Human Resource and Benefits Summary

2016

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
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Welcome

Whether you are a prospective, new or existing employee of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (HMFP) or Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (APHMFP), this booklet has been designed to assist you in better understanding our comprehensive benefit program as well as other employment-related information. We are committed to offering you fast and efficient service for all of your Human Resources, benefits and payroll needs. The descriptions provided in this booklet are summaries only. Full details of each coverage option are provided in the plan documents and other publications available from Human Resources. Should there be any discrepancy in any of the enrollment materials with the plan documents, the information in the detailed plan documents will govern.

Looking for Help?
Our office hours are from 8:00 a.m. to 4:30 p.m. Monday through Friday. There are many ways you can get your questions answered:

☐ Access our new intranet site through the BIDMC Portal (https://portal.bidmc.org/hmfp) with your “ITS” username and password. This site will allow employees of HMFP/APHMFP, regardless of where you are located, to access information related to Human Resources, Finance and Compliance.

☐ Call 617-632-8694, option 4.

☐ E-mail your questions to our corporate e-mail address at HMFPCo@bidmc.harvard.edu. Your e-mail will be triaged to the most appropriate person.

☐ Visit our office at 375 Longwood Avenue, 3rd floor, left off the elevator.

☐ Our confidential fax number is 617-632-9752 should you need to submit any documents or forms.

HMFP/APHMFP External Website
HMFP/APHMFP has launched a new website in 2015! To access the new website go to www.hmfphysicians.org. The new site explains who HMFP/APHMFP is, provides information on all our departments as well as offers the opportunity to search for open positions at HMFP/APHMFP.

Important Contact Information
Below are some useful telephone numbers if you have questions about payroll, benefits or compliance.

<table>
<thead>
<tr>
<th>FOR</th>
<th>CALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Changes, Leave of Absence, &amp; Worker’s Compensation</td>
<td>617-632-9732</td>
</tr>
<tr>
<td>Retirement Plan Information</td>
<td>617-632-9737</td>
</tr>
<tr>
<td>New Hire/Rehire</td>
<td>617-632-7132</td>
</tr>
<tr>
<td>Payroll Information</td>
<td>617-632-9743</td>
</tr>
<tr>
<td>Compliance</td>
<td>617-632-9589</td>
</tr>
</tbody>
</table>
Human Resources Forms
Below you will find forms that are required for certain employment events.

<table>
<thead>
<tr>
<th>FORM</th>
<th>NEW HIRE/REHIRE</th>
<th>MID-YEAR CHANGE OR ANY TIME</th>
<th>OPEN ENROLLMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-9/E-Verify Form</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>CORI Forms</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invitation to Self-ID Disability and Veterans Form</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Direct Deposit Form</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tax Forms</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mid-year Change Form</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Open Enrollment Online</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Benefit Elections</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Life, Business Travel and AD&amp;D Beneficiary Form</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fidelity Investments Beneficiary Form</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Vendor Contact Information
Below you will find telephone numbers and website information for many of the vendors used by HMFP/APHMFP.

<table>
<thead>
<tr>
<th>VENDOR</th>
<th>PHONE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Plan</td>
<td>1-888-333-4742</td>
<td><a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a></td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care</td>
<td></td>
<td><a href="http://www.harvardpilgrim.org/bidmc">www.harvardpilgrim.org/bidmc</a></td>
</tr>
<tr>
<td>Dental Plan</td>
<td>1-800-872-0500</td>
<td><a href="http://www.deltadentalma.com">www.deltadentalma.com</a></td>
</tr>
<tr>
<td>FlexChoice FSA and COBRA</td>
<td>1-888-762-6088</td>
<td><a href="http://www.sentinelgroup.com">www.sentinelgroup.com</a></td>
</tr>
<tr>
<td>Sentinel Benefits &amp; Financial Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance Programs</td>
<td>1-800-843-8358</td>
<td><a href="http://www.securian.com">www.securian.com</a></td>
</tr>
<tr>
<td>Minnesota Mutual</td>
<td></td>
<td><a href="http://www.lifebenefits.com">www.lifebenefits.com</a></td>
</tr>
<tr>
<td>Disability Programs</td>
<td>1-800-214-7039</td>
<td><a href="http://www.insmedinsurance.com">www.insmedinsurance.com</a></td>
</tr>
<tr>
<td>InsMed Insurance Agency Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement Program Vendors</td>
<td>1-800-343-0860</td>
<td><a href="http://www.fidelity.com/atawork">www.fidelity.com/atawork</a></td>
</tr>
<tr>
<td>Fidelity</td>
<td>1-800-842-2776</td>
<td><a href="http://www.tiaa-cref.org/hmfp">www.tiaa-cref.org/hmfp</a></td>
</tr>
<tr>
<td>TIAA-CREF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term Care Insurance</td>
<td>1-800-482-0022</td>
<td><a href="http://group.jhancock.com/">http://group.jhancock.com/</a></td>
</tr>
<tr>
<td>Former Program – John Hancock (closed program)</td>
<td>1-800-214-7039</td>
<td><a href="http://www.insmedinsurance.com">www.insmedinsurance.com</a></td>
</tr>
<tr>
<td>Current Option – InsMed Insurance Agency Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care.com BackUp Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chubb Umbrella Liability Policy</td>
<td>1-781-444-0347</td>
<td>E-mail to:</td>
</tr>
<tr>
<td>Provider Insurance Group</td>
<td></td>
<td><a href="mailto:privateclient@providerig.com">privateclient@providerig.com</a></td>
</tr>
</tbody>
</table>
Welcome

Changes to Name and Address

Name or address changes should be updated with Human Resources soon as possible to keep your payroll and benefit information current. You can e-mail us at HMFPCo@bidmc.harvard.edu. Official documentation for name changes, such as marriage license is required. You can fax your name change documentation to our confidential fax 617-632-8752. Also, if applicable, it is important that you notify the following agencies if you have a change in address:

**LICENSING BOARDS:**

- **MA Board of Registration in Medicine (MD/DO)**
  200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
  Phone: 781-876-8200

- **MA Board of Registration in Nursing:** 617-973-0900
- **MA Board of Registration of PA:** 617-973-0806
Both have the same address: 239 Causeway St., Suite 500, Boston, MA 02114

**FEDERAL DRUG ENFORCEMENT AGENCY (DEA):**

- **Drug Enforcement Agency**
  15 New Sudbury St., 4th Fl., Boston, MA 02203
- **Massachusetts Phone:** 617-557-2468
- **Other New England States Phone:** 617-557-2200

To change your address with the federal DEA: Submit a letter, to the address above, along with a copy of your current Massachusetts medical license, current federal DEA, and MA Control Substance certificate.

**Overnight mailing address to expedite DEA application:**

- **DEA Headquarters Registration Unit**
  2401 Jefferson Davis Hwy
  Alexandria, VA 22301

**MA DEPT OF PUBLIC HEALTH STATE CONTROL SUBSTANCE CERTIFICATION:**

- **Department of Public Health**
  Division of Food and Drugs
  99 Chauncy Street
  Boston, MA 02111
- **Phone:** 617-983-6700

Clinician Health Service Program

The Clinician Health Service Program is open to all HMFP/APHMFP 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, you should contact Pamela Peck, PsyD, Director at ppeck@bidmc.harvard.edu. Reference: HMFP/APHMFP employee.

**CLINICAL HEALTH SERVICE STAFF**

<table>
<thead>
<tr>
<th>Pamela Peck, PsyD, Director</th>
<th>Michael Kahn, M.D.</th>
<th>Rohn Friedman, M.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>617-667-0651</td>
<td>617-667-8322</td>
<td>617-632-8404</td>
</tr>
</tbody>
</table>
Leaves of Absence

HMFP/APHMFP recognizes that medical, personal and family needs sometimes require an extended absence from work. To accommodate these needs, we provide leaves of absence for a variety of reasons. Eligibility, your right to continue benefits, maximum duration of leave, and return-to-work provisions vary with each type of leave. A leave of absence may include paid, unpaid or a combination of paid and unpaid time depending upon your department's vacation/sick/holiday program.

You are responsible for ensuring that your supervisor or manager is kept apprised of any absence from work, whether paid or unpaid. Generally, you will be expected to ask your supervisor or manager for time off for periods of less than five days. Although the reason for this shorter term absence may qualify under some of the leaves described below, no Leave of Absence forms need to be filled out.

For leaves anticipated to last more than five days, a Leave of Absence form must be obtained, completed, approved and filed with Human Resources. You should give as much advance notice as possible, usually at least two weeks. If you need additional information, call the Human Resources Leave Coordinator at 617-632-9732.

Types of Leaves

The following is a brief description of the specific leaves of absence:

**Family and Medical Leaves (FMLA):** FMLA is a leave (12-week maximum) taken by eligible employees for one of the following reasons: the birth of a child and to care for that child; the placement of a child for adoption or foster care; the care of a spouse or same-sex domestic partner, child, or parent with a serious health condition (as defined by law); a qualified Exigency Leave, Military Caregiver Leave, or the serious health condition of the employee that makes him/her unable to perform the essential functions of his/her position. Documentation from a physician or other health care provider may be required to qualify for this leave.

To be eligible for FMLA leave, you must have been employed with HMFP/APHMFP for 12 months and must have worked at least 1,250 hours during the 12-month period immediately before the leave commenced. If you return to work at or before the conclusion of 12 weeks of FMLA leave, you will be returned to your same job or a job with equivalent status, pay, benefits and other employment terms. If your leave is longer than 12 weeks and your position is filled, you may apply for other positions for which you are qualified. You will be given preference in re-hire for any job you are qualified to perform, provided you were in good standing prior to taking your leave.

**Intermittent Leave:** Intermittent leave is a Family and Medical Leave (FMLA) taken in separate periods of time due to a single illness or injury as determined by the health care provider of the individual, rather than one continuous period of time. Leaves may include periods from an hour or more to several weeks.

**Maternity and Adoption Leave:** An eight-week leave will be granted to regular full-time or benefits-eligible part-time employees with at least three months of continuous employment for the purpose of giving birth or adopting a child. If you also are eligible for FMLA leave, such leave will run concurrently. Documentation from a physician or other health care provider may be required to qualify for this leave. If you return to work at or before the conclusion of your approved leave, you will be returned to your same job or a job with equivalent status, pay, benefits and other employment terms. If your leave is longer than eight weeks and your position is filled, you may apply for other positions for which you are qualified. You will be given preference in re-hire for any job you are qualified to perform, provided you were in good standing prior to taking your leave.

**“Small Necessities” Leave:** This leave is for time away from work (up to 24 hours during a 12-month period) for participation in: educational activities of a son or daughter, such as parent-teacher conferences; accompanying a son or daughter to routine medical/dental visits; accompanying an elderly relative of the employee (60 years or older) to routine medical/dental visits or other professional services related to elder care. You must complete 12 months of continuous employment and have worked a minimum of 1,250 hours to be eligible for this leave. At least seven days’ notice, or, if unforeseeable, as much notice as possible is required for this leave.
Worker's Compensation Leave: This is a leave taken due to a work-related illness or injury. If the illness or injury is a serious health condition, the leave also may be an FMLA leave and will run concurrently. If you return to work at or before the conclusion of 12 weeks of leave, you will be returned to your same job or a job with equivalent status, pay, benefits and other employment terms. If you return from an approved leave of longer duration, you will be returned to your same or similar position, when possible. If your leave is longer than 12 weeks and your position is filled, you may apply for other positions for which you are qualified. You will be given preference in re-hire for any job you are qualified to perform, provided you were in good standing prior to taking your leave.

Personal or Educational Leave: This means a leave (12-month maximum) taken for personal reasons or a leave taken to pursue educational advancement in an area or field that is work-related. To be eligible for this leave, 12 months of continuous employment is required. Under this leave, there is no job reinstatement guarantee. Your position may be held open or filled at any time, depending on your manager’s discretion.

Military Leave: A leave taken by a member of the Armed Forces of the United States or the Commonwealth of Massachusetts to attend assigned military service. If you are required to serve an annual tour of duty as a member of a reserve component, then HMFP/APHMFP will pay any difference between your military pay and your regular pay up to a maximum of 17 days within the calendar year. During periods of crisis, all employees other than temporary employees called to active duty or who volunteer for active duty are eligible for military leaves of absence. HMFP/APHMFP may issue special pay and benefit provisions to correspond to the circumstances at the time.

Exigency Leave: An employee can take up to a 12-week FMLA leave during the designated 12-month FMLA leave year when the employee’s son, daughter or parent is a member of a regular component of the Armed Forces and is on active duty or call-to-active-duty status for one or more qualifying exigencies. These include short-notice deployment, military events and related activities, certain childcare and related activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities, deployment to a foreign country, and any other event that the employer and employee agree constitute a qualifying exigency.

Domestic Violence Leave: Employees are entitled to as many as 15 days of job-protected leave to address domestic violence issues affecting them or members of their family. An employee may take the leave to attend to health, safety, or legal issues related to domestic violence, stalking, sexual assault, and certain other abuses that affect the employee or certain family members unless the employee is the abuser. Covered family members include a spouse, child, or parent (including those related by marriage). It also includes a sibling, grandchild, or grandparent, a domestic partner, any person with whom the employee has a child or with whom the employee has a guardianship relationship. Where possible, an employee must give the employer “appropriate advance notice” of the need to take leave. But in the event of “imminent danger,” the employee can take up to three days after leave has begun to notify the employer. The employee may take up to 30 days after the leave to provide documentation, which may take a variety of forms, including medical records, court or law enforcement documents, or a sworn statement. All documentation will be kept confidential. An employee must exhaust all other available vacation, personal, and sick time before requesting leave under the new law. Returning employees must be restored to the same or equivalent position and can’t be subject to termination or other employment discrimination for taking leave.

Military Caregiver Leave: An eligible employee is able to take up to 26 work weeks of FMLA leave in a specifically designated 12-month FMLA leave year, measured forward from the first time an employee takes FMLA leave to care for a covered servicemember with a serious illness or injury, where the employee is the spouse, son, daughter, parent or “next of kin” of the covered servicemember. Under the National Defense Authorization Act for Fiscal Year 2010 (NDAA), the definition of a “covered servicemember includes veterans who are undergoing medical treatment, recuperation or therapy for a serious injury or illness and who was a member of the Armed Forces, including the National Guard and Reserves, at any time during the five-year period preceding the date on which the veteran undergoes treatment.”
Your Benefits While on Leave of Absence
The following will describe in general the provisions affecting benefits during an approved leave of absence. Please note that if your leave is for personal or educational reasons, benefits may vary from those listed below. Please contact Human Resources at 617-632-9732 for additional details.

Medical and Dental: If you are currently enrolled, your medical and dental coverages will continue provided you pay your share of the cost (for up to one year). You will be billed for your portion of the insurance on a monthly basis. Payment is due upon receipt and failure to pay the balance due will result in termination of your coverage. However, if your leave is less than six months, we will give you the option to catch up your premiums upon your return. If the leave is for Worker’s Compensation, the insurance may be covered for up to one year at no cost to you.*

Life Insurances and Accidental Death and Dismemberment (AD&D): If you are currently enrolled, your life insurance programs through Minnesota Life will continue for 12 months if you are on family or medical leave. Your coverage will continue provided you pay your share of the cost. You may be billed for your portion of the insurance on a monthly basis. In some cases of short-term absences, we will catch up your deductions when you return to payroll. Payment is due upon receipt and failure to pay the balance due may result in termination of your coverage. For longer term absences, if you currently have a policy through Minnesota Life for GUL/VGUL, spousal and/or dependent life insurance, you will receive a bill directly from the carrier for premiums due. Failure to pay the invoice will result in the termination of your coverage. If you believe you will be out for more than one year due to a medical disability, it is recommended that you apply for a waiver of premiums from Minnesota Life for your term life policy following your ninth month of leave. Contact Minnesota Life at 1-800-843-8356 for additional details.

Short-Term and Long-Term Disability: Short-term and long-term disability coverage is extended at no cost if you are on medical or maternity leave. During all other types of leave, disability coverage will end on the last day of work and begin again when you return to a benefit eligible position.

FlexChoice Flexible Spending Accounts: If you participate in a flexible spending account, contributions will stop as soon as the unpaid portion of your leave begins. You may still submit claims to your account through March 31st of the following calendar year. Deductions for the current tax year will be made up upon your return. In no event will deductions for the previous year be taken in a new calendar year.

Retirement Plans: Contributions stop when you are on an unpaid leave and resume when you return to work (provided you meet eligibility requirements).

Voluntary Investment Contributions: Contributions stop when you are on an unpaid leave and resume when you return to work (provided you meet eligibility requirements). Please discuss options for catching up missed contributions with the Leave Coordinator.

Parking/MBTA Pass: If you have a subsidized parking space or payroll deduction for a T Pass, please contact Commuter Services to arrange payment or suspension of the deduction or you will be responsible for the cost while on leave. You need to contact them again upon return to regain your space or restart your T Pass payroll deductions.

*There are associated tax implications to this benefit, please discuss with Human Resources.
Welcome

On the Job Injuries (Worker’s Compensation)

Our goal is provide a safe work environment for all our employees at HMFP/APHMFP but we recognize on the job injuries do occur from time to time. To ensure you know what to do, we are providing you with a step-by-step process if a work-related injury should occur.

Step 1:

<table>
<thead>
<tr>
<th>ALL EMPLOYEES SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY:</th>
<th>During business hours</th>
<th>After business hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMFP/APHMFP employees working in Boston</td>
<td>Report to the BIDMC Employee Occupational Health Department in the Libby Building at 169 Pilgrim Road</td>
<td>Report to the BIDMC Emergency Department or other urgent care facility</td>
</tr>
<tr>
<td>HMFP/APHMFP employees working in Community</td>
<td>Report directly to your site’s Occupational Health Department or local Emergency Department</td>
<td></td>
</tr>
</tbody>
</table>

Step 2:

<table>
<thead>
<tr>
<th>THE INCIDENT MUST BE REPORTED TO YOUR SUPERVISOR AS SOON AS POSSIBLE:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HMFP/APHMFP employees working in Boston</td>
<td>If you go to BIDMC Employees Occupational Health or the BIDMC Emergency Department, you will complete the necessary forms and notify our insurance carrier.</td>
</tr>
<tr>
<td>HMFP/APHMFP employees working in Community</td>
<td>If you went to your site’s Occupational Health Department you will be able to complete the necessary forms, However, if you go to your local Emergency Department or private physician’s office, you should, as soon as practical, go to your site’s Employee Occupational Health Department to complete the necessary forms. Your site’s Employee Occupational Health Department will then notify HMFP/APHMFP insurance carrier with the appropriate information. You can also obtain the necessary forms by contacting Human Resources directly at 617-632-9732.</td>
</tr>
</tbody>
</table>

Photo ID/Badge Requests

BIDMC ID Request

Per BIDMC policy, all persons issued an ID must wear it visibly on their person at all times while on hospital property. It is assumed that all personnel understand the responsibility of being issued ID/access cards. ID cards must not be loaned or transferred to another person and must be returned to Public Safety upon termination.

Photo IDs are now printed onto access cards. Pictures for IDs are taken daily at the Public Safety Office on the West Campus in the Farr Building, 1st floor, 24 hours a day, 7 days a week (holidays included). You will be asked to provide another form of photo identification. A driver’s license, official state identification or another form of official photo identification is required. There is a $5.00 replacement fee for lost or missing access cards. This fee is payable at the Cashier on Feldberg, 2nd floor or Clinical Center West, Main Lobby. A paid receipt must be presented along with this authorization form.

Your division administrator will provide you with the Photo ID & Access Card Authorization Form. To be processed, the form must bear an original signature of your supervisor/manager and you must have been cleared by Employee Occupational Health.

APHMFP Employees or HMFP Employees Working at a Community Location ID Request

If you are scheduled to work in a facility other than BIDMC, please contact your division administrator for details on how to obtain an ID.
Welcome

How to Obtain a Harvard Identification Card

To obtain a Harvard Identification Card, you will need to go to the School of Public Health’s Harvard ID Office. They are located at 677 Huntington Ave., Suite 119, Boston. For questions, contact them at 617-432-0389 or by e-mail at id_service@harvard.edu. You must have an active Academic Appointment to obtain this card.

Payroll Information

You will be paid semi-monthly, receiving your paychecks on or about the 15th and 30th of each month. When 15th or 30th of the month falls on a Saturday or Sunday you will be paid on the Friday before. For federal weekday holidays, you will be paid the day before. Direct Deposit is available with up to three different banking options. It is important to remember that any new or changed direct deposits take one payroll cycle to be approved by the receiving bank. During this time, you will receive an actual check mailed to your home.

As a newly employed member of HMFP/APHMFP, you will receive your first paycheck by mail to the home address on file. During your first payroll, steps will be taken to test your banking information (called pre-noting) for accuracy. Following receipt of your first check, you will need to enroll in our online payroll statement program called iPayStatement. Through ADP, our payroll provider, we are able to offer you online access to your earnings statements and W-2 forms 24 hours a day, 7 days a week. This feature eliminates mailing you the Direct Deposit Vouchers. In addition, you can make changes to your W-4. Simply type in your changes, print, sign the form, and fax the completed form to Human Resources at 617-632-9752.

How to Register on ADP iPayStatements

1. Go to ipay.adp.com (do not type in “www.”)
2. “Welcome to ADP iPayStatements” – click on the “Register Now” bullet
3. Enter the Registration Code you were provided during your newhire meeting or found on our Intranet site and click “Next”
4. Verify your identity by entering your Social Security number and name and click “Next”
5. View your system-generated ADP User ID (You will need this to log on in the future.)
6. Create your case sensitive password and click “Submit”
7. Select “Security Questions and Answers” and click “Next”
8. Enter your contact (e-mail) information for future notifications and click “Next”
9. Enter the activation code sent to you via your contact e-mail address and click “Next”
10. Review and submit security and contact information and click “Next”
11. Click the “Login” button to access ADP Services

Note: If you’re using a MAC, you may need to use the Firefox Browser

Upon registration, you may elect to have an automatic e-mail notification sent to you when your current earnings statement is available. Log in and click on “Change Your Notification Options.” Click on the box for “Send E-mail Notifications” and click on “Save.” Once you have completed the registration process, you should “Bookmark” or “Add to your Favorites” the URL, ipay.adp.com.

Locked out? For security purposes the system will automatically deactivate your account if you do not access the site at least once every three months. To reactivate your access you will need to reset your password. If you are locked out due to forgetting your password, the system will reset in about 20 minutes allowing you to change your password. For additional information or if you experience any problems, you can call 617-632-9757.
## How to Interpret Your ADP iPayStatements

<table>
<thead>
<tr>
<th>WHAT’S ON YOUR CHECK</th>
<th>WHAT IT MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imp Inc Transit = D and E</td>
<td>Imputed Income Parking / T-Pass</td>
</tr>
<tr>
<td>PARKING = D</td>
<td>Pre-tax Cost for Parking</td>
</tr>
<tr>
<td>T-Pass = D</td>
<td>Train/Bus Pass</td>
</tr>
<tr>
<td>POST TAX PARKIN = D</td>
<td>Post Tax Cost for Parking</td>
</tr>
<tr>
<td>Supplemental LF = D</td>
<td>Supplemental Life Insurance Premiums</td>
</tr>
<tr>
<td>SP Life = D</td>
<td>Spousal Life Insurance Premiums</td>
</tr>
<tr>
<td>Add $ VGUL = D</td>
<td>Additional VGUL $ added</td>
</tr>
<tr>
<td>Med HPHC POS = D</td>
<td>Health Insurance BIDMC Choice Premiums</td>
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<tr>
<td>Med HPHC PPO = D</td>
<td>Health Insurance PPO Premiums</td>
</tr>
<tr>
<td>DENTAL = D</td>
<td>Dental Insurance Premiums</td>
</tr>
<tr>
<td>AD&amp;D = D</td>
<td>Accidental Death &amp; Dismemberment Premiums</td>
</tr>
<tr>
<td>LTD-Tfb = D</td>
<td>Long-term Disability Imputed Income</td>
</tr>
<tr>
<td>LTD = E</td>
<td>Short-term Disability Imputed Income</td>
</tr>
<tr>
<td>HEALTH FSA = D</td>
<td>Reimbursement Account for Health Expenses</td>
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<tr>
<td>DEPFSA = D</td>
<td>Reimbursement Account for Dependent Expenses</td>
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<tr>
<td>MEDICARE SURTAX = D</td>
<td>If your salary hits $200k in the year you are required to pay this surtax</td>
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<td>Malpractice = D</td>
<td>Malpractice Insurance</td>
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<tr>
<td>Be Well Fitness = D</td>
<td>Fitness Center at BIDMC</td>
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<tr>
<td>LT Care = D</td>
<td>Long-term Care</td>
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<tr>
<td>401k CONTRIB = D</td>
<td>401k Contribution and 401k Catch-up Contributions</td>
</tr>
<tr>
<td>401k50+CNTRB = D</td>
<td>401k Contribution and 401k Catch-up Contributions at Age 50</td>
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<tr>
<td>ROTH 401k = D</td>
<td>Roth 401k Contribution</td>
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<td>ROTH CUP 401K = D</td>
<td>Roth 401k Contribution over Age 50</td>
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<tr>
<td>CHUBB DED = D</td>
<td>Personal Excess Liability Ins.(PELI) $ provided for PELI</td>
</tr>
<tr>
<td>CHUBB EARN = E</td>
<td></td>
</tr>
<tr>
<td>Universal Life = D</td>
<td>Basic 2x Salary for Life Insurance Premiums</td>
</tr>
<tr>
<td>Benefit $ = E</td>
<td>$ provided for Life Insurance</td>
</tr>
</tbody>
</table>
What Happens If I Terminate My Employment

If you leave HMFP/APHMFP, you will receive information from Human Resources regarding the transition of your benefits shortly after your last day. Access to the Medical Center and its systems will be shut off following your termination. It is important if you plan to continue seeing patients at BIDMC or other locations that your sponsoring department applies for continuation of an appropriate access level. Information on the termination process can be found by going to the HMFP/APHMFP intranet site https://portal.bidmc.org/hmfp and click on the Benefits tab.
New and Re-Hire Process

Initial Human Resources Personal Meeting
All newly hired or returning members to HMFP/APHMFP receive a welcome e-mail with a link to access all the necessary onboarding forms. The link returns you to the same system you used to apply for your position. The e-mail also includes a request to contact Human Resources to set up a personal meeting to review the onboarding forms as well as elect benefits. This meeting will occur prior to or within three business days following your start date. The onboarding forms will include:

- **CORI Form:** You will be asked to complete the Consumer Report Investigative Consumer Report Disclosure and Release of Information Authorization form as well as the Criminal Offender Record Information Acknowledgement form. Any individual who refuses to complete the required forms will not be permitted to commence his or her relationship with HMFP/APHMFP.

- **The Employment Eligibility Verification Form (I-9):** As of September 8, 2009, we are required by law to use the federal government's E-Verify system to verify the employment eligibility of all newly hired employees. The Department of Homeland Security in partnership with the Social Security Administration operates this internet-based system.

- **Other Forms:** You will be asked to complete various forms for payroll purposes including direct deposit; federal and state tax forms, and a voluntary self-ID form. During the personal meeting you may need to complete additional benefit enrollment forms. (See the Benefits Overview section in this booklet for more detail.)

Corporate Policies and Procedures
Regardless of your physical work location, it is important to remember that you are an employee of HMFP/APHMFP. As a reminder, employees of HMFP/APHMFP are required to follow organizational policies and procedures as well as the policies and procedures at any of the institutions where you work.

- **myPATH:** This learning management system (Performance and Training Hub) is a personalized, all-in-one online resource, to take and report your training. All new hires to HMFP/APHMFP will be required to use myPath for their training.

- **New Provider Training:** HMFP/APHMFP (non-leased employees) will be required to complete New Provider Training within 90 days of hire. Contact the HMFP Compliance Office at 617-632-9589 to schedule your training.

Employee Occupational Health Service
All employees are required to be cleared by Employee Occupational Health Services (EOHS) to meet state and federal regulations, Joint Commission Standards and Infection Control Policy. Currently we contract with BIDMC’s EOHS for a number of these regulatory requirements. Clearance by Occupational Health is required for all employees whether you will provide patient care or not. The pre-employment process verifies immunization records along with tuberculosis test results.

EOHS is located in the Libby Building at 169 Pilgrim Rd, Boston, MA. Current hours of operation are Monday – Friday, 7:30 am to 3:30 pm. Documentation can be faxed to EOHS at 617-632-0906.

BIDMC Credentialing
The management and oversight of all Medical Staff credentialing and privileging for BIDMC is performed through the Office of Professional Staff Affairs (PSA). You will receive an application packet from the PSA. Please complete and return promptly (especially if you do not have a MA License) to the PSA. If you would like assistance in completing the application, please contact the PSA Office at 617-667-1913.
**New and Re-Hire Process**

**Note about other sites**: Should you be working at another site other than BIDMC, please contact your Department Administrator to confirm the credentialing process for those sites.

All physicians receive an evaluation of their performance at BIDMC every 8 months. As such, all medical staff members are regularly evaluated for their compliance to BIDMC or home institution policies, procedures and mandates from the respective Medical Executive Committee(s). Orientation and ongoing training documentation required by BIDMC and/or your home institution must be documented with the institution’s Medical Staff Office. It is imperative that you understand who in your division maintains this documentation and that you keep copies of any documentation for your records.
Benefits Overview

Who Is Eligible for Benefits
Benefits are available to eligible employees of HMFP/APHMFP who are in a budgeted position and 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 are not program-eligible regardless of the number of hours worked per week.

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 are older than age 26, provided they were disabled before their 26th birthday and meet the eligibility and medical criteria.

NOTE: PLEASE CONSULT THE TERMS OF THE APPLICABLE BENEFIT PROGRAM TO DETERMINE IF THE PLAN PROVIDES DEPENDENT COVERAGE AND WHETHER A SPECIFIC INDIVIDUAL QUALIFIES AS AN ELIGIBLE DEPENDENT.

Important: Falsification, omission or misstatement of dependent information is grounds for disciplinary action up to and including suspension and/or termination of employment. If a dependent does not meet the legal or contractual definitions, then all benefits will be denied to those individuals and the employee will be responsible for any costs paid by HMFP/APHMFP.

Initial Enrollment in Benefit Programs
If you are just joining HMFP/APHMFP or enrolling for the first time, you will select your benefits during your meeting with Human Resources. To arrange your meeting, you can call us at 617-632-8694, option 4 or e-mail us at HMFPCo@bidmc.harvard.edu.

Annual Open Enrollment
You will have an opportunity to review your benefit choices and make changes once a year. For 2016, the site will be open from October 30, 2015 through November 15, 2015. Your benefits for this enrollment will be effective from January 1, 2016 through December 31, 2016.

You will be required to complete the enrollment process using our online system. This site can be found at www.eElect.com. An enrollment packet will be mailed to your home with your personalized PIN and password. Once you choose your benefits, you may not change them until the next enrollment period unless you have a qualifying change in lifestyle. (See Mid-Year Changes.) Please refer to this enrollment booklet as needed for additional information on each benefit. Except for FlexChoice FSA elections, the site has maintained your 2015 open enrollment elections and/or any changes you made during the year.
Mid-Year Changes

Once you have made your elections, you may not change them during the year unless you have a qualifying change in lifestyle as defined by the Internal Revenue Code. If you request an election change, it must reflect your lifestyle change and must be made within 30 days of the change. Lifestyle changes generally include:

- Marriage, divorce, annulment, or legal separation
- Loss of spouse or qualified dependent
- Birth, adoption or placement for adoption of a child
- Commencement or termination of spouse’s employment
- Gain or loss of benefit coverage through spouse’s employer
- Commencement or return from an unpaid leave of absence by the employee
- Change in benefit eligibility status by the employee, spouse, or dependent
- Spouse’s annual open enrollment period
- Relocation out of a health maintenance organization service area
- Qualified medical child support orders
- Events relating to Medicare, Medicaid, or Health Insurance Marketplace eligibility
- Significant cost increases or decreases in a coverage available under the benefit plan (This does not apply to the Health Care Flexible Spending Account.)
- Significant curtailment of coverage available under the benefit plan (This does not apply to the Health Care Flexible Spending Account.)
- Availability of a new benefit option or an existing benefit option is significantly improved under the benefit plan (This does not apply to the Health Care Flexible Spending Account.)

You will need to complete a Change in Lifestyle Form, found on the HMFP/APHMFP intranet under the Forms Section of the Benefits tab, 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.

If you have a change in lifestyle, you can change your category of coverage (Employee Only, Employee plus One, or Employee plus Family), but generally not your plan option. Also, any election change must reflect your lifestyle change. For example, if you get married, you can change from Employee Only to Employee plus One or Employee plus Family.

You can switch from one medical plan to another between annual enrollment periods only as follows:

- You may change from a plan to the No Coverage Option if you become eligible for coverage through your spouse’s employer.
- You may change from the No Coverage Option to HMFP/APHMFP’s medical plan if you lose coverage through your spouse’s plan.
Mid-Year Changes – Without Event
Certain benefits allow enrollment or fund changes to existing coverage through the year without requiring a qualified event. They include:

- Long-term care insurance
- Group Universal Life (GUL) or Variable Group Universal Life (VGUL) insurance
- Voluntary savings and investment plans that allow for contribution and fund changes
- Supplemental disability programs

For additional information and/or forms, please contact Human Resources at 617-632-8694, option 4.

Your Contributions
Your contributions for medical, dental and FlexChoice flexible spending accounts are made with pre-tax dollars. That is, they are deducted from your pay before any federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld. Pre-tax contributions lower the amount of your taxable income and, therefore, lower the taxes you pay.

Your contributions towards supplemental/optional life insurance, spouse and dependent life insurance, and accidental death and dismemberment are made with after-tax contributions. That is, they are deducted from your pay after federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld.

All contributions are taken from your paycheck semi-monthly while your coverage is effective. Given the various department structures, rate information is available upon request. Please contact Human Resources at 617-632-8694, option 4. During open enrollment, you will find this information on the enrollment site. Coverage costs may be revised from time to time.

Employer Contributions
Certain contributions are funded by your department. Departments have the authority to allocate department expenses to individual profit and loss statements. You are 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. Examples of these benefits include employer-sponsored disability, parking, T-pass, and certain life and umbrella liability insurance programs.
Health Care Benefits

Your health care benefits provide financial assistance for medical expenses you incur during the year and protect you against the high cost of care if you have a serious illness or injury. With Health Care Reform, and the mandate to have health insurance coverage, the federal government requires employers to provide information on the Health Insurance Marketplace. (See page 24 for more information.)

BIDMC Choice Point of Service Plan (POS)

The BIDMC Choice Plan is a managed care plan with a network of tiered providers and facilities along with the option to get self-referred care outside of the network. Your out-of-pocket cost is dependent on your selection of both your provider and the location where you receive care as well as your prescription drug use. This is called “combined Rx out-of-pocket maximum”. As a non-grandfathered plan, preventive care services are covered in full. HPHC follows federal law for these covered services. From time to time, this list is updated as required by government agencies. For a list of current recommendations for preventive care, go to Harvard Pilgrim’s website (www.harvardpilgrim.org). Remember, if you receive care without a referral or from a non-network provider, you pay more out-of-pocket expenses and some services are subject to deductibles, coinsurance, balance billing and out-of-pocket maximums.

There are two levels of coverage: in-network and out-of-network:

- **In-network coverage** applies to all covered benefits provided or arranged by your Primary Care Physician (PCP). The only exceptions are a serious medical emergency or when you use a plan provider for one of the services that do not require a referral. A list of these special services can be found in your HPHC Benefit Handbook.

- **Out-of-network coverage** applies when you use a non-plan provider or a plan provider without a referral when a referral is required for covered benefits. When using non-plan providers, the plan pays only a percentage of the cost of the care you receive up to the usual, customary and reasonable charge for the service. In most cases, this will be higher than the HPHC-contracted rate. If a non-plan provider charges any amount in excess of the usual, customary and reasonable charge, you are responsible for the excess amount. Please refer to section on Member Cost Sharing in your HPHC Benefit Handbook for additional information about out-of-network charges in excess of the usual, customary and reasonable charge.

You always have coverage for care in a medical emergency and a referral from your PCP is not needed. In a medical emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room member cost sharing is listed under the heading “Emergency Care.”

**Member Responsibility for Notification and Prior Approval.** Members must contact HPHC for coverage of a number of services. These are listed below.

- **Mental Health Care (Including the Treatment of Substance Abuse Disorders).** Prior approval must be obtained before receiving certain mental health services from non-plan providers. This requirement also applies to the treatment of substance abuse disorders. Please refer to www.harvardpilgrim.org, or contact the Member Services Department at 1-888-333-4742 for a list of services. To obtain prior approval for mental health or substance abuse services, please call the Behavioral Health Access Center at 1-888-777-4742.

- **Medical Services.** Members are required to notify HPHC before the start of any planned inpatient admission to a non-plan medical facility. Members are also required to obtain prior approval from HPHC for certain services. Before you receive services from a non-plan provider, please refer to www.harvardpilgrim.org. You may also contact the Member Services Department at 1-888-333-4742 for a list of out-of-network services that require prior approval. If you do not provide notification or obtain prior approval when required, you will be responsible for paying the penalty amount stated in the Schedule of Benefits in addition to any applicable member cost sharing. No coverage will be provided if HPHC determines that the service is not medically necessary, and you will be responsible for the entire cost of the service.
Benefits Overview

Emergency Care. You do not need to contact HPHC before receiving care in a medical emergency. In the event of an emergency hospital admission to a non-plan provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the member’s condition permits it, the member is responsible for the penalty amount stated in the Schedule of Benefits. Please call 1-800-708-4414 to notify HPHC of an emergency admission to a non-plan facility.

Clinical Review Criteria. HPHC uses clinical review criteria to evaluate whether certain services or procedures are medically necessary for a member’s care. Members or their practitioners may obtain a copy of the clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling 1-888-888-4742 ext. 38723.

Preventive Services – In-network. Certain preventive services received from plan providers are covered in full. These services are summarized below and further described in the Schedule of Benefits:

- Annual preventive gynecological examinations
- Immunizations
- Specified preventive services and tests
- Routine prenatal and routine postpartum care
- Routine well physical examinations (including well childcare, vision and auditory screening for children, health education)

Note: Member cost sharing applies to all preventive care services received from non-plan providers (out-of-network providers). You must use plan providers (in-network providers) for coverage of the listed preventive care services with no member cost sharing.

Tiered Providers – In-network. In-network acute hospitals, Primary Care Physicians (PCPs), and medical specialists are placed into one of three benefit levels or “tiers”. Member cost sharing for these providers depends upon the tier in which a provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Please see your HPHC Benefit Handbook for more information on how hospitals and physicians are tiered under the plan. Only acute care hospitals, PCPs, and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 2. In some cases, a provider may practice at more than one location and may have a different tier assigned to each location. Keep in mind that different out-of-pocket costs may apply to the same provider based upon where you are treated by that provider.

You can lower your out-of-pocket cost by selecting in-network physicians and hospitals in the lower cost tiers. You can access the Provider Directory at www.harvardpilgrim.org/BIDMC. You may also obtain a paper copy of the directory, free of charge, by calling our Member Services Department at 1-888-333-4742.

Note: When you choose a provider, it is important to consider the tier of the hospital that your provider uses. For example, a Tier 1 doctor may admit patients to a Tier 2 or to a Tier 3 hospital.

Under BIDMC Choice if you need medical care, you have the following choices:

TIER 1: If you choose a BIDCO physician as your PCP and use BIDMC or any Tier 1 facility, you will receive the highest level of care. Preventive services are covered in full; primary/specialist visits have a $10/$15 co-pay. There are no deductibles, coinsurance, or co-pays for inpatient hospital care when you use a Tier 1 provider or facility. Emergency room co-pays are $75 unless you are admitted and no claim forms are required.
Benefits Overview

TIER 2: If you choose a Tier 2 provider or facility, your preventive services are covered in full. Primary/specialist co-pays are $15/$20. Children under the age of 19 will be covered at the Tier 1 co-pays for office visits and have 100% coverage for inpatient services. Emergency room co-pays are $75 unless you are admitted and no claim forms are required.

TIER 3: If you choose a Tier 3 provider or facility, your preventive services are covered in full. Primary/specialist co-pays are $35/$45. There is an inpatient coinsurance of 20% until you reach the annual combined Rx out-of-pocket Maximum of $3,000 per member or $6,000 per family. Please note that children under the age of 19 are subject to Tier 3 co-pays. Emergency room co-pays are $75 unless you are admitted and no claim forms are required.

TIER 4: You may seek care outside the Harvard Pilgrim network (care that is not provided or arranged by your PCP) and receive the fourth level of benefits. After you meet a $2,000 per member annual deductible ($4,000 for your family), the plan will pay 70% of covered expenses; you pay 30% up to the plan’s annual combined Rx out-of-pocket limit of $6,000 ($12,000 for your family). Once you meet this limit, you receive 100% coverage for the rest of the year for most services. You may be balance billed by providers, however, for charges that exceed Harvard Pilgrim’s reasonable and customary limits. These charges will not apply against your combined Rx out-of-pocket maximum. You are required to submit claim forms when you receive treatment out of the network.

To receive coverage in Tiers 1, 2, and 3, your care must be provided or arranged by your PCP. Care not provided or arranged by your PCP is always reimbursed at the fourth level regardless of whether the provider or facility falls under Tiers 1, 2, or 3.

Harvard Pilgrim Health Care – Selection of a Primary Care Physician

When you join, you have access to over 7,000 primary care physicians who participate in the Harvard Pilgrim network, including Beth Israel Deaconess physicians. When enrolling for the first time in the BIDMC Choice plan, you must select a primary care physician. You have the right to designate any primary care physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician. You do not need prior authorization from Harvard Pilgrim Health Care or from any other person (including a primary care physician) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or obtaining referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Harvard Pilgrim at 1-888-333-4742. Following your enrollment into the plan, HPHC will contact you to select your primary care physician or you can go online to www.harvardpilgrim.org to update your selections.

UnitedHealthcare’s National Provider Network. You have in-network access to UnitedHealthcare’s extensive national provider network. This means that, when you are outside of Massachusetts, Maine, New Hampshire, Connecticut, Rhode Island and Vermont, you can receive care for covered services from UnitedHealthcare providers and be covered at the in-network benefit level.
Below is a summary of the benefits provided through the BIDMC Choice Plan. For detailed information, refer to the plan publications because they determine plan benefits.

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<thead>
<tr>
<th>Benefits Overview</th>
<th>BIDMC CHOICE</th>
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<tbody>
<tr>
<td></td>
<td>Tier 1</td>
</tr>
<tr>
<td>Annual Deductible</td>
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<tr>
<td>Annual Combined (RX Out-of-Pocket Max - $3k/$6k)</td>
<td>$1,500 per member</td>
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<td></td>
<td>$4,500 per family</td>
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<tr>
<td></td>
<td>$12,000 per family</td>
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</tbody>
</table>

**Hospital Care**

- **Inpatient Semi-private Room, Board, other services (including maternity and doctor’s services)**: Covered at 100% / Covered at 80% / Covered at 70% after deductible
- **Same Day Surgery**: Covered at 100% / $250 co-pay then covered at 80% / Covered at 70% after deductible
- **Psychiatric Care (Inpatient and Outpatient)**: Please refer to the Schedule of Benefits for detailed information on mental health benefits. This information can be found online at [www.harvardpilgrim.org](http://www.harvardpilgrim.org).

**Office Visits**

- **Preventive** / Covered at 100% / Covered at 70% after deductible
- **Primary Care**: $10 co-pay / $15 co-pay; under 19 – $10 / $35 co-pay
- **Specialist**: $15 co-pay / $20 co-pay; under 19 – $15 / $45 co-pay
- **Mental Health Visits**: $15 co-pay then 100% / Covered at 70% after deductible

**Emergency Room**

- $75 co-pay (waived if admitted)

**Labs / X-Rays / Diagnostic**

- **Hospital-Based**: Covered at 100% / Covered at 80% / Covered at 70% after deductible
- **Non-Hospital-Based**: Covered at 100% / Covered at 70% after deductible
- **High-End Radiology – Hospital-Based**: Covered at 100% / $250 co-pay then covered at 100% / Covered at 70% after deductible
- **High-End Radiology – Non-Hospital-Based**: $100 co-pay; under 19 – 100% / Covered at 70% after deductible
- **PT/OT/ST**: $15 co-pay (36 visits per year) / Covered at 70% after deductible; (36 visits per year)

**Prescription Drugs**

- Co-pays at participating pharmacies: $10 generic, $30 brand formulary, $50 brand non-formulary for a 30-day supply
- Mail order prescription co-pays: $20 generic, $60 brand formulary, $150 brand non-formulary for a 90-day supply

The above summarizes the BIDMC Choice Plan. Actual contracts and/or plan documents take precedence and will determine benefits. Some benefits pose specific eligibility requirements and limitations. Please refer to the corresponding sections of the HPHC Benefit Handbook and applicable summary plan descriptions prepared by the vendors and/or employer. HMFP/APHMFP reserves the right to amend, change and discontinue benefits at any time without advance notice.
### Benefits Overview

#### BIDMC CHOICE PLAN HOSPITAL NETWORK

<table>
<thead>
<tr>
<th>Massachusetts - Tier 1 Hospitals</th>
<th>Massachusetts - Tier 2 Hospitals</th>
<th>Massachusetts - Tier 3 Hospitals</th>
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<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>Anna Jaques Hospital</td>
<td>Baystate Medical Center</td>
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<td>BID Milton</td>
<td>Athol Memorial Hospital</td>
<td>Berkshire Medical Center</td>
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<td>BID Needham</td>
<td>Baystate Franklin Medical Center</td>
<td>Brigham and Women's Hospital*</td>
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<td>BID Plymouth</td>
<td>Baystate Mary Lane Hospital</td>
<td>Cape Cod Hospital</td>
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<td>Boston Medical Center</td>
<td>Cooley Dickinson Hospital</td>
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<td>Carney Hospital</td>
<td>Dana-Farber Cancer Institute</td>
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<td>Charlton Memorial Hospital</td>
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<td>Clinton Hospital</td>
<td>Faulkner Hospital</td>
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<td>Fairview Hospital</td>
<td>Hallmark Health Systems (Lawrence Memorial Hospital and Melrose Wakefield Hospital)</td>
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<td></td>
<td>Good Samaritan Medical Center</td>
<td>Lahey Clinic Hospital</td>
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<td>Harrington Memorial Hospital</td>
<td>Martha's Vineyard Hospital</td>
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<td>HealthAlliance Hospital</td>
<td>Massachusetts Eye and Ear Infirmary</td>
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<td></td>
<td>(Burbank Campus and Leominster Campus)</td>
<td>Massachusetts General Hospital*</td>
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<td>Heywood Hospital</td>
<td>Nantucket Cottage Hospital</td>
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<td>Holy Family Hospital</td>
<td>Newton Wellesley Hospital</td>
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<td>Holyoke Medical Center, Inc.</td>
<td>Northshore Medical Center (Salem Hospital and Union Hospital)</td>
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<td>Hubbard Regional Hospital</td>
<td>South Shore Hospital</td>
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<td>Lawrence General Hospital</td>
<td>St. Elizabeth's Medical Center</td>
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<td>Lowell General Hospital</td>
<td>Sturdy Memorial Hospital</td>
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<td>Marlborough Hospital</td>
<td>UMass Memorial Medical Center (Hahnemann, Memorial and University Campuses)</td>
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<td></td>
<td>Mercy Medical Center</td>
<td>*Includes satellite facilities and ancillary services.</td>
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<td>Merrimack Valley Hospital</td>
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<td>Metrowest Medical Center</td>
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<td>(Framingham Union and Leonard Morse Hospital)</td>
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<td>Milford Regional Medical Center, Inc.</td>
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<td>Morton Hospital and Medical Center</td>
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<td>Mount Auburn Hospital</td>
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<td>Nashoba Valley Medical Center</td>
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<td>New England Baptist Hospital</td>
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<td>Noble Hospital</td>
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<td>North Adams Regional Hospital</td>
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<td>Northeast Hospital Corporation</td>
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<td>(Addison Gilbert Hospital and Beverly Hospital)</td>
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<td>Norwood Hospital</td>
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<td>Quincy Medical Center</td>
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<td>Saints Medical Center</td>
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<td>Signature Health Care Brockton Hospital</td>
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<td>St. Luke’s Hospital</td>
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<td>The Cambridge Health Alliance</td>
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<td>Tobey Hospital</td>
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<td>Tufts Medical Center</td>
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<td>Winchester Hospital</td>
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<td>Wing Memorial Hospital and Medical Center</td>
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<td>Maine - Tier 2 Hospitals</td>
<td>Maine - Tier 3 Hospitals</td>
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<td>Blue Hill Memorial Hospital</td>
<td>Central Maine Medical Center</td>
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<td>Bridgton Hospital</td>
<td>Eastern Maine Medical Center</td>
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<td>Calais Regional Hospital</td>
<td>Maine Medical Center</td>
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<td>Cary Medical Center</td>
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<td>Charles A. Dean Memorial Hospital</td>
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<td>Down East Community Hospital</td>
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<td>Franklin Memorial Hospital</td>
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<td>Goodall Hospital</td>
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<td>Houlton Regional Hospital</td>
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<td>Inland Hospital</td>
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<td>Maine Coast Memorial Hospital</td>
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<td>Maine General Medical Center</td>
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<td>Mayo Regional Hospital</td>
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<td>Mercy Hospital</td>
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<td>Mid Coast Hospital</td>
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<td>Miles Memorial Hospital</td>
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<td>Millinocket Regional Hospital</td>
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<td>Mount Desert Island Hospital</td>
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<td>Northern Maine Medical Center</td>
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<td>Parkview Hospital</td>
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<td>Penobscot Bay Medical Center</td>
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<td>Penobscot Valley Hospital</td>
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<td>Redington-Fairview General Hospital</td>
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<td>Rumford Hospital</td>
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<td>Sebasticook Valley Hospital</td>
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<td>Southern Maine Medical Center</td>
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<td>St. Andrew’s Hospital</td>
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<td>St. Joseph Hospital</td>
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<td>St. Mary’s Regional Medical Center Stephens Memorial Hospital</td>
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<td>The Aroostook Medical Center</td>
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<tr>
<td>Waldo County General Hospital</td>
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<td>York Hospital</td>
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<th>New Hampshire – Tier 2 Hospitals</th>
<th>New Hampshire – Tier 3 Hospitals</th>
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<tr>
<td>Alice Peck Day Memorial Hospital</td>
<td>Androscoggin Valley Hospital</td>
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<td>Catholic Medical Center</td>
<td>Concord Hospital</td>
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<td>Cottage Hospital</td>
<td>Exeter Hospital</td>
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<td>Elliot Hospital</td>
<td>Littleton Regional Hospital</td>
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<td>Franklin Regional Hospital</td>
<td>Mary Hitchcock Memorial Hospital</td>
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<td>Frisbie Memorial Hospital</td>
<td>The Memorial Hospital</td>
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<td>Huggins Hospital</td>
<td>Portsmouth Regional Hospital</td>
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<td>Lakes Region General Hospital</td>
<td>Upper Connecticut Valley Hospital</td>
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<td>Monadnock Community Hospital</td>
<td>Valley Regional Hospital</td>
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<td>New London Hospital</td>
<td>Weeks Medical Center</td>
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<td>Parkland Medical Center</td>
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<td>Southern NH Medical Center</td>
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<td>Speare Memorial Hospital</td>
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<td>St. Joseph Hospital</td>
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<td>The Cheshire Medical Center</td>
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<td>Wentworth-Douglass Hospital</td>
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<th>Rhode Island – Tier 2 Hospitals</th>
<th>Rhode Island – Tier 3 Hospitals</th>
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<tr>
<td>Landmark Medical Center</td>
<td>Kent County Memorial Hospital</td>
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<tr>
<td>Memorial Hospital of Rhode Island</td>
<td>Miriam Hospital</td>
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<tr>
<td>Newport Hospital</td>
<td>Rhode Island Hospital</td>
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<tr>
<td>South County Hospital</td>
<td>Roger Williams Medical Center</td>
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<tr>
<td>St. Joseph Health Services</td>
<td>Women and Infants Hospital</td>
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| Vermont – Tier 2 Hospitals | | |
|---------------------------| | |
| Brattleboro Memorial Hospital | | |
| Grace Cottage Hospital | | |
| Mount Ascutney Hospital and Health Center | | |
| Northeastern Vermont Regional Hospital | | |
| Springfield Hospital | | |
Preferred Provider Organization (PPO) Plan

The Harvard Pilgrim PPO Plan offers you the ability to self-refer to either in- or out-of-network specialists. You are not required to have a primary care physician or to obtain referrals. The level of benefits you receive depends on where you receive services.

A Preferred Provider Organization offers preferred and non-preferred provider coverage. It pays for some preventive care as well as eligible expenses when you are ill. In general, you pay less out-of-pocket when you use preferred providers because you do not have any deductibles and your coinsurance is lower. You pay a co-pay for physician office visits and most other services are covered in full once you meet the deductible and reach the out-of-pocket maximum. If you receive care from an out-of-network provider, you pay more for out-of-pocket expenses and some services are subject to deductibles, coinsurance, balance billing and out-of-pocket maximums.

The above summarizes the PPO Plan. Actual contracts and/or plan documents take precedence and will determine benefits. Some benefits pose specific eligibility requirements and limitations. Please refer to the corresponding sections of the HPHC Benefit Handbook and applicable summary plan descriptions prepared by the vendors and/or employer. HMFP/APHMFP reserves the right to amend, change and discontinue benefits at any time without advance notice.
Benefits Overview

PPO Out-of-Network Coverage
If a member obtains covered services from a non-participating provider (except in emergency situations), services will be paid at the out-of-network benefit payment level, which includes the following financial obligations for members:

- **Deductible:** $500 per member or $1,000 per family, per calendar year, applied to the eligible expense
- **Coinsurance:** 30% of covered charges after the deductible is met until the annual combined Rx out-of-pocket maximum is reached
- **Any applicable co-pay amounts, and any charges in excess of the usual, customary and reasonable charge**
- **Annual combined Rx out-of-pocket maximum:** $3,000 per member or $6,000 per family, including the deductible and coinsurance (excluding coinsurance for durable medical equipment, prosthetic devices and vision hardware for special conditions)

**What is a BIDCO Physician?**
BIDCO physicians include those on staff as well as those with offices in surrounding communities who admit patients to Beth Israel Deaconess Medical Center, BID Needham, BID Milton, and BID Plymouth provided they are members of Beth Israel Deaconess Medical Physician Organization. Refer to FIND A DOC on the BIDMC website for a detailed listing of these physicians.

Other Benefits From HPHC

Prescription Drug Coverage
Both the PPO and POS programs offer pharmacy coverage through participating pharmacies. Your co-pay for up to a 30-day supply depends on the tier classification of the medication. Your co-pays for a 30-day supply are:

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
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<tr>
<td>$10</td>
<td>$30</td>
<td>$50</td>
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These co-pay amounts will be shown on your plan identification (ID) card. Bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the applicable co-pay.

Pharmacy Mail Order Program
HPHC offers a mail order program for maintenance medications. If you have a condition (e.g., high blood pressure) that requires maintenance medications, you can order up to a 90-day supply of these drugs through Harvard Pilgrim’s mail service prescription drug program. When you order a 90-day supply for Tiers 1 and 2, you will save one-third on your co-pays as well as a trip to the pharmacy.

Your co-pays for a 90-day supply are:

<table>
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<tr>
<th>Tier 1</th>
<th>Tier 2</th>
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<tr>
<td>$20</td>
<td>$60</td>
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For more information on a list of participating pharmacies or the mail service prescription drug program, go to **www.harvardpilgrim.org.**
Benefits Overview

Lifetime Limits
HMFP/APHMFP’s medical plans do not have a maximum lifetime limit on the dollar value of benefits.

Coordination of Benefits
If your family is covered by more than one health plan, Harvard Pilgrim Health Plan will coordinate benefits with the other carrier. In determining coverage, total payments from both carriers cannot exceed the allowable charge for the service. If you have questions about Coordination of Benefits (COB), please contact HPHC’s Customer Service Department at 1-888-333-4742.

Emergency/Out-of-State Care
Under both medical plans, in cases of an emergency hospital admission to a non-participating provider, HPHC must be notified within 48 hours of the admission at 1-888-333-4742. If notification is not received, the member is responsible for the first $500 of the eligible expense. The $500 payment does not count towards the deductible or the annual out-of-pocket maximum. This would include care for dependent children who are out-of-state.

HPHC Member Savings Program
As an HPHC member, you have more ways to save money and take steps toward being healthier. You may receive special savings on many health-related products and services, including a wide range of discount programs for fitness (e.g., up to a $150 fitness reimbursement) and diet, to just name a few. To learn more about these programs, including eligibility, restrictions and limitations, go to www.harvardpilgrim.org.

Online Tools for Taking Charge of Your Health
At www.harvardpilgrim.org, you’ll find resources to help you take charge of your health and well-being. You can easily find a doctor or pharmacy, access reliable health information through Health Topics A-Z and the Web Library, compare hospitals, prepare for medical procedures and make a plan to get healthier. Other resources include a personal and confidential HPHConnect account that enables you to check benefit details and look up claims, prescription history, typical costs for medical services and much more.

Opting Out of the Medical Plan
You may elect to decline medical coverage if you have alternative coverage elsewhere.

APHMFP and HMFP departments of Dermatology, Neonatology, Pathology and Radiology offer a monthly cash subsidy should you choose to decline health insurance.

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 for health insurance coverage through the Marketplace will be November 1, 2015 through January 31, 2016. Coverage can start as soon as January 1, 2016.

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 does not offer coverage, or offers coverage that doesn’t meet certain standards. The premium savings depend on your household income.
Benefits Overview

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 will not 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 does not offer coverage to you at all or does not 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 does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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 HMFCO@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:** 375 Longwood Ave., 3rd floor, Boston, MA 02215
**CONTACT:** Human Resources – Benefits 617-632-8694 option 4 or HMFCO@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 still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be 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 are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

¹An 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 percent of such costs.
Health Insurance Marketplace – Specifically for Massachusetts

What is the Massachusetts Health Connector?

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

1. **Employer-Sponsored Health Coverage**: Does this employer offer employer-sponsored health insurance coverage that is 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).

   **Answer**: Yes

   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 617-632-9732.

   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.

2. **“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 is not subject to the requirement?

   **Answer**: Yes

   If **yes**, employees can find out more by contacting or referring to HMFP/APHMFP Human Resources at 617-632-9732.

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

Delta Dental of MA is HMFP/APHMFP’s dental program provider. As the largest dental benefits administrator in the United States, Delta Dental is committed to delivering excellent service access to network providers and to focusing on oral health. Benefits are provided through the Delta Dental PPO Plus Premier network which combines two of Delta Dental’s national dental networks: Delta Dental PPO and Delta Dental Premier. If you choose to enroll, you may elect coverage for yourself, yourself plus one dependent, or yourself plus your family.

Things to Consider

When deciding if you want coverage under the dental plan, you should consider what other dental coverage is available to you and your family. If you have coverage options available from a source other than HMFP/APHMFP, you should compare the coverage options and their costs with Delta Dental PPO Plus Premier. The dental choice you make is completely separate from your medical plan.

Here are some features of the Delta Dental plan:

- Diagnostic and preventive care is covered, including routine checkups, restorative care and oral surgery.
- There are no claim forms to fill out when you receive services from a participating dentist.
- Services performed by non-participating dentists are covered; members are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Identification Cards

As a Delta Dental PPO Plus Premier member, you will receive two ID cards from Delta Dental shortly after your enrollment. Both cards are issued in the subscriber’s name, but can be used by everyone covered under your dental plan. If you misplace your ID card, you may request a new ID card through Delta’s Online Services. If you do not have a login ID, you can sign up by using the navigation button “Login for Online Services” and then clicking in the new window “Members Click Here to Register.” Once registered, you can use the Tools button, select “Contact Delta Dental of Massachusetts” and then select “Request New ID Card” from the drop down menu. If, during open enrollment, you elect the dental program for the first time, you will receive ID cards for services beginning January 2016.

Rollover Maximum

This valuable benefit feature allows you to roll over a portion of your unused spending to increase your maximum benefit limit next year, and beyond. So, you can save and accumulate part of your unused benefit dollars from a healthy year and use if for larger, more expensive procedures in the future. Rules and restrictions do apply. To view your rollover benefit, log onto your account at www.deltadentalma.com or call Delta Dental at 1-800-872-0500.

Choosing a Delta Dental PPO Plus Premier Dentist

You’ll receive the greatest value when you receive your dental care from a participating dentist. You can choose from over 104,000 dentist locations in the Delta Dental PPO network, or you can choose to visit one of Delta Dental Premier’s 186,000 dentist locations. Benefits include:

- Lower out-of-pocket costs
- Discounted fees for services from participating dentists and
- No claim forms and direct payment to your dentist from Delta Dental.

To find out if your dentist is part of the Delta Dental PPO Plus Premier network, check the Directory of Participating Dentists at www.deltadentalma.com or call Delta’s Customer Service Department at 1-800-872-0500.
Benefits Overview

About Non-Participating Dentists and Out-of-Network Coverage

Your dental plan provides coverage for services received from dentists who don’t participate in the Delta Dental PPO Plus Premier network. However, your out-of-pocket expenses may be more. Out-of-network coverage is only available for those services covered by your Delta Dental PPO Plus Premier plan, and is subject to the same limitations and exclusions. Delta Dental’s payment for services received from non-participating dentists is based on either the dentist’s fee or the maximum plan allowance for non-participating dentists, whichever is lower. If you utilize the services of a non-participating dentist whose fees are higher than the maximum plan allowance, you will be responsible for the difference between Delta Dental’s payment and the dentist’s total submitted charges.

The Claims Process

**Delta Dental PPO Plus Premier Dentists**

- You provide your dentist with the information printed on your ID card.
- The dentist will submit your claim to Delta Dental.
- Delta Dental will send you an Explanation of Benefits (EOB) detailing what Delta Dental paid the dentist under your plan’s coverage and the remaining patient balance, which you pay directly to the dentist.

**Non-Participating Dentists**

- Your dentist will collect his/her fees directly from you.
- Delta Dental will reimburse you based on a claim form that you submit to Delta Dental, P.O. Box 9695, Boston, MA 02114. Your dentist may be willing to prepare and submit the claim for you if you provide your dentist with the information printed on your ID card.
- You are responsible for the difference between what Delta Dental pays and what the dentist charges.

If you receive treatment that is not covered under your plan or a treatment that exceeds your annual maximum, you may be billed at the dentist's normal rate rather than Delta Dental’s negotiated rate.

Coordination of Benefits

If your family is covered by more than one dental plan (or a medical plan that offers dental coverage), Delta Dental will coordinate benefits with the other carrier. In determining coverage, total payments from both carriers cannot exceed the allowable charge for the service. If you have a question about Coordination of Benefits (COB), please contact Delta Dental’s Customer Service Department at 1-800-872-0500.

Other Claims Information

- You may want to ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will enable Delta Dental to help you estimate any out-of-pocket expenses you may incur.
- All claims must be submitted within one year.
- If a claim is denied, you can request an appeal by writing to Delta Dental within 180 days of receiving notice on the claim. Send appeals to Delta Dental, P.O. Box 9695, Boston, MA 02114.
- Under the plan’s subrogation clause, you may be required to reimburse Delta Dental for claim payments if you also receive payment from a third party who is held liable for an injury that required the dental care.

Where to Get More Information

If you have further questions, please contact Delta Dental’s Customer Service Department at 1-800-872-0500. This information should be used only as a guideline for your dental plan. For detailed information on your plan, riders, terms and conditions, or limitations and exclusions, please see the subscriber certificate. Copies of the subscriber certificate are available through Human Resources.
# Benefits Overview

## DELTA DENTAL PPO PLUS PREMIER WITH NATIONAL COVERAGE

**DEDUCTIBLE:** $50 PER INDIVIDUAL/$150 PER FAMILY  
**DEDUCTIBLE WAIVED FOR DIAGNOSTIC AND PREVENTIVE CATEGORIES**  
**CALENDAR YEAR MAXIMUM:** $1,500 PER PERSON

<table>
<thead>
<tr>
<th>CATEGORY/PROCEDURE</th>
<th>QUALIFICATIONS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic</strong></td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Comprehensive Evaluation</td>
<td>Once every 60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Exam</td>
<td>Twice per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Mouth X-rays</td>
<td>Once every 60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>Twice per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Tooth X-rays</td>
<td>As needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Teeth Cleaning</td>
<td>Twice per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>Twice per calendar year for members under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>Unrestored permanent molars, every 4 years per tooth for members through age 15; sealants are also covered for members aged 16 up to age 19 for those who had a recent cavity and are at risk for decay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorhexidine Mouth Rinse</td>
<td>This is a covered benefit only when administered and dispensed in the dentist’s office following scaling and root planing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Toothpaste</td>
<td>This is a covered benefit only when administered and dispensed in the dentist’s office following periodontal surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Restorative</strong></td>
<td></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Silver Fillings</td>
<td>Once every 24 months per surface per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Fillings (Front Teeth)</td>
<td>Once every 24 months per surface per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White Fillings (Back Teeth)</td>
<td>Single surfaces covered 1x every 24 months per surface/tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary Fillings</td>
<td>Once per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stainless Steel Crowns</td>
<td>Once every 24 months per tooth after a pulpotomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>General anesthesia and IV sedation are allowed with covered surgical impacted teeth only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions</td>
<td>Once per tooth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefits Overview

<table>
<thead>
<tr>
<th>CATEGORY/PROCEDURE</th>
<th>QUALIFICATIONS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Periodontal Surgery</td>
<td>One surgical procedure per quadrant in 36 months, on natural teeth</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Scaling and Root Planing</td>
<td>Once in 24 months, per quadrant. Only two quadrants are allowed per date of service</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td><strong>Periodontal Cleaning</strong></td>
<td>Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.</td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td></td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Root Canal Treatment</td>
<td>Once per tooth</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Vital Pulpotomty</td>
<td>Limited to deciduous teeth</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td><strong>Prosthetic Maintenance</strong></td>
<td></td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Bridge or Denture Repair</td>
<td>Once within 12 months, same repair</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Rebase or Reline of Dentures</td>
<td>Once within 36 months</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Recement of Crowns and Onlays</td>
<td>Once per tooth</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td><strong>Emergency Dental Care</strong></td>
<td></td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>Minor Treatment for Pain Relief</td>
<td>Three occurrences in 12 months</td>
<td><strong>80%</strong></td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>Fixed Bridges and Crowns</td>
<td>Once within 60 months</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>Implants – only in lieu of a three unit bridge</td>
<td>When part of a bridge, once within 60 months</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td></td>
<td>An Endosteal Implant is covered to replace one missing tooth, and when all adjacent teeth are healthy and do not require crowns; once per 60 months per Implant</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td><strong>Major Restorative</strong></td>
<td></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>Crowns</td>
<td>When teeth cannot be restored with regular fillings; once within 60 months per tooth</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>Covered at 50% of Maximum Plan Allowance charges to age 19; $1,500 separate LIFETIME maximum</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td><strong>Dependent Eligibility</strong></td>
<td>Eligible dependents through the end of the month in which they reach age 26</td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
</tbody>
</table>

- Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

** The deductible is waived for periodontal cleanings.
Certificate of Coverage Under Group Health Plans

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 do not 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.

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 (other 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).
Benefits Overview

- **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/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 were not provided a HIPAA Certificate, HMFP/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 1-866-444-3272 (for free HIPAA publications ask for publications concerning the changes in health care laws). You may also contact the CMS PUBLICATION HOTLINE at 1-800-998-7542 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/HealthInsReformforConsume.
Benefits Overview

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

If you are 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 are not eligible for Medicare 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, you can 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 toll-free 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 July 31, 2015. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
</tr>
</thead>
</table>
| Website: [www.myalhipp.com](http://www.myalhipp.com)  
Phone: 1-855-692-5447 | Website: [dch.georgia.gov/](http://dch.georgia.gov/)  
- Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)  
Phone: 404-656-4507 |

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
</table>
| Website: [http://health.hss.state.ak.us/dpa/programs/medicaid/](http://health.hss.state.ak.us/dpa/programs/medicaid/)  
Phone (Outside of Anchorage): 1-888-318-8890  
Phone (Anchorage): 907-269-6529 | Website: [http://www.in.gov/fssa](http://www.in.gov/fssa)  
Phone: 1-800-889-9949 |

<table>
<thead>
<tr>
<th>COLORADO – Medicaid</th>
<th>IOWA – Medicaid</th>
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</thead>
</table>
| Medicaid Website: [http://www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)  
Medicaid Customer Contact Center: 1-800-221-3943 | Website: [www.dhs.state.ia.us/hipp/](http://www.dhs.state.ia.us/hipp/)  
Phone: 1-888-346-9562 |

<table>
<thead>
<tr>
<th>FLORIDA – Medicaid</th>
<th>KANSAS – Medicaid</th>
</tr>
</thead>
</table>
| Website: [https://www.flmedicaidtplrecovery.com/](https://www.flmedicaidtplrecovery.com/)  
Phone: 1-877-357-3268 | Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
Phone: 1-800-792-4884 |

<table>
<thead>
<tr>
<th>KENTUCKY – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
</tr>
</thead>
</table>
| Website: [chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 603-271-5218 |

<table>
<thead>
<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW JERSEY – Medicaid</th>
</tr>
</thead>
</table>
| Website: [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
Phone: 1-888-695-2447 | Medicaid Website: [http://www.state.nj.us/humanservices/dmaha/clients/medicaid/](http://www.state.nj.us/humanservices/dmaha/clients/medicaid/)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710 |

<table>
<thead>
<tr>
<th>MAINE – Medicaid</th>
<th>NEW YORK – Medicaid</th>
</tr>
</thead>
</table>
Phone: 1-800-977-6740  
TTY 1-800-977-6741 | Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831 |

<table>
<thead>
<tr>
<th>MASSACHUSETTS – Medicaid and CHIP</th>
<th>NORTH CAROLINA – Medicaid</th>
</tr>
</thead>
</table>
| Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120 | Website: [http://www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)  
Phone: 919-855-4100 |

<table>
<thead>
<tr>
<th>MINNESOTA – Medicaid</th>
<th>NORTH DAKOTA – Medicaid</th>
</tr>
</thead>
</table>
| Website: [http://www.dhs.state.mn.us/id_006254](http://www.dhs.state.mn.us/id_006254)  
Click on Health Care, then Medical Assistance  
Phone: 1-800-657-3739 | Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-800-755-2604 |

<table>
<thead>
<tr>
<th>MISSOURI – Medicaid</th>
<th>OKLAHOMA – Medicaid and CHIP</th>
</tr>
</thead>
</table>
| Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005 | Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)  
Phone: 1-888-365-3742 |
<table>
<thead>
<tr>
<th>MONTANA – Medicaid</th>
<th>OREGON – Medicaid</th>
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<thead>
<tr>
<th>NEBRASKA – Medicaid</th>
<th>PENNSYLVANIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633</td>
<td>Website: <a href="http://www.dhs.state.pa.us/hipp">http://www.dhs.state.pa.us/hipp</a> Phone: 1-800-692-7462</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEVADA – Medicaid</th>
<th>RHODE ISLAND – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 401-462-5300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOUTH CAROLINA – Medicaid</th>
<th>VIRGINIA – Medicaid and CHIP</th>
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<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059</td>
<td>Website: <a href="http://www.hca.wa.gov/medicaid/premium">http://www.hca.wa.gov/medicaid/premium</a> pymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a> Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<th>UTAH – Medicaid and CHIP</th>
<th>WISCONSIN – Medicaid and CHIP</th>
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<tr>
<th>VERMONT– Medicaid</th>
<th>WYOMING – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427</td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a> Phone: 307-777-7531</td>
</tr>
</tbody>
</table>
Benefits Overview

To see if any more states have added a premium assistance program since July 31, 2015 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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 option 4, Ext. 61565

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:

1. 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.

2. HMFP/APHMFP have determined that the prescription drug coverage offered by Harvard Pilgrim Health Care (HPHC) PPO and POS Plans 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 plan.

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.
Benefits Overview

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/APHMFP’s HR Department at 617-632-8694, option 4 or email us at HMFPco@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/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 (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

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: September 30, 2015
Name: Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.
Associated Physicians of Harvard Medical Faculty Physicians at BIDMC, Inc.
Contact: HMFP/APHMFP’s Benefits Department
Address: 375 Longwood Ave., 3rd floor, Boston, MA 02215
Phone: 617-632-8694 (option 4)
COBRA Rights and Responsibilities

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/APHMFP
375 Longwood Ave., 3rd floor
Boston, MA 02215

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.

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 qualifying 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:

HMFP/APHMFP
375 Longwood Ave., 3rd floor
Boston, MA 02215

How Is COBRA Coverage Provided?

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.
Benefits Overview

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:

HMFP/APHMFP
375 Longwood Ave., 3rd floor
Boston, MA 02215

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:

HMFP/APHMFP
375 Longwood Ave., 3rd floor
Boston, MA 02215

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](http://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](http://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](http://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

HMFP/APHMFP
375 Longwood Ave., 3rd floor
Boston, MA 02215
Qualified Medical Child Support Order (QMCSO)

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.

Women’s Health and Cancer Rights Act of 1998

Congress enacted the Women’s Health and Cancer Rights Act of 1998 (the “Act”). This notice describes the most important provisions of the Act. 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.

The Act 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 and
- Prostheses and 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, the Act 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.

Clarification of the Newborns’ and Mothers’ Protection Act of 1996

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.
Benefits Overview

**Genetic Information Nondiscrimination Act (GINA)**
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.

**The Uniformed Services Employment and Reemployment Rights Act of 1994 (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. Coverage may continue for up to 24 months after the date the employee is first absent due to uniformed 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
- 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.
Benefits Overview

**Term 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 are on long-term disability, you may discuss options for a premium waiver on this program. This coverage terminates when you terminate employment or retire. You do have the option, however, 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 or Variable Group Universal Life Insurance**

All benefits-eligible employees will receive a cash contribution (benefit dollars) toward the purchase of life insurance coverage equal to a minimum of 2x 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 6x salary. The maximum insurance benefit is $2,000,000. If your total coverage amount exceeds 3x salary or $700,000, evidence of insurability is required. The minimum insurance coverage is 2x salary 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, the employee, may purchase Group Universal Life Insurance (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 6x 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 1-800-843-8358 or through Human Resources.

**Note:** Any benefits-eligible employee age 65 or older can elect to 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**

If you apply, 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.

**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 will need to notify Minnesota Life at 1-800-843-8358 to have them removed from your Policy. Dependent life insurance enrollment and continued eligibility is the responsibility of the policy holder. See Obtaining Additional Information for instructions on how to update your policy.
Benefits Overview

Additional Life Insurance Information

What Happens If I Terminate?

Upon termination or retirement from HMFP/APHMFP, the universal life coverage is portable and can be continued by paying premiums directly to Minnesota Life. For more information, contact Minnesota Life at 1-800-843-8358 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 HMFP/APHMFP intranet (http:\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 1-651-665-4827. For more complete information about Variable Group Universal Life, including charges and expenses, call 1-800-843-8358 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 3x 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 to be eligible for this guaranteed coverage. The plan coverage maximum is the lesser of 6x 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.

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.

Accidental Death and Dismemberment (AD&D) Insurance

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. 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 1x to 6x your salary. (The AD&D 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. If you elect AD&D and you receive a pay increase during the year, your coverage amount and payroll deduction will increase automatically.

**Business Travel Insurance**

Business Travel Insurance is available to provide coverage for injuries sustained while you are 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.

**Disability Coverage**

**Short-term Disability**

Short-term disability (STD) is provided for all benefits-eligible employees. HMFP/APHMFP has selected Standard Insurance Company to administer this program. Under this program, you are eligible to receive up to 60% of your weekly earnings (up to $3,000 per week) once you have been disabled for 14 calendar days. Benefits can continue for up to 13 weeks from the onset of full disability. The income you receive under this program is tax-free; no taxes are deducted from your benefits. If you continue to be disabled after 13 weeks, you may be eligible for long-term disability benefits. Benefits are reduced by other benefits you receive such as state disability benefits.

The STD program has a pre-existing condition clause. The maximum weekly benefit will be reduced from $3,000 to $2,500 for disabilities that occur during the first 12 months following your date of hire if the disability is caused by a condition which was diagnosed, treated or recommended for treatment during the three months immediately preceding your hire date.

**A Note about Maternity:** If your pregnancy is not a pre-existing condition at hire, and you deliver a child, you are eligible to receive disability benefits under the STD program. Disability benefits for maternity are subject to the same regulations as for any other disability.

**Long-term Disability**

Long-term disability (LTD) will provide a monthly income should you become unable to work because of illness or injury. LTD is provided for all benefits-eligible employees. As noted above, there is a three month pre-existing condition clause for all new hires. No LTD benefits will be paid for disabilities that occur during the first 12 months following your date of hire, if the disability is caused by a condition which was diagnosed, treated or recommended for treatment during the three months immediately preceding your hire date.
Benefits Overview

The plan includes the following features:

- The waiting period is 90 calendar days. If the member is still disabled after 90 days from the onset of disability, the LTD program replaces STD.
- The maximum monthly benefit payment under the group LTD policy is 50% of base pay up to $10,000 per month.
- Total disability is the inability to perform duties of the insured’s own occupation (defined as specialty or subspecialty) and a minimum income loss of 20% of pre-disability earnings.
- Proportionate benefits are available if you return to work and suffer an income loss greater than 20% of your pre-disability earnings.
- There is a cost of living increase after the fifth year of disability.
- There is a lifetime limit of 24 monthly payments for disabilities caused by mental/nervous disorders and/or substance abuse.
- Benefits are offset for benefits received through government programs such as Social Security, etc.
- Members under age 60 earning above $240,000 per year are eligible for a portable individual disability insurance policy. The policy is provided by the employer and requires no medical underwriting. The coverage will replace 50% of income from $240,000 to $360,000 (up to $5,000 per month). The availability of this benefit will be offset by other personal coverage maintained by the employee. An application is required to obtain this coverage.

W2-Gross Up

Although your department pays the premiums for your disability benefits, the cost of the premiums (imputed income) will be added to your W2 earnings. This is done so that if you become disabled, your disability earnings will not be taxed.

Enrollment and Certificates

Enrollment and certificates for both STD and LTD are distributed during your new hire meeting. Additional copies may be found on the HMFP/APHMFP intranet (https:\portal.bidmc.org\hmfp) or by calling Human Resources at 617-632-8694, option 4.

Supplemental Disability Insurance Option

This sponsored voluntary program allows physicians to apply for a supplemental policy that can protect a larger percentage of salary (up to as much as 75%), increase the maximum monthly benefit (up to $20,000/month), insure any non-salary compensation or outside practice earnings, and guarantee your ability to maintain or increase the benefit should you terminate your employment relationship.

This coverage is provided through a non-cancellable individual contract offered with a permanent rate discount. This policy provides tax-free benefits that you begin after 90 or 180 days and continue until you recover or reach retirement age. The policy can also include a future increase rider that allows you to increase the coverage in the future to as much as $15,000 without further medical underwriting. This insurance policy is not in force until the policy is issued and paid.

For more information and age-related restrictions, please contact InsMed Insurance Agency, Inc. at 1-800-214-7039 to obtain a personalized proposal or speak with a sales representative.

Voluntary “Guaranteed Issue” Supplemental Disability Coverage

Once a year in early fall, most employees regularly scheduled to work 30 hours or more will be notified by e-mail that they have an opportunity to apply for additional disability insurance coverage that can better protect their income, retirement plan contributions and provide additional benefit amounts in the event of a catastrophic loss. Benefits are provided on a tax-free basis.
This is a time-limited access opportunity. The coverage may be obtained WITHOUT a medical evaluation* and the portable policy will include permanently discounted "gender neutral" rates.

Depending on your salary, you may be eligible to obtain up to $5,000/month of income replacement, $4,080/month of retirement plan contributions and as much as $8,000/month of catastrophic coverage. Existing coverage may reduce the available amounts under this offer.

* Five medical questions must be answered to obtain catastrophic coverage.

**The FlexChoice Flexible Spending Accounts (FSAs)**

The FlexChoice accounts let you pay certain expenses with pre-tax dollars. There are two accounts:

- **The Health Care Account** can be used to help pay for uninsured medical, dental and vision expenses.

- **The Dependent Care Account** can be used to help pay for dependent care expenses (for children under 13) that are necessary for you (and your spouse, if you are married) to work.

**The Advantages of These Accounts**

When you use a FlexChoice FSA, you set aside dollars from your gross pay before any taxes are withheld. The government taxes only the reduced amount so you pay lower taxes each paycheck. The dollars you have elected to set aside are held for you in a special account(s) until you submit claims for reimbursement. When you have paid for an eligible expense, you can reimburse yourself with the pre-tax dollars in your account(s).

**Eligibility and Participation**

All benefits-eligible employees may participate in the Health Care Account (up to $2,550 per year) and the Dependent Care Account (up to $5,000 per year). Participation is voluntary. You decide whether to participate in either or both accounts when you first become eligible for benefits and then again at each open enrollment.

**Determining Your Need for a Health Care Account**

To determine the level of expenses you are likely to incur, review what you have spent on medical expenses for the last two years. You should also consider your participation in your medical and dental plan(s) and their coverage levels. In general, most health care expenses (medical, dental, vision, hearing, etc.) can be paid through your Health Care Account.

**Special Note:** Due to government regulations, over-the-counter drugs are not considered an eligible expense unless prescribed by your doctor. It is important that you familiarize yourself with eligible and ineligible expenses. Additional information can be obtained through our vendor, Sentinel Benefits Financial at 1-888-762-6088, Option 1 or via their website www.sentinelgroup.com.

If your spouse and his/her children do not qualify as your dependents for tax purposes, then their expenses are not eligible for reimbursement through a Health Care Account.

**Determine Your Need for a Dependent Care Account for Children Under Age 13**

A Dependent Care Account allows you to set aside tax-free income to pay for day care expenses you incur in order for you (and your spouse) to work. An eligible dependent is any individual whom you claim on your tax return as your dependent, and who is a child **under the age of 13**, or a person who is physically or mentally incapable of caring for his or her own needs, regardless of age.

You are required to obtain a Social Security number for each individual you claim as a dependent who is two or more years old. The Social Security number must be reported on your federal income tax return. Failure to comply with this requirement may result in a penalty.
If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care Account, you must report the name, address and taxpayer identification number of each dependent care provider. If you do not comply, you will either lose the tax credit or pay taxes on the income placed in your Dependent Care Account. Please note that the IRS stipulates $5,000 to be a family maximum under a Dependent Care Account ($2,500 if married and filing separately) but no more than the lesser of the earned income of the participant or his or her spouse (if applicable).

Certain “highly paid” employees as defined by the IRS may have their contributions to the Dependent Care Account limited.

How to Participate

You will be eligible to enroll in these plans when you are initially benefits-eligible. Each calendar year thereafter, you must re-enroll in this benefit option to participate. Failure to re-enroll will cause your deductions to stop. Paychecks are issued 24 times per calendar year. Elections can be made at hire, open enrollment or qualifying mid-year changes.

Use It or Lose It

Be sure to estimate both your health care and dependent care expenses carefully. Under IRS rules, you will forfeit any unused account balances at the end of the 2 ½-month grace period following the end of the plan year.

If you currently use the Benny Pre-Paid Benefits Card for your 2015 account and elect to have a 2016 account, any expenses incurred in the first 2-1/2 months of 2016 and paid for with your card will automatically be applied to your 2015 remaining balance. Account information and forms can be found at [www.sentinelgroup.com](http://www.sentinelgroup.com) by logging in as a plan participant.

What Happens If I Terminate During the Year?

Under current law, if you terminate mid-year, you can only use allowed health care expenses from your date of entry into the plan through your termination date. To continue the program on an after-tax basis, you can use the COBRA option as described in the Termination Package that will be sent to your home to extend coverage through the end of the plan year. Coverage may not be extended beyond the plan year in which you terminate.

For dependent care expenses, you can submit eligible expenses incurred from your date of entry into the plan through the end of the plan year. You will only have access to funds contributed into the plan.

All claims must be submitted by the following March 31st or you will forfeit any unclaimed balance.

Sentinel Benefits & Financial Group – Online Claim Submission and Account Access

HMFP/APHMFP has engaged the recordkeeping services of Sentinel Benefits & Financial Group to administer the FlexChoice accounts. Their website, [www.sentinelgroup.com](http://www.sentinelgroup.com), allows you to log in as a plan participant and access information concerning eligible expenses, the status of your account, applicable forms and other helpful information. Participants who have forgotten their online login information will be able to request and immediately receive an e-mail containing their user ID and password. First-time web users will be allowed to create their own user ID and password by clicking “Register Online”, entering their Plan Access Code then selecting and answering three security questions. If you have any trouble accessing your account, please contact Sentinel Benefits & Financial Group at 1-888-762-6088. Plan Access Codes are:

| HMFP 22264501 | APHMFP 22770501 |

Additional protection for each person’s account requires that authentication questions be answered any time a user ID or password is forgotten and when a participant logs into his/her account from an unknown computer.
Sentinel Benefits & Financial Group Pre-paid Benefits Card

As a participant in the Health Care and/or Dependent Care Accounts, you can elect the Sentinel Benefits & Financial Group Pre-paid Benefits Card, also known as the Benny Debit Card. This program will allow you to purchase qualified expenses with this card and eliminate the need for claim submission. The card can be used to pay co-pays, prescriptions, as well as dependent care expenses. HMFP/APHMFP will provide, if requested during the annual enrollment period or at the time of new hire, two debit cards free of charge. If you wish to have additional cards, they can be obtained through Sentinel Benefits & Financial Group. The cost is $5.00 for each additional set (2) of cards. Applications for extra cards can be found at www.sentinelgroup.com by logging in as a plan participant. These forms should be returned directly to Sentinel Benefits & Financial Group.

When using your Benny Card, you will have the option to pay for expenses using a PIN at the point of sale. This does not replace the signature process. When using your Benny Card, you may be prompted to enter a PIN. If the card has been set up with a PIN and you want to use it as such, the PIN may be entered and the card will be used as a debit. If no PIN has been set up, or if you would like to use the card as a ‘credit’, you may hit ‘Cancel’ or simply let the merchant know that you wish to pay using the signature process and they will direct you accordingly.

**Note:** Pre-paid benefit cards have expiration dates similar to a credit card. Each January 1st, your new election for that year will be pre-loaded to your existing card. Please do not throw away your cards as there is a charge for replacing them.

**Long-term Care Insurance**

Long-term care insurance is a voluntary benefit that can help you protect your financial resources and provide peace of mind for you and your family, should you or a family member need care. If you are interested in learning more about this program, please call InsMed Insurance Agency, Inc. at 1-800-214-7039.
Commuter Services
We encourage the use of public transportation. You can purchase your monthly T-Pass via payroll deductions. If you are working onsite at BIDMC, you can contact Commuter Services at 617-667-3052 or visit them on the East Campus, Kirstein 2. Please identify yourself as being on the HMFP payroll when signing up. HMFP/APHMFP employees who work offsite should contact their department administrator to see what options are available at their offsite work location.

If you are in need of local parking, Commuter Services can work with you to discuss your parking options and work with you to start or stop any required deductions.

Fitness Program/Tanger Be Well Center at BIDMC
Joining the Tanger Be Well Center at BIDMC offers you the convenience of a full-service facility right at the hospital. It’s an easy way to start your new healthy lifestyle and includes the following features:

- Full line of Nautilus strength training equipment and Fitness Advisor Tracking system
- Cardiovascular equipment including treadmills, elliptical trainers, upright and recumbent bikes, stair climbers, rowers, and upper body ergometer
- Smith machine, free weight plates, and bar, dumbbells, and benches
- Free individual exercise program with an exercise physiologist
- Free towel service
- Rental overnight lockers and free day use
- Exercise studio and group exercise classes
- Free stress management, nutrition, and exercise educational programs
- One free guest pass each month
- Punch card memberships
- A friendly and professional staff

The Tanger Be Well Center is located in the Carl J. Shapiro Building on the Ground Floor, BIDMC Campus. They are open Monday to Thursday 5:30 a.m.-8:00 p.m.; Friday 5:30 a.m. – 7:00 p.m. and Saturday 8:00 a.m. – 2:00 p.m. Feel free to stop in or call 617-667-4695 for more information.

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. HMFP/APHMFP provides you with a $1 million non-portable policy which renews each December 16th, provided you are active and continue to be benefits-eligible. If you need to file a claim, you can do so by calling 1-800-252-4670. For more information on this policy and supplemental options, call Provider Insurance Group at 781-444-0347 or e-mail privateclient@providerig.com
Backup Childcare and Adult Care Program
Backup care is a benefit available to all HMFP/APHMFP benefits-eligible employees, through Care.com BackupCare. Care.com BackupCare provides backup services when your regular childcare or adult care arrangements are not 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 are 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 BackupCare offers qualified and carefully screened providers, available 24 hours a day, seven days a week. Care.com BackupCare, can also offer short-term on-site group childcare if, for example, a group of potential physicians are participating in training and interviews in the same day or if there is a departmental retreat.

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

- Call Care.com BackupCare directly at 1-855-781-1303 to request childcare or adult care services. You may also go online to register and request care at www.care.com/backupcare.
- Be certain to identify yourself as an employee of HMFP at BIDMC.
- Care.com BackupCare 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.
- 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.
- For information on hourly fees or to answer other questions, call Care.com BackupCare directly at 1-855-781-1303.

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 50/50 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 1-800-396-0960 or 617-495-8840 or visit the REAP website. Search available properties through Coldwell Banker Residential Brokerage. Please do not contact an agent directly or you may not be eligible for the cash back program. Visit them online at http://www.facultyrealestate.harvard.edu.

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, overnight 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 call Monique Messervey at 617-450-4417 or Cheryl Moderski at 617-450-4402.
Voluntary Savings and Retirement Programs

HMFP/APHMFP helps eligible members reach their financial goals for retirement by offering both voluntary and automatic retirement programs. Under the voluntary programs, you may set aside up to $18,000 (indexed from time to time) and if you are turning age 50 or older, you can set aside an additional catch-up contribution of $6,000. These are payroll deductions that you elect to take as a traditional pre-tax arrangement or post-tax Roth option. The retirement program is employer-funded and formula-driven by department. For HMFP members, your investment option is through Fidelity and/or TIAA-CREF, and for APHMFP members, your investment vendor is Fidelity Investments. Additional information can be obtained in the Retirement Summary Plan Description available online or by contacting Human Resources at 617-632-8694, option 4.

Travel Assistance

If you are planning on traveling, don’t forget that Global Rescue provides travel assistance services to HMFP/APHMFP employees. 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 have group life insurance through HMFP/APHMFP, you and your spouse/eligible dependents will have access to these services. No additional premium or enrollment is required. Call 1-855-516-5433 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.

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 are happy to announce the addition of 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, receive referrals to local attorneys and mediators, download legal forms and much more.

For more information:
Call Ceridian LifeWorks at 1-877-849-6034 or visit www.lifeworks.com.
User Name: will
Password: preparation

Legacy Planning

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 LegacyPlanningServices.com.
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
617-632-8694, option 4

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
617-632-8694, option 4

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
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)

APHMFP
Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. Welfare Benefit Plan (plan number: 501)
APHMFP Savings and Retirement Plan (plan number: 001)

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 and PPO medical plans, as well as Delta Dental, are self-funded health plans, with respect to which HMFP/APHMFP has purchased stop loss insurance to minimize exposure to significant losses. The current re-insurer is Symetra Financial.
Plan Year
The plan year for all five plans is January 1 through December 31.

Future of the Plan
While the Plan Sponsor intends to continue the plans indefinitely, it is 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 are entitled at the time.

No Guarantee of Employment
These plans are not 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.

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 617-632-8694, option 4. A copy of the Privacy Notice for the dental plan is available through Delta Dental.
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 and the Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. Welfare Benefit Plan (collectively the “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.

How Your Health Information May be Used or Disclosed

The Plan is required by law to protect the confidentiality of each member’s PHI, and notify affected individuals following a breach of unsecured PHI. Your Plan may use and disclose your PHI without your authorization for the following purposes, and as otherwise permitted or required by law:

For Treatment. The Plan may use your PHI in connection with the provision of health treatments or services, or the coordination or management of health treatments or services. For example, information obtained by a health care provider (such as a physician nurse, or other person providing health services to you) will be recorded as it relates to your treatment. Health care providers need this information to determine what treatment you should receive.

For Payment. Your Plan may use and disclose your PHI to others for the purpose of receiving payment for covered services (e.g., to determine eligibility, manage enrollment records, collect premiums, make coverage determinations, administer claims, conduct utilization and medical necessity reviews, and coordinate benefits with other coverage you may have).

For Health Care Operations. Your Plan may use – or disclose PHI for general administrative or business purposes to function as a group health plan (e.g., quality assessment and improvement; performance measurement and outcomes assessment; preventive health and disease management, submitting claims for stop loss; legal services; audit services; and other general administrative activities such as data and information systems management and participant services). In no event will the Plan use or disclose genetic information for underwriting purposes.

Treatment Alternatives. Your Plan may use your PHI to provide information about treatment alternatives or other health-related benefits and services that may be of interest.

Business Associates. The Plan may disclose PHI to a third party that provides services to the Plan. Prior to any disclosure of PHI, the Plan will have a written contract in place requiring the third party to protect your PHI.

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.
Administrative Information

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.

Your Health Information Rights

You have the right to:

- 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 will not 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, Mary Leupold, 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
Your Plan is required to:

- 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 Mary Leupold, Privacy Officer, HMFP/APHMFP at Beth Israel Deaconess Medical Center, Inc., MASCO Building, 375 Longwood Avenue, 3rd floor, Boston, MA 02215 or 617-632-8694, option 4.
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.

- 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.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have “creditable coverage” from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage ceases (if you request it before losing coverage), or if you request it up to 24 months after losing coverage. Without losing evidence of creditable coverage, you may be subject to pre-existing condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage under the plan.

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.

If your claim for a benefit under a plan is denied, in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not 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 were not 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 are discriminated against for asserting your rights, you make 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 are 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.

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.
Plan Administration
Besides giving you special protection as a plan participant, ERISA places certain responsibilities upon the people who administer the plans. These people are referred to as “fiduciaries.” They have a duty to act in your interests and the interests of other plan participants and beneficiaries.

Amendment or Termination of Plan
HMFP/APHMFP reserves the right to amend, modify, suspend or terminate any plan at any time.

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 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 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.
Administrative Information

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 does not 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)
- 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 or 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 – not later than 72 hours after receiving your request for a review.
- Pre-Service Claims – not later than 30 days after receiving your request for a review.
- Post-Service Claims – not 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.

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.

Filing a Claim for Benefits Based on Determination of 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, not 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 will 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.

**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.
Subrogation/Reimbursement
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 cannot 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.

Responsibility for Goods/Services
HMFP/APHMFP does not guarantee and will not 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 outside of the control of HMFP/APHMFP.

Massachusetts Identity Theft Law
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.
Each year, Human Resources likes to remind all employees of certain employment policies. It is important to know that HMFP/APHMFP take these issues very seriously. You are encouraged to read them carefully.

**Personal Information Confidentiality Policy**

It is the intention of Harvard Medical Faculty Physicians at BIDMC, Inc. and Associated Physicians of Harvard Medical Faculty Physicians at BIDMC, Inc. to comply with the requirements of MGL CH 93H/CMF 17.00, particularly as they relate to confidentiality of Protected Personal Information (PI).

Personal Information consists of an individual’s first name and last name, or first initial and last name, in combination with any of the following data elements that relate to such individual: Social Security number, driver’s license number or state-issued identification card number, financial account number or credit or debit card number, with or without any required security code, access code, personal identification number or password that would permit access to an individual’s financial account. PI does not include information lawfully obtained from publicly available information, or from federal, state, or local government records made available to the general public.

All employees shall actively comply with this policy.

**Sexual Harassment Policy**

It is the goal of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (“HMFP”) and Associated Physicians of HMFP (“APHMFP”) to promote a workplace that is free of sexual harassment. An environment free of sexual harassment is not only the law, it is fundamental to HMFP/APHMFP’s culture. Sexual Harassment of employees occurring in the workplace or in other settings in which employees may find themselves in connection with their employment is unlawful and will not be tolerated by these organizations. Further, any retaliation against an individual for complaining in good faith about sexual harassment or retaliation against individuals for cooperating with an investigation of a sexual harassment complaint is similarly unlawful and will not be tolerated. To achieve our goal of providing a workplace free from sexual harassment, the conduct that is described in this policy will not be tolerated and we have provided a procedure by which inappropriate conduct will be dealt with, if encountered by employees.

Because HMFP/APHMFP take allegations of sexual harassment seriously, we will respond promptly to complaints of sexual harassment and where it is determined that such inappropriate conduct has occurred, we will act promptly to eliminate the conduct and impose such corrective action as is necessary, including disciplinary action up to and including suspension or termination of employment where appropriate.

Please note that while this policy sets forth our goals of promoting a workplace that is free of sexual harassment, the policy is not designed or intended to limit our authority to discipline or take remedial action for workplace conduct which we deem unacceptable, regardless of whether that conduct satisfies the legal definition of sexual harassment.
Definition of Sexual Harassment

In Massachusetts, the legal definition of sexual harassment means sexual advances, requests for sexual favors, and verbal or physical conduct of a sexual nature when:

- Submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of employment or as a basis for employment decisions or
- Such advances, requests or conduct have the purpose or effect of unreasonably interfering with an individual’s work performance by creating an intimidating, hostile, humiliating or sexually offensive work environment.

Under these definitions, direct or implied requests by a supervisor for sexual favors in exchange for actual or promised job benefits such as favorable reviews, salary increases, promotions, increased benefits, or continued employment constitutes sexual harassment.

The legal definition of sexual harassment is broad and in addition to the above examples, other sexually oriented conduct, whether it is intended or not, that is unwelcome and has the effect of creating a workplace environment that is hostile, offensive, intimidating, or humiliating to male or female workers may also constitute sexual harassment.

While it is not possible to list all those additional circumstances that may constitute sexual harassment, the following are some examples of conduct which, if unwelcome, may constitute sexual harassment depending upon the totality of the circumstances including the severity of the conduct and its pervasiveness:

- Unwelcome sexual advances – whether they involve physical touching or not
- Sexual epithets, jokes, written or oral references to sexual conduct, gossip regarding one’s sex life, comment on an individual’s body, comment about an individual’s sexual activity, deficiencies, or prowess
- Displaying sexually suggestive objects, pictures, or cartoons
- Unwelcome leering, whistling, brushing against the body, sexual gestures, suggestive or insulting comments
- Inquiries into one’s sexual experiences and
- Discussion of one’s sexual activities.

No Retaliation

All employees should take special note that, as stated above, retaliation against an individual who has complained about sexual harassment, and retaliation against individuals for cooperating with an investigation of a sexual harassment complaint, is unlawful and will not be tolerated by these organizations.

Likewise, accusations made maliciously or otherwise not in good faith will not be tolerated by these organizations and may result in disciplinary action up to and including suspension or termination of employment.
Employee Responsibility

Every employee, including physicians, supervising physicians, and chiefs or service, is responsible for behaving in a professional manner that does not constitute sexual harassment of others. Every employee is also urged to report any behavior that he or she believes violates this policy, whether directed toward him/herself or others, to one of the individuals listed below.

Managers are responsible for ensuring compliance with this policy and maintaining a work environment free of sexual harassment. Managers are also responsible for elevating to one of the individuals listed below any complaints of sexual harassment they may receive and any violations of this policy they observe.

Complaints of Sexual Harassment

HMFP/APHMFP can only address issues of which it is aware. As such, HMFP/APHMFP strongly encourages all employees including physicians, supervising physicians, and chiefs of service, who have concerns regarding sexual harassment to discuss them with one of the individuals listed below.

If any of our employees, including physicians, supervising physicians, and chiefs of service, believes that he or she has been subjected to sexual harassment, the employee has the right to file a complaint with our organizations. This may be done in writing or orally. This process applies to all complaints of sexual harassment, including those made against physicians, supervising physicians, and chiefs of service. Complaints under this policy also may be raised about the conduct of any HMFP/APHMFP employee regardless of level, including supervising physicians, chiefs of service, and senior administrators. Complaints also may be raised about the conduct of any other individuals whom HMFP/APHMFP employees must interact as part of their jobs, such as employees of Beth Israel Deaconess Medical Center (BIDMC).

If you would like to file a complaint, you may do so by contacting Mary Leupold, Director, HR Operations, HMFP/APHMFP’s Human Resources, 375 Longwood Ave., 3rd floor, Boston, MA 02215 or at 617-632-8694, option 4 or Stuart Rosenberg, President and CEO, HMFP/APHMFP, 375 Longwood Ave., 3rd floor, Boston, MA 02215 or at 617-632-7441. These persons are also available to discuss any concerns you may have and to provide information to you about our policy on sexual harassment and our complaint process.

Sexual Harassment Investigation

When we receive a complaint of sexual harassment we promptly will investigate the allegation in a fair, expeditious, and discrete manner. The investigation will be conducted in such a way as to maintain confidentiality to the extent practicable under the circumstances. Our investigation will include a private interview with the person filing the complaint and with witnesses. The investigation also include an interview the person alleged to have committed sexual harassment.

When appropriate or necessary to conduct an investigation, we may collaborate with BIDMC and/or Harvard Medical School; in appropriate circumstances, the investigation may be led by either BIDMC or Harvard Medical School.

When we have completed our investigation, we will, to the extent appropriate, inform the person filing the complaint and the person alleged to have committed the conduct of the results of that investigation.

If it is determined that inappropriate conduct has occurred, we will act promptly to eliminate the offending conduct, and, where it is appropriate, we will also impose disciplinary action up to and including suspension or termination of employment.

Disciplinary Action

If it is determined that inappropriate conduct has been committed by one of our employees, we will take such action as is appropriate under the circumstances. Such action may range from counseling to suspension or termination of employment and may include such other forms of disciplinary action as we deem appropriate under the circumstances.
Benefits Overview

State and Federal Remedies

In addition to the above, if you believe you have been subjected to sexual harassment, you may file a formal complaint with either or both of the government agencies set forth below. Using our internal complaint process does not prohibit you from filing a complaint with their agencies. Each of the agencies has a short time period for filing a claim (EEOC-300 days; MCAD-300 days).


   Boston Office: One Ashburton Place, Sixth Floor, Room 601, Boston MA 02108, 617-994-6000.
   Springfield Office: 436 Dwight Street, Second Floor, Room 220, Springfield, MA 01103, 413-739-2145.

Discrimination and Harassment Policy

It is the goal of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. (“HMFP”) and Associated Physicians of HMFP at BIDMC, Inc. (“APHMFP”) to promote a workplace that is free of discrimination and harassment based on race, color, religion, sex, sexual orientation, national origin, ancestry, age, handicap (disability), genetics, active military or veteran status or any other classes protected by law (“protected classes”). An environment free of unlawful harassment is fundamental to HMFP/APHMFP’s culture. With regard to sexual harassment specifically, employees should consult HR001 (“Sexual Harassment Policy”).

Harassment or discrimination based on race, color, religion, sex, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, genetics, military service, veteran status or any other classes protected by law against applicants or employees occurring in the workplace or in other settings in which employees may find themselves in connection with their employment is unlawful and will not be tolerated by these organizations. Harassment includes verbal or physical conduct that may or does offend, denigrate or belittle any individual because of or due to race, color, religion, sex (including pregnancy), sexual orientation, gender identity or expression, national origin, ancestry, age, disability, genetics, military service, veteran status or any other classes protected by law. Such conduct includes, but is not limited to pictures, jokes, comments, innuendos or any other behavior which creates an environment that is hostile, offensive, intimidating, or humiliating. Further, any retaliation against an individual for complaining about harassment or discrimination, or retaliation against individuals for cooperating with an investigation of a harassment or discrimination complaint, is similarly unlawful and will not be tolerated. To achieve our goal of providing a workplace free from harassment, discrimination, and retaliation, we have provided a procedure by which inappropriate conduct will be dealt with, if encountered by applicants or employees.

Because HMFP/APHMFP take allegations of discrimination and harassment seriously, we will respond promptly to complaints and where it is determined that such inappropriate conduct has occurred, we will act promptly to eliminate the conduct and impose such corrective action as is necessary, including disciplinary action up to and including suspension or termination of employment where appropriate.

Please note that while this policy sets forth our goals of promoting a workplace that is free of discrimination and harassment, the policy is not designed or intended to limit our authority to discipline or take remedial action for workplace conduct which we deem unacceptable, regardless of whether that conduct satisfies the legal definition of discrimination or harassment.

All applicants and employees should take special note that, as stated above, retaliation against an individual who has complaint about harassment or discrimination, and retaliation against individuals for cooperating with an investigation of harassment or discrimination complaint is unlawful and will not be tolerated by this organization. This includes the prohibition specifically with regard to disability and veteran status, that applicants and employees shall not be subjected to harassment, intimidation, threats, coercion or discrimination because they have filed a complaint, assisted in an investigation or opposed any practice made unlawful by Section 503 of the Rehabilitation Act of 1973, as amended or the Vietnam Era Veterans’ Readjustment Assistance Act (VEVRAA), as amended.
Benefits Overview

Definition of Discrimination
In Massachusetts, treating an individual unequally in terms of hiring, advancement, discharge, compensation or other terms, conditions or privileges of employment, on the basis of race, color, religion, sex (including pregnancy), sexual orientation, gender identity or expression, national origin, ancestry, age, disability, genetics, active military or veteran status, or any other characteristics protected by law, may constitute discrimination unless based upon a bona fide occupational qualification. Qualified handicapped (disabled) individuals capable of performing the essential functions of the job with or without reasonable accommodation also must be treated equally in these regards. HMFP/APHMFP makes reasonable accommodations for qualified disabled individuals when necessary for such individual to perform their essential job functions, to the extent that the accommodation does not cause an undue hardship. Disabled employees who need reasonable accommodations to perform their essential job functions should contact Mary Leupold at (617) 632-8694. Employees who need disability- and military-related leaves of absence should consult HR-003 (“Leave of Absence Policy”). HMFP/APHMFP also makes reasonable accommodations when necessary for employees to observe a religious practice to the extent that the accommodation does not cause an undue hardship.

Definition of Harassment
In Massachusetts, the legal definition of harassment is broad. Unlawful harassment is verbal or physical conduct that denigrates or shows hostility or aversion to an individual or others because of race, color, religion, sex (including pregnancy), sexual orientation, gender identity or expression, national origin, ancestry, age, handicap (disability), genetics, active military or veteran status, or any other classes protected by law and that (1) has the purpose or effect of creating an intimidating, hostile, humiliating or offensive working environment; (2) has the purpose of effect of unreasonable interfering with an individual’s work performance; or (3) otherwise adversely affects and individual’s employment opportunity. Depending on the circumstances, the following conduct may constitute discriminatory harassment:

- Verbal or physical conduct that denigrates or shows hostility or aversion to an individual because of his/her race, color, religion, sex (including pregnancy), sexual orientation, gender identity or expression, national origin, ancestry, age, disability, genetics, active military or veteran status or any other classes protected by law
- Epithets, slurs, negative stereotyping, or threatening, intimidating, or hostile acts that relate to the characteristics described above and
- Written, oral or graphic material, including e-mail and instant messages, voice mails and/or text messages, that denigrates or shows hostility or aversion toward an individual or group because of the characteristics described above.

Special Note on Retaliation and Good Faith
All employees should take special note that, as stated above, retaliation against an individual for complaining in good faith about discrimination or harassment, and retaliation against individuals for cooperating with an investigation of a discrimination or harassment complaint is unlawful and will not be tolerated by these organizations. (Refer to HR-0013 Prohibition Against Retaliation)

Likewise, accusations made maliciously or otherwise not in good faith will not be tolerated by these organizations and may result in disciplinary action up to and including suspension or termination of employment.

Employee Responsibility
Every employee, including physicians, supervising physicians, and chiefs or service, is responsible for behaving in a professional manner that does not constitute unlawful harassment of others. Every employee is also urged to report any behavior that he or she believes violates this policy, whether directed toward him/herself or others, to one of the individuals listed below.

Managers are responsible for ensuring compliance with this policy and maintaining a work environment free of unlawful harassment. Managers are also responsible for elevating to one of the individuals listed below any complaints of unlawful harassment they may
Complaints of Discrimination or Harassment

HMFP/APHMFP can only address issues of which it is aware. As such, HMFP/APHMFP strongly encourages all employees including physicians, supervising physicians, and chiefs of service, who have concerns regarding unlawful harassment to discuss them with one of the individuals listed below.

If any of our employees, including physicians, supervising physicians, and chiefs of service, believes that he or she has been subjected to discrimination or harassment, the employee has the right to file a complaint with our organizations. This may be done in writing or orally. This process applies to all complaints of unlawful harassment, including those made against physicians, supervising physicians, and chiefs of service. Complaints under this policy also may be raised about the conduct of any HMFP/APHMFP employee regardless of level, including supervising physicians, chiefs of service, and senior administrators. Complaints also may be raised about the conduct of any other individuals whom HMFP/APHMFP employees must interact as part of their jobs, such as employees of Beth Israel Deaconess Medical Center (BIDMC).

If you would like to file a complaint, you may do so by contacting Mary Leupold, Director, Human Resource Operations, HMFP/APHMFP’s Human Resources, 375 Longwood Ave., 3rd floor, Boston, MA 02215 or at 617-632-8694, option 4 or Stuart Rosenberg, President and CEO, HMFP/APHMFP, 375 Longwood Ave., 3rd floor, Boston, MA 02215 or at 617-632-7441. These persons are also available to discuss any concerns you may have and to provide information to you about our policy on sexual harassment and our complaint process.

Discrimination or Harassment Investigation

When we receive a complaint of discrimination or harassment based on membership in a protected class, we will promptly investigate the allegation in a fair, expeditious, and discrete manner. The investigation will be conducted in such a way as to maintain confidentiality to the extent practicable under the circumstances. Our investigation will include a private interview with the person filing the complaint and with witnesses. The investigation also will include an interview the person alleged to have committed discrimination or harassment.

When appropriate or necessary to conduct an investigation, we may collaborate with BIDMC and/or Harvard Medical School; in appropriate circumstances, the investigation may be led by either BIDMC or Harvard Medical School.

When we have completed our investigation, we will, to the extent appropriate, inform the person filing the complaint and the person alleged to have committed the conduct of the results of that investigation.

If it is determined that inappropriate conduct has occurred, we will act promptly to eliminate the offending conduct, and, where it is appropriate, we will also impose disciplinary action up to and including suspension or termination of employment.

Disciplinary Action

If it is determined that inappropriate conduct has been committed by one of our employees, we will take such action as is appropriate under the circumstances. Such action may range from counseling to suspension or termination of employment and may include such other forms of disciplinary action as we deem appropriate under the circumstances.

State and Federal Remedies

In addition to the above, if you believe you have been subjected to discrimination or harassment based on membership in a protected class, you may file a formal complaint with either or both of the government agencies set forth below. Using our internal complaint process does not prohibit you from filing a complaint with their agencies. Each of the agencies has a short time period for filing a claim (EEOC-300 days; MCAD-300 days).

Prohibition Against Retaliation Policy

HMFP/APHMFP affirm their commitment to promote and maintain a work environment in which its employees, including chiefs of service, supervising physicians, and other medical staff, may exercise their rights and duties under HMFP’s and APHMFP’s policies and procedures, medical staff bylaws, rules and regulations, or state and federal regulation and laws without fear of retaliation. For the purposes of this policy, retaliatory action is any form of intimidation, threats, coercion, discrimination, or reprisal against an employee or physician.

HMFP/APHMFP expects that any employee or physician, including chiefs of service and supervising physicians, who becomes aware of a potential or actual violation of HMFP/APHMFP or BIDMC policies or any laws or regulations to which HMFP/APHMFP or BIDMC is subject will report such violation to HMFP’s leadership, including but not limited to the reporting employee’s supervisor, Human Resources, Corporate Compliance Department, and/or CEO of HMFP.

It is expressly forbidden for anyone to take any form of retaliatory action against any employee, including physicians, supervising physicians, and chiefs of service, who in good faith voices concerns, seeks advice, files a complaint or grievance, seeks the aid of Human Resources, testifies or participates in investigations, compliance reviews, proceedings or hearings, or opposes actual or perceived violations of HMFP/APHMFP and/or BIDMC policy or unlawful acts. Any person determined to have acted in retaliation may be subject to disciplinary action.

If it is determined that information was knowingly fabricated, distorted, exaggerated, or minimized either to injure someone else or to inappropriately protect an individual, the information communicated will be deemed to be given not in good faith and the person communicating such information may be subject to disciplinary action up to and including termination of employment.

Procedure

Representatives from Human Resources, Corporate Compliance Department, or the CEO are available to assist any employee or physician wishing to bring forward a good faith complaint of retaliation.

Members of the above departments may separately or together investigate a complaint of retaliation making every effort to maintain confidentiality whenever possible. Claims of retaliation will be analyzed to ensure they are legitimate. They will be reviewed to ensure retaliation was not a motivation for any action taken.

At a minimum, a prompt investigation will be conducted including, but not limited to, an interview with the employee or physician bringing the complaint, review of any documentation, and an interview with the person who has allegedly acted in a retaliatory manner.

If retaliation played a determinative part in the action taken, prompt and appropriate corrective action will be taken against the offender.

Questions regarding this policy should be directed to Human Resources at 375 Longwood Avenue, 3rd floor, Boston, MA 02215 or by calling 617-632-9737.

Other HMFP/APHMFP Policies

If you are interested in obtaining copies of other HMFP/APHMFP policies, please call us at 617-632-8694, option 4.