2024 PROGRAMS AND PREMIUMS

Harvard Business Publishing

AT A GLANCE

HARVARD
Human Resources

WELCOME TO YOUR
HARVARD UNIVERSITY BENEFITS!

At Harvard, we are committed to offering an array of benefits that are part of your generous total rewards package. We encourage you to take the time to review your benefit options so that you can make the best choices for you and your family. And remember: **You have 30 days from your date of hire or qualifying life event to make your benefit elections**.

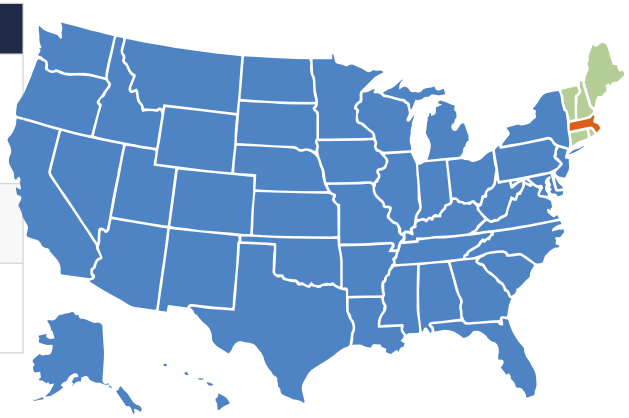
2024 HEALTH PLANS (HUGHP AND BCBSMA)

Harvard offers subsidized medical coverage from Harvard University Group Health Plan (HUGHP) and Blue Cross Blue Shield of MA (BCBSMA). You may select employee, employee plus spouse/domestic partner, employee plus child(ren), or family coverage from the following types of plans:

- **Health Maintenance Organization (HMO)—**With an HMO, you select a primary care provider (PCP) who coordinates your care and can provide you with referrals to in-network specialists. Out-of-network care is not covered, except in certain emergency situations.
- **Point-of-Service (POS)—**As with an HMO, you designate a PCP. However, you have the flexibility to use out-of-network providers with higher out-of-pocket costs.
- **POS Plus—**With the same benefits as a traditional POS, the POS Plus plan has higher premiums and a higher out-of-pocket maximum in exchange for no deductible or coinsurance for in-network services.
- **High Deductible Health Plan (HDHP)—**This plan is offered through BCBSMA. It features lower premiums and higher deductibles than the HMO or POS plans and is offered in conjunction with a Health Savings Account. Except for in-network preventive care (for example, annual physicals and preventive screenings), **you'll pay the full cost of all services, including prescriptions (excluding certain medications used to treat chronic conditions), until you reach your deductible**. If you have family coverage, you need to meet the entire family deductible before the plan begins paying. In-network and out-of-network costs can be combined to satisfy the deductible.
- **Preferred Provider Organization (PPO)—**This plan, offered through BCBSMA, is available only to subscribers who reside outside New England. With this plan, you can go to any health care professional you choose, in or out of the network, without a PCP referral. You will have higher out-of-pocket costs for out-of-network care.
- **PPO Plus—**This plan, offered through BCBSMA, is available only to subscribers who reside outside New England. It offers the same benefits as a traditional PPO but has higher premiums and a higher out-of-pocket maximum in exchange for no deductible or coinsurance for in-network services.

MEDICAL PLAN ELIGIBILITY BY REGION

IF YOU LIVE HERE:	YOU ARE ELIGIBLE FOR:	
Massachusetts	BCBSMA HMO BCBSMA POS BCBSMA POS Plus BCBSMA HDHP	HUGHP HMO HUGHP POS HUGHP POS Plus
Rest of New England (CT, ME, NH, RI, VT)	BCBSMA HMO BCBSMA POS	BCBSMA POS Plus BCBSMA HDHP
Outside of New England	BCBSMA PPO BCBSMA PPO Plus BCBSMA HDHP	



COMPARE YOUR MEDICAL PLANS

IN-NETWORK	HMO	POS PPO*	POS PLUS PPO PLUS*	HDHP†
DEDUCTIBLE				
Per Individual	$250	$250	None	$1,700
Family Maximum	$750	$750	None	$3,400‡
OUT-OF-POCKET (OOP) MAXIMUM				
Per Individual	$1,500	$1,500	$2,000	$3,400
Family Maximum	$4,500	$4,500	$6,000	$6,800‡
MEMBER COSTS				
Inpatient Hospital	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Fully covered, no OOP cost to member	Deductible, then 15% coinsurance
Emergency Room	$100 copay	$100 copay	$100 copay	Deductible, then 15% coinsurance
Preventive Care as Defined by Affordable Care Act	Fully covered, no OOP cost to member	Fully covered, no OOP cost to member	Fully covered, no OOP cost to member	Fully covered, no OOP cost to member
Office Visits—PCP & Specialist	$30 copay	$30 copay	$30 copay	Deductible, then 15% coinsurance
Telehealth via Well Connection (and any network provider for behavioral health)	$15 copay	$15 copay	$15 copay	Deductible, then 15% coinsurance
Physical/Occupational Therapy (limited to 100 visits per calendar year)	$30 copay	$30 copay	$30 copay	Deductible, then 15% coinsurance
Chiropractic Care (limited to 18 visits per calendar year)	$30 copay	$30 copay	$30 copay	Deductible, then 15% coinsurance
Acupuncture (limited to 20 visits per calendar year)	$30 copay	$30 copay	$30 copay	Deductible, then 15% coinsurance
High-Tech Imaging (MRI, PET scan, CT scan, etc.)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Fully covered, no OOP cost to member	Deductible, then 15% coinsurance
Mental Health/Substance Misuse	Inpatient: deductible, then 10% coinsurance Outpatient: $30 copay Telehealth: $15 copay	Inpatient: deductible, then 10% coinsurance Outpatient: $30 copay Telehealth: $15 copay	Inpatient: fully covered Outpatient: $30 copay Telehealth: $15 copay	Deductible, then 15% coinsurance
Outpatient Diagnostic Labs/ X-Rays	Fully covered, no OOP cost to member	Fully covered, no OOP cost to member	Fully covered, no OOP cost to member	Deductible, then 15% coinsurance

* Available only through BCBSMA for employees who reside outside New England.
† Under the HDHP, amounts paid for both in-network and out-of-network care can be combined to satisfy the deductible.
‡ Under the HDHP (for all coverage levels other than individual), you must meet the full family deductible before coinsurance begins for any individual, and you must reach the full family out-of-pocket maximum before costs are covered in full for any individual. Note: this is different from the HMO, POS, and PPO plans.

COMPARE YOUR MEDICAL PLANS

OUT-OF-NETWORK	POS PPO*	POS PLUS PPO PLUS*	HDHP†
DEDUCTIBLE			
Per Individual	$750	$750	$1,700
Family Maximum	$2,500	$2,500	$3,400‡
OUT-OF-POCKET MAXIMUM			
Per Individual	$2,500	$2,500	$6,800
Family Maximum	$7,500	$7,500	$13,600‡
MEMBER COSTS			
Member-Paid Coinsurance	30% after out-of-network deductible	30% after out-of-network deductible	35% after out-of-network deductible
Mental Health Coinsurance	Inpatient: deductible, then 30% Outpatient: 20%, no deductible	Inpatient: deductible, then 30% Outpatient: 20%, no deductible	Deductible, then 35%

* Available only through BCBSMA for employees who reside outside New England.
† Under the HDHP, amounts paid for both in-network and out-of-network care can be combined to satisfy the deductible.
‡ Under the HDHP (for all coverage levels other than individual), you must meet the full family deductible before coinsurance begins for any individual, and you must reach the full family out-of-pocket maximum before costs are covered in full for any individual. Note: this is different from the HMO, POS, and PPO plans.

MONTHLY RATES FOR 2024

	EMPLOYEE COST				HBP CONTRIBUTION			
	EMPLOYEE	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	FAMILY	EMPLOYEE	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	FAMILY
HMO								
HUGHP*	$158.22	$406.41	$411.22	$417.31	$616.78	$1,584.59	$1,515.78	$1,723.69
BCBSMA	$162.93	$418.77	$405.25	$429.75	$635.07	$1,631.23	$1,578.75	$1,775.25
POS								
HUGHP*	$167.20	$428.89	$415.14	$440.69	$651.80	$1,672.11	$1,618.86	$1,820.31
BCBSMA	$171.92	$441.25	$427.05	$453.14	$671.08	$1,719.75	$1,663.95	$1,871.86
POS Plus								
HUGHP*	$193.84	$497.85	$481.71	$514.44	$642.16	$1,647.15	$1,594.29	$1,794.56
BCBSMA	$199.45	$511.64	$494.99	$528.66	$659.55	$1,693.36	$1,639.01	$1,844.34
HDHP								
BCBSMA	$54.35	$139.86	$135.35	$150.47	$677.65	$1,744.14	$1,687.65	$1,875.53
PPO†								
BCBSMA	$171.92	$441.25	$427.05	$453.14	$671.08	$1,719.75	$1,663.95	$1,871.86
PPO Plus†								
BCBSMA	$199.45	$511.64	$494.99	$528.66	$659.55	$1,693.36	$1,639.01	$1,844.34

* HUGHP is available only to subscribers who reside in Massachusetts. In-network adult primary care providers are primarily located in Eastern Massachusetts.
† Available only to subscribers who reside outside of New England.

PRIMARY CARE PROVIDER (PCP) NETWORKS

Before selecting a plan, confirm that your preferred PCP is in-network. See the back page for contact information.

PLAN	PCP NETWORK
HUGHP HMO, POS, POS Plus	**Adult** • Harvard University Health Services (HUHS) • Atrius Health Locations **Pediatric** • Any HMO Blue MA Network pediatrician or family medicine practitioner, including Mt. Auburn Pediatrics and Atrius Health
BCBSMA* HMO, POS, POS Plus	• HMO Blue New England
BCBSMA* PPO and PPO Plus	• BCBS PPO/EPO Network
BCBSMA HDHP	• BCBS PPO/EPO Network • HUHS Locations

* Cannot have primary care provider at HUHS

MONTHLY RATES FOR 2024 (CONTINUED)

TOTAL PREMIUM			
EMPLOYEE	**EMPLOYEE + SPOUSE/DP**	**EMPLOYEE + CHILD(REN)**	**FAMILY**
$775.00	$1,991.00	$1,927.00	$2,141.00
$798.00	$2,050.00	$1,984.00	$2,205.00
$819.00	$2,101.00	$2,034.00	$2,261.00
$843.00	$2,161.00	$2,091.00	$2,325.00
$836.00	$2,145.00	$2,076.00	$2,309.00
$859.00	$2,205.00	$2,134.00	$2,373.00
$732.00	$1,884.00	$1,823.00	$2,026.00
$843.00	$2,161.00	$2,091.00	$2,325.00
$859.00	$2,205.00	$2,134.00	$2,373.00

PRESCRIPTION DRUG COSTS

	PREVENTIVE MEDICATIONS LIST		ALL OTHER DRUGS*	
	Retail at Participating Pharmacy (up to 30-day supply)	Mail Order Through Express Scripts (up to 90-day supply)	Retail at Participating Pharmacy (up to 30-day supply)	Mail Order Through Express Scripts (up to 90-day supply)
Generic	$0	$0	$7	$14
Preferred Brand	$10	$25	$20	$50
Non-Preferred Brand	N/A	N/A	$45	$110

* Unlike with the other plans, if you enroll in HDHP coverage, you must meet the deductible before these prescription copayments apply. If you have one of the HDHP family coverage levels, you must meet the full family deductible before these prescription drug copayment costs apply. You do not need to satisfy the deductible to receive the drugs on the preventive medications list at the copays listed above. Per IRS guidelines, only drugs on preventive medication lists may bypass the deductible.

DENTAL PLAN PREMIUMS

MONTHLY COST	
EMPLOYEE	$18
EMPLOYEE + SPOUSE/DP	$47
EMPLOYEE + CHILD(REN)	$46
FAMILY	$49

VISION PLAN PREMIUMS

MONTHLY COST	
EMPLOYEE	$6.03
EMPLOYEE + SPOUSE/DP	$14.72
EMPLOYEE + CHILD(REN)	$13.70
FAMILY	$17.08

LONG TERM DISABILITY INSURANCE PREMIUMS

FTE SALARY TIER	ANNUAL COST PER $100 OF SALARY
LESS THAN $15,000	$0.201
$15,000–$69,999	$0.229
$70,000–$94,999	$0.494
$95,000 AND ABOVE	$0.623

LEGAL PLAN

MONTHLY COST OF COVERAGE

$16.50

IDENTITY THEFT PROTECTION

MONTHLY COST OF COVERAGE

Individual	$9.95
Family*	$17.95

* Those you financially support or who live under your roof are covered under the family plan.

SUPPLEMENTAL LIFE INSURANCE PREMIUMS

COST PER COVERED INDIVIDUAL (EMPLOYEE, SPOUSE/DP)	
AGE	**MONTHLY COST PER $1,000 OF INSURANCE***
< 25	$0.022
25–29	$0.025
30–34	$0.029
35–39	$0.035
40–44	$0.043
45–49	$0.064
50–54	$0.099
55–59	$0.156
60–64	$0.199
65–69	$0.363
70–74	$0.578
75–79	$1.061
80+	$1.518

* Based on age of employee, not age of spouse/DP.

COST OF COVERAGE FOR DEPENDENT CHILD(REN)*	
COVERAGE AMOUNT	**MONTHLY COST OF COVERAGE**
$5,000	$0.455
$10,000	$0.910

* One monthly premium covers all of your eligible children.

BENEFITS CONTACTS

Have questions or need more information about your benefits? Here's where you can find more information and answers. Remember: You can always find the latest benefits contact information at **hr.harvard.edu/vendor-contacts**.

TOPIC	WHOM TO CONTACT	PHONE	ONLINE
General Benefits Questions	Benefits Office	617-496-4001	hr.harvard.edu/health-welfare-benefits benefits@harvard.edu
Dental Coverage	MetLife Dental	855-638-3941	metlife.com/Harvard-Dental
Disability—Short Term and Long Term	Lincoln Financial Group	844-600-3978 (toll-free Harvard-dedicated line)	MyLincolnPortal.com
Flexible Spending Accounts—Health Care, Dependent Care, Limited Purpose **Health Savings Account**	Voya Financial	855-HVD-FLEX 855-483-3539 (F) 603-232-1854	presents.accp.voya.com/content/delivers/harvard hvdflex@voya.com
Identity Theft Protection	Allstate	800-789-2720	allstateidentityprotection.com
Legal Plan	MetLife Legal Plans	800-821-6400	info.legalplans.com
Life Insurance	MetLife	800-638-6420 (prompt 1)	metlife.com
Long Term Care Insurance	Genworth Life Insurance Company	800-416-3624	genworth.com/harvard
Medical Coverage Questions—Service Areas, Costs, Provider Networks, Emergency Coverage, and Referrals	HUGHP: HMO, POS, and POS Plus	617-495-2008	hughp.harvard.edu
	BCBSMA: HMO, POS, POS Plus, HDHP, PPO, and PPO Plus	888-389-7732	bluecrossma.com
Prescription Drug Coverage	Express Scripts	877-787-8684	express-scripts.com
Reimbursement Program	Voya Financial	855-HVD-FLEX 855-483-3539 (F) 603-232-1854	presents.accp.voya.com/content/delivers/harvard hvdflex@voya.com
Tax-Deferred Annuity Plan and Retirement Programs	Harvard University Retirement Center	800-527-1398	hr.harvard.edu/retirement
	TIAA (including financial/retirement planning, one-on-one appointments, and planning tools)	800-527-1398 Appointments: 800-732-8353	tiaa-cref.org tiaa.org/schedulenow
Tuition Reimbursement Program	Refer to the HBP Employee Guidebook or contact your local human resources office for details.		
Vision Care	EyeMed	866-804-0982	eyemed.com

The information in this document is a summary of Harvard's benefits, and every attempt has been made to ensure its accuracy. The actual provisions of each benefit program will govern if there is any inconsistency between the information in this document and Harvard's formal plans, programs, policies, or contracts or any subsequent change in such plans, programs, policies, or contracts.