

Caring for Your Health: Medical Coverage

- The **PPO \$1000** and **PPO \$1500** are national Preferred Provider Plans using the Harvard Pilgrim Healthcare network in New England and the United Healthcare Network nationwide. With these plans you will not need a referral to see a specialist. You receive the highest level of coverage by using In-Net-work providers and risk much higher out of pocket costs when using Out-of-Net-work providers.
- The **HMO \$1000** requires exclusive In-Network use of providers in New England and offers no coverage for Out-of-Network providers. Participants are required to select a primary care physician (PCP) and use referrals for additional services.
- All plans include an **HRA** that partially covers the deductibles.
- *Important note:* For the PPO plans, balance billing is not covered by the Out-of-Pocket Maximum. This means that if you use an out-of-network provider, you may be billed the balance in addition to the 20% co-insurance.

Summaries of Benefits and Coverage (SBCs) for your health insurance are available online at <https://karyopharm.sharepoint.com/sites/humanresources> or online with your benefits enrollment in Sage. You can also request to receive a copy at benefits@Karyopharm.com



KPTI knows that each family is different, so we offer multiple benefit options to make sure you have the protection you need, as well as additional opportunities to save.

Caring for Your Health: Medical Coverage

Medical Service	HMO \$1,000		PPO \$1,000		PPO \$1,500	
	In-Network (New England) ONLY You Pay		In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Karyopharm contribution to HRA	\$1,000 Individual, \$2,000 Individual+1 and Family					
Plan Year Deductible	\$1,000 Individual \$2,000 Individual +1 and Family		\$1,000 Individual \$2,000 Individual +1 and Family		\$1,500 Individual \$3,000 Individual +1 and Family	
Plan Year Out of Pocket Maximum	\$6,600 Individual, \$13,200 Individual+1 and Family					
Preventive doctor visits	Covered in Full		Covered in Full	20% coinsurance after Deductible	Covered in Full	20% coinsurance after Deductible
Doctor Visit	\$25 / \$30 Co-pay		\$25 / \$30 Co-pay	20% coinsurance after Deductible	\$25 / \$30 Co-pay	20% coinsurance after Deductible
Diagnostic Tests and Imaging	Covered in full after Deductible		Covered in full after Deductible	20% coinsurance after Deductible	Covered in full after Deductible	20% coinsurance after Deductible
Inpatient Hospital	Covered in full after Deductible		Covered in full after Deductible	20% coinsurance after Deductible	Covered in full after Deductible	20% coinsurance after Deductible
ER visit	\$100 Co-pay after Deductible (waived if admitted for 24 hours)		\$100 Co-pay after Deductible (waived if admitted for 24 hours)		\$100 Co-pay after Deductible	
Behavioral Health	\$25 Co-pay		\$25 Co-pay	20% coinsurance after Deductible	\$25 Co-pay	20% co-insurance
Retail Prescriptions (30 day supply)	\$5/\$20/\$30/\$50		\$5/\$20/\$30/\$50		\$5/\$20/\$30/\$50	

Caring for Your Health: Medical Coverage Prescription Drugs



PRESCRIPTION DRUG COVERAGE TIERS

There are four levels of coverage with different copays for each

- **Tier 1:** Selected generic drugs that are equivalent to brand name drugs and your cheapest option
- **Tier 2:** Brand name drugs that do not have a generic equivalent and some high-cost generic drugs
- **Tier 3:** Brand name drugs that have a generic option and some lower cost specialty drugs
- **Tier 4:** Specialty drugs and high-cost brand name drugs that have a generic option

You can visit harvardpilgrim.org/rx and choose *Value 4-Tier* to review covered drugs with Optum.

All Plans	Coverage and Cost
Tier 1 - Generic 30-day supply Mail Order: 90 day supply	\$5 Co-pay \$10 Co-pay
Tier 2 - Brand name no generic 30-day supply Mail Order: 90 day supply	\$20 Co-pay \$40 Co-pay
Tier 3 - Preferred brand name 30-day supply Mail Order: 90 day supply	\$30 Co-pay \$60 Co-pay
Tier 4 - Non-preferred brand name 30-day supply Mail Order: 90 day supply	\$50 Co-pay \$150 Co-pay

FORMULARY EXCEPTIONS

Step Therapy: Some medications on your plan require that you take a generic equivalent before taking the brand name. Once you have tried the generic, your doctor can request an exception for the brand name drug from Optum.

Prior Authorization: Some medications on your plan require that your doctor explain the medically necessary reason for the prescription. Your doctor can contact Optum directly to request the authorization. Your providers can contact Optum at 855-258-1561.



All KPTI's medical plans include prescription drug coverage through Optum. These benefits include prescription medication provided either by a retail pharmacy (30-day supply) or by mail order (90-day supply).

**With mail order you
get 3 months supply
for the price of 2!**



When you enroll in one of our medical plans, KPTI provides a Health Reimbursement Account (HRA) that automatically funds a portion of your deductible when you use the plan.

This benefit is administered by HRC Total Solutions.

Always wait to receive an Explanation of Benefits before paying any provider bills.

Caring for Your Health: Medical Coverage

EMPLOYER-FUNDED HEALTH REIMBURSEMENT ACCOUNT

When you use the medical plan to see a physician, purchase prescription drugs, have a test, etc. Karyopharm's Health Reimbursement Account partially covers your deductible, if needed, as follows:

- \$1,000 for Individual coverage
- \$2,000 for Employee + 1 and Family coverage

How deductible is used to pay claims

- Your provider bills Harvard Pilgrim after your visit
- Harvard Pilgrim pays your claim less any deductible
- Harvard Pilgrim sends your claim to HRC
- HRC pays the deductible amount directly to your provider

Bottom line? Always wait to receive an Explanation of Benefits from Harvard Pilgrim Health Care and wait for everything to be paid through your insurance before paying any bills. If the "your responsibility" amount on your EOB is only for the deductible, wait at least a month's billing cycle for HRC to pay the deductible amount due.

If you have further questions you can call Benefits Concierge at (877) 835-1361 or csclaims@nfp.com for help with your claims questions.

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ADDITIONAL BENEFITS COVERAGE:

Chiropractic: 12 visits per year, \$30 copay In-Network

Acupuncture: 20 visits per year, \$30 copay In-Network

Annual Routine Eye Exam: \$25 copay In-Network

OTHER BENEFITS:

Your dollars go further with your Harvard Pilgrim card. Discover many great savings on products and services to help you keep fit, healthy and well.

Here are some ways you can save:

- Fitness Reimbursement benefit
- Generous discounts on eye-wear (frames, lenses, supplies, laser correction surgery)
- Healthy discounts with nutrition programs, fitness & sports clubs, athletic footwear, health & fitness magazine subscriptions, exercise DVDs & videos, hearing aids and more

TELEMEDICINE:

Harvard Pilgrim Health Care has partnered with Doctor on Demand (DoD) to ensure members will have access to virtual consultations for medical conditions that can be treated through video visits. With Telemedicine, you can see a doctor anywhere you have online access, including your home, workplace, or wherever else you may be.

- Real-time interactive access to have a virtual visit with a doctor through DoD's network
- On-demand medical consultations, available 24/7
- You are covered to receive virtual visits, or telemedicine/telemental health, urgent medical care and routine behavioral health care using live video on a smartphone, tablet or computer
- Visits are typically subject to the applicable outpatient office visit cost sharing



KPTI embraces wellness in all forms and ensures additional Benefits Coverage is available with Harvard Pilgrim Healthcare enrollment for things like acupuncture, nutrition programs, and Doctor on Demand.



KPTI's dental benefit plan is designed to cover a portion of your dental expenses after you meet an annual deductible (except for Preventive services paid at 100%).

Caring for Your Health: Dental Coverage

DELTA DENTAL PPO COVERAGE

DELTA DENTAL PPO COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Diagnostic/Preventive (Type I) (Exams, Teeth Cleaning)	100%	100%
Basic Restorative (Type II) (Fillings, Extractions, Root Canals)	85%	80%
Major Restorative (Type III) (Crowns, Dentures)	55%	50%
Deductible (For Types II & III, waived for Type I)	\$50 per Individual/ \$150 per Family	
Calendar Year Maximum (Type I, II, III)	\$1,500	
Orthodontics Lifetime Maximum	Covers 50% up to \$1,500 per Individual	

*Subject to reasonable and customary charges when seeking care outside of network.

The Delta Dental PPO plan provides access to Delta Dental's extensive national networks of dentists offering great discounts for you and your family

Caring for Your Health: Dental Coverage

ROLLOVER MAXIMUM

This valuable benefit feature allows you to roll over a portion of your unused spending to increase your maximum benefit limit next year, and beyond. So, you can save and accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future—such as bridges, crowns, and root canals.

Your plan includes a Rollover Maximum - \$500 of your calendar maximum will rollover from one plan year to the next if:

- you receive at least one cleaning or oral exam in the plan year
- you are enrolled for dental coverage before the 4th quarter of the calendar year
- your paid claims do not exceed the maximum “threshold” amount

(Rollover Max dollars do not apply to orthodontic services.)

Your calendar year maximum benefit amount.	If your total yearly claims don't exceed this threshold amount...	If your total yearly claims don't exceed this threshold amount...	Your accumulated rollover total is capped at this amount.
\$1,500	\$700	\$500	\$1,250



Rollover Max increases your dental benefit value. You get more flexibility in planning and paying for your dental care, as well as the peace of mind knowing you have more benefits, if you need them, when you need them. Best of all, Rollover Max comes as part of your Delta Dental coverage. There's no additional fee.



KPTI provides a vision plan through VSP, with coverage for annual comprehensive eye exams as well as benefits towards the purchase of eyeglasses or contact lenses.

Caring for Your Health: Vision Coverage

DELTA DENTAL PPO PLUS PREMIER COVERAGE

VISION SERVICE	IN-NETWORK	OUT-OF-NETWORK
Well Vision Exam	\$10 Copay (1 every 12 months)	\$10 Copay Up to \$55
Prescription Glasses (lenses and/or frames)	\$25 Copay	\$25 Copay
Lenses (every 12 months)	(Included in Prescription Glasses Copay) Single Vision Lined Bifocal Lined Trifocal	Single Vision – Up to \$50 Lined Bifocal – Up to \$75 Lined Trifocal – Up to \$100
Frames (every 24 months)	(Included in Prescription Glasses Copay) \$140 allowance \$160 allowance for featured brands	Up to \$70
Contacts (instead of glasses, every 12 months)	Contact lens exam (fitting and evaluation) Copay up to \$60 \$140 allowance	Up to \$105

Save with VSP! VSP offers additional savings through Exclusive Member Extras, including discounts on featured frame brands and savings on LASIK! For more great offers, visit vsp.com/specialoffers.