals for care
- Get expert guidance finding treatment for a cancer diagnosis (see page 21)
- Shop for the best quality care at the best price
- Obtain remote second opinions from leading specialists
- Resolve medical claims issue

There’s no fee for using ConsumerMedical.

Get started today: 1-888-361-3944 (toll-free) or www.myConsumerMedical.com.

Online registration code for first-time users: MASSMUTUAL

Telehealth services: 24/7 access to a doctor

When you want to consult a doctor for nonemergency care by phone, email or video, HSA1350, HSA2000 and PPO750 participants have access to providers from the Amwell and MDLIVE telehealth network providers.

At an affordable per-session cost, ($45 for MDLIVE and $49 for Amwell) Cigna’s Telehealth services provide affordable, around-the-clock help with routine medical issues like rashes, pinkeye, cough or fever. Because Amwell and MDLIVE are in the Cigna network, it’s treated as an in-network office visit (i.e., subject to the deductible and coinsurance for HSA2000 and HSA1350 and subject to the office-visit copay for PPO750).

Get started today:
In the myCigna app, choose Find Care, then Cigna Telehealth Connection, or go directly to:

AmwellforCigna.com 1-855-667-9722
MDLIVEforCigna.com 1-888-726-3171
‘Maximum Reimbursable Charge’: Is that a thing?

The answer is yes, maximum reimbursable charge, or MRC, is a thing, but only when you use out-of-network services.

If you’re enrolled in HSA1350, HSA2000 or PPO750, when you receive services from an Open Access Plus (OAP) network provider, you’re charged a discounted rate that Cigna has negotiated with their network providers.

However, when you receive services out of network, the maximum reimbursable charge comes into play.

**So what is it?** Cigna’s maximum reimbursable charge (MRC) is the highest charge Cigna allows under its plan for a certain service or product. It’s based on typical charges in a given geographic region for a similar service or supply. Only out-of-network charges are subject to the MRC.

**Here’s how the MRC works.** Remember, this is for out-of-network services only.

**In the deductible phase of coverage:**
- You pay the entire amount of charges subject to the deductible, plus any portion over the maximum reimbursable charge (MRC).
- The portion of the charge within the MRC will count toward your deductible and out-of-pocket maximum.
- Any portion of the bill above the MRC will not count toward your deductible or out-of-pocket maximum.

**In the coinsurance phase of coverage (e.g., you have met your deductible):**
- The plan will pay 70% of the charge up to the MRC (80% for behavioral health).
- You’ll pay 30% of the MRC (20% for behavioral health) — plus any amount over the MRC.
- Any portion of the bill above the MRC will not count toward your out-of-pocket maximum.

**In the plan-pays-all phase of coverage (e.g., you have met your deductible and out-of-pocket maximum):**
- The plan will pay 100% of the charge up to the MRC.
- You pay any amount above the MRC.

**W H A T I F I T’ S A N E M E R G E N C Y ?**

If you have a medical emergency — don’t wait! Get help from the nearest available facility. Emergency health services at in-network facilities are covered at the in-network level. Services at an out-of-network facility will be paid at the in-network level of benefit up to MRC.

**Note:** If you are balance-billed for an out-of-network emergency department claim, call Cigna; they will attempt to negotiate those charges on your behalf.

**Benefit contacts**

Need more information? Contact a benefit carrier or Agent Operations.
Glossary

It’s important that you understand the words that describe how your plan works. We hope these definitions help. For more definitions, visit HealthCare.gov/sbc-glossary.

Coinsurance — A percentage of the cost of service that you’re obligated to pay for certain eligible services. Your coinsurance percentage may vary, depending on whether the service was obtained in-network or out-of-network.

Copay — A set dollar amount that you’re obligated to pay when you receive certain eligible, in-network services.

Deductible — An amount you must pay towards eligible covered services before other plan provisions begin to pay.

Formulary — A list of prescription drugs covered by the plan.

Health savings account — A health savings account is a special kind of tax-advantaged savings account that allows people enrolled in a high deductible health plan to pay for current health care expenses and save for future health care expenses.

Lifetime maximum — The maximum amount, or maximum number of services, that the plan will cover for a certain service over the course of your lifetime.

Mid-year qualifying event or life event — An event that affects your need for benefits coverage — for instance, getting married, divorced, having a baby, adopting a child, or losing or gaining coverage due to a change in your spouse or domestic partner’s employment.

Network — A plan administrator (i.e., Cigna) contracts with providers and services (i.e., doctors, hospitals, etc.) to steer plan participants to those providers and services. In exchange, these providers agree to charge plan participants negotiated rates, which are less than the rates charged to others using the same provider.

- In-network — If a provider is in-network, they’ve agreed to the plan’s negotiated rates. In addition, the plan will typically provide more favorable provisions for seeing an in-network provider. For example, in MassMutual’s plan, if you go to an in-network provider, your share of the coinsurance for seeing an in-network provider is less and you will typically pay less money because you’ll also be getting the provider’s negotiated rate.

- Out-of-network — If the provider has not agreed to the plan’s negotiated rates, that provider will be an out-of-network provider. The plan typically provides less favorable provisions for seeing an out-of-network provider. For example, in MassMutual’s plan, your share of the coinsurance for seeing an out-of-network provider is generally more than when you see an in-network provider. So in addition to not getting the plan’s negotiated rates, you’ll pay a higher percentage of the charges.

continued next page>
• **Maximum reimbursable charge** — Cigna’s maximum reimbursable charge (MRC) is the highest charge Cigna allows under the plan for a certain service or product. It’s based on typical charges in a given geographic region for a similar service or supply. Only out-of-network charges are subject to the MRC.

  **Out-of-pocket maximum** — This is the maximum amount you will pay out of pocket for in-network covered expenses in a calendar year.

  **Preventive care** — Routine health care, including certain screenings or check-ups to prevent or discover illness, disease or other health problems. Medical services that are considered preventive by the federal government are covered at 100% (no deductible or coinsurance). To see a list of preventive care services that are covered at 100%, see Cigna’s Preventive Care Guide.

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For more definitions, visit [HealthCare.gov/sbc-glossary](http://HealthCare.gov/sbc-glossary).