

HARVARD MEDICAL FACULTY PHYSICIANS
AT BETH ISRAEL DEACONESS MEDICAL CENTER, INC.

With our community affiliates

ASSOCIATED PHYSICIANS OF HARVARD MEDICAL FACULTY PHYSICIANS AT BIDMC, INC.

Affiliated with



Beth Israel Deaconess
Medical Center



Harvard Medical School

Summary Plan Description

Health & Welfare Plans

Effective January 1, 2019





Table of Contents

- 1.0 INTRODUCTION 7
 - 1.1 Benefits Overview 7
 - 1.2 How Your Benefits Are Paid For? 7
 - 1.3 Important Notice Regarding Employer Contributions 8
- 2.0 AM I ELIGIBLE FOR BENEFITS? 8
 - 2.1 Benefit Eligibility 8
 - 2.2 Other Eligibility 8
 - 2.3 Who You May Cover 8
- 3.0 HOW TO ENROLL OR MAKE CHANGES IN BENEFITS 9
 - 3.1 Benefit Election Requirements 9
 - 3.2 Initial Benefit Enrollment 9
 - 3.3 Enrollment Deadlines 9
 - 3.4 What Happens If I Miss the 30-day Enrollment Period? 9
 - 3.5 Changing Benefits during the Year 9
- 4.0 WHEN DOES COVERAGE BEGIN OR END 10
 - 4.1 Coverage Start Dates 10
 - 4.2 Coverage End Dates 11
 - 4.3 Loss of Benefits 11
- 5.0 WHAT ARE MY BENEFITS? 11
 - 5.1 Health Insurance – Live Healthy 11
 - 5.2 Dental Insurance 15
 - 5.3 Vision Care Insurance 16
 - 5.4 Flexible Spending Accounts (FSAs) 16
 - 5.5 Health Savings Account (HSA) 17
 - 5.6 Disability Insurance 18
 - Supplemental Disability Options 19
 - Cost of the plan 19
 - Absence from work 19
 - Maximum benefit period 19
 - Impact on other benefits 20
 - 5.7 Life Insurance 20

Additional Life Insurance Information	22
What Happens If I Terminate?	22
Obtaining Additional Information.....	22
Guaranteed Insurance Amounts.....	23
5.8 Global Benefits Plan	24
Eligibility.....	24
Enrollment	24
6.0 OTHER BENEFIT PROGRAMS	26
6.1 Clinician Health Services	26
6.2 Child & Family Resources.....	26
6.3 Group Personal Excess Liability Insurance	27
6.4 Travel Assistance.....	27
6.5 Will Preparation and Legal Services.....	27
6.6 Legacy Planning Services.....	28
6.7 Harvard Real Estate Advantage Program.....	28
6.8 Harvard Club of Boston	28
7.0 YOUR ERISA RIGHTS	29
Continued Group Health Plan Coverage.....	29
Prudent Actions by Plan Fiduciaries.....	29
Enforce Your Rights.....	29
Assistance with your Questions	30
Amendment or Termination of Plan	30
7.1 FILING A CLAIM FOR BENEFITS – HEALTH PLANS.....	30
Who determines my benefits?.....	31
How will I know what action has been taken on my claim?	31
What do I do if my claim is denied?.....	32
Can I use arbitration to settle the claim disputes?	33
7.2 TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW	33
7.3 FILING A CLAIM FOR BENEFITS – PENSION PLANS.....	33
7.4 FILING A CLAIM FOR BENEFITS - DISABILITY	34
7.5 ERISA CLAIM PROCEDURES - OTHER WELFARE PLANS	36
8.0 REQUIRED NOTICES.....	37

8.1 Health Insurance Marketplace Notice	37
8.2 COBRA Rights and Responsibilities Notice.....	39
8.3 HIPAA Notice of Special Enrollment Rights.....	42
8.4 Certificate of Coverage under Group Health Plans Notice	44
8.5 Notice of Creditable Coverage	45
8.6 Loss or Gain of Eligibility for a State Children’s Health Insurance Program (CHIP) or Medicaid	47
Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families	47
8.7 Women’s Health and Cancer Rights Act (WHCRA) Notice.....	50
8.8 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	50
8.9 Michelle’s Law Enrollment Notice	51
8.10 Newborns’ and Mothers’ Protection Act of 1996 Notice (NMHPA)	51
8.11 Genetic Information Nondiscrimination Act (GINA) Notice	51
8.12 Notice of Right to Designate a Primary Care Provider (PCP)	51
8.13 Uniformed Services Employment & Reemployment Rights Act (USERRA).....	52
8.14 Qualified Medical Child Support Order (QMCSO) Notice	52
8.15 Massachusetts Identity Theft Law Notice.....	53
8.16 Earned Sick Time — Notice of Employee Rights	53
9.0 ADMINISTRATIVE INFORMATION	53
The Plan Administrator	53
The Plan Sponsor.....	53
Plan Types, Names and Numbers	53
HMFP & APHMFP	54
Administration	54
Participating Employers	54
Plan Year	54
Future of the Plan	54
No Guarantee of Employment.....	54
Additional Information.....	54
Sources of Plan Contributions.....	54
9.1 Privacy of Health Information.....	55
9.2 Notice of Privacy Practices.....	55

9.3 How Your Health Information May be Used or Disclosed	56
9.4 Your Health Information Rights	56
Request Restriction on Uses and Disclosures of Your PHI	56
Inspect and Obtain a Copy of Your Health Records	57
Amend Your Health Records	57
Request Confidential Communications	57
Authorize Release of Your PHI for Purposes Not Otherwise Permitted By Law	57
Request Accounting of Disclosures of Your PHI	57
Receive a Notice of a Security Breach	57
Obtain a Paper Copy of this Notice Upon Request	57
Complaints	58
Obligations of the Plan	58
Contact Information	58
9.6 Sources of Plan Contributions and Election of Benefits	58
9.7 Tax Consideration	58
9.8 Third Party Liability	58
9.9 Responsibility for Goods/Services	59
9.10 Additional Documentation	59
9.11 Agent for Service of Legal Process	59
10.0 HOW TO CONTACT US AND OUR VENDORS	59
10.1 Contact Human Resources & Benefits Team	59
10.2 VENDOR CONTACT INFORMATION	60

1.0 INTRODUCTION

1.1 Benefits Overview

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (HMFP) and Associated Physicians of Harvard Medical Faculty Physicians at BIDMC, Inc. (APHMFP), collectively (HMFP-APHMFP) are committed to helping you plan well and live well. That’s why we offer an array of competitive benefits that are designed to help you live your best life. From medical plans and retirement programs to child care and family resources, you’ll have the services and support you need to take care of yourself—and your family.

HMFP-APHMFP offers the following benefit programs. Some programs you’re automatically enrolled in while others require you to opt in or meet certain eligibility requirements. Benefits are an important part of your total compensation package.

Company Provided Benefits:

Term Life Insurance	Business Travel Insurance	Basic Group Universal Life Insurance/Variable Life Insurance (application required)
Short Term Disability	Long Term Disability	Personal Excess Liability Insurance

Additional Benefit Options:

Medical/Rx	Dental	Vision Care
Supplemental Group Universal Life Insurance or Variable Life Insurance	Spousal & Dependent Life	Accidental Death & Dismemberment
FlexChoice Limited Purpose Health Care	FlexChoice FSA Health Care	FlexChoice FSA Dependent Care
Health Savings Account	Supplemental Disability	Supplemental Personal Excess Liability Insurance
Global Benefits		

1.2 How Your Benefits Are Paid For?

As allowed by the Internal Revenue Service (IRS), your share of the costs for certain benefits may be deducted from your pay on a pre-tax basis while other benefits are paid for with after-tax dollars. When paid for on a pre-tax basis it save you significant money by reducing your taxable income. These include:

Medical/Rx	Dental	Vision Care
Limited Purpose FlexChoice Health Care	FlexChoice FSA Health Care	FlexChoice FSA Dependent Care
Health Savings Account	Global Benefits	

1.3 Important Notice Regarding Employer Contributions

Certain contributions are funded by your department. Departments have the authority to allocate department expenses to individual profit and loss statements (P&L). You're encouraged to discuss with your division administrator how these allocations will impact you. From time to time, the cost and/or value of the employer-provided premiums are required by the Internal Revenue Service (IRS) to be added to your W-2 earnings for tax purposes. This is known as imputed income. Examples of these benefits include employer-sponsored disability, parking, T-pass, and certain life and umbrella liability insurance programs.

2.0 AM I ELIGIBLE FOR BENEFITS?

2.1 Benefit Eligibility

Benefits are available to you if you're regularly scheduled to work at least 20 hours or more each week. Participation begins on the first of the month following or coinciding with employment or transfer into a benefits-eligible position and completion of required applications. Temporary and per diem employees aren't program-eligible regardless of the number of hours worked per week.

2.2 Other Eligibility

In order to meet Affordable Care Act requirements, an individual not otherwise eligible for health care benefits under the Plan may, at the discretion of the employer, be treated as benefits-eligible for purposes of medical plan enrollment. Contact the [Benefits Team](#) if you have questions regarding your eligibility status.

2.3 Who You May Cover

For the purposes of health, dental and certain life insurance products, you may choose to cover yourself, yourself and one dependent, or yourself and your family. Eligible members generally include:

- Your legally married spouse
- Your children (a son, daughter, stepchild, adopted child, (including children placed for adoption and foster children), in most cases, up to the end of the month following their 26th birthday
- For health and dental only, disabled children who are dependent upon you for support even if they're older than age 26, provided they were disabled before their 26th birthday and meet the eligibility and medical criteria

3.0 HOW TO ENROLL OR MAKE CHANGES IN BENEFITS

3.1 Benefit Election Requirements

You have 30 days from your hire date, the date you are first eligible for benefits, or the date of an IRS-defined change in status (see section 3.5) to enroll in the Plan. Other than individual policies that require applications, your benefit elections will be retroactively effective as of your hire date, the date you are first eligible for benefits, or the date of your IRS-defined change in status.

3.2 Initial Benefit Enrollment

If you're joining us or enrolling for the first time, please visit www.hmfphysicians.org/employee-area and select **New to our Organization**. You'll need a username and password to get into the site:

Username: HMFP-APHMFP

Password: Welcome!

From here you can download our Benefit Guide and enrollment forms, and find instructions on how to return mandatory enrollment documents to the Benefits Team.

3.3 Enrollment Deadlines

Certain dependent coverage is contingent on receiving required dependent documentation within 30 days of a qualifying event. These include:

- Within 30 days of gaining an eligible dependent by marriage, birth, or adoption
- Within 30 days of an IRS-defined change in status (defined in Section 3.5)

3.4 What Happens If I Miss the 30-day Enrollment Period?

New hires and newly benefits-eligible employees who don't complete their enrollment within the 30-day enrollment period won't have any coverage except Term Life, Business Travel, Short and Long Term Disability and personal Excess Liability Insurance. If you miss the 30-day enrollment period, you won't be able to enroll in or make changes to your benefit elections until the next annual Open Enrollment period. This is usually the first two weeks of November, with a benefit start date of January 1st. However, if you experience an IRS-defined change in status, you'll be able to make changes to your benefits during the year consistent with the type of status change.

3.5 Changing Benefits during the Year

Certain IRS-defined changes in status permit you to make benefit changes during the year that normally can only be made during the annual Open Enrollment period. If you experience an IRS-defined change in status, you have 30 days from the IRS-defined change in status date to make any eligible changes. Change(s) must be consistent with the IRS-defined change in status.

For example you may be allowed to make changes to your benefits for the following:

- Marriage, divorce, annulment or legal separation, loss of spouse or qualified dependent
- Birth, adoption or placement for adoption of a child

- Have a dependent who loses or gains eligibility elsewhere
- Experience a change in employment status, (i.e. you or your eligible dependent begins or ends employment, or takes an unpaid leave of absence or family medical leave)
- Experience a significant change in medical coverage or cost to you or your eligible dependent
- Relocation out of your plan’s coverage service area
- Qualified medical child support orders
- Events relating to Medicare, Medicaid, or Health Insurance Marketplace eligibility

You’ll need to complete a qualified change form, as well as provide proof of the change, for example, marriage certificate, divorce certificate or letter from your spouse’s employer on letterhead (if your spouse gains or loses coverage), and any appropriate applications.

4.0 WHEN DOES COVERAGE BEGIN OR END

4.1 Coverage Start Dates

	Newly Eligible Employee	Open Enrollment	IRS-Defined Change in Status
Medical, Rx, Dental, and Vision Plan	1 st of month coinciding with or following eligibility date	January 1 st	Date of an IRS-defined change in status
Disability		No Changes	Date coverage is approved
FlexChoice FSA HC /DC or Limited Purpose FSA		January 1 st	Date of an IRS-defined change in status
Health Savings Account		January 1 st	
Basic Life Insurance		No Changes	
Supplemental Life Insurance		Date coverage changes are approved	Date of an IRS-defined change in status
Dependent Life*		Date coverage changes are approved	Date of an IRS-defined change in status
AD&D Individual/Family*		January 1 st	Date of an IRS-defined change in status
Personal Excess Liability Insurance		December 16th	

*Dependent eligibility for program is 14 days to 19, or up to age 25 if full time student.

4.2 Coverage End Dates

Most coverages under the Plan ends at midnight on the earliest of the following dates:

- When you no longer meet the eligibility requirements to participate in these plans
- When you fail to make the required payment
- When your employment with HMFP-APHMFP terminates
- When HMFP-APHMFP opts to no longer maintain the benefit program

Medical, Dental, and Vision benefits will end on the last day of the month in which you lose eligibility.

4.3 Loss of Benefits

While the Plan Sponsor intends to continue the plans indefinitely, it is difficult to predict the future. The Plan Sponsor in its sole discretion reserves the right to amend, modify, or terminate the provisions, terms, and conditions of the Plan without the consent of any participant or any beneficiary under the Plan. Any modification, amendment, or termination of the Plan will be by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate, and delivered to the benefits-specific Plan Administrator. No vested rights of any nature are provided by the Plan. Circumstances that may result in the disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefits are described in the separate Plan documents.

If you or your eligible dependents lose coverage under the Plan, contact the [benefits team](#) as some group benefit programs have the ability to convert to individual policies. Certain rights to continued health care coverage through COBRA are outline in section 8.2.

5.0 WHAT ARE MY BENEFITS?

5.1 Health Insurance – Live Healthy

The following is a brief summary of the medical plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit www.harvardpilgrim.org/hmfp.

When you enroll in one of our medical plans, you pay a portion of the total group premium, with HMFP-APHMFP paying most of the total premium. The benefits team will provide you with your individual department's rate sheet at time of eligibility, each Open Enrollment or upon request.

Choose from two Medical Plans

The HMFP/APHMFP Choice Network offers two medical plans, both administered by Harvard Pilgrim Health Care (HPHC).

1. **myAdvantage CDHP:** This Consumer-Driven Health Plan (CDHP) features lower premiums with higher out-of-pocket costs and deductibles. With this plan, you designate a primary care physician (PCP) who coordinates your care. The CDHP is offered in conjunction with an HSA.
2. **myClassic POS Plan:** This plan features higher premiums but with lower out-of-pocket costs and deductibles when you receive services. With this plan, you designate a primary care physician (PCP) who coordinates your care.

Note: If you're enrolled in the HPHC PPO Grandfathered Plan, please contact the [benefits team](#) for additional information.

Prescription Drug Coverage

Visit www.CVSCaremark for additional details on your coverage options.

If you enroll in one of our medical plans, your prescription drug coverage will be provided through **CVS Caremark**, a pharmacy benefits manager. Upon initial enrollment in the HMFP-APHMFP sponsored medical plan, you will receive instructions for prescription drug services. You'll be able to order prescription refills, check drug costs and coverage, and find ways to save on your medication. Prescription drug coverage has three copayment tiers, with most generic medications having the lowest copayment.

CVS Caremark Comparison Tools:

- [Pharmacy Locator](#)

myAdvantage CDHP	myClassic POS	HPHC PPO
Individual Pre-Deductible Individual Post Deductible	Individual	Individual
Employee+1 Family Pre Deductible Employee +1/Family Post Deductible	Employee Plus 1 / Family	Employee Plus 1 / Family

New BIDMC Pharmacy Benefit

New in 2019, if you are enrolled in HMFP-APHMFP's health plans, any prescription filled through the new BIDMC pharmacy in-person or through the mail will have a \$0 co-pay. If you're enrolled in the myAdvantage CDHP you must meet your deductible before the \$0 co-pay applies. This also applies to drugs filled from the specialty pharmacy in Norwood and their retail pharmacy located at 330 Brookline Ave. in Boston. Personalized pharmacist services are included.

Questions?

BIDMC pharmacy team can be reached by phone at 617-667-6400 or email pharmacy@bidmc.harvard.edu. Retail hours of operation are Mon-Fri 7AM-7PM and Sat 7AM-5PM.

myAdvantage CDHP

	IN-NETWORK ONLY	IN-NETWORK ONLY	OUT-OF-NETWORK
Annual Deductible	Tier 1 & 2	Tier 3	
Individual	\$1,500	\$1,500	\$3,000
Individual + 1	\$3,000	\$3,000	\$6,000
Family	\$3,000	\$3,000	\$6,000
HSA Employer Funded	\$500 Individual/\$1,000 Individual + 1 or Family		
Out-of-Pocket Maximum	Tier 1 & 2	Tier 3	
Individual	\$2,700	\$4,000	\$6,000
Individual + 1	\$5,400*	\$8,000***	\$12,000****
Family	\$5,400*	\$8,000***	\$12,000****
Coinsurance (after deductible)	Tier 1 & 2 0%	Tier 3 20%	30%
Office/Specialist Visits	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance adults; co-pay \$15/\$20 Pediatrics*****	Deductible, then 30% coinsurance
Hospital Emergency Room (co-pay waived if admitted)	Deductible, \$100 co-pay	Deductible, \$100 co-pay	Deductible, then 30% coinsurance
Inpatient Hospital Care	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient Surgery	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Lab/Radiology/Diagnostic Services			
Lab Non-Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then no charge	Deductible, then 30% coinsurance
Lab Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
High-End Radiology Non-Hospital Based	Tier 1 & 2 Deductible only	Tier 3 Deductible only	Deductible, then 30% coinsurance
High-End Radiology Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
PT/OT/ST (limited to 36 visits/year)	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then no charge	Deductible, then 30% coinsurance
CVS Caremark Prescription Drug Co-pays			
Generic - Tier 1	Deductible, then \$10 co-pay**	Deductible, then \$10 co-pay**	Deductible, then \$10 co-pay**
Brand Preferred - Tier 2	Deductible, then \$30 co-pay**	Deductible, then \$30 co-pay**	Deductible, then \$30 co-pay**
Brand Non-Preferred - Tier 3	Deductible, then \$50 co-pay**	Deductible, then \$50 co-pay**	Deductible, then \$50 co-pay**

*IND + 1 and Family Plans have an embedded Max OOP of \$2,700/** Ind. Max OOP of \$5,400 /
 ****Max OOP of \$6,000 /**** under age 19 **Prescription drugs are subject to the deductible

myClassic POS Plan

	IN-NETWORK ONLY	IN-NETWORK ONLY	OUT-OF-NETWORK
Annual Deductible	Tier 1 & 2	Tier 3	
Individual	\$ 500	\$ 500	\$2,000
Individual + 1	\$1,000*	\$1,000*	\$4,000
Family	\$1,000*	\$1,000*	\$4,000
Out-of-Pocket Maximum	Tier 1 & 2	Tier 3	
Individual	\$1,500	\$3,000	\$6,000
Individual + 1	\$4,500**	\$6,000***	\$12,000****
Family	\$4,500**	\$6,000***	\$12,000****
Coinsurance (after deductible)	Tier 1 & 2 0%	Tier 3 20%	30%
Office/Specialist Visits	Tier 1 & 2 Office \$15 co-pay/Specialist \$20 co-pay	Tier 3 Deductible, then 20% coinsurance adults; co-pay \$15/\$20 Pediatrics*****	Deductible, then 30% coinsurance
Hospital Emergency Room (co-pay waived if admitted)	\$100 co-pay	\$100 co-pay	\$100 co-pay
Inpatient Hospital Care	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient Surgery	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Lab/Radiology/Diagnostic Services			
Lab/x-rays Non-Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then no charge	Deductible, then 30% coinsurance
Lab/x-rays Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
High-End Radiology Non- Hospital Based	Tier 1 & 2 Deductible only	Tier 3 Deductible only	Deductible, then 30% coinsurance
High-End Radiology Hospital Based	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
PT/OT/ST (limited to 36 visits/year)	Tier 1 & 2 \$20 co-pay	Tier 3 \$20 co-pay	Deductible, then 30% coinsurance
CVS Caremark Prescription Drug Co-pays			
Generic - Tier 1	\$10 co-pay	\$10 co-pay	\$10 co-pay
Brand Preferred - Tier 2	\$30 co-pay	\$30 co-pay	\$30 co-pay
Brand Non-Preferred - Tier 3	\$50 co-pay	\$50 co-pay	\$50 co-pay

*\$500 embedded Member Deductible per Calendar Year

**\$1,500 embedded Member Out-of-Pocket Maximum per Calendar Year

***\$3,000 embedded Member Out-of-Pocket Maximum per Calendar Year

****\$6,000 embedded Member Out-of-Pocket Maximum per Calendar Year

***** Under age 19

5.2 Dental Insurance

The following is a brief summary of the dental plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at www.deltadentalma.com

When you enroll in one of our dental plans, you pay a portion of the total group premium, with HMFP-APHMFP paying a portion as well. The benefits team will provide you with your individual department's rate sheet at time of eligibility, each Open Enrollment or upon request.

Choose from two Dental Plans

We offer two comprehensive dental plans through Delta Dental of MA. You have the option of selecting a plan that works best for you and your family.

1. ***Delta Dental Core Plan:*** This plan offers lower monthly premiums in exchange for a slightly higher deductible, a \$1,000 individual annual plan maximum and no orthodontia coverage
2. ***Delta Dental Enhance Plan:*** This plan offers a higher monthly premium, but you have a lower deductible, a higher annual plan maximum (\$3,000) and it offers orthodontia coverage

Both programs include dentists in the Delta Dental PPO Plus Premier plan networks. You may also use out-of-network dentists, but this may increase your out-of-pocket costs.

	Delta Dental Core	Delta Dental Enhanced
Annual Deductible	\$75 Individual, \$225 Family	\$50 Individual, \$150 Family
Type I Services	100%, no deductible	100%, no deductible
Type II Services	Deductible, then 70%	Deductible, then 80%
Type III Services	Deductible, then 50%	Deductible, then 50%
Annual Plan Maximum	\$1,000	\$3,000
Orthodontia	Not Covered	50%
Orthodontia Lifetime Maximum	Not Covered	\$2,000
Adult Orthodontia	Not Covered	Not Covered
Rollover Max	Up to \$350 annually	Up to \$750 annually

5.3 Vision Care Insurance

The following is a brief summary of the vision plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at www.eyemed.com.

In addition to the vision benefits offered under our medical plans, we also offer a comprehensive vision care plan through EyeMed. This standalone care benefit provides coverage for vision exams, eye glasses and contacts at greatly reduced and/or discounted rates.

When you enroll in our vision plan, you pay the total group premium. The benefits team will provide you with your individual department’s rate sheet at time of eligibility, each Open Enrollment or upon request.

	In-Network What you’ll Pay:	Out-of-Network You’ll be reimbursed up to:
Exam (once every 12 months)	\$0 co-pay	\$50
Frames (once every 12 months)	\$0 co-pay, \$200 allowance 20% off balance over \$200	\$130
Contact Lenses in lieu of Frames (once every 12 months)	Conventional: \$0 co-pay; \$200 allowance, 15% off balance over \$200 Disposable: \$ co-pay; \$200 allowance, plus balance over \$200 Medically necessary: \$0 co-pay, paid in full	Conventional: \$160 Disposable: \$160 Medically necessary: \$210
Standard Plastic Lenses in lieu of Contact Lenses (once every 12 months)	Co-pays range from \$10 to \$185	\$42 to \$196

5.4 Flexible Spending Accounts (FSAs)

The following is a brief summary of the FSA coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit www.sentinelgroup.com.

We have partnered with Sentinel Benefits as our FSA administrator. The FSA is a great way to help save money on your out-of-pocket medical, dental and vision or dependent care expenses. Employees enrolled in this program will save on federal, state and FICA taxes. Annual contribution amounts are limited by IRS regulations.

We offer three Flexible Spending Account options:

1. ***FlexChoice FSA Health Care:*** Allows you to pay for qualified eligible medical, dental, and vision care expenses for you and your eligible dependent(s); you may enroll in the Health Care FSA even if you aren't enrolled in an HMFP-APHMFP sponsored medical plan. If you're eligible to participate in a health savings account (HSA) please see the Limited Purpose FSA listed below.
2. ***FlexChoice FSA Limited Purpose:*** Allows you to pay for dental and vision care expenses only, and is available if you're actively participating in an HSA. Other qualified medical expenses may be covered by an HSA.
3. ***FlexChoice FSA Dependent Care:*** Allows you to pay for eligible dependent care expenses for a child or elder dependent so that you (and/or spouse) may work, attend school, or look for a job.

2019 Flex Choice FSA Limits

Health Care & Limited Purpose = \$2,650

Dependent Care: \$5,000 per family

Each year you'll need to make a new election in these accounts for the following calendar year. You may also be able to make changes during the year if you experience an IRS-defined change in status. Annual contributions amounts are limited by IRS regulations.

FSA's are **"USE-IT-OR-LOSE IT"** accounts, which means you'll forfeit any month left in your account at the end of a calendar year. **Beginning in 2019, you'll be eligible to rollover up to \$500 from your 2019 FlexChoice FSA Health Care or FlexChoice FSA Limited Purpose to use toward services in 2020. If you enroll in the Dependent Care FSA you'll have until March 15, 2020 to use up any funds remaining in your previous years account and have until March 30, 2020 to submit for reimbursement.**

Note: Global benefit eligible employees can opt to participate in the FlexChoice FSA Health or Dependent Care Accounts; however, only U.S related expenses qualify for reimbursement.

5.5 Health Savings Account (HSA)

The following is a brief summary of the HSA plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit www.healthequity.com.

We have partnered with HealthEquity as our HSA administrator. If you're enrolled in the myAdvantage CDHP Plan, you can pay for qualified medical expenses for you and your eligible dependent(s) using an HSA. The benefit of having an HSA is the funds can roll over from year to year and accumulate on a tax free basis. Investment options are also available. Annual contribution amounts are limited by IRS regulations. Please review IRS qualifications & exclusion before signing up.

2019 Health Savings Account Limits

Individual \$3,000 + Employer Contribution up to \$500 annually	Family & Employee +1 \$6,000 + Employer contribution up to \$1,000 annually	Over 55? An additional \$1,000 can be contributed
---	---	---

5.6 Disability Insurance

The following is a brief summary of the short term (STD) and long term (LTD) disability coverages. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit www.standard.com.

Group Short Term Disability (STD)

STD insurance is a salary replacement benefit that helps you meet your financial commitments if you're unable to work for more than 14 calendar days due to an injury or sickness. Maximum payment period is 90 days. As a benefit eligible employee, you are automatically enrolled in this benefit.

Group Long Term Disability (LTD)

LTD insurance is a salary replacement benefit that continues to meet your needs if you're unable to work after the 90 day elimination period due to injury or sickness. As a benefit eligible employee, you are automatically enrolled in this benefit.

	Short Term Disability	Long Term Disability
Eligibility for Coverage and Benefits	You're eligible for coverage as soon as you're a "benefit-eligible" member of HMFP/APHMFP. To receive benefits, you must be unable to perform the duties of your own occupation (specialty subspecialty) and have lost at least 20% of your pre-disability earnings.	
Waiting and Benefit Periods	Benefits begin after 14 days of disability and continue for up to 13 weeks. Partial benefits available. Pre-existing condition limitations	Benefits begin after 90 days of disability and continue until recovery the Maximum Disability Period, whichever occurs first. Partial benefits available.
Benefits Provided	You receive a tax-free benefit of up to 60% of the first \$5,000 of your basic weekly earnings. The maximum benefit is \$3,000 per week.	You receive a tax-free benefit of up to 50% of the first \$240,000 of your base annual earnings. The maximum benefit is \$10,000 per month.
Coverage Limitations	The Plans carry a pre-existing condition clause for any illness/injury treated in the 90 days prior to the effective date of the policy. See the policy for details on benefit limitation for both programs. Claims due to mental or nervous conditions are limited to 24 months. See the LTD policy for details on this and offset provisions for individual policies.	

Supplemental Disability Options

Individual LTD and Supplemental disability programs are also available.

	Individual Disability Programs	Supplemental Disability Programs
Enrollment	You must apply for coverage within 60 days of becoming benefit-eligible. No evidence of insurability is required. To receive benefits, you must be unable to work in your own specialty for the entire benefit period.	
Waiting and Benefit Periods	Benefits begin after 90 days of disability and continue until recovery or age 65, whichever occurs first. If you are disabled after 65, you're eligible for benefits based on a benefit schedule. (See the policy for details.)	
Benefits Provided	You receive a tax-free benefit of up to 50% of the amount of your base annual earnings between \$240,000 and \$360,000. The maximum benefit is \$5,000 per month. Benefits may be reduced if you have other disability coverage.	
Coverage Limitations	HMFP/APHMFP pays the cost of coverage for eligible employees whose base annual compensation is between \$240,000 and \$360,000. Financial underwriting is required. See the policy for details.	You may purchase additional coverage by contacting InsMed Insurance Agency, Inc. at 1-800-214-7039. Different options are available.
Supplemental Disability Program with Pension and Catastrophic Protection		
Enrollment	During your first three years of employment or eligibility, this program is open to employees regularly scheduled to work 30 hours or more each week and under age 64. Information is communicated by mail and work email. Program features include, increased income replacement; retirement contribution replacement; and additional coverage in event of catastrophic disabling event.	

Cost of the plan

Premiums for Group STD, LTD and Individual LTD programs are billed back to your department or individual profit & loss statement (P&L). The cost of these non-contributory premiums is included in your gross wages for tax withholding purposes as required by IRS regulations. Benefits paid by the plan result in a tax-free payment to you.

Waiver of Premium

Standard insurance will waive payment of your premium for your LTD insurance coverage while you are receiving LTD benefit payments.

Absence from work

You must be actively at work on the day before the scheduled effective date of your STD and LTD insurance to become effective as scheduled. If you're not actively at work because of a medical leave due to your own disabling condition on the day before the scheduled effective date of your coverage, it will not become effective until the day after you complete one full day of active work. STD and LTD certificates are available on our intranet. If you believe you'll be out longer than 5 calendar days, please email the Leave of Absence coordinator at HMFPHumanResources@bidmc.harvard.edu.

Maximum benefit period

The Maximum Benefit Period is the longest period for which STD and LTD benefits are payable for any one period of continuous disability, whether from one or more causes. The Maximum Benefit Period begins at the end of the Elimination period. For STD the maximum is 90 days. No LTD benefits are payable after the end of the Maximum Benefit Period, even if you're still disabled.



Maximum Benefit Period for LTD Benefits	
Your age When Disability Begins	Maximum Benefit Period
61 or younger	To age 65, or 3 years 6 months, if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Impact on other benefits

If you become disabled, the benefit programs in which you are enrolled in at the time you become disabled continue as follows:

Benefit Program	Impact While Receiving LTD Benefits
Medical, Dental and Vision Care	You'll be billed for the employee rate of any program in which you're enrolled in.
Term Life Insurance	Premiums continue until you're no longer eligible for plan or qualify for a waiver of premiums.
Group Universal Life coverage plus Spouse & Dependent rider	Minnesota will bill you directly for any supplemental or spousal premiums.
STD benefits	Premiums will be suspended until you return to a benefits eligible position.
LTD Insurance	Premiums are waived while receiving benefits.
Flexible Spending HC, DC, and Limited HC Plans	You may not contribute to these spending accounts while on LTD. If you have an existing account you can incur claims up to the start of your LTD. You're eligible for continued contributions if you return to work in a partial payment role.

5.7 Life Insurance

The following is a brief summary of the life insurance program. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit www.lifebenefits.com.

Basic Term Life Insurance

All benefits-eligible employees participate in a group term life insurance program with a death benefit of up to \$50,000. If you are over age 65, certain age reductions on the term policy apply. That is, benefits are: 65% at age 65, 50% at age 70 and 25% at age 75. If you're on long-term disability, you may discuss options for a premium waiver on this program. You must designate a beneficiary for Term Life Insurance which ensures the person(s) you choose will receive your insurance benefit in the event of your death. This coverage terminates when you terminate employment or retire. You do have the option of converting this coverage to an individual whole life insurance policy through Minnesota Life Insurance Company. Term insurance is offered under policy form series MHC-96-13180.

Group Universal Life Insurance (GUL/VGUL)

As a benefits-eligible employee you'll receive a cash contribution (benefit dollars) toward the purchase of life insurance coverage equal to a minimum of 2 x salary or \$700,000 (lesser of the two). Please note that the VGUL minimum face amount is \$50,000. You may elect to purchase additional insurance up to a

total of 6 x salary. The maximum insurance benefit is \$2,000,000. If your total coverage amount exceeds 3 x salary or \$700,000, evidence of insurability is required. The minimum insurance coverage is 2 x salaries for all eligible members. GUL insurance is offered under MHC-86-18510T and VGUL is offered under MHC-94-18660.

The Minnesota Life Insurance program offers you maximum flexibility to help meet your individual financial objectives. With these policies, you can take advantage of state-of-the-art, customized life insurance at group rates and choose the level of death benefits to meet your needs. You must designate a beneficiary for your GUL/VGUL Life Insurance which ensures the person(s) you choose will receive your insurance benefit in the event of your death.

You, the employee, may purchase GUL, which offers life insurance with the ability to invest in a guaranteed cash value account, or Variable Group Universal Life Insurance (VGUL), which offers life insurance protection with variable and guaranteed cash value subaccounts. The guarantees for the guaranteed account are based solely on the financial strength and claims paying ability of Minnesota Life. The financial strength, while important, has no bearing on the performance of the variable cash value sub-accounts. GUL and VGUL are available in salary increments up to a maximum of 6 x salary; subject to the plan maximum of \$2,000,000 (minimum policy is \$50,000). All employees are eligible to apply for additional insurance throughout the year. To do this, you need to submit a Service Request Form and Evidence of Insurability Form. These forms are available by calling Minnesota Life at **800-843-8358** or email the [Benefits Team](#).

Note: Any benefits-eligible employee age 65 or older can opt out of this life insurance program. The employee will be required to sign a waiver as this will eliminate the employer contribution for this program.

Spousal Life Insurance

Coverage is also available for your spouse. He or she may apply for GUL protection with the option of investing in the guaranteed cash value account. Coverage is available in increments of \$25,000, \$50,000, \$100,000 or \$200,000. Your spouse is required to complete an application and only during your initial enrollment period, your spouse may elect \$25,000 of coverage without providing evidence of insurability. You pay the full cost of this benefit via payroll deductions with after-tax dollars.

Dependent Life Insurance

There is also a child term insurance rider available on your GUL or VGUL policy which provides \$10,000 coverage on your **dependent children 14 days old up to age 19 and 25 if a full-time student**. If your child is no longer eligible for this rider, you'll need to notify Minnesota Life at **800-843-8358** to have them removed from your policy. Dependent life insurance enrollment and continued eligibility is the responsibility of the policy holder. Only during your initial enrollment period can you elect coverage without providing evidence of insurability. You pay the full cost of this benefit via payroll deductions with after-tax dollars.

Business Travel Insurance

Business Travel Insurance is automatically provided and covers injuries sustained while you're engaged in a work-related travel activity. This coverage provides a principle sum of \$500,000 per person and applies to work-related travel. Excluded from this benefit is travel to certain Middle East countries, Afghanistan and Sub Sahara African countries. For the United Arab Emirates, Kuwait, Israel and Saudi Arabia coverage will limit travel to 14 days and will not pay out more than \$1.5 million aggregate on any one accident. Age reductions apply. The age reductions on the Business Travel Insurance are: 65% at age 65; 45% at age 70; 35% at age 75; and 15% at age 80. Unless otherwise noted, the beneficiary designation for Business Travel will be the same as your Term Life policy.

Accidental Death & Dismemberment Insurance (AD&D)

Accidental Death and Dismemberment (AD&D) Insurance pays a benefit if you pass away or suffer certain injuries as the result of an accident. If you choose to cover your family as well, each family member receives coverage that equals a percentage of your coverage amount. **Only dependent children 14 days old up to age 19, and 25 if a full-time student, are eligible.** Coverage for this benefit is provided through Minnesota Mutual Life Insurance Company. AD&D insurance is offered under 02-30475T or any state variation thereof. Unless otherwise noted, the beneficiary designation for AD&D will be the same as your Term Life policy.

If you choose to participate in this program, you can elect salary increments from 1 x up to 6 x your salary (maximum is \$2,000,000.) Other AD&D benefits include:

- Day Care Benefit
- Special Education Benefit Airbag Benefit
- Common Disaster Benefit Dismemberment Benefits Seatbelt Benefit
- Felonious Assault Benefit

For a more detailed explanation of the plan and a description of the injuries for which benefits are paid, please refer to your certificate of insurance. You pay the full cost of this benefit via payroll deductions with after-tax dollars. If you receive a pay increase during the year, your coverage amount and payroll deduction will increase automatically.

Additional Life Insurance Information

What Happens If I Terminate?

The universal life coverage is portable and can be continued by paying premiums directly to Minnesota Life. For more information, contact Minnesota Life at **800-843-8358** or Human Resources.

Obtaining Additional Information

A Service Request Form can be found online during the open enrollment process or can be accessed throughout the year by going to the intranet (<https://portal.bidmc.org/hmfp>). If you would like to apply for coverage in excess of the guaranteed amount, make changes to your existing coverage, or obtain information about the VGUL or GUL plans, simply complete the appropriate information and fax it to Minnesota Life at **651-665-4827**. For more complete information about Variable Group Universal Life,

including charges and expenses, call **800-843-8358** for a Prospectus. Read it carefully before you invest. Variable Group Universal Insurance is distributed through Securian Financial Services, Inc., Securities Dealer, Member, NASH/SIPX, 400 Robert St. North, Saint Paul, MN 55101.

Guaranteed Insurance Amounts

As a current employee, you are guaranteed to retain your current level of insurance through Minnesota Life. If you would like to increase your coverage amount, you may need to complete the Evidence of Insurability Form. Salary updates to Minnesota Life are communicated every pay period. Minnesota Life will contact you directly if you are eligible to increase your insurance levels due to a salary increase.

New employees will be guaranteed insurance coverage equal to 3 x salary subject to a maximum of \$700,000. This includes the employer-provided GUL coverage equal to 2x salary. You may apply for either GUL or VGUL for the optional guaranteed insurance. You may apply for coverage within 31 days of your hire date, or eligibility date, to be eligible for this guaranteed coverage. The plan coverage maximum is the lesser of 6 x your salary or \$2,000,000. If you would like to apply for more than the guaranteed amount, you will simply need to provide proof of good health for coverage in excess of the guaranteed amount.

Completed applications are required by the carrier prior to issuance of policy and will not be retroactive to your benefit eligibility effective date.

Spouses of new employees or new spouses of current employees are eligible for \$25,000 of guaranteed coverage if applied for within 31 days of your hire date or, if applicable, a qualifying event. Guaranteed term life insurance coverage is also available for dependent children. You must apply for coverage within 31 days of your hire date or within 31 days of the birth, adoption or placement of adoption for the child.

Information in this booklet is intended as a general guide to the insurance coverage. If there are any differences between this booklet and the policy or certificates, the policy or certificates will govern. For additional information, you can log on to **www.lifebenefits.com**.

Waiver of Premium

Minnesota Life will waive payment of your term life premiums if you are disabled for greater than one year. Employees eligible must apply for this benefit through your leave of absence coordinator. You will still be responsible for any individual premiums including: universal life, spouse or dependent life, and accidental death and dismemberment insurance policies.

Beneficiaries

You must designate a beneficiary for your life insurance programs at the time of enrollment. This ensures that the person(s) you choose will receive your insurance benefit in the event of your death. You can update your beneficiary designation by contacting the [Benefit Team](#).

Portability & Conversion Options

If your life insurance coverage ends, you may continue coverage with Minnesota Life by contacting them at [800-843-8358](tel:800-843-8358) within 31 days of the loss of coverage.

5.8 Global Benefits Plan

The following is a brief summary of our Global Benefits Plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator or visit <https://www.aetnainternational.com/>.

The Global Benefits Plan is for benefits-eligible APHMFP employees working abroad for six months or longer. The Global Benefits Plan offers benefits that are comparable to those available to benefit eligible employees working in the United States, with access to a network of participating providers, including a network of coverage for eligible dependents that remain in the United States.

The Global Benefits Plan provides bundled health (i.e. medical, Rx, dental, and vision care) and is offered through Aetna International.

Aetna International offers convenient web and mobile tools to make managing your health simple. You'll have access to one of the world's largest networks of doctors, hospitals and clinics and they have a member services and clinical team available 24/7/365 to help you navigate global health care more easily.

When you enroll in the Global Benefit Plan, you pay a portion of the total group premium, with APHMFP paying most of the total premium. The benefits team will provide you with your individual department's rate sheet at time of eligibility, each Open Enrollment and upon request.

Eligibility

You are eligible for benefits under the Global Benefits Plan if you're in a benefit eligibility eligible status and are an APHMFP employee on temporary assignment outside the United States for six (6) months or more. If your international assignment ends during the calendar year, your eligibility in the program will end on December 31st of that calendar year.

Enrollment

You have 30 days from your hire date, the date you are first eligible for benefits, or the date of an IRS-defined change in status to enroll in the Global Benefits Plan. Once you enroll in benefits under the Global Benefits Plan, you'll receive an introduction/welcome kit from Aetna Global, which provides essential information about how to access your benefits and get assistance with questions. You and/or your dependents will be assigned a policy identification card that will be mailed to you or accessed online.

AETNA INTERNATIONAL

	Outside the U.S	In the U.S Preferred Benefits In Network	In the U.S Non Preferred Benefits Out of Network
Individual Deductible	None	None	None
Family Deductible	None	None	None
Individual Out-of-Pocket Maximum	\$500	\$500	\$1,000
Family Out-of-Pocket Maximum	\$1,000	\$1,000	\$2,000
Inpatient Per Confinement Deductible <i>(Maximum of 3 per calendar year)</i>	None	None	\$250
Office/Specialist Visits	No Charge	No Charge	30%
Hospital Emergency Room Visit	No Charge	No Charge	No Charge
Inpatient	No Charge	No Charge	30% after \$250 Inpatient per confinement deductible
Outpatient	No Charge	No Charge	30%
Other Services			
Diagnostic Outpatient Lab/ Diagnostic Outpatient X-Rays	No Charge	No Charge	30%
PT/OT/ST (limit 60 combined visits/year)	No Charge	No Charge	30%
Routine Eye Exam	No Charge	No Charge	30%
Vision Care Supplies	No Charge, \$200 max	No Charge, \$200 max	No Charge, \$200 max
Prescription Drug			
Generic	No Charge	\$20 copay/month (includes Mail Order)	30%
Formula Brand Name Drug	No Charge	\$30 copay/month (includes Mail Order)	30%
Non-Formula Brand Name Drug	No Charge	\$50 copay/month (includes Mail Order)	30%

Dental			
Individual Deductible	\$50 per calendar year	\$50 per calendar year	\$50 per calendar year
Family Deductible	\$150 per calendar year	\$150 per calendar year	\$150 per calendar year
Type A Expense (Diagnostic & Preventive)	No Charge	No Charge	No Charge
Type B Expense (Basic Restorative)	20% after deductible	20% after deductible	20% after deductible
Type C Expense (Major Restorative)	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	\$1,500	\$1,500	\$1,500
Orthodontic Treatment/Lifetime Max Coverage for Adults and Dependents	50% up to \$1,000 lifetime max	50% up to \$1,000 lifetime max	50% up to \$1,000 lifetime max

6.0 OTHER BENEFIT PROGRAMS

We have a number of other programs & benefits that you can use throughout the year.

6.1 Clinician Health Services

The Clinician Health Service Program is open to all employees and provides a safe place to discuss concerns, problem solve and consider recommendations. This program provides up to three sessions which are completely confidential. Appointments are set up directly with the clinician. There is NO fee to the employee and NO online record of the meeting or billing of insurance. All referrals are confidential. This is a self-referred treatment. To meet with one of the clinicians contact Pamela Peck, PsyD, and Director at ppeck@bidmc.harvard.edu. Reference: HMFP-APHMFP employee.

6.2 Child & Family Resources

As a benefit eligible employee you're eligible for a free membership at [Care.com](https://www.care.com). You can access discounts on in-home & in-center back up care for children to 17 years old and adults in your family, including yourself. This benefit provides backup services when your regular childcare or adult care arrangements aren't available. Childcare services include care when your child is mildly ill, there is a gap in nanny care, a parent must travel for business or work late hours, or on a holiday when a regular day care center or school is closed. Adult care services may be needed when your spouse is recuperating at home from surgery and needs temporary assistance, you're waiting for an opening in an assisted living facility for an older relative, an adult needs transportation to a medical appointment or any time there is a gap in your adult care arrangements and you need to work.

Care.com offers qualified and carefully screened providers, available 24 hours a day, seven days a week. Care.com can also offer short-term on-site group childcare if, for example, a group of potential physicians are participating in training and inter-views in the same day or if there is a departmental retreat.

It's our hope that this service will be helpful in reducing the anxiety level our employees experience when faced with unanticipated work and family conflicts. Here is the process for arranging care:

- Call Care.com directly at **855-781-1303** to request back up care. You may also go online to register and request care **care.com**.
- Be certain to identify yourself as an employee of HMFP at BIDMC even if you're an APHMFP employee.
- Care.com Backup Care will locate a provider for you who meets your specific needs, then will contact you with the provider's name and background information.
- The provider will call you to confirm the date, time and location of the job.
- Care can be In-home or adult center care
- When the job has been completed, pay the childcare provider and sign the time sheet. For adult care, your credit card will be charged for the hourly cost of care.

6.3 Group Personal Excess Liability Insurance

Group Personal Excess Liability Insurance from Chubb provides you or a family member with broad protection and liability limits in excess of your primary auto, homeowners, renters, recreational vehicle, motorcycle, and watercraft insurance. At time of hire HMFP-APHMFP will apply for a \$1 million dollar policy on your behalf. You have an opportunity to add supplemental coverage at this time as well. This individual policy renews annually on December 16th for anyone in a benefit eligible position. This policy is not portable. If you need to file a claim, you can do so by calling **800-252-4670**. For more information on this policy and supplemental options, call Provider Insurance Group at **781-444-0347** or e-mail privateclient@providerig.com.

6.4 Travel Assistance

If you're planning on traveling, don't forget that Red Point provides travel assistance services. The basic travel assistance services include assistance in locating and accessing physicians, dentists, medical facilities and pharmacies, arranging and paying for medical evacuation (up to the plan limit), providing interpreters or relaying messages to friends and family and so much more. If you're in a benefit eligible status, you and your spouse and eligible dependents will have access to these services. No additional premium or enrollment is required. Call **855-516-5433** in the U.S. and Canada or **617-426-6603** (collect) from other locations. For pre-trip information, feel free to visit www.lifebenefits.com/travel.

6.5 Will Preparation and Legal Services

You spend your whole life building a legacy, but because you never created a will, the state gets to decide how your assets will be distributed. To ensure your estate passes to the right people, we're happy to offer will preparation services, available through Minnesota Life and provided by Ceridian LifeWorks and in conjunction with your group life insurance program. With this service, you may consult with an attorney, create wills, determine financial power of attorney, create living wills or final arrangements, and receive referrals to local attorneys and mediators, down load legal forms and much more. For more information call Ceridian LifeWorks at **877-849-6034** or visit www.lifeworks.com.

User Name: lfg Password: resources

6.6 Legacy Planning Services

The Legacy Planning Services program provides online information designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing. These services are available to all insureds, active or retired, and their spouses and dependents. Visit LegacyPlanningResources.com.

6.7 Harvard Real Estate Advantage Program

For employees with an Academic Appointment, Harvard Real Estate services has partnered with Coldwell Banker Residential Brokerage to provide special services, including cash back on private market home purchases and sales, to Harvard faculty and staff. The cash back benefit is funded by a referral fee negotiated by the University with Coldwell Banker. The portion of the referral fee given back to Harvard is split approximately 50 and 50 between the Harvard employee and the Faculty Real Estate Services department, which manages the Real Estate Advantage Program for the University.

To get started, please send an e-mail to Susan Keller, or call **617-495-9368**. You can also call Coldwell Banker directly at **800-396-0960** or **617-495-8840** or visit the REAP website. Search available properties through Coldwell Banker Residential Brokerage. Please don't contact an agent directly or you may not be eligible for the cash back program. Visit them online at <http://www.facultyrealestate.harvard.edu>.

6.8 Harvard Club of Boston

If you hold a Harvard Academic Title, you are eligible for membership in the Harvard Club of Boston! Amenities include: Premier Squash facilities and outstanding programs (including lessons), a modern, state-of-the-art fitness center and boxing gym, over-night accommodations, our Downtown Club on the top floor of One Federal Street; a la carte dining, private functions, member events, and parking at both Clubhouses, and a world-wide network of over 120 reciprocal clubs. For more information, visit the Harvard Club of Boston's website at: www.HarvardClub.com, or contact Jackie Deschamps at **617-450-8406** or jdeschamps@harvardclub.com.

7.0 YOUR ERISA RIGHTS

As a participant in a pension or welfare benefits plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operations of the plan, including insurance and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continued Group Health Plan Coverage

In certain instances, you’ll be entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a “qualifying event.” You or your dependents may have to pay for such coverage. Review this plan description and the documents governing the health plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan – called “fiduciaries” of the plan – have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under a plan is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and don’t receive them within 30 days, you may file suit in a federal court. In such cases, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials weren’t sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the plan’s fiduciaries misuse the plan’s money, or if you’re discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your Questions

If you have any questions about a plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory (One Bowdoin Square, 7th floor, Boston, MA, telephone **617-424-4950**) or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

Amendment or Termination of Plan

HMFP-APHMFP reserves the right to amend, modify, suspend or terminate any plan at any time.

7.1 FILING A CLAIM FOR BENEFITS – HEALTH PLANS

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims:

- **Concurrent Care Claim** – a concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- **Pre-Service Care Claim** – a pre-service claim is a claim for a benefit under the plan with respect to which the terms of the plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.
- **Post-Service Care Claim** – a post-service claim is a claim for a benefit under the plan that is not a pre-service claim.
- **Urgent Care Claim** – an urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

You may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, yourself, by your authorized representatives, or by your health care service provider. Any of these types of claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery, by facsimile, or as an attachment to electronic mail (e-mail). Telephone submissions using the toll-free telephone number for HPHC or CVS Caremark for Rx appeals may be processed conditionally, subject to receipt of the required format by any of the delivery methods described in the preceding sentence.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone (using the toll-free telephone number for HPHC POS/PPO or CVS Caremark) or by U.S. Mail, by hand delivery, by facsimile, or as an attachment to electronic mail (e-mail). If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the plan may require in support of your claim.



You may file any claim yourself, or may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person’s designation. In that case, all subsequent notices will be provided to you through your authorized representative and decisions concerning that claim will be provided to your authorized representative.

The Plan Administrator provides forms for filing those claims and authorized representative designations under the plan that must be filed in writing. You may submit a claim for benefits up to 90 days after the close of the plan year. For example, because each health plan year ends on December 31, if you or your dependent incurs a medical expense on December 31, you have until 90 days after December 31 (or March 31 of the next year) to submit this medical claim for payment.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than two years after the deadline.

Who determines my benefits?

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the plan as they apply to the claim. In any case, you will receive only those benefits under the plan that the Plan Administrator, in its sole discretion, determines you are entitled to receive.

How will I know what action has been taken on my claim?

If your claim involves urgent care, you or your authorized representative will be notified of the plan’s initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim doesn’t include sufficient information for the Plan Administrator to make an informed decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request. The Plan Administrator then must inform you of its decision within 48 hours of receiving the additional information.

If your claim is one involving concurrent care, the Plan Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. You will be given time to provide any additional information required to reach a decision.

If your claim is for a pre-service authorization, the Plan Administrator will notify you of its initial determination, whether adverse or not, as soon as possible, but no more than 15 days from the date it receives the claim. This 15-day period may be extended by the Plan Administrator for an additional 15 days if the extension is required due to matters beyond the Plan Administrator’s control. You will have at least 45 days to provide any additional information requested of you by the Plan Administrator.

If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of the Plan Administrator’s decision on your claim only if it is denied in whole or in part. This notification will be issued no more than 30 days after the Plan Administrator receives the claim. The Plan Administrator may extend the 30-day period once for up to 15 days if the extension is required due to matters beyond the Plan Administrator’s control. You will have at least 45

days to provide any additional information requested of you by the Plan Administrator, if the need for the extension is due to the Plan Administrator's additional information from you or your health care providers.

In response to the initial claim, the notice of adverse benefit determination (written or electronic) must:

- Specify the reasons for denial or reduction
- Refer to the specific plan provision(s) relied upon
- Describe any additional information needed to perfect the claim and why such information is necessary. State that you have the right to receive and review all relevant documents or other information
- Disclose any internal rules, guidelines and protocols that the plan relied on in making the adverse determination (or advise that such information will be provided free of charge upon request) and
- Describe the plan's appeal procedures, applicable time limits, and the right to sue.
- Disclose any internal rules, guidelines and protocols that the plan relied on in making the adverse determination (or advise that such information will be provided free of charge upon request) and
- Describe the plan's appeal procedures, applicable time limits, and the right to sue.

If an adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion or limit, either (1) an explanation of the scientific or clinical basis for the determination or (2) a statement that the explanation will be furnished free of charge upon request must be provided.

If the claim is an urgent care claim, a description of the expedited review process applicable to such claims must be provided. This information may be provided orally as long as it is provided in writing or electronically within three days after the oral notification.

What do I do if my claim is denied?

The Plan Administrator will provide you with written notice of the denial of your claim. You have at least 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing unless your claim involves urgent care in which case the request may be made orally.

In connection with your right to appeal the Plan Administrator's initial determination regarding your claim, you also:

- May review pertinent documents and submit issues and comments in writing
- Will be given the opportunity to submit written comments, documents, records or any other matter relevant to your claim
- Will have, at your request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits
- Will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination and

- Are entitled to have your claim reviewed by a health care professional retained by the plan. If the denial was based on a medical judgment, this individual may not have participated in the initial denial and shall give no deference to the initial denial.

The Plan Administrator must issue a review decision on your appeal according to the following timetable:

- **Urgent Care Claims:** no later than 72 hours after receiving your request for a review.
- **Pre-Service Claims:** no later than 30 days after receiving your request for a review.
- **Post-Service Claims:** no later than 60 days after receiving your request for a review. Under special circumstances, an extension of time may be needed. If an extension is needed, the Plan Administration must inform you of the extension and must make a decision within 120 days from the receipt of your review request.

Can I use arbitration to settle the claim disputes?

Yes. After you have exhausted the plan procedures as described above, you may settle the dispute through arbitration. The Plan Administrator must make a copy of the rules for you. This plan follows and incorporates the arbitration rules under the Employee Benefit Plan Claims Arbitration Rules of the American Arbitration Association.

HMFP-APHMFP bears all the costs of arbitration, except prehearing discovery, travel costs and attorney's fees. The decision made by the arbitrator is final and binding on all parties.

Note: *Any determination by the Plan administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily and capriciously.*

7.2 TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

For the purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be counted from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

7.3 FILING A CLAIM FOR BENEFITS – PENSION PLANS

You and your authorized representative may file a claim with a plan, in accordance with the terms of the plan, by submitting to the Plan Administrator or the person or entity designated by the Plan Administrator for the processing of such claims for the plan:

The complete claim form application, etc. required by the Plan Administrator

Any bills, invoices, or other supporting documentation required by the Plan Administrator

If Your Claim Is Denied

If your claim is wholly or partially denied, you will be furnished a written or electronic notice stating:

- The specific reasons for the denial

- The specific plan provisions on which the denial is based
- A description and reason for needing any additional material or information needed to consider the claim and
- An explanation of the plan's claims review procedure, the time limits applicable to such procedures, and a statement noting your right to bring a civil action under section 502(a) of ERISA following a denial of the claim on review.

A written claim denial will be sent to you within 90 days after receipt of the claim by the plan. The 90 days may be extended for another 90 days if special circumstances warrant an extension of time. If such an extension of time for processing is required, written notice of the extension will be furnished to you prior to the commencement of the extension. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render a decision.

Then, you or your authorized representative may, within 60 days of receiving your written claim denial:

- Be provided a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regards to whether such information was submitted or considered in the initial determination
- Be provided, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim and
- Submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

The Plan Administrator must make a final written decision on your claim review within 60 days of the receipt of the appeal. The 60 days may be extended for another 60 days if the Plan Administrator finds special circumstances, written notice of the extension will be furnished to you prior to the commencement of the extension. The decision of the Plan Administrator shall be final and binding.

The final decision shall be provided in writing or electronically and shall include specific reasons for the decision written in a manner calculated to be understood by you, and specific reference to the pertinent provisions of the plan on which the decision is based, a statement indicating that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, a statement describing any voluntary appeal procedures offered by the plan (if any) and your right to receive information about such procedures, and a statement noting your right to bring action under section 502(a) of ERISA.

7.4 FILING A CLAIM FOR BENEFITS - DISABILITY

With respect to a claim filed on or after January 1, 2002 for benefits based on a determination of disability, if the claim is denied, you will be given written or electronic notice of such denial by the Plan Administrator within 45 days after the Plan Administrator receives the claim. This 45-day period may be extended twice by 30 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide to you written or electronic notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information and will allow you 45 days from receipt of the notice to

which to provide the specified information. Where the time period for the notice of denial of a claim is extended because additional information is needed, the time period will stop running from the time the notice of extension is sent until the date of the response to the request for additional information.

Notification of a denied claim will include the following:

- The specific reason(s) for the denial
- The specific plan provisions on which the denial is based
- A description of additional information needed to perfect the claim and an explanation as to why such information is needed
- A description of the plan's review procedures and the time limits that apply to them
- A statement of your right to bring suit under Section 502 of ERISA following an adverse determination on review
- An internal rule, guideline, protocol, or similar criterion that was relied upon, or a statement that an internal rule, guideline, protocol, or similar criterion was relied upon and will be provided free upon request.

If the claim is denied, you will have 180 days after the receipt of the notification of denied claim to file a request for a review of the claim denial with the Plan Administrator or other entity designated by the plan to receive a request for review of a denied claim. Review of a denied claim will be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party, and no deference will be given to the initial denial.

If the initial denial was based in whole or in part on a medical judgment, the named fiduciary reviewing the denied claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in connection with the initial denial or was subordinated to that health care professional. The identity of any medical or vocational experts who provided advice to the plan in connection with the initial denial will be provided to you without regard to whether such advice was relied upon. You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all relevant documents as denied by applicable U.S. Department of Labor regulations. The review of the initial denial will take into account all new information you submit, whether or not it was submitted or considered in the initial denial.

You'll be given written or electronic notice of the determination of the denied claim on review (regardless of whether adverse) within a reasonable period, but not later than 45 days after receipt by the Plan Administrator or your request for review of the initial claim denial. This 45-day period may be extended by an additional 45 days if the Plan Administrator determines that a hearing is needed or if other special circumstances require an extension. You will be given written notice of any extension, including the reasons for extension and the date by which a decision by the Plan Administrator is expected to be made. In the event of an adverse determination of the denied claim on review, you will be given a notice of adverse determination on review, which will include the following:

- The specific reason(s) for adverse determination
- Reference to the specific plan provisions on which the determination is based
- A statement that you are entitled to receive, free upon request, reasonable access to and copies of all documents, records, and other information relevant to the claim
- A statement describing any voluntary appeal procedures offered by the plan

- Any internal rule, guideline, protocol, or a similar criterion that was relied upon, or statement that an internal rule, guideline, protocol, or a similar criteria was relied upon and will be provided free upon request and
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Note: You may authorize a representative to act on your behalf in pursuing or appealing a claim for benefits under the plan due to your disability by filing with the Plan Administrator a written authorization signed by you in a form provided to you by the Plan Administrator.

7.5 ERISA CLAIM PROCEDURES - OTHER WELFARE PLANS

If your claim is wholly or partially denied, the Plan Administrator will provide you with a written notification which will include:

- The specific reason(s) for adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional information necessary for you to perfect your claim with an explanation of why the information is needed, and
- A description of the Plan’s claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of benefits on review.

A written claim denial will be sent to you within 90 days after receipt of the claim by the Plan. The 90 days may be extended for up to another 90 days if special circumstances warrant an extension of time.

If such an extension is needed, you will be notified in writing prior to the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a decision.

You, your beneficiary (when an appropriate claimant), or duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review of your claim to the Plan Administrator. In connection with such a request, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

A document, record, or other information shall be considered “relevant” to your claim if the document, record, or other information:

- Was relied upon in making the benefit determination
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or other information was relied upon in make the benefit determination
- Demonstrates compliance with the administrative process and safeguards within these claims procedures in making the benefit determination

The review of your claim will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial determination of your claim.

You may have representation throughout the review procedure.

A request for a review must be filed within 60 days of your receipt of the written notice of denial of claim. The full and fair review will be held and a decision rendered by the Plan Administrator no longer than 60 days after receipt of the request for review.

If there are special circumstances (such as the need to hold a hearing), the decision will be made as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is needed, you will be notified in writing prior to the end of the initial 60-day period.

The extension notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be reached. The decision with respect to your review will be provided in writing and will include specific reasons for the decision; specific references to the pertinent Plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and a statement of the claimant's right to bring an action under section 502(a) of ERISA.

8.0 REQUIRED NOTICES

8.1 Health Insurance Marketplace Notice

The Patient Protection and Affordable Care Act (Affordable Care Act) requires that additional information be distributed regarding the creation of private health insurance exchanges designed to expand access to affordable health coverage. There is now a way to buy health insurance through the Health Insurance Marketplace. To help you evaluate options for you and your family, this notice provides basic information about the Marketplace and employment-based health coverage.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium. Open enrollment through the Marketplace will be November 1, 2018 through December 15, 2018. Coverage can start as soon as January 1, 2019.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer doesn't offer coverage, or offers coverage that doesn't meet certain standards. The premium savings depend on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you won't be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in

certain cost-sharing if your employer doesn't offer coverage to you at all or doesn't offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides doesn't meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.(1)

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. This employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for federal and state income tax purposes. Also, your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about the coverage offered by your employer, please check your summary plan description or contact Human Resources at HMFPBenefits@bidmc.harvard.edu. Should you decide to complete an application for coverage in the Marketplace, you will be asked to provide the following information about health coverage offered by HMFP-APHMFP:

EMPLOYER NAME: HMFP – EIN# 22-2768204 or APHMFP – EIN# 32-0058309

ADDRESS: c/o Human Resources, 600 Unicorn Park Drive, 4th Floor, Woburn, MA 01801

CONTACT: Human Resources – 781-528-2850 select option 3 or HMFPBenefits@bidmc.harvard.edu

As your employer, we offer health coverage to any employee and their legal dependents regularly scheduled to work 20 hours or more per week. For the purposes of health coverage, your dependents generally include your legally married spouse, your dependent children up to age 26, and disabled children who are dependent upon you for support even if they are older than age 26. This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may be eligible for a premium discount through the Marketplace. The Marketplace uses your household income, along with other factors, to determine if you're eligible for a premium discount. For example, if your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you're newly employed mid-year, or you have other income losses, you may qualify for a premium discount.

Health Insurance Marketplace – Specifically for Massachusetts

What is the Massachusetts Health Connector?

The Connector is the state's Health Insurance Marketplace. You can find out more by visiting MAhealthconnector.org or calling **1-877-MA ENROLLS (877-623-6765)**. As background about the Health Care Reform requirements, you should know about the following:

Employer-Sponsored Health Coverage: Does this employer offer employer-sponsored health insurance coverage that's affordable and meets a minimum value standard (according to federal standards) to at

least some of its employees? **Note:** *Whether a plan meets “minimum value” can be found on the plan’s Summary of Benefits and Coverage (SBC).*

If yes, and if the employee receiving this notice qualifies for such benefits, they can find out more by contacting: HMFP- APHMFP Human Resources at **781-528-2850 option 3**.

If no, or if the employee receiving the notice does not qualify for such benefits, the Health Connector can help employees evaluate coverage options, cost and eligibility. Please visit **MAhealthconnector.org** for more information, including an online application for health insurance coverage.

“Cafeteria Plan” Eligibility: Many Massachusetts employers (those with 11 or more full-time equivalent employees) are required to offer a Section 125 plan, or “Cafeteria Plan.” These plans allow employees to pay for their health insurance on a pre-tax basis. This Massachusetts law (956 CMR 4.00, authorized by M.G.L. c. 176Q, §16) requires employers to provide an option for their employees to buy health insurance with pre-tax income, even if those employees don’t qualify for a health insurance plan offered by the employer. This is done by setting up a payroll deduction that lets workers make a health insurance premium payment with pre-tax dollars.

Does this employer offer a Section 125 plan in accordance with the state requirement, if it has 11 or more full-time equivalent workers? Or does it offer such a plan, even if it’s not subject to the requirement?

If yes, employees can find out more by contacting: HMFP- APHMFP Human Resources at **781-528-2850**.

If no, employees should contact their employer or visit MAhealthconnector.org for more information about health insurance options for which they might be eligible.

8.2 COBRA Rights and Responsibilities Notice

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HMFP- APHMFP plans. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the plan and under federal law, you should review the plan’s Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215

Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215

Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; Your spouse become entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When Is COBRA Coverage Available?

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following events:

- The end of employment or reduction of hours of employment, Death of the employee,
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both), or

- If the plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

**The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215**

**Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice should be sent to:

**The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215**

**Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801**

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the

plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215

Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep the Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:
The Plan Administrator is:
HMFP and APHMFP
375 Longwood Ave., 3rd Floor
Boston, MA 02215

Human Resources is located at:
HMFP and APHMFP
600 Unicorn Park Dr. 4th Floor
Woburn, MA 01801

8.3 HIPAA Notice of Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes certain provisions that may affect decisions that you make about your participation in the plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Please carefully read the following:

HIPAA Special Enrollment Rights Notification

HIPAA provides certain "special enrollment provisions" that may provide a right to enroll in the plan if: (i) you acquire a new dependent, (ii) you decline coverage under this Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying

reasons, (iii) you or a dependent lose coverage under Medicaid or CHIP due to a loss of eligibility (rather than non-payment), or (iv) you or a dependent become eligible for Medicaid or a State Children's Health Insurance Program. If you request a change pursuant to one of these special enrollment provisions, your coverage will be effective as of the event date that makes you eligible. Specific restrictions may apply, depending on federal and state law.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be eligible to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within sixty (60) days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be eligible to enroll yourself and your dependents in this Plan. However, you must request enrollment within sixty (60) days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact your Plan Administrator.

Pre-existing Condition Exclusion Notification

Certain plans may impose a pre-existing condition exclusion that requires you to wait a certain period of time before the plan will provide coverage. Such an exclusion may last up to twelve (12) months (18 months for a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of an exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least sixty-three (63) days. To reduce/eliminate the twelve (12) month (or 18-month) exclusion period by your creditable coverage, you should provide HMFP and APHMFP a copy of a HIPAA Certificate of Creditable Coverage (HIPAA Certificate), which is a form required by HIPAA that describes the health coverage you and your dependents, if any, have or had, and the dates that you were covered by such plan(s).

If you were covered by a group health plan(s) prior to your employment with us, your previous employer and/or their insurance carrier should have provided you with a HIPAA Certificate. If you had coverage

under a previous employer but weren't provided a HIPAA Certificate, HMFP and APHMFP will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact your Plan Administrator if you need help demonstrating creditable coverage. Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator with the assistance of the prior plan administrator or insurer, if necessary, to determine its authenticity. Most prior health coverage is creditable coverage and can be used to reduce any pre-existing condition exclusions if you have not experienced a break in coverage of at least sixty-three (63) days.

Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing conditions rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plans(s) may terminate your COBRA coverage.

Where can I get more information about HIPAA?

HIPAA has a number of special rules, and the information above covers only basic points. If you want to know more about your HIPAA rights, you may contact your state insurance department or call the U.S. Department of Labor, Employee Benefit Security Administration (EBSA) toll free **866-444-3272** (for free HIPAA publications ask for publications concerning the changes in health care laws). You may also contact the CMS PUBLICATION HOTLINE at **800-998-7542** and ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at <http://www.dol.gov/ebsa> or <http://www.cms.hhs.gov/HealthInsReformforConsumer>.

8.4 Certificate of Coverage under Group Health Plans Notice

Certificates of coverage are written documents provided by a group health plan (or another source that offers health care coverage) to show the type of health care coverage a person had (e.g., employee only, family, etc.) and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you don't receive a certificate, you have the right to request one. Certificates apply to both participants and covered dependents. The primary purpose of the certificate is to show the amount of "creditable coverage" that you had under a group health plan or other health insurance coverage, because this can reduce or eliminate the length of time that any pre-existing condition clause in a new plan otherwise might apply to you.

The plan will automatically give you a certificate after you lose health coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. The plan will provide automatic certificates for your dependents when it has reason to know that they are no longer receiving health coverage. In addition, the plan will provide a certificate of health coverage for you (or your dependents) upon request if you make the request within two years (24 months) after your coverage terminates. The Plan Administrator can give you forms to make such a request. In accordance with federal law, the certificate of coverage will only show your health coverage under the plan on or after July 1, 1996. For purposes of this paragraph, a group health plan is a welfare benefit plan that provides health care. It does not include stand-alone limited scope dental and vision plans, or health care flexible spending

accounts that are limited to employee salary reduction contributions. See the Plan Administrator for details about certificates of creditable coverage and confirming any health coverage you had before July 1, 1996.

8.5 Notice of Creditable Coverage

Important Notice from HMFP- APHMFP about Your Prescription Drug Coverage and Medicare for Employees and Spouses age 65 and over on HMFP-APHMFP's Health Plan

Please read this notice carefully and keep it where you can find it. This notice contains information about your current prescription drug coverage with HMFP-APHMFP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

HMFP-APHMFP have determined that the prescription drug coverage offered by CVS Caremark are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current HMFP-APHMFP coverage will not be affected. [In other words, you will be eligible to participate in the group HPHC prescription drug plan without any restrictions.] If you do decide to join a Medicare drug plan and drop your current HMFP-APHMFP coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or with a mid-year qualified change.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you drop or lose your current coverage with HMFP-APHMFP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact HMFP and APHMFP's Benefits Team at **781-528-2850**, select option 3 or e-mail us at HMFPBenefits@bidmc.harvard.edu.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HMFP and APHMFP changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (See the inside back cover of your copy of the "Medicare & You" handbook for their phone number.) for personalized help.
- Call **1-800-MEDICARE (800-633-4227)**. TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call **800-772-1213 (TTY 800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2019

Name: Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.

Associated Physicians of Harvard Medical Faculty Physicians at BIDMC, Inc.

Contact: HMFP or APHMFP's Benefits Department

Address: 600 Unicorn Park Drive, 4th Floor Woburn, MA 01801

Phone: 781-528-2850 (select option 3)

8.6 Loss or Gain of Eligibility for a State Children’s Health Insurance Program (CHIP) or Medicaid

If you’re eligible for, but not enrolled in, a HMFP-APHMFP medical plan (or your dependent is eligible for, but not enrolled in, the medical plan), you (and your dependent) may enroll in the medical plan, or switch medical benefit options, if either of the following conditions is met:

- You or your dependent is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and
- You request coverage under a HMFP-APHMFP medical plan not later than 60 days after the date of termination of such CHIP or Medicaid coverage or you or your dependent becomes eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under the medical plan, if you request coverage under a HMFP-APHMFP medical plan not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS-NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

FLORIDA – Medicaid

Website: <http://flmedicaidprecovery.com/hipp/>
Phone: 1-877-357-3268



ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	IOWA – Medicaid Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	NORTH CAROLINA – Medicaid Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealt	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medic

h/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp>
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
<https://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website:
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: <https://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

aid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website:
<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
<http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

8.7 Women’s Health and Cancer Rights Act (WHCRA) Notice

Congress enacted the Women’s Health and Cancer Rights Act of 1998 (the “WHCRA”). This notice describes the most important provisions of WHCRA . Please review this information carefully. If your spouse is covered by our group health plan, please make certain that he or she also has the opportunity to review this information.

WHCRA requires a group health plan that provides medical and surgical benefits for a mastectomy to also provide coverage, in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Coverage for any complications in all stages of mastectomy, including lymphedema

Such coverage and benefits may be subject to annual deductible and coinsurance provisions to the extent they are consistent with those for other coverage and benefits under the group health plan.

In addition, WHCRA prohibits a group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage to avoid the requirements of the Act
- Penalizing, reducing or limiting reimbursement to a health care provider (e.g., physician, clinic or hospital) to induce such provider to provide care inconsistent with the Act
- Providing monetary or other incentives to a health care provider to induce such provider to provide care inconsistent with the Act

8.8 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

If any medical insurance option under the Plan (1) Provides for both medical and surgical mental health or substance use disorder benefit and 92) is not subject to an increased cost exemption (within the meaning of the (MHPAEA):

- The health insurance option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The medical insurance option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance options with respect to mental health or substance use disorder benefits shall be made available by the Plan

Administrator (in accordance with the MHPAEA) to any current or potential participant upon request.

- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant shall, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan shall be operated and constructed in all respects in compliance with the MHPAEA.

“Mental health benefits” and “substance use disorder benefits” are defined in the medical benefit contract applicable to the medical insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

8.9 Michelle’s Law Enrollment Notice

Michelle’s Law went into effect for health plans beginning January 1, 2010. This law is a result of a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while the child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the child to lose student status for purposes of coverage under the plan.

If the dependent child’s treating physician doesn’t provide written documentation the child is suffering from a serious illness or injury and the leave of absence is medically necessary, the plan won’t provide continued coverage.

8.10 Newborns’ and Mothers’ Protection Act of 1996 Notice (NMHPA)

Under this Act, group health plans and health insurers generally may not limit the length of a hospital stay in connection with childbirth, for either the mother or newborn child, to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section. A mother or her newborn may be discharged earlier than 48 hours following a vaginal delivery, or earlier than 96 hours following a cesarean section, as long as the mother’s or newborn’s attending physician, after consultation with the mother, agrees to the earlier discharge.

8.11 Genetic Information Nondiscrimination Act (GINA) Notice

Under this Act, group health plans and health insurers are prohibited from discriminating against or refusing coverage to individuals based on the results of genetic testing, including by adjusting premiums and contribution amounts.

8.12 Notice of Right to Designate a Primary Care Provider (PCP)

Certain coverage options under the HMFP Welfare Benefit Plan require the designation of a PCP (the medical insurance under the Aetna Global and HPHC PPO plan don’t require the designation of a PCP). If you enroll in one of those options under the HMFP Medical Plan, you have the right to designate any PCP who participates in the HMFP/APHMFP Choice Network through Harvard Pilgrim Health Care (HPHC) and who is available to accept you or your family members. Until you make this designation, the applicable coverage option designates one for you. For information on how to select a PCP, and for a list

of the participating PCP's, contact HPHC's member services at [888-333-4742](tel:888-333-4742), or online www.harvardpilgrim.org/hmfp.

8.13 Uniformed Services Employment & Reemployment Rights Act (USERRA)

Health plans must allow employees who are absent due to service in the uniformed services and/or their dependents to continue coverage under the plan during time of service.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty. An employee's dependents that have health benefit plan coverage immediately prior to the date of the employee's covered absence are eligible to elect continuation coverage under USERRA.

Premium Payment

If continuation of health plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 31 days, the cost may be up to 102% of the cost of coverage under the respective plan. This includes the employee's share and any portion previously paid by the employer.

In no event shall an employee on military leave receive benefits that are less generous than those available during other forms of employer-approved leaves (e.g., FMLA).

Duration of Coverage

Coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for or return to employment as required by USERRA, after completion of service in the Armed Forces.

Under federal law, the period of continuation coverage available under USERRA shall be considered alternative COBRA coverage. Therefore, individuals who elect continuation coverage under USERRA are not eligible for COBRA continuation coverage.

Other Information

Employees should contact Human Resources with any questions regarding coverage normally available during a military leave of absence or continuation coverage along with updating any changes in marital status, or a change of address.

8.14 Qualified Medical Child Support Order (QMCSO) Notice

The Plan Administrator has adopted the required procedures and provisions for complying with and enforcing the regulations regarding Qualified Medical Child Support Orders ("QMCSOs") as legally required, pursuant to ERISA Section 609(a) as may be amended from time to time. The Plan Administrator reserves the right to alter, amend, or terminate the procedures and substitute alternative procedures to satisfy legal requirements. A copy of the procedures is available from Human Resources at no charge, upon request.

8.15 Massachusetts Identity Theft Law Notice

This law provides for notification requirements in case of a breach, and new penalties and procedures for reported and unreported breaches. In addition, there are provisions of the law that require the amendment of all third party vendor contracts to assure vendors are compliant with the new law.

Under the new law, Private Information (PI) is defined as a person's first and last name (or first initial and last name) and one of the following: Social Security number, driver's license number or state issued identification card number. A "Breach of Security" is defined as an unauthorized acquisition of PI that creates a substantial risk of identity theft or fraud against a resident of Massachusetts.

8.16 Earned Sick Time — Notice of Employee Rights

All employees in Massachusetts can earned sick time. This includes full-time, part-time, temporary, and seasonal employees. Employees earn 1 hour of sick time for every 30 hours they work. You can earn, rollover and use up to 40 hours per year. You can begin using time after 90 days of employment. HMFP-APHMFP has sick leave built into its vacation, sick or personal time off program.

Time can be taken when the employee or the employee's child, spouse, parent or parent of a spouse is sick, has a medical appointment or has to address the effects of domestic violence. Employees are required to notify your supervisor before they use sick time, except in an emergency. Documentation can be required for periods of absence greater than 3 days or prior to termination.

For full details on your rights, visit www.mass.gov/ago/earnedsicktime or call the Fair Labor Division at 617-727-3456.

9.0 ADMINISTRATIVE INFORMATION

The Plan Administrator

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
375 Longwood Avenue, 3rd Floor Boston, MA 02215
781-528-2850, select option 3

The Plan Sponsor

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
375 Longwood Avenue, 3rd Floor Boston, MA 02215
781-528-2850, select option 3

Please note: Human Resources Offices are located at 600 Unicorn Park Dr. 4th Floor, Woburn, MA 01801
HMFP Employer Identification Number: 22-2768204 APHMFP Employer Identification Number: 32-0058309

Plan Types, Names and Numbers

Our plans are considered welfare plans or defined contribution plans.

HMFP & APHMFP

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. Welfare Benefit Plan (Plan number: 501)

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. 401(k) Savings and Investment Plan (Plan number: 001)

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. Retirement Plan (Plan number: 002)

Administration

The plans are administered by the Plan Administrator. For life insurance, short-term disability, long-term disability, accidental death and dismemberment and long-term care, benefits are provided according to the provisions of the insurance policies issued to the Plan Sponsor. Certain administrative functions (including claims administration) are performed on behalf of the Plan Administrator according to administrative vendor contracts.

The HPHC POS, PPO and CDHP medical plans, as well as Delta Dental, are self-funded health plans, with respect to which HMFP-APHMFP have purchased stop loss insurance to minimize exposure to significant losses. The re-insurer for medical plans is Voya Financial Inc.

Participating Employers

In addition to Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. ("APHMFP") also is a participating employer. APHMFP's Employer Identification Number (EIN) is 32-0058309.

Plan Year

The Plan year for all both plans is January 1 through December 31.

Future of the Plan

While the Plan Sponsor intends to continue the plans indefinitely, it's difficult to predict the future. The Plan Sponsor reserves the right to terminate these plans, or amend or eliminate benefits under these plans at any time for any reason. Any amendment, however, may not deprive you of any benefits to which you're entitled at the time.

No Guarantee of Employment

These plans aren't employment contracts. Nothing contained in this summary, the plan documents or the insurance contracts gives you the right to continue employment or interferes with the Plan Sponsor's right to discharge you or to terminate your service at any time.

Additional Information

For additional information about these plans, you should refer to the official plan documents and the full insurance contracts. Copies are available from the Plan Administrator upon request. If the terms of this summary conflicts with the terms of the plan documents, the plan documents shall govern.

Sources of Plan Contributions

Contributions for coverage may be made only by the Plan Sponsor or by participating employees. Some of the coverages require joint contributions from participating employees and the Plan Sponsor. Contributions made by the Plan Sponsor include benefit dollars (i.e., departmental contributions to

cover the costs of certain benefit dollars). Departments have the authority to allocate department expenses to individual profit and loss statements. From time to time, this may include benefits.

9.1 Privacy of Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that health plans (e.g., medical, dental and medical reimbursement plans) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the plan’s Privacy Notice, which is provided to you along with this Benefits Summary booklet and is also available from Human Resources.

Neither the health plan nor the employer will use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations, or as permitted or required by law. By law, the health plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the health plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions, in connection with another benefit or employee benefit plan or the employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy your information, receive an accounting of certain disclosures of your information, have your information sent to an alternative location or by alternative means, and under certain circumstances, amend your information. You also have the right to file a complaint with the health plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The plan maintains a Privacy Notice, provided together with this Human Resources and Benefits Summary booklet that provides a complete description of your rights under HIPAA’s privacy rules. For another copy of the Privacy Notice, questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact Human Resources at 781-528-2849, select option 3. A copy of the Privacy Notice for the dental plan is available through Delta Dental.

9.2 Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

The Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. Welfare Benefit Plan (“Plan”) provide group health plan benefits that are self-insured (for example, health and medical flexible spending account plans). If you participate in such group health plan benefits, then your Plan may use your protected health information (“PHI”) obtained through such group health benefits for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This Notice describes how the Plan may use or disclose your PHI and it explains your legal rights. If you are (or become) enrolled in a fully-insured plan or HMO, the insurer or HMO will provide its own notice describing its privacy practices.

PHI means information created or received by the Plan that identifies you and relates to your past, present or future health, treatment, or payment for health care services. This may include eligibility and enrollment information.

9.3 How Your Health Information May be Used or Disclosed

Plan Sponsor. The Plan may disclose PHI to the Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. or the Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (collectively the “Plan Sponsor”), but only for purposes of activities performed by the Plan Sponsor on behalf of the Plan. The Plan Sponsor may not use your PHI for any other purpose and is required to safeguard your PHI.

Required by Law. Your Plan may use and disclose PHI about you as required by law. For example, your Plan may disclose PHI for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority
- To report information related to victims of abuse, neglect or domestic violence and to assist law enforcement officials in their official duties.

Public Health. Your PHI may be used or disclosed for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. PHI may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donations. Your PHI may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Your Plan may use your PHI for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Health and Safety. Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions, such as protection of public officials or reporting to various branches of the armed services, may require use or disclosure of your PHI.

Worker’s Compensation. Your PHI may be used or disclosed to comply with laws and regulations related to Compensation.

Individuals Involved in Your Care or Personal Representatives. Unless you object in writing, the Plan may disclose PHI to a close friend or family member involved in your care, but only to the extent of his/her involvement in your care. The Plan may also disclose PHI to your personal representative who has the same rights concerning your PHI as you. The Plan will automatically recognize as a personal representative a parent or guardian of an unemancipated minor, or a treating physician with respect to an urgent care claim. We use physical, electronic and procedural safeguards to protect your privacy. Even when allowed, use and disclosure is limited to the minimum necessary to accomplish a given task.

9.4 Your Health Information Rights

Request Restriction on Uses and Disclosures of Your PHI



You may request a restriction of uses or disclosures of your PHI for treatment, payment or health care operations. You also have the right to ask the Plan to restrict disclosures to persons involved in your health care; while the Plan will consider all reasonable requests, the Plan is not required to agree to your request. The Plan, however, must agree to a request to restrict the disclosure of your PHI if: (i) the disclosure is for purposes of payment or health care operations and is not otherwise required by law, and (ii) the payment is only for a health care item or service for which you (or another person acting on your behalf, other than the Plan) has paid for in full.

Inspect and Obtain a Copy of Your Health Records

You may have access to and obtain a copy of your PHI. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and may direct that such PHI be sent to another person or entity. The Plan may ask you to make your request in writing, and may charge a reasonable fee for producing or mailing the copies. In certain cases, the Plan may deny the request. If your request is denied, the Plan will notify you in writing.

Amend Your Health Records

You may request that the Plan amend your PHI that is in a designated record set. Your request must be in writing and must include a reason for the request. If the Plan denies the request, you may file a written statement of disagreement. If your doctor or another person created the PHI that you want to change, you must contact that person to amend the information.

Request Confidential Communications

You have the right to request that your PHI be sent to you at any address of your choice or that the Plan communicate with you in a certain way. For example, you may ask the Plan to call you on your cell phone or send you an e-mail.

Authorize Release of Your PHI for Purposes Not Otherwise Permitted By Law

You may revoke your authorization to use of disclosed your PHI except to the extent that the use or disclosure has already occurred.

Request Accounting of Disclosures of Your PHI

You have the right to request a list (an accounting) of certain non-routine disclosure of PHI that may have occurred during the six years (or less) prior to your request. In general, the list won't include disclosures made: (i) in connection with your receiving treatment, payment for such treatment, and for the Plan's health care operations, (ii) to you regarding your own PHI, (iii) pursuant to your written authorization, (iv) to a person involved in your health care (or other similar authorized person) or (v) for national security. If you request such an accounting more than once in a 12-month period, the Plan may charge a reasonable fee.

Receive a Notice of a Security Breach

You have the right to receive written notification if the Plan discovers a breach of your unsecured PHI, and determine through a risk assessment that notification is required.

Obtain a Paper Copy of this Notice Upon Request

You may make any of the requests described above or may request a copy of this Notice by contact the Plan's Privacy Officer.

Complaints

You may make a formal complaint to the Plan's Privacy Officer at the address listed below under Contact Information and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of the Plan

- Maintain the privacy of your PHI
- Provide you with this notice of its legal duties and privacy practices with respect to your PHI
Abide by the terms of this notice
- Notify you if the Plan is unable to agree to a requested restriction on how your information is used or disclosed
- Accommodate reasonable requests you may make to communicate health information by alternative means or to alternative locations and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

The Plan reserves the right to change their information practices and to make the new provisions effective for all Protected Health Information it maintains. Revised notices will be made available to you by e-mail and/or in hard copy within sixty (60) days of any change.

Contact Information

If you have questions or complaints, please contact HMFP and APHMFP's Privacy Officer at HMFP and APHMFP at Beth Israel Deaconess Medical Center, Inc., 600 Unicorn Park Drive, 4th Floor, Woburn, MA 01801 or **781-528-2850**, select option 3.

9.6 Sources of Plan Contributions and Election of Benefits

Contributions for certain benefits under the Plan may be made solely by the participating employers or solely by the participating employees. Some of the benefits require joint contributions from participating employees and participating employers. The requirements governing election of and payment for any benefits available to participating employees are described in the Plan.

9.7 Tax Consideration

Personal circumstances affect individual tax considerations, as do changes to the tax laws and regulations. We suggest you seek professional advice for individual tax matters.

9.8 Third Party Liability

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you must reimburse the plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you must repay the plan for the health benefits you collect from the third party responsible for the accident, this insurance company or anyone else from which you receive payment from the accident. You can't avoid reimbursing the plan by treating the recovery as damages for pain and suffering or otherwise not treating the recovery as a payment for medical expenses. You must notify the plan of any claim you have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the plan, and you must cooperate with the plan in all attempts to collect from the third party. This means that the plan has the right to act on your behalf in pursuing payment from the third

party. Contact your insurer or consult your Harvard Pilgrim Health Care Benefit Handbook for details on your medial plan’s right to recover benefits on behalf of you or your dependent(s).

9.9 Responsibility for Goods/Services

HMFP-APHMFP doesn’t guarantee and won’t be responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services will be provided by personnel and agencies out-side of the control of HMFP-APHMFP.

9.10 Additional Documentation

The Plan Administrator will furnish the following documentation without charge as a separate document:

- Upon request, a description of the Plan’s procedures for Qualified Medical Child Support Orders
- Upon request, provider lists/directories for the applicable health provider networks utilized by the Plan
- Automatically, claims procedures for medical and disability benefits to the extent such procedures change prior to the next revision of this SPD

9.11 Agent for Service of Legal Process

Legal process may be served on the Plan Administrator:

If a legal summons is to be served on the Plan, it should be directed to:

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
Office of Human Resources
375 Longwood Ave., 3rd Floor
Boston, MA 02215
617-632-9755

10.0 HOW TO CONTACT US AND OUR VENDORS

10.1 Contact Human Resources & Benefits Team

For benefit questions, contact the HMFP-APHMFP Benefits Team or use the vendor contact list below:

HMFP-APHMFP Benefit Team

HMFPBenefits@bidmc.harvard.edu
General HR P. 781-528-2850 | HR F. 781-528-2830
600 Unicorn Park 4th Fl. Woburn, MA 01801

W. <https://hmfphysicians.org/employee-area>

Username: HMFP-APHMFP Password: Welcome!

10.2 VENDOR CONTACT INFORMATION

Benefit Program	Carrier Name	Website	Customer Service Number
Medical	Harvard Pilgrim Health Care	harvardpilgrim.org harvardpilgrim.org/hmfp	888-333-4742
Prescription Drug	CVS Caremark	Caremark.com	844-257-6072
Dental	Delta Dental	deltadentalma.com	800-872-0500
Vision	EyeMed	Eyemed.com	866-800-5457
Health Savings Acc't	HealthEquity	healthequity.com	866-346-5800
FlexChoice (FSA Health, Limited Purpose, Dependent Care)	Sentinel Benefits	sentinelgroup.com	888-762-6088
Life Insurance	Minnesota Life	lifebenefits.com	800-843-8358
Legal/Financial & Grief Support		lifeworks.com Lifeworks User ID = lfg Password = resource	877-849-6043
Legacy Planning		legacyplanningresources.com	
Disability	Standard Insurance Co. InsMed Insurance Agency, Inc.	standard.com insmedinsurance.com	888-937-4783 800-214-7039
Savings and Retirement Plans	Fidelity Investments TIAA	fidelity.com/atwork tiaa.org/hmfp	800-343-0860 800-842-2776
Excess Liability Insurance	Chubb Provider Insurance Group	chubb.com/personal privateclient@providerig.com	781-444-0347
Adult and Child Care	Care.com	care.com/backupcare	800-688-4697
Travel Assistance	Minnesota Life	lifebenefits.com/travel	855-516-5433 (U.S./Canada) 617-426-6603 (all other locations)
Bike Share	Blue Bikes Boston	https://www.bluebikes.com/	Password WvKtZLn7 select "BIDMC"
Global Benefits	Aetna Global Health	aetnainternational.com	800-231-7729