

HARVARD MEDICAL FACULTY PHYSICIANS  
AT BETH ISRAEL DEACONESS MEDICAL CENTER



and at our affiliates

Beth Israel Lahey Health 

# SUMMARY PLAN DESCRIPTION

## HEALTH & WELFARE PLANS

EFFECTIVE JANUARY 1, 2021



## CARES ACT – BENEFIT PROGRAM CHANGES

The recent passing of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) has allowed employers to modify benefit programs to address financial pressures facing individuals due to the pandemic. Many of our benefit vendors have created a COVID-19 section on their site to help you find specifics on these changes. Many of these changes are in effect for the near future.

### HEALTH INSURANCE

- Waiving of deductibles, co-pays, and co-insurance for all COVID-19 related testing and treatment for illness, visit [HPHC](#) for more information
- Deductible, co-insurance, and copays waived for telehealth in-network visits
- Expanded virtual visits for essential non-COVID-19 related services
- Created behavioral health care options during the pandemic include Emotional Support Help Line at (866)342-6892 or [Optum](#).

### RX COVERAGE

- Early refills on 30-day maintenance prescriptions
- Extended prior authorization automatically for up to 3 months
- Expanded home delivery and mail order options, at no extra cost
- Visit [CVS Caremark](#) to learn more

### FLEXIBLE SPENDING & HEALTH SAVINGS PLANS

- Expanded definition of “qualified medical expenses” to cover certain over-the-counter medications (without a prescription)
- Changes occurred for 2020:
  - ✓ The IRS allowed employees to make changes to their Dependent Care & Healthcare FSA Elections for any reason
  - ✓ 2019 HSA contributions extended through July 15, 2020
- Visit [Sentinel Benefits](#) & [HealthEquity](#) to learn more

### RETIREMENT\*

The CARES Act includes temporary changes to 401(k) and 403(b) retirement plans. Retirement plan relief for qualified individuals impacted by COVID-19 include:

- Ability to defer current retirement plan loan repayments for up to one year
- Penalty-free withdrawals of up to \$100,000 (certain COVID related criteria required)
- The borrowing limit has increased from \$50,000 to \$100,000 through September 22, 2020
- Safe Harbor Hardship Withdrawals may be available to some employees
- Suspended Required Minimum Distributions (RMD) for 2020 along with increasing the age requirement to 72
- Visit [Fidelity](#) & [TIAA](#) for more information

### LIFE INSURANCE

We have confirmed with Minnesota Life that the pandemic has not affected our current term life insurance coverage.

\*See HMFP Retirement Summary Plan Description for more details

## DEADLINE EXTENTIONS FOR WELFARE PLANS AND PARTICIPANTS

The DOL and IRS have issued COVID-19 related guidance that temporarily extends certain deadlines applicable to welfare plans and their participants and beneficiaries.

In April 2020, the DOL issued EBSA Disaster Relief Notice 2020-01, and the DOL and IRS (collectively, the “Agencies”) jointly issued final regulations providing temporary extensions of certain deadlines applicable to health plans and their participants and beneficiaries.

These temporary deadline extensions, which became effective March 1, 2020, will continue until 60 days after the announcement of the end of the COVID-19 National Emergency, or such other date announced by the Agencies (*i.e.*, the “Outbreak Period”):

### Extended Deadlines Applicable to both Welfare Plan Participants and Beneficiaries:

- *Claims and Appeals:* The final regulations extend the deadline to file a claim or appeal in connection with an adverse benefit determination during the Outbreak Period. This extension applies to claims and appeals due on or after March 1, 2020, and suspends the applicable timelines for claims and appeals currently pending during the Outbreak Period.
- *HIPAA Special Enrollment:* Under HIPAA, an individual generally has 30 days (60 days in certain cases, however) to request enrollment information in a group health plan following the occurrence of a HIPAA special enrollment event (*e.g.*, birth of a child, marriage, loss of other coverage). The final regulations require plans to disregard the Outbreak Period when determining the deadline by which an individual must request a HIPAA special enrollment.
- *Notice to the Plan of COBRA Qualifying Event or Disability:* The final regulations require plans to disregard the Outbreak Period when determining the 60-day deadline for individuals to notify the plan of a COBRA-qualifying event (*e.g.*, divorce, legal separation, a child’s loss of dependent status under the plan, or a disability determination by SSA).

NOTE: The deadline for employers to notify the plan of a qualifying event remains unchanged.

- *COBRA Election Period:* The final regulations require plans to disregard the Outbreak Period when determining the 60-day deadline for individuals to elect COBRA continuation coverage as a result of experiencing a qualifying event.
- *COBRA Premium Payments:* COBRA requires an individual who enrolls in COBRA continuation coverage to make the initial premium payment required for the coverage within 45 days after the election, and plans must provide a grace period of at least 30 days for subsequent premium payments. The final regulations require plans to disregard the Outbreak Period when determining the deadline to submit COBRA premium payments.
- *External Review:* For non-grandfathered plans, the final regulations require plans to disregard the Outbreak Period when determining the deadline for participants to file a request for external review after receiving an adverse benefit determination or to submit information to perfect a request for external review during the Outbreak Period.



Extended Deadline Applicable to Welfare Plans:

- *Disclosures/Documents Required by Title I of ERISA:* Notice 2020-01 extends the deadline for plans to timely provide participants and dependents with any notices, disclosures, or documents required under Title I of ERISA (*e.g.*, SPDs, Summary Annual Reports) that are due to be furnished during the Outbreak Period. Plans must make a good faith effort to provide these documents as soon as administratively possible.
- *Extended Deadline for Employers to Submit Participant Contributions:* Notice 2020-01 provides that the DOL will not take enforcement action against employers and services providers if they fail to timely remit participant contributions during the Outbreak Period.

NOTE: For group health plans, participant contributions must be submitted no later than 90 days from the date on which participant contributions are received by the employer or the date on which such amounts would otherwise be payable to the employee in cash.

- *Form 5500 and Form M-1 Filings:* Notice 2020-01 confirms prior IRS guidance that extends the deadline to file a Form 5500 to July 15, 2020, for filings due on or after April 1, 2020 and before July 15, 2020. Form M-1 filings, which are required for Multiple Employer Welfare Arrangements (“MEWAs”) are afforded relief for the same period as the Form 5500 relief.

NOTE: There is currently no COVID-19 related relief for calendar year plans that have a Form 5500 filing due date of July 31, 2020.

- *COBRA Election Notices:* The final regulations provide that plans do not have to send a COBRA Election Notice during the Outbreak Period.

NOTE: Group health plans must normally notify qualified beneficiaries of their right to elect COBRA continuation coverage within 14 days of receiving notice of the occurrence of a qualifying event.



## Table of Contents

1.0 INTRODUCTION.....	8
1.1 Benefits Overview .....	8
1.2 How Your Benefits Are Paid? .....	8
1.3 Important Notice Regarding Employer Contributions .....	9
2.0 AM I ELIGIBLE FOR BENEFITS? .....	9
2.1 Benefit Eligibility .....	9
2.2 Other Eligibility.....	9
2.3 Who You May Cover.....	9
3.0 HOW TO ENROLL OR MAKE CHANGES IN BENEFITS .....	9
3.1 Benefit Election Requirements .....	9
3.2 Initial and Newly Eligible Benefit Enrollment.....	9
3.3 Enrollment Deadlines.....	10
3.4 What Happens If I Miss the 30-day Enrollment Period?.....	10
3.5 Changing Benefits during the Year.....	10
4.0 WHEN DOES COVERAGE BEGIN OR END.....	11
4.1 Coverage Start Dates.....	11
4.2 Coverage End Dates .....	11
4.3 Loss of Benefits .....	13
5.0 WHAT ARE MY BENEFITS?.....	13
5.1 Health Insurance .....	13
5.2 Dental Insurance .....	17
5.3 Vision Insurance .....	18
5.4 Flexible Spending Accounts (FSAs).....	18
5.5 Health Savings Account (HSA).....	19
5.6 Disability Insurance .....	20
5.7 Life Insurance .....	22
5.8 Global Benefits Plan .....	24
6.0 OTHER BENEFIT PROGRAMS .....	26
6.1 Clinician Health Services .....	26
6.2 Critical Illness Insurance.....	26
6.3 Identity Protection .....	27

6.4 Paid Family Leave .....	27
6.5 Child & Family Resources .....	28
6.6 Group Personal Excess Liability Insurance .....	28
6.7 Travel Assistance .....	28
6.8 Legal Services .....	29
6.9 Legacy Planning Services .....	29
6.10 Harvard Real Estate Advantage Program .....	29
6.11 Harvard Club of Boston .....	29
7.0 YOUR ERISA RIGHTS .....	30
7.1 FILING A CLAIM FOR BENEFITS – HEALTH PLANS .....	31
7.2 TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW .....	34
7.3 FILING A CLAIM FOR BENEFITS – PENSION PLANS .....	34
7.4 FILING A CLAIM FOR BENEFITS - DISABILITY .....	35
7.5 ERISA CLAIM PROCEDURES - OTHER WELFARE PLANS .....	37
8.0 REQUIRED NOTICES .....	38
8.1 Health Insurance Marketplace Notice .....	38
8.2 COBRA Rights and Responsibilities Notice .....	40
8.3 HIPAA Notice of Special Enrollment Rights .....	42
8.4 Certificate of Coverage under Group Health Plans Notice .....	44
8.5 Notice of Creditable Coverage .....	44
8.6 Loss or Gain of Eligibility for a State Children’s Health Insurance Program (CHIP) or Medicaid .....	46
8.7 Women’s Health and Cancer Rights Act of 1998 (WHCRA) Notice .....	47
8.8 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) .....	48
8.9 Newborns’ and Mothers’ Protection Act of 1996 Notice (NMHPA) .....	48
8.10 Genetic Information Nondiscrimination Act (GINA) Notice .....	48
8.11 Notice of Right to Designate a Primary Care Provider (PCP) .....	48
8.12 Uniformed Services Employment & Reemployment Rights Act (USERRA) .....	49
8.13 Qualified Medical Child Support Order (QMCSO) Notice .....	50
8.14 Massachusetts Identity Theft Law Notice .....	50
8.15 Earned Sick Time — Notice of Employee Rights .....	50
8.16 Massachusetts Paid Family Medical Leave .....	50
9.0 ADMINISTRATIVE INFORMATION .....	51
9.1 Privacy of Health Information .....	53



9.2 Notice of Privacy Practices .....	53
9.3 How Your Health Information May be Used or Disclosed .....	54
9.4 Your Health Information Rights .....	55
9.5 Sources of Plan Contributions and Election of Benefits.....	56
9.6 Tax Consideration.....	56
9.7 Third Party Liability .....	56
9.8 Responsibility for Goods/Services.....	57
9.9 Additional Documentation.....	57
9.10 Agent for Service of Legal Process .....	57
10.0 HOW TO CONTACT US AND OUR VENDORS .....	57
10.1 Contact the Benefits Team.....	57
10.2 Contact Vendors & Resources.....	58

## 1.0 INTRODUCTION

### 1.1 Benefits Overview

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

HMFP offers the following benefit programs. Some benefits are company provided so enrollment is automatic while others require you to opt in or meet certain eligibility requirements. Benefits are an important part of your total compensation package.

#### Company Provided Benefits:

Basic Term Life Insurance	Business Travel Insurance	Umbrella Liability Insurance
Short and Long Term Disability		

#### Additional Benefit Options:

Medical/Rx	Dental	Vision
Supplemental Term Life Insurance (Legacy Life Grandfather Plan)	Spousal & Dependent Term Life	Accidental Death & Dismemberment
FlexChoice Limited Purpose Health Care	FlexChoice FSA Health Care	FlexChoice FSA Dependent Care
Health Savings Account	Supplemental Umbrella Liability Insurance	Global Benefits
Identity Theft Protection	Critical Illness Insurance	Legal

#### Other Benefits:

Massachusetts Paid Family and Medical Leave
---

### 1.2 How Your Benefits Are Paid?

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

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

### 1.3 Important Notice Regarding Employer Contributions

Your department funds certain contributions and have the authority to allocate department expenses to individual profit and loss statements (P&L). You are encouraged to discuss with your administrator how these allocations will affect you. From time to time, the cost and/or value of the employer-provided premiums are added to your W-2 earnings for tax purposes as required by the Internal Revenue Service (IRS), also known as imputed income. Examples of these benefits include employer-sponsored disability, parking, T-pass, and certain life and umbrella liability insurance programs.

## 2.0 AM I ELIGIBLE FOR BENEFITS?

### 2.1 Benefit Eligibility

If regularly scheduled to work at least 20 hours or more each week benefits are available to you. Participation begins on the first of the month following or coinciding with employment or transfer into a benefits-eligible status. Temporary/per diem employees are not eligible regardless of the number of hours worked per week.

### 2.2 Other Eligibility

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

### 2.3 Who You May Cover

For the purposes of health, dental, vision 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, dental, and vision only, disabled children who are dependent upon you for support even if they're older than age 26, provided they were disabled before their 26th birthday and meet the eligibility and medical criteria

## 3.0 HOW TO ENROLL OR MAKE CHANGES IN BENEFITS

### 3.1 Benefit Election Requirements

You have 30 days from your hire date, the date you are first eligible for benefits, or the date of an IRS defined change in status ([Section 3.5](#)) to enroll in the Plan. Your benefit elections will be retroactively effective as of your hire date, the date you are first eligible for benefits, or the date of your IRS-defined change in status.

### 3.2 Initial and Newly Eligible Benefit Enrollment

If you are newly eligible for benefits through HMFP, you can find benefit enrollment information by accessing the Benefit application in your Workday account:



You will have 30 days to complete the enrollment process. You also have access to links to various program providers where you can find additional detailed information on how these programs work.

### 3.3 Enrollment Deadlines

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

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

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

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

### 3.5 Changing Benefits during the Year

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

For example, you can make changes to your benefits for the following:

- Marriage, divorce, annulment or legal separation, loss of spouse or qualified dependent
- Birth, adoption or placement for adoption of a child
- Dependent who loses or gains eligibility elsewhere
- Experience a change in employment status, (i.e. you or your eligible dependent begins or ends employment, or takes an unpaid leave of absence or family medical leave)
- Experience a significant change in medical coverage or cost to you or your eligible dependent
- Relocation out of your plan's coverage service area
- Qualified medical child support orders
- Events relating to Medicare, Medicaid, or Health Insurance Marketplace eligibility

You will need to provide proof of the change, for example, birth, marriage, or divorce certificate or letter from your spouse's employer on letterhead (if your spouse gains or loses coverage).

## 4.0 WHEN DOES COVERAGE BEGIN OR END

### 4.1 Coverage Start Dates

Benefit	Newly Eligible	Open Enrollment	IRS-Defined Change in Status
Medical/Rx, Dental & Vision	1 <sup>st</sup> of month coinciding with or following eligibility date	January 1 <sup>st</sup>	Date of an IRS-defined change in status
Disability		No Changes	No Changes
FlexChoice FSA HC/DC or Limited Purpose FSA		January 1 <sup>st</sup>	Date of an IRS-defined change in status
Health Savings Account		January 1 <sup>st</sup>	N/A
Basic Life Insurance		No Changes	No Changes
Supplemental, Spousal & Dependent Term Life		Date coverage changes are approved	Date of an IRS-defined change in status
AD&D Individual/ Family		January 1 <sup>st</sup>	Date of an IRS-defined change in status
Legal		January 1 <sup>st</sup>	Date of an IRS-defined change in status
Critical Illness		January 1 <sup>st</sup>	Date of an IRS-defined change in status
Identify Protection		January 1 <sup>st</sup>	Date of an IRS-defined change in status
Umbrella Liability Insurance		January 1 <sup>st</sup>	N/A

### 4.2 Coverage End Dates

Benefit	End Date	Information
Medical/Rx, Dental, & Vision	Last day of the month in which you terminate or you no longer meet the eligibility requirements, fail to make the required payments or HMFP no longer maintains the benefit program	A COBRA packet will be mailed to you. Go to <a href="#">Sentinel Benefits</a> for more information.
Disability	When your employment terminates, you no longer meet the eligibility requirements, fail to make the required payments or HMFP no longer maintains the benefit program	To request a form to convert to an individual policy email <a href="#">The Standard</a> or call them at <b>800-378-4668</b>



### 4.3 Loss of Benefits

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

If you or your eligible dependents lose coverage under the Plan, your Workday account will include details on what happens to your benefits and if you have the ability to convert any to individual policies. Certain rights to continue health care coverage through COBRA are outline in [Section 8.2](#). Contact the [Benefits Team](#) with any questions.

## 5.0 WHAT ARE MY BENEFITS?

### 5.1 Health Insurance

The following is a brief summary of the medical plan coverage. For more detailed information, refer to the Plan Documents or contact the Plan Administrator. Additional information can be found at [HPHC](#).

When you enroll in one of our medical plans, you pay a portion of the total group premium, with HMFP paying most of the total premium. Listed in Workday are the rates for employee and employer individual coverage. To obtain rates for yourself plus one dependent or family you will need to add your dependents in Workday first.

#### *Choose from two Medical Plans*

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

1. **myAdvantage CDHP:** This Consumer-Driven Health Plan (CDHP) features lower premiums with higher out-of-pocket costs and deductibles. Once your deductible is met, most services are covered in full. The myAdvantage CDHP is offered in conjunction with a Health Savings Account (HSA) option. To learn more about HSAs please refer to [Section 5.5](#).
2. **myClassic POS:** This plan features higher premiums but features lower out-of-pocket costs and deductibles when you receive services. The plan has two types of In-Network copayments that apply to certain office visits with physicians and other health professionals. A lower copayment, known as “Primary Care copayment” and a higher copayment, known as the “Specialty Care copayment”.

With both the myAdvantage CDHP and myClassic POS plans, you designate a primary care physician (PCP), for yourself and your dependents, who coordinates your care. If you need to find a PCP, Specialist, Behavioral Health Provider or Hospital, Urgent Care or Lab in the HMFP Choice Network go to the HPHC [Find a Provider Directory](#).

In addition, when you enroll in either of these plans, HPHC offers many discounts and savings to help you live well. These include:

\$150 Fitness Reimbursement	Weight Management Reimbursement	Childbirth Class Reimbursement
Vision Discounts	Holistic Wellness Discounts	Hearing Discounts
Dental Discounts	Family and Senior Care Discounts	Healthy Eating Discounts

**Note: If enrolled in the HPHC PPO Grandfathered Plan, please contact the [Benefits Team](#) or visit [HPHC PPO](#) for additional information.**

### **Prescription Drug Coverage**

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

### **Prescription Co-pay Assistant Program**

This program, through PillarRx, helps employees and family members who take **specialty medications for complex or chronic medical conditions**. This program uses drug manufacturers' coupons to cover most or all of your out-of-pocket costs for eligible medications. If you are prescribed an eligible medication, you will be contacted by PillarRx to facilitate enrollment in the manufacturer's programs. Any manufacturer dollars applied will not apply toward the annual out-of-pocket maximum. In addition, your out-of-pocket cost per 30-day supply will not exceed the set plan design maximum. If you enroll in the myAdvantage CDHP, the employer contributions for the HDHP include the cost of co-pay assistance services.

### **BIDMC Pharmacy Benefit**

If you enroll in one of our medical plans, most prescriptions can be filled through BIDMC's pharmacy in-person or through the mail will have a \$0 co-pay. **If you are enrolled in the myAdvantage CDHP you must meet your deductible before the \$0 co-pay applies.** This also applies to drugs filled from the specialty pharmacy in Norwood and their retail pharmacy located at 330 Brookline Ave., Boston. Personalized pharmacist services are included. BIDMC pharmacy team can be reached by phone at 617-667-6400 or email [BIDMC Pharmacy](#). Retail hours of operation are Mon-Fri 7AM-7PM and Sat 7AM-5PM.

**myAdvantage CDHP**

	IN-NETWORK ONLY	IN-NETWORK ONLY	OUT-OF-NETWORK
<b>Annual Deductible</b>	<b>Tier 1 &amp; 2</b>	<b>Tier 3</b>	
Individual	\$1,500	\$1,500	\$3,000
Individual + 1	\$3,000	\$3,000	\$6,000
Family	\$3,000	\$3,000	\$6,000
<b>HSA Employer Funded</b>	\$500 Individual/\$1,000 Individual + 1 or Family		
<b>Out-of-Pocket Maximum</b>	<b>Tier 1 &amp; 2</b>	<b>Tier 3</b>	
Individual	\$2,800	\$4,000	\$6,000
Individual + 1	\$5,600*	\$8,000*	\$12,000*
Family	\$5,600*	\$8,000*	\$12,000*
<b>Coinsurance (after deductible)</b>	<b>Tier 1 &amp; 2 0%</b>	<b>Tier 3 20%</b>	30%
<b>Office/Specialist Visits</b>	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance or 100% after deductible for dependents age 19 and under	Deductible, then 30% coinsurance
<b>Hospital Emergency Room (co-pay waived if admitted)</b>	Deductible, \$100 co-pay	Deductible, \$100 co-pay	Deductible, then 30% coinsurance
<b>Inpatient Hospital Care</b>	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>Outpatient Surgery</b>	Tier 1 & 2 100% after deductible	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>Lab/Radiology/Diagnostic</b>			
<b>Non-Hospital Based</b>	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then no charge	Deductible, then 30% coinsurance
<b>Lab/Xray Hospital Based</b>	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>High-End Radiology Non-Hospital Based</b>	Tier 1 & 2 Deductible only	Tier 3 Deductible only	Deductible, then 30% coinsurance
<b>High-End Radiology Hospital Based</b>	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>PT/OT/ST (limit 36 visits/year)</b>	Tier 1 & 2 Deductible, then no charge	Tier 3 Deductible, then no charge	Deductible, then 30% coinsurance
<b>CVS Caremark RX:</b>			
<b>Generic (Tier 1)</b>	Deductible, then \$10 co-pay		
<b>Brand-Name, Preferred (Tier 2)</b>	Deductible, then \$30 co-pay		
<b>Brand-Name, Non-Preferred (Tier 3)</b>	Deductible, then \$50 co-pay		
	For designated specialty drugs use <b>PillarRx Assistance Program</b> or pay a 30% copay		

\*Once a family member meets the Individual-level deductible (even if it's before the Individual + 1 or Family deductible is met), then that family member will be considered to have met his/her deductible and will move to coinsurance. Once a family member meets the Individual-level out-of-pocket maximum (even if it's before the Individual + 1 or Family out-of-pocket maximum is met), then that family member will be covered and will no longer be responsible for qualifying out-of-pocket expenses for the remainder of the calendar year.

myClassic POS Plan

	IN-NETWORK ONLY	IN-NETWORK ONLY	OUT-OF-NETWORK
<b>Annual Deductible</b>	<b>Tier 1 &amp; 2</b>	<b>Tier 3</b>	
Individual	\$500	\$500	\$2,000
Individual + 1	\$1,000*	\$1,000*	\$4,000*
Family	\$1,000*	\$1,000*	\$4,000*
<b>Out-of-Pocket Maximum</b>	<b>Tier 1 &amp; 2</b>	<b>Tier 3</b>	
Individual	\$1,500	\$3,000	\$6,000
Individual + 1	\$4,500*	\$6,000*	\$12,000*
Family	\$4,500*	\$6,000*	\$12,000*
<b>Coinsurance (after deductible)</b>	<b>Tier 1 &amp; 2</b> 0%	<b>Tier 3</b> 20%	30%
<b>Office/Specialist Visits</b>	<b>Tier 1 &amp; 2</b> Office \$15 copay/Specialist \$20 co-pay	<b>Tier 3</b> Deductible, then 20% coinsurance. Dependents age 19 and under \$15/\$20 co-pay	Deductible, then 30% coinsurance
<b>Hospital Emergency Room (co-pay waived if admitted)</b>	\$100 co-pay	\$100 co-pay	\$100 co-pay
<b>Inpatient Hospital Care</b>	<b>Tier 1 &amp; 2</b> 100% after deductible	<b>Tier 3</b> Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>Outpatient Surgery</b>	<b>Tier 1 &amp; 2</b> 100% after deductible	<b>Tier 3</b> Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>Lab/Radiology/Diagnostic Non-Hospital Based</b>	<b>Tier 1 &amp; 2</b> Deductible, then no charge	<b>Tier 3</b> Deductible, then no charge	Deductible, then 30% coinsurance
<b>Lab/X-ray Hospital Based</b>	<b>Tier 1 &amp; 2</b> Deductible, then no charge	<b>Tier 3</b> Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>High-End Radiology Non-Hospital Based</b>	<b>Tier 1 &amp; 2</b> Deductible only	<b>Tier 3</b> Deductible only	Deductible, then 30% coinsurance
<b>High-End Radiology Hospital Based</b>	<b>Tier 1 &amp; 2</b> Deductible, then no charge	<b>Tier 3</b> Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
<b>PT/OT/ST (limited 36 visits/year)</b>	<b>Tier 1 &amp; 2</b> \$20 co-pay	<b>Tier 3</b> \$20 co-pay	Deductible, then 30% coinsurance
<b>CVS Caremark RX:</b>			
<b>Generic (Tier 1)</b>	\$10 co-pay		
<b>Brand-Name, Preferred (Tier 2)</b>	\$30 co-pay		
<b>Brand-Name, Non-Preferred (Tier 3)</b>	\$50 co-pay		
	For designated specialty drugs use <b>PillarRx Assistance Program</b> or pay a 30% copay		

\*Once a family member meets the Individual-level deductible (even if it's before the Individual + 1 or Family deductible is met), then that family member will be considered to have met his/her deductible and will move to coinsurance. Once a family member meets the Individual-level out-of-pocket maximum (even if it's before the Individual + 1 or Family out-of-pocket maximum is met), then that family member will be covered and will no longer be responsible for qualifying out-of-pocket expenses for the remainder of the calendar year.

## 5.2 Dental Insurance

The following is a brief summary of the dental plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [Delta Dental](#).

When you enroll in one of our dental plans, you pay a portion of the total group premium, with HMFP paying a portion as well. Listed in Workday are the rates for employee and employer individual coverage. To obtain rates for yourself plus one dependent or family you will need to add your dependents in Workday first.

### *Choose from two Dental Plans*

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

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

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

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

### *How to find a participating Dentist*

Delta Dental offers both local and national networks of dentist. To find dentist that participate in the Delta Dental PPO and Premier Network visit: [Find a Dentist](#).

### 5.3 Vision Insurance

The following is a brief summary of the vision plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [EyeMed](#).

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

When you enroll in our vision plan, you pay the total group premium. Listed in Workday are the rates for individual coverage. To obtain rates for yourself plus one dependent or family you will need to add your dependents in Workday first.

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

### 5.4 Flexible Spending Accounts (FSAs)

The following is a brief summary of the FSA coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [Sentinel Benefits](#).

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

**We offer three Flexible Spending Account options:**

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

Flexchoice FSA Options:	IRS Maximum Limit 2021
Health Care & Limited Purpose FSA	\$2,750
Dependent Care FSA	\$5,000 per family

Each year you will need to make a new election/re-enroll in these accounts for the following calendar year. You may also be able to make changes during the year if you experience an IRS-defined change in status. Global benefit eligible employees can opt to participate in the FlexChoice FSA Health or Dependent Care Accounts; however, only U.S related expenses qualify for reimbursement.

**The “use it or lose it” rule: You can roll over \$550 in your FlexChoice FSA Health Care or LPFSA to the following calendar year. At the end of 2021, you will forfeit any unused funds over \$550 in your account. If you enroll in the Dependent Care FSA you will have until March 15, 2022 to use up any funds remaining in your previous years account. The deadline to submit FSA claims is March 31, 2022.**

**5.5 Health Savings Account (HSA)**

The following is a brief summary of the HSA plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [HealthEquity](#).

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

2021 HSA Limits	HMFP Contribution	Your Maximum Contribution	IRS Maximum
Individual	\$500 annually (prorated)	\$3,100	\$3,600
Individual +1 or Family	\$1,000 annually (prorated)	\$6,200	\$7,200
If you are over age 55, you may contribute an additional \$1,000 per year.			

## 5.6 Disability Insurance

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

### Group Short Term Disability (STD)

STD insurance is a salary replacement benefit that helps you meet your financial commitments if you are unable to work for more than 14 calendar days due to an injury or sickness. Maximum payment period is 90 days. Benefit eligible employees receive this benefit automatically.

### Group Long Term Disability (LTD)

LTD insurance is a salary replacement benefit that continues to meet your needs if you are unable to work after the 90-day elimination period due to injury or sickness. Benefit eligible employees receive this benefit automatically.

	Short Term Disability	Long Term Disability
Eligibility for Coverage and Benefits	You are eligible for coverage as soon as you are a “benefit-eligible” member of HMFP. To receive benefits, you must be unable to perform the duties of your own occupation (specialty subspecialty) and have lost at least 20% of your pre-disability earnings.	
Waiting and Benefit Periods	Benefits begin after 14 days of disability and continue for up to 13 weeks. Partial benefits available. Pre-existing condition limitations	Benefits begin after 90 days of disability and continue until recovery the Maximum Disability Period, whichever occurs first. Partial benefits available.
Benefits Provided	You receive a tax-free benefit of up to 60% of the first \$5,000 of your basic weekly earnings. The maximum benefit is \$3,000 per week.	You receive a tax-free benefit of up to 50% of the first \$360,000 of your base annual earnings. The maximum benefit is \$15,000 per month.
Coverage Limitations	The Plans carry a pre-existing condition clause for any illness/injury treated in the 90 days prior to the effective date of the policy. See the policy for details on benefit limitation for both programs. Claims due to mental or nervous conditions are limited to 24 months. See the LTD policy for details on this and offset provisions for individual policies.	
Massachusetts Paid Medical Leave	12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child; 20 weeks of paid medical leave in a benefit year if you have a serious health condition that incapacitates you from work See <a href="#">Section 6.4</a> for more details	

### Cost of the plan

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

### Waiver of Premium

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

### Absence from work

You must be actively at work on the day before the scheduled effective date of your STD and LTD insurance to become effective as scheduled. If you are not actively at work because of a medical leave due to your own disabling condition on the day before the scheduled effective date of your coverage, it will not become effective until the day after you complete one full day of active work.



STD and LTD certificates are available in Workday. If you believe, you will be out longer than five (5) calendar days; you can request a leave through your Workday Absence application.

If you have questions, you can email the [Benefits Team](#).

### Maximum benefit period

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

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

### Impact on other benefits

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

Benefit Program	Impact While Receiving LTD Benefits
Medical, Dental and Vision Care	Your coverage continues. If you return within 90 day's your first check will include any missed premiums; if not you will be billed.
Basic and Supplemental Term Life Insurance	Premiums continue until you are no longer eligible for plan or qualify for a waiver. If you return within 90 day's your first check will include any missed premiums; if not you will be billed.
Spouse & Dependent Term Life Insurance	If you return within 90 day's your first check will include any missed premiums; if not you will be billed.
STD benefits	Premiums are suspended until you return to a benefits eligible position.
LTD Insurance	Premiums are waived while receiving LTD benefits.
Flexible Spending Health Care, Dependent Care, and Limited Health Care Plans	You may not contribute to these spending accounts while on LTD. If you have an existing account, you can incur claims up to the start of your leave of absence. You are eligible for continued contributions if you return to work in a partial payment role. Missed contributions will be made up upon return if possible.
Health Savings Accounts	You can contribute to your health Savings Account by directly making payments to HealthEquity. Be sure to offset your payroll contributions to reflect any changes. You can do this through your <i>Workday Benefit Application – Change Benefits – Change Health Savings Account Event</i> .

### 5.7 Life Insurance

The following is a brief summary of the life insurance programs. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [Life Insurance](#).

**Note: Employees that opted to retain their Legacy Group Universal Life Insurance Policy in 2020 are not eligible for the following Term Life Insurance Programs. Legacy participants will see a taxable cash contribution equal to the cost of the basic term life program.**

No matter where you are in life, there are many reasons to consider life insurance. As your life, career and or family changes, consider the following coverage options. Newly eligible employees will have options to enroll without answering health questions.

### ***Basic Term Life Insurance***

Basic Term Life is a simple, cost-effective way to provide an extra level of financial protection for your family during your working years. Beneficiaries receive funds to help with their everyday living expenses - such as mortgage payments or medical bills, education expenses, your funeral costs and more - so they can continue to live the lifestyle they live today. HMFP provides 2x your base salary up to \$2,000,000 with a \$1,000,000 guaranteed issue. Your salary will be updated yearly, on the 1<sup>st</sup> of the plan year, as long as you are in an active status.

### ***Supplemental Term Life Insurance***

In addition to Basic Term Life provided by HMFP you can elect supplemental term life insurance of 1 to 5x salary up to \$1,500,000 with a guaranteed issue equal to the lesser of 3x salary or \$500,000. Your salary will be updated yearly, on the 1<sup>st</sup> of the plan year, as long as you are in an active status.

### ***Spousal Term Life Insurance***

Coverage is also available for your spouse. He or she may apply for coverage from \$25,000, up to \$200,000. Only during your initial enrollment period, your spouse may elect \$25,000 of coverage without providing evidence of insurability. **A spouse is not eligible if they are also eligible for employee coverage.** You pay the full cost of this benefit via payroll deductions with after-tax dollars.

### ***Dependent Term Life Insurance***

There is also a \$10,000 dependent term life insurance for your children under age 26. **A child(ren) may only be covered by one parent in the event both parents are employed by HMFP.** You pay the full cost of this benefit via payroll deductions with after-tax dollars.

### ***Business Travel Insurance***

Business Travel Insurance is provided and covers 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 \$5 million aggregate on any one accident. Age reductions apply. Unless otherwise noted, the beneficiary designation for Business Travel will be the same as your Term Life policy.

### ***Accidental Death & Dismemberment Insurance (AD&D)***

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. Dependent children are covered to age 26. Coverage for this benefit is provided through Minnesota Mutual Life Insurance Company and is offered under 0230475T or any state variation thereof.

You can elect salary increments from 1x up to 6x your salary (maximum is \$2,000,000.) Other AD&D benefits include:

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

If you are over age 69, certain age reductions on the term policy apply. That is, benefits are: 65% at age 70 to 74, 45% at age 75 to 79, 30% at age 80 to 84 and 15% at age 85 and above.

For a more detailed explanation of the plan and a description of the injuries for which benefits are paid, please refer to your certificate of insurance. You pay the full cost of this benefit via payroll deductions with after-tax dollars. Your salary will be updated yearly, on the 1<sup>st</sup> of the plan year, as long as you are in an active status.

### **Additional Life Insurance Information**

#### **Will Preparation**

In conjunction with your group life insurance benefit, Will preparation is available to you through Minnesota Life and provided by Ceridian LifeWorks. For more information call Ceridian LifeWorks at [877-849-6034](tel:877-849-6034) or visit [LifeWorks](#). You will need the following information to access their site:

**User Name:** lfg

**Password:** resources

#### **Evidence of Insurability (EOI)**

Elections made outside of initial eligibility and elections exceeding guarantee issue, as mentioned above, require EOI. The insurance company will contact you directly if required.

#### **Waiver of Premium**

Minnesota Life will waive term life premiums for employees disabled prior to age 64 and continues until the earlier of retirement, recovery or age 65; provision includes a 9-month elimination period and is not available with ported coverage. You will still be responsible for any individual premiums including spouse or dependent life, and accidental death and dismemberment insurance policies.

#### **Beneficiaries**

You will designate a beneficiary or beneficiaries for your life insurance programs at the time of enrollment through Workday. This ensures that the person(s) you choose will receive your insurance benefit in the event of your death. If you need to make a beneficiary change during the year, go to the Workday Home Page and click on the Benefit application.

Information in this booklet is 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 log onto [Life Benefits](#).

### **5.8 Global Benefits Plan**

The following is a summary of our Global Benefits Plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator. Additional information can be found at [Aetna International](#).

The Aetna International Global Benefits Plan provides bundled health (i.e. medical, Rx, dental, and vision care) for employees on temporary assignments outside the United States for six months or longer. The plan offers benefits that are comparable to employees working in the US, with access to a network of participating providers, including a network of coverage for eligible dependents that remain in the United States.

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

When you enroll, you pay a portion of the total group premium, with APHMFP paying most of the total premium.

### Eligibility

You are eligible if you are in a benefit eligible status and are an APHMFP employee on temporary assignment outside the United States for six months or longer. Contact the Benefits Team when you know when your international assignment ends so we can discuss your coverage.

### Enrollment

You will receive an introduction welcome kit from Aetna Global, which provides essential information about how to access your benefits and get assistance with questions. Your identification card can be accessed online.

AETNA INTERNATIONAL			
	Outside the U.S	In the U.S Preferred Benefits In Network	In the U.S Non Preferred Benefits Out of Network
Individual Deductible	None	None	\$250 per calendar year
Family Deductible	None	None	\$250 per calendar year
Individual Out-of-Pocket Max	\$500	\$500	\$1,000
Family Out-of-Pocket Max	\$1,000	\$1,000	\$2,000
Inpatient Per Confinement Deductible (3/per yr)	None	None	\$250
Office/Specialist Visits	No Charge	No Charge after \$15 copay for Office & \$20 for Specialist	30% after deductible
Hospital Emergency Room Visit	No Charge	No Charge after \$100 copay	No Charge after \$100 copay
Non-Emergency Use of ER	No Charge	No Charge after \$100 copay	30% after deductible
Urgent Care & Non-Urgent Use of Urgent Care Provider	No Charge	No Charge after \$25 copay	30% after deductible
Inpatient	No Charge	No Charge	30% after \$250 Inpatient per confinement deductible
Outpatient	No Charge	No Charge	30% after deductible
Other Services			
Diagnostic Outpatient Lab/X-Rays	No Charge	No Charge	30% after deductible
PT/OT	No Charge	No Charge after \$10 copay	25% after deductible
Speech Therapy	No Charge	No Charge after \$20 copay	30% after deductible
Routine Eye Exam	No Charge	No Charge	30% after deductible
Vision Care Supplies	No Charge, \$200 max	No Charge, \$200 max	No Charge \$200 max



Prescription Drug			
Generic	No Charge	\$10 copay/month (includes Mail Order)	30% after deductible
Formula Brand Name Drug	No Charge	\$40 copay/month (includes Mail Order)	30% after deductible
Non-Formula Brand Name Drug	No Charge	\$70 copay/month (includes Mail Order)	30% after deductible
International Dental			
Individual Deductible	\$50 per calendar year	\$50 per calendar year	\$50 per calendar year
Family Deductible	\$150 per calendar year	\$150 per calendar year	\$150 per calendar year
Type A Expense (Diagnostic & Preventive)	No Charge	No Charge	No Charge
Type B Expense (Basic Restorative)	20% after deductible	20% after deductible	20% after deductible
Type C Expense (Major Restorative)	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	\$1,500	\$1,500	\$1,500
Orthodontic Lifetime Max	\$1,000	\$1,000	\$1,000

## 6.0 OTHER BENEFIT PROGRAMS

We have a number of other programs & benefits that you can use throughout the year. Take advantage of the [HMFP Discount](#) site to help you find savings on everyday items that you use. Check back often as the site is updated regularly.

### 6.1 Clinician Health Services

Clinician Health Services is open to all employees and provides a safe place to discuss concerns, problem solve and consider recommendations. This program provides up to three sessions, which are completely confidential. Appointments are set up directly with the clinician. There is NO fee to the employee and NO online record of the meeting or billing of insurance. All referrals are confidential. This is a self-referred treatment. To meet with one of the clinicians contact [Pamela Peck](#), PsyD, and Director. Please reference: HMFP/APHMFP employee.

### 6.2 Critical Illness Insurance

Critical Illness insurance pays a lump-sum benefit if you, or a dependent, is diagnosed with a covered disease or condition including COVID-19. You can use this money however you like, for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses. Benefits are paid directly to you and pay in addition to any other health insurance you may have. Employees are able to elect \$10,000, \$20,000 or \$30,000 in coverage for self or family.



Common Covered Medical Events	
Heart Attack	Benign Brain Tumor
Stroke	Alzheimer's
Major Organ Transplant	Cerebral Palsy
Coma	End Stage Renal Failure
Invasive Cancer	Non-Invasive Skin Cancer

To learn more visit [Critical Illness Insurance](#).

### 6.3 Identity Protection

[Identity Protection](#), offered through Allstate, delivers the most advance identity and privacy protection. Unique tools and proactive monitoring help you see, manage, and protect your personal data. Monitor your identity, credit, financial transactions, social media, and more – all in one place. If fraud occurs, Allstate Identity Protection includes reimbursement for up to \$1M of many out of pocket expenses, lost wages, and legal fees. To learn more go to [PrivacyArmor](#) or call **800-789-2720**.

### 6.4 Paid Family Leave

The Massachusetts Paid Family and Medical Leave law applies to all employees who “work” in the state of Massachusetts regardless of where they live. This benefit is funded through a state required payroll deduction that went into effect in October 2019. Employers were given an opportunity to apply for an exemption if they could provide another option that satisfied the state’s requirements. HMFP has done just that. This alternative option, through The Standard, is at least as generous as what the state requires.

Beginning January 1, 2021, you may be entitled to up to:

- 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
- 20 weeks of paid medical leave in a benefit year if you have a serious health condition that incapacitates you from work
- 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member’s military service.

Beginning July 1, 2021, you may be entitled to up to:

- 12 weeks of paid family leave in a benefit year to care for a family member with a serious health condition;
- 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.

Your weekly benefit amount will be based on your earnings, with a maximum benefit of \$850 per week. To learn more review the [Employer Notice](#).

## 6.5 Child & Family Resources

Balancing work and family can be challenging, but our goal is to support our employees through all stages of their life. HMFP offers a number of [resources](#) to support employees in their childcare and family needs.

### Care@Work from Care.com

As a benefit eligible employee, you are eligible for a free membership at [Care@Work](#) (a \$140 value). You can access discounts on in-home & in-center back up care for children to 17 years old and adults in your family, including yourself. This benefit provides backup services when your regular childcare or adult care arrangements 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, and 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.

**EXPERT ASSISTANCE:** Work with a Care Specialists to find the right care for your family. First, you will share requirements, budget, and other details for the care needed. Then, a Care Specialist will post a job and review results and applicants to provide you with the best options.

[Care.com](#) offers qualified and carefully screened providers, available 24 hours a day, seven days a week. It's our hope that this service will be helpful in reducing the anxiety level our employees experience when faced with unanticipated work and family conflicts. Call [Care.com](#) directly at [855-781-1303](tel:855-781-1303) to request back up care or go online to register and request care. Be certain to identify yourself as an employee of HMFP at BIDMC even if you are an APHMFP employee.

### Other Child and Family Resources

Other HMFP sponsored child and family resources include:

- [Boston Baby Nurse and Nanny Family Support Services](#)
- [Bright Horizons Family Center at Landmark](#)
- [Additional Boston Area Childcare & Family Resources and Contact Information](#)

HMFP offers a monthly newsletter as well as a Google chat group where you can share ideas with your colleagues. If you are interested in receiving this Child and Family Newsletter and/or being added to the Child Family Connections Group, email the [Benefits Team](#).

## 6.6 Umbrella Personal Excess Liability Insurance

Group coverage 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 will apply for a \$1 million dollar policy on your behalf. You have an opportunity to add supplemental coverage as well. This policy is not portable. If you need to file a claim, you can do so by calling [800-252-4670](tel:800-252-4670). For more information contact [Brown & Brown](#).

## 6.7 Travel Assistance

If you are planning to travel, do not forget that Red Point provides travel assistance services. The basic travel assistance services include assistance in locating and accessing physicians, dentists, medical facilities and pharmacies, arranging and paying for medical evacuation (up to the plan limit), providing interpreters or relaying messages to friends and family and so much more. If you are in a benefit eligible status, you and your spouse and

eligible dependents will have access to these services. No additional premium or enrollment is required. Call [855-516-5433](tel:855-516-5433) in the U.S. and Canada or [617-426-6603](tel:617-426-6603) (collect) from other locations. For pre-trip information, feel free to visit [Life Benefits](#).

## 6.8 Legal Services

MetLife provides access to a national network of experienced attorneys, with an average attorney experience of 25 years to help you prepare for life's challenges, whether expected or unplanned. There are no out-of-pocket costs, no claim forms, no usage limits, and a money-back guarantee. Coverage includes your spouse. Personal legal matters include:

- Wills/Trusts and estate planning
- Real estate matters
- Debt matters (bankruptcy, debt collect etc)
- Traffic & Vehicle matters
- Divorce & Family law
- Document prep & review
- Consumer Protection
- Personal Injury

For more information call the Client Service Center at [800-821-6400](tel:800-821-6400) or visit [MetLife](#) and enter access code: **9904010**.

## 6.9 Legacy Planning Services

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

## 6.10 Harvard Real Estate Advantage Program

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

Contact Coldwell Banker directly at [800-396-0960](tel:800-396-0960) or [617-495-8840](tel: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 [Harvard Faculty Real Estate](#).

## 6.11 Harvard Club of Boston

If you hold a Harvard Academic Title, you are eligible for membership in the Harvard Club of Boston! Amenities include: Premier Squash facilities and outstanding programs (including lessons), a modern, state-of-the-art fitness center and boxing gym, over-night accommodations, our Downtown Club on the top floor of One Federal Street; a la carte dining, private functions, member events, and parking at both Clubhouses, and a world-wide network of over 120 reciprocal clubs. For more information, visit the [Harvard Club of Boston](#).

## 7.0 YOUR ERISA RIGHTS

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

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

### Continued Group Health Plan Coverage

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

### Prudent Actions by Plan Fiduciaries

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

### Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and 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 may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

The court will decide who should pay court costs and legal fees. If you 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.

## Assistance with your Questions

If you have any questions about a plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory (JFK Federal Bldg, 15 New Sudbury St. Rm 575, Boston, MA, 02203 telephone [617-565-9600](tel:617-565-9600)) or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Room N5625, Washington, DC 20210, telephone [866-444-3272](tel:866-444-3272).

## Amendment or Termination of Plan

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

## 7.1 FILING A CLAIM FOR BENEFITS – HEALTH PLANS

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

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

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

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

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



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

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

### **Who determines my benefits?**

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

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

If your claim involves urgent care, you or your authorized representative will be notified of the plan's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim 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. The Plan Administrator may extend this 15-day period for an additional 15 days if the extension is required due to matters beyond the Plan Administrator's control. You will have at least 45 days to provide any additional information requested of you by the Plan Administrator.

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

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

- Specify the reasons for denial or reduction
- Refer to the specific plan provision(s) relied upon

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

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

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

### **What do I do if my claim is denied?**

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

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

- May review pertinent documents and submit issues and comments in writing
- Will be given the opportunity to submit written comments, documents, records or any other matter relevant to your claim
- Will have, at your request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits
- Will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination and
- Are entitled to have your claim reviewed by a health care professional retained by the plan. If the denial was based on a medical judgment, this individual may not have participated in the initial denial and shall give no deference to the initial denial.

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

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

### Can I use arbitration to settle the claim disputes?

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

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

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

### 7.2 TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

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

### 7.3 FILING A CLAIM FOR BENEFITS – PENSION PLANS

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

- The complete claim form application, etc. required by the Plan Administrator
- Any bills, invoices, or other supporting documentation required by the Plan Administrator

#### If Your Claim Is Denied

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

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

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

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

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

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

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

#### **7.4 FILING A CLAIM FOR BENEFITS - DISABILITY**

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

Notification of a denied claim will include the following:

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

If the claim is denied, you will have 180 days after the receipt of the notification of denied claim to file a request for a review of the claim denial with the Plan Administrator or other entity designated by the plan to receive a request for review of a denied claim. Review of a denied claim will be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, 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'll be given written or electronic notice of the determination of the denied claim on review (regardless of whether adverse) within a reasonable period, but not later than 45 days after receipt by the Plan Administrator or your request for review of the initial claim denial. This 45-day period may be extended by an additional 45 days if the Plan Administrator determines that a hearing is needed or if other special circumstances require an extension. You will be given written notice of any extension, including the reasons for extension and the date by which a decision by the Plan Administrator is expected to be made. In the event of an adverse determination of the denied claim on review, you will be given a notice of adverse determination on review, which will include the following:

- The specific reason(s) for adverse determination
- Reference to the specific plan provisions on which the determination is based
- A statement that you are entitled to receive, free upon request, reasonable access to and copies of all documents, records, and other information relevant to the claim
- A statement describing any voluntary appeal procedures offered by the plan
- Any internal rule, guideline, protocol, or a similar criterion that was relied upon, or statement that an internal rule, guideline, protocol, or a similar criteria was relied upon and will be provided free upon request and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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

## 7.5 ERISA CLAIM PROCEDURES - OTHER WELFARE PLANS

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

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

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

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

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

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

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

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

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

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

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

## 8.0 REQUIRED NOTICES

### 8.1 Health Insurance Marketplace Notice

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

#### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers, "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium. Open enrollment through the Marketplace will be November 1, 2020 through December 15, 2020. Coverage can start as soon as January 1, 2021.

#### 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 does not meet certain standards. The premium savings depend on your household income.

**Does employer health coverage affect eligibility for premium savings through the Marketplace?** Yes. If you have an offer of health coverage from your employer that meets certain standards, you 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 doesn't offer coverage to you at all or doesn't offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. This employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for federal and state income tax purposes. In addition, 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 the [Benefits Team](#). 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:

**EMPLOYER NAME:** HMFP – EIN# 22-2768204 or APHMFP – EIN# 32-0058309 **ADDRESS:** c/o Human Resources, 600 Unicorn Park Drive, 4th Floor, Woburn, MA 01801 **CONTACT:** Human Resources – 781-528-2850 or [HMFPBenefits@bidmc.harvard.edu](mailto:HMFPBenefits@bidmc.harvard.edu).

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

**Note:** Even if your employer intends your coverage to be affordable, you may be eligible for a premium discount through the Marketplace. The Marketplace uses your household income, along with other factors, to determine if you are 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 you have other income losses, you may qualify for a premium discount.

### Health Insurance Marketplace – Specifically for Massachusetts

#### What is the Massachusetts Health Connector?

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

**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).*

**If yes,** and if the employee receiving this notice qualifies for such benefits, they can find out more by contacting: the [Benefits Team](#) or by calling **781-528-2850**.

**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 [MA Health Connector](#) for more information, including an online application for health insurance coverage.

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

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

*If yes*, employees can find out more by contacting: the [Benefits Team](#) or by calling at **781-528-2850**.

*If no*, employees should contact their employer or visit [MA Health Connector](#) for more information about health insurance options for which they might be eligible.

## 8.2 COBRA Rights and Responsibilities Notice

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HMFP 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.

**Note:** The Coronavirus Aid, Relief, and Economic Security Act extended deadlines applicable to both welfare plan participants and beneficiaries for COBRA purposes. Please reference the [CARES Act](#) section at the beginning of this SPD.

### **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 does not 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 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 is losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension of 18-month Period of Continuation Coverage**

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

### **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 [Healthcare.gov](https://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](https://www.ebsa.dhs.gov) website. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit [Healthcare.gov](https://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.

### **8.3 HIPAA Notice of Special Enrollment Rights**

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

#### **HIPAA Special Enrollment Rights Notification**

HIPAA provides certain "special enrollment provisions" that may provide a right to enroll in the plan if: (i) you acquire a new dependent, (ii) you decline coverage under this Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons, (iii) you or a dependent lose coverage under Medicaid or CHIP due to a loss of eligibility (rather than non-payment), or (iv) you or a dependent become eligible for Medicaid or a State Children's Health Insurance Program. If you request a change pursuant to one of these special enrollment provisions, your coverage will be effective as of the event date that makes you eligible. Specific restrictions may apply, depending on federal and state law.

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

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

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

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

#### **Pre-existing Condition Exclusion Notification.**

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

If you were covered by a group health plan(s) prior to your employment with us, your previous employer and/or their insurance carrier should have provided you with a HIPAA Certificate. If you had coverage under a previous employer but were not provided a HIPAA Certificate, HMFP and APHMFP will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact your Plan Administrator if you need help demonstrating creditable coverage. Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator with the assistance of the prior plan administrator or insurer, if necessary, to determine its authenticity. Most prior health coverage is creditable coverage and can be used to reduce any preexisting 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 because of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plans(s) may terminate your COBRA coverage.

#### ***Where can I get more information about HIPAA?***

HIPAA has a number of special rules, and the information above covers only basic points. If you want to know more about your HIPAA rights, you may contact your state insurance department or call the U.S. Department of Labor, Employee Benefit Security Administration (EBSA) toll free [866-444-3272](tel:866-444-3272) (for free HIPAA publications ask for publications concerning the changes in health care laws). You may also contact the CMS PUBLICATION HOTLINE at [800-998-7542](tel:800-998-7542) and ask for "Protecting Your Health Insurance Coverage"). These publications are available at [EBSA](#) or [CMS](#).

#### **8.4 Certificate of Coverage under Group Health Plans Notice**

Certificates of coverage are written documents provided by a group health plan (or another source that offers health care coverage) to show the type of health care coverage a person had (e.g., employee only, family, etc.) and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you 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.

#### **8.5 Notice of Creditable Coverage**

##### **Important Notice from HMFP about Your Prescription Drug Coverage and Medicare for Employees and Spouses age 65 and over on HMFP'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 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 have determined that the prescription drug coverage offered by CVS Caremark are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

#### ***When can you join a Medicare drug plan?***

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. 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 coverage will not be affected. [In Other words, you will be eligible to participate in the group CVS Caremark prescription drug plan without any restrictions.] If you do decide to join a Medicare drug plan and drop your current HMFP coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or with a mid-year qualified change.

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

If you drop or lose your current coverage with HMFP and do not 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:*** Email the [Benefits Team](#) or call us at **781-528-2850**.

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

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

To learn more about Medicare plans that offer prescription drug coverage review the handbook from Medicare: “[Medicare & You 2021](#)”. You will 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 [Medicare](#)
- Call your State Health Insurance Assistance Program (See the inside back cover of your copy of the “Medicare & You” handbook for their phone number.) for personalized help.
- Call [1-800-MEDICARE \(800-633-4227\)](#). TTY users should call [877-486-2048](#).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit [Social Security](#) or call [800-772-1213 \(TTY 800-325-0778\)](#).

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

**Date: October 1, 2020**

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

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

**Contact: HMFP or APHMFP’s Benefits Department**

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

**Phone: 781-528-2850**

**8.6 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, an HMFP 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 one of the following conditions are 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 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 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 are 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 Medicaid or CHIP, you will not 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 [Healthcare.gov](#).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or call **1-877-KIDS-NOW** or visit [InsureKidsNow.gov](http://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 are not 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](#) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The list is current as of July 31, 2020. Contact your State for more information on eligibility.**

<p style="text-align: center; margin: 0;"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p style="font-size: small; margin: 0;">Website: <a href="http://www.mass.gov/eohhs/gov/departmetns/masshealth/" style="color: white;">http://www.mass.gov/eohhs/gov/departmetns/masshealth/</a> Phone: 800-862-4840</p>	<p style="text-align: center; margin: 0;"><b>NEW HAMPSHIRE – Medicaid</b></p> <p style="font-size: small; margin: 0;">Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm" style="color: white;">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free for HIPP Program: 800-852-3345 x 5218</p>
---	--

**To see a list of all the states that have a premium assistance programs, visit [EBSA CHIP](#).**

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

<p>U.S. Department of Labor Employee Benefits Security Administration <a href="#">EBSA</a> <b>866-444-EBSA (3272)</b></p>	<p>U.S Department of Health and Human Services Centers for Medicare &amp; Medicaid Services <a href="#">CMS</a> <b>877-267-2323, Menu Option 4, X 6165</b></p>
---	--

### 8.7 Women’s Health and Cancer Rights Act of 1998 (WHCRA) Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and
- Treatment of physical complications of mastectomy, including lymphedemas

Such coverage and benefits may be subject to annual deductible and co-insurance provisions as may be deemed appropriate and are consistent with those for other established for other benefits under the plan or coverage.

In addition, WHCRA prohibits a group health plan from:

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

- Providing monetary or other incentives to a health care provider to induce such provider to provide care inconsistent with the Act

Written notice of the availability of such coverage will be delivered to the participant upon enrollment and annually thereafter. 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. Contact HPHC for more information.

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

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

- The health insurance option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The medical insurance option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance options with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant shall, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan shall be operated and constructed in all respects in compliance with the MHPAEA.

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

### **8.9 Newborns’ and Mothers’ Protection Act of 1996 Notice (NMHPA)**

Under this Act, group health plans and health insurers generally may not limit the length of a hospital stay in connection with childbirth, for either the mother or newborn child, to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section. A mother or her newborn may be discharged earlier than 48 hours following a vaginal delivery, or earlier than 96 hours following a cesarean section, as long as the mother’s or newborn’s attending physician, after consultation with the mother, agrees to the earlier discharge. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **8.10 Genetic Information Nondiscrimination Act (GINA) Notice**

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

### **8.11 Notice of Right to Designate a Primary Care Provider (PCP)**

Certain coverage options under the HMFP Welfare Benefit Plan require the designation of a PCP (the medical insurance under the Aetna Global and HPHC PPO plan do not require the designation of a PCP). If you enroll in

one of those options under the HMFP Medical Plan, you have the right to designate any PCP who participates in the HMFP/APHMFP Choice Network through Harvard Pilgrim Health Care (HPHC) and who is available to accept you or your family members. Until you make this designation, the applicable coverage option designates one for you. For information on how to select a PCP, and for a list of the participating PCP's, contact HPHC's member services at [888-333-4742](tel:888-333-4742), or online at [HPHC](http://HPHC).

## **8.12 Uniformed Services Employment & Reemployment Rights Act (USERRA)**

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

### **Eligibility**

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

### **Premium Payment**

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

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

### **Duration of Coverage**

Coverage under USERRA will continue until the earlier of:

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

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

### **Other Information**

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

### **8.13 Qualified Medical Child Support Order (QMCSO) Notice**

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

### **8.14 Massachusetts Identity Theft Law Notice**

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

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

### **8.15 Earned Sick Time — Notice of Employee Rights**

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

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

For full details on your rights, visit [Mass.gov](https://www.mass.gov) or call the Fair Labor Division at **617-727-3456**.

### **8.16 Massachusetts Paid Family Medical Leave**

The Massachusetts Paid Family and Medical Leave law applies to all employees who “work” in the state of Massachusetts regardless of where they live. Please refer to [Section 6.4](#) for more information.

## 9.0 ADMINISTRATIVE INFORMATION

### The Plan Administrator

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.  
375 Longwood Avenue, 3rd Floor Boston, MA 02215  
Phone: **781-528-2850**

### The Plan Sponsor

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.  
375 Longwood Avenue, 3rd Floor Boston, MA 02215  
Phone: **781-528-2850**

Please note: Human Resources Offices are located at 600 Unicorn Park Dr. 4th Floor, Woburn, MA 01801

**HMFP Employer Identification Number: 22-2768204**

**APHMFP Employer Identification Number: 320058309**

### 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)

#### Administration

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

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

Critical Illness Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies.

This summary should be read in combination with the booklets, certificates, insurance contracts, and evidence of coverage documents (together and individually referred to as "Underlying Documents") provided by the insurance companies and service providers.

The Underlying Documents are intended to describe the health and welfare benefits available to you as an 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., and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Underlying Documents for details of Plan benefits. For additional information or for copies of the Underlying Documents, please contact the Plan Administrator.

Below is a list of each Underlying Benefit and the Named Fiduciary for each benefit:

Underlying Benefits	Named Fiduciary
Medical and Prescription Drugs	HMFP
Dental	HMFP
Vision	EyeMed
Short-Term & Long-Term Disability	Standard Insurance
Life & Accident	Minnesota Life Insurance
Critical Illness	ReliaStar Life Insurance Company
Healthcare and Dependent Care* Flexible Spending Accounts under the HMFP Cafeteria/125 Flexible Benefit Plan	HMFP

\*NOTE: Dependent Care Flexible Spending Account benefits are not part of an "employee benefit plan" subject to ERISA but are merely a pre-tax accounts for the payment of eligible dependent care expenses.

### Participating Employers

In addition to Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Associated Physicians of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. ("APHMFP") also is a participating employer. APHMFP's Employer Identification Number (EIN) is 320058309.

### Plan Year

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

### Future of the Plan

While the Plan Sponsor intends to continue the plans indefinitely, it 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.

## 9.1 Privacy of Health Information

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

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

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy your information, receive an accounting of certain disclosures of your information, have your information sent to an alternative location or by alternative means, and under certain circumstances, amend your information. If you believe your rights under HIPAA have been violated, you 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.

The plan maintains a Privacy Notice, provided together with this booklet, that provides a complete description of your rights under HIPAA’s privacy rules. For another copy of the Privacy Notice, questions regarding the privacy of your health information or if you wish to file a complaint under HIPAA, please contact Human Resources at [781-528-2850](tel:781-528-2850). A copy of the Privacy Notice for the dental plan is available through Delta Dental.

## 9.2 Notice of Privacy Practices

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

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

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

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

### 9.3 How Your Health Information May be Used or Disclosed

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

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

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

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

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

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

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

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

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

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

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

## **9.4 Your Health Information Rights**

### **Request Restriction on Uses and Disclosures of Your PHI**

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

### **Inspect and Obtain a Copy of Your Health Records**

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

### **Amend Your Health Records**

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

### **Request Confidential Communications**

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

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

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

### **Request Accounting of Disclosures of Your PHI**

You have the right to request a list (an accounting) of certain non-routine disclosure of PHI that may have occurred during the six years (or less) prior to your request. In general, the list 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 at the address listed below under Contact Information and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

### **Obligations of the Plan**

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

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

### **Contact Information**

If you have questions or complaints, please contact HMFP and APHMFP's Privacy Officer at HMFP at Beth Israel Deaconess Medical Center, Inc., 600 Unicorn Park Drive, 4th Floor, Woburn, MA 01801 or [781-528-2850](tel:781-528-2850).

### **9.5 Sources of Plan Contributions and Election of Benefits**

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

### **9.6 Tax Consideration**

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

### **9.7 Third Party Liability**

If you file a claim for benefits for medical expenses you have incurred, which may be the responsibility of a third party, you must reimburse the plan from any recovery you receive. For example, if you are injured in an automobile accident, which is not your fault, you must repay the plan for the health benefits you collect from the third party responsible for the accident, this insurance company or anyone else from which you receive payment from the accident. You 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. Contact your insurer or consult your Harvard Pilgrim Health Care Benefit Handbook for details on your medial plan's right to recover benefits on behalf of you or your dependent(s).

### **9.8 Responsibility for Goods/Services**

HMFP 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 out-side of the control of HMFP.

### **9.9 Additional Documentation**

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

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

### **9.10 Agent for Service of Legal Process**

Legal process may be served on the Plan Administrator.

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

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc.  
Office of Human Resources  
375 Longwood Ave., 3<sup>rd</sup> Floor  
Boston, MA 02215  
Phone: [781-528-2800](tel:781-528-2800)

## **10.0 HOW TO CONTACT US AND OUR VENDORS**

### **10.1 Contact the Benefits Team**

[HMFPBenefits@bidmc.harvard.edu](mailto:HMFPBenefits@bidmc.harvard.edu)

General HR P. [781-528-2850](tel:781-528-2850) | HR F. [781-528-2830](tel:781-528-2830)

600 Unicorn Park 4<sup>th</sup> Fl. Woburn, MA 01801

## 10.2 Contact Vendors & Resources

Benefit Program	Vendor Name	Vendor Website	Vendor Customer Service Phone Number
Medical	Harvard Pilgrim Health Care	<a href="http://harvardpilgrim.org">harvardpilgrim.org</a> <a href="http://harvardpilgrim.org/hmfp">harvardpilgrim.org/hmfp</a>	888-333-4742
Global (Medical, Dental & Vision)	Aetna	<a href="http://aetnainternational.com">aetnainternational.com</a>	800-231-7729
Prescription Drug	CVS Caremark	<a href="http://caremark.com">caremark.com</a>	844-257-6072
	BIDMC Pharmacy	<a href="mailto:email@bidmcpharmacy.com">email: BIDMC Pharmacy</a>	617-667-6400
Dental	Delta Dental	<a href="http://deltadentalma.com">deltadentalma.com</a>	800-872-0500
Vision	EyeMed	<a href="http://eyemed.com">eyemed.com</a>	866-800-5457
Critical Illness	VOYA	<a href="http://presents.voya.com/ebrc/hmfp">presents.voya.com/ebrc/hmfp</a>	877-236-7564
Health Savings Account	HealthEquity	<a href="http://healthequity.com">healthequity.com</a>	866-346-5800
Flexible Spending Accounts	Sentinel Benefits	<a href="http://sentinelgroup.com">sentinelgroup.com</a>	888-762-6088
Legal	MetLife	<a href="http://info.legalplans.com">info.legalplans.com</a> <a href="http://members.legalplans.com">members.legalplans.com</a>	800-821-6400
Life	Minnesota Life	<a href="http://lifebenefits.com">lifebenefits.com</a>	800-843-8358
Life/Family Legal Support	LifeWorks User ID = lfg Password: resources	<a href="http://lifeworks.com">lifeworks.com</a>	877-849-6043
Legacy Planning	Minnesota Life	<a href="http://legacyplanningresources.com">legacyplanningresources.com</a>	
Identity Protection	Allstate (InfoArmor)	<a href="mailto:clientservices@infoarmor.com">clientservices@infoarmor.com</a> <a href="http://myprivacyarmor.com">myprivacyarmor.com</a>	800-789-2720
Disability	Standard	<a href="http://standard.com">standard.com</a>	888-937-4783
Retirement	Fidelity Investments	<a href="http://Fidelity.com/atwork">Fidelity.com/atwork</a>	800-343-0860
Umbrella Liability Insurance	Chubb	<a href="http://chubb.com/personal">chubb.com/personal</a>	
	Brown & Brown	Last Name Begins with: A-B contact <a href="mailto:ppajak@bbinsgc.com">ppajak@bbinsgc.com</a> C-E contact <a href="mailto:ltrop@bbinsgc.com">ltrop@bbinsgc.com</a> F-J contact <a href="mailto:mpalman@bbinsgc.com">mpalman@bbinsgc.com</a> K-P contact <a href="mailto:mbrandofino@bbinsg.com">mbrandofino@bbinsg.com</a> Q-S contact <a href="mailto:larana@bbinsg.com">larana@bbinsg.com</a> T-Z contact <a href="mailto:mmarx@bbinsg.com">mmarx@bbinsg.com</a>	(516) 247-5845 (516) 247-5898 (516) 247-5813 (516) 247-5840 (516) 247-5815 (516) 247-5818
Adult & Child Care	Care.com	<a href="mailto:care@work">care@work</a>	800-688-4697
Travel Assistance	Minnesota Life	<a href="http://lifebenefits.com/travel">lifebenefits.com/travel</a>	855-516-5433 (U.S./Canada)



Bike Share	Blue Bikes Boston	<a href="http://bluebikes.com">bluebikes.com</a>	Password WvKtZLn7 select "BIDMC"
Discount Hub	Benefit Hub	<a href="http://benefithub.com">benefithub.com</a>	866-644-4621