Benefits for Residents

2014 ENROLLMENT GUIDE
Partners HealthCare is pleased to offer you

Partners Benefits for Residents will offer you the flexibility you need to design a benefits program that best suits your needs.

Prior to enrolling, we encourage you to:
- make use of this informational guide by reading through each of the benefit descriptions
- do the exercise on page 32
- go online to eBenefits to enroll
- contact a dedicated HR/Benefits Specialist (listed on the next page) if you need assistance

eBenefits Imagine the Convenience!

To get connected over the Internet, at any time, from any place, enter this address:
https://ibridge.partners.org

To get connected over the Intranet, at work:
click on Partners Applications>PeopleSoft

Public terminals for Intranet access are available at the Benefits Office, 101 Merrimac Street, 5th floor. Or, check with your local Human Resources Office.

GETTING Started!

Enter your NT user ID. This is the same ID you use to sign on to your computer. Then, click Log In. If you do not have NT login access, click the Password Management link and follow the prompts.

Verify that your security image and phrase are correct, then enter the password you use to sign on to your computer. Click Log In.

Select PeopleSoft HRMS Production.
To access eBenefits, navigate: Main Menu > Self Service > eBenefits

eBenefits Home Page

View your benefits year-round. You can update your elections during open enrollment (November) or when you have a qualifying life event.

Benefits Summary
Summarizes your current or past benefit elections.

Insurances
Provides a summary of your current or past Life, AD&D, and Disability elections. Links are available that will allow you to update your beneficiary designations.

FSA Express
Provides access to submit your claims electronically and to review the status of electronic submissions. It also gives details of your participation in the Health Care Account and/or Dependent Care Account, including year-to-date contributions; claims submitted, approved and paid.

Health
Lists a summary of your current or past medical, dental and vision elections. Covered dependents are also listed.

Dependents
Lists all dependents and beneficiaries; allows for updating life insurance beneficiary information.

Life Event
Allows access to initiate a family status change (marriage, birth, spouse loss or gain of coverage, etc.), which then allows you to change your elections according to your needs.

Savings
Allows enrollment and/or change of tax-sheltered annuity contribution amounts in dollars or percentages. If you make a change, it will take effect in the next pay period.

Enrollment
Provides access to update your benefits during the open enrollment period. It also allows for enrollment or updating of benefits if you are newly eligible or when you have a status change.

Information contained in this guide is a summary of the Partners Benefits for Residents Program. If there is a discrepancy between this summary and the plan documents, the plan documents will govern. Plan documents are available in the Benefits Office.
Need Information on Your Benefits?

The Professional Staff Benefits Office specializes in supporting our Residents, Fellows and Professional Staff. HR/Benefits Specialists for Partners Residents can be reached as follows:

For MGH Residents
If your last name begins with A-G, call Susan Frain at 617-726-9264 or email sfrain@partners.org
If your last name begins with H-O, call Linda Gulla at 617-726-9266 or email lgulla@partners.org
If your last name begins with P-Z, call Virginia Rosales, CEBS at 617-724-9356 or email vrosales@partners.org

For BWH Residents call Angela Carter at 617-724-9357 or email bwhprofstaffbene@partners.org

Other helpful websites

**Partners Plus, Partners Value**
www.bluecrossma.com/Partners  
1-888-211-4521

**Harvard Pilgrim Health Care**
http://www.providerlookuponline.com/  
Harvardpilgrim/p07/Search.aspx  
(select the HPHC Plan for Partners)  
1-888-333-4742

**Neighborhood Health Plan**
http://nhp.spectralogix.com/partners.asp  
1-800-462-5449

**Tufts Health Plan**
http://www.tuftshealthplan.com/partners  
1-800-843-1008

**Express Scripts**
**Prescription Drug Program**
http://www.express-scripts.com  
1-800-711-4541

**Delta Dental**
www.deltadentalma.com  
1-800-872-0500

**Davis Vision Plan**
http://www.davisvision.com  
1-800-999-5431

**Fidelity Investments**
http://www.netbenefits.com/partners  
1-855-999-1PHS (1747)

**TIAA-CREF (annuities only)**
http://www.tiaa-cref.org  
1-800-842-2776

Get information online or over the phone!
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Eligibility

You are eligible for Partners Benefits for Residents if you are a Resident and you:

- Have an appointment at a sponsoring institution, and
- Are a monthly-paid regular Resident, scheduled to work at least 87 hours per month at a standard hospital salary of at least $833.33 per month.

Eligible Residents must enroll in Medical, Dental, and Life insurance within 30 days of initial eligibility or wait until the annual enrollment period in the Fall.

In addition to the benefits in this guide, there are many special opportunities available to Partners Residents.

BWH and MGH send out weekly emails listing the latest available PERKS. You can also view this information online at: http://is.partners.org/hr/New _Web/mgh/mgh_perks.htm or http://www.bwhpikenotes.org/employee_resources/perks/default.aspx

Core Benefits

Partners automatically provides you with basic group term life insurance at no cost to you. This insurance is equal to one times your annual salary.

Choice Pay

In addition, you will be provided with “Choice Pay” that you can use to purchase other benefits:

- You can choose from five medical plans to protect yourself and your family in the event of illness or injury. A prescription drug benefit managed by Express Scripts offers a convenient mail service program.
- Two dental insurance plans offer differing levels of insurance support for dental services, ranging from regular preventive care to orthodontia.
- A vision plan provides cost-effective coverage for annual comprehensive eye examinations and corrective lenses.
- You can purchase different levels of coverage for medical, dental, and vision care (including coverage for your spouse), tailoring each to best fit your needs.
- Two Flexible Spending Accounts save tax dollars and reduce your out-of-pocket costs for health care and dependent day care.
- Long-term disability (LTD) insurance, with unique features for Residents, is available for financial protection in the event you cannot work due to an extended illness or injury.
- Optional group term life insurance allows you to purchase additional life insurance for yourself, your spouse or your dependents.
- Accidental Death and Dismemberment (AD&D) insurance is available to protect you and your spouse.
- A tax-sheltered annuity plan offers you a tax-smart way to save for the future.

You must make your elections within 30 days of your benefits eligibility date. Coverage is effective on the date you become eligible.
Determining Your Choice Pay Amount

The amount of your Choice Pay appears on your Personal Benefits Summary.

There are three types of Choice Pay available under Partners Benefits for Residents.

### Basic Choice Pay
You will receive a basic amount which can be used to purchase benefits.

### PLUS

### Medical and/or Dental Participation Choice Pay
If you enroll in one of the medical or dental plans, you will receive an additional amount based on the level of coverage you select:

- Employee
- Employee and Spouse
- Employee and Children
- Family

**Note:** Actual Choice Pay amounts appear on your Personal Benefits Summary or rate sheet.

### If You Have Extra Choice Pay
If you have extra Choice Pay that you do not wish to use for benefits, you can take it in cash as additional taxable pay (provided you can show you are covered under another medical plan, e.g., your spouse’s plan).

### If You Choose More Benefits Than You Have Choice Pay
If you choose more benefits than your Choice Pay will cover, you will pay the additional amount through payroll deduction.

Whatever you choose, you’ll be the one designing your own benefits program. Choosing your benefits is only one of many Partners Benefits for Residents advantages.
Dependent Eligibility

Your eligible dependents are your legal spouse, your dependent children under age 26 and your legal spouse’s dependent children under age 26. Coverage will end automatically on the child’s 26th birthday.

Unmarried dependent disabled children over age 26 are eligible for the medical, dental, and vision plans, provided coverage has been continuous and they have applied for and been approved by the carrier for coverage within 30 days of the time they would normally lose coverage. Please contact your Professional Staff Benefits Office for details.

Dependents can be enrolled in Child Life Insurance from birth until their 26th birthday.

You can add your child to your medical, dental, and/or vision coverage by going into eBenefits during open enrollment, or if you experience a qualifying life event. If you do not have access to eBenefits, call your Professional Staff Benefits Office.

The Professional Staff Benefits Office reserves the right to request documented proof of a dependent’s eligibility for coverage. Examples of documentation include, but are not limited to:

- Marriage license
- Birth certificate or adoption paperwork that name either the employee or the employee's spouse as the parent
- Finalized divorce decree that states the conditions under which the former spouse and/or former spouse's children are to be covered
- Legal Guardianship paperwork that names the employee or the employee's spouse as the Legal Guardian

Coverage for Same-Sex Domestic Partners

Effective January 1, 2014, employees cannot add same-sex domestic partners or the dependent children of same-sex domestic partners to their coverage. Same-sex domestic partners and their dependent children who are covered on employees’ plans on or before January 1, 2014, will continue to receive the same benefits they received previously.

Insurance coverage for a same-sex domestic partner or his/her children is paid after tax and may result in imputed income.

Same-sex domestic partners who legally marry must update their status in eBenefits within 30 days of their marriage in order to receive benefits coverage and the tax advantages of marriage.
To use *Partners Benefits for Residents* to your advantage it is necessary to understand the choices you will be making. Take a careful look at this guide, and review your Personal Benefits Summary or your rate sheet (if you are newly eligible for benefits). Use the worksheet on page 32 of this booklet — and keep the following questions in mind.

**Ask yourself:**

- Which medical plan is best for my family and me? Could I be covered under another medical plan and use all available Choice Pay to purchase other benefits? Keep in mind that health coverage is mandatory for employees age 18 and older under the Affordable Care Act (ACA) (see page 10).
- Should I buy dental coverage for myself and my family? What level of dental coverage should I choose?
- Should I buy vision care for myself and my family?
- Will I need more life insurance than one times my annual base salary?
- Do I need to buy optional life insurance for my dependents?
- Should I participate in either or both Flexible Spending Accounts to pay for certain health care and dependent care expenses?
- Should I begin saving for retirement?

**Important:** If you are eligible for coverage under another medical plan, you should review that coverage to avoid signing up for a benefit that you may not need. If you provide proof of alternate medical coverage, you can use your Choice Pay toward the purchase of other benefits.
The Tax Advantage
Payroll deductions you authorize as payment for many of your benefits can be made with pre-tax dollars*, resulting in lower taxes for you.

Pre-Tax Benefits: before federal and state income and Social Security taxes are withheld:
- Medical, dental, vision care, Health Care and Dependent Care Flexible Spending Accounts and long-term disability (LTD)

Pre-Tax Benefits: before federal and state income taxes are withheld:
- Traditional Tax-Sheltered Annuity contributions

Pre-Tax Benefits: before federal income tax and Social Security taxes are withheld:
- Public Transportation Passes (up to certain limits)

After-Tax Benefits: subject to federal and state income and Social Security taxes:
- Employee, spouse and dependent optional life insurance
- Accidental death and dismemberment insurance
- Roth Tax-Sheltered Annuity contributions

* Coverage for your same-sex domestic partner and his/her dependent children (whose coverage was already in place on 1/1/2014) is considered post-tax for both federal and state tax purposes.
Making Changes After the Open Enrollment Period Ends

Newly eligible employees have 30 days from the date first eligible to enroll in the Partners Benefits for Residents program.

Open enrollment in Partners Benefits for Residents is held annually, usually in late Fall. During open enrollment employees can make changes to their benefits for any reason. All choices become effective on the first date of the new plan year — January 1.

Qualified Change of Status

After the enrollment deadline has passed, under IRS regulations you may not add, change, or cancel your benefit elections until the next plan year, unless you have a qualified change of status. A qualified change of status occurs if you experience:

- Marriage or divorce
- Addition of a dependent through birth, adoption, or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare, or other group coverage
- You, your spouse, or your child (up to age 26) change from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse’s employment ends
- You move out of your medical plan’s coverage area

You must make your benefit change within 30 days of your qualifying event. Your benefit change must be consistent with your change of status. If you get married, for example, you may change your medical coverage from employee to employee plus spouse within 30 days of the date of your marriage.

Making Your Change: If your qualified change of status event involves a birth; marriage; gain or loss of Medicaid/Medicare or other group coverage; change in spousal eligibility; or change in coverage for a child under age 26, go to the "Status Change" page on eBenefits within 30 days of the event. You will be able to update your benefit elections immediately. Make sure to click the "Submit" button to process your selections. All changes are subject to verification by Partners.

Some qualified change of status events cannot be made via eBenefits. Contact your Professional Staff Benefits Office within 30 days of an adoption; divorce; death of a spouse or dependent; or a move out of your medical plan’s coverage area. Your Professional Staff Benefits Office will request official documentation of these events and will help you make the change.

Changes to your LTD or life insurance elections are allowed during open enrollment. However, adding or increasing coverage is subject to evidence of good health.
Your Medical Plan Options

*Partners Benefits for Residents* offers the following medical plans for employees who live in zip codes beginning with 017 to 024. (If you live in zip codes 02501 to 02799 or 01001 to 01699, or if you live out of state, please see page 10 for details about plans for out of area employees.)

**Partners Plus (a Blue Cross Blue Shield Plan)**
A Preferred Provider Organization (PPO) that offers cost-effective, high quality care.

**Partners Value (a Blue Cross Blue Shield Plan)**
A Preferred Provider Organization (PPO) plan that offers basic coverage and access to the same networks of physicians as Partners Plus. This is the same plan as Partners Plus, except that your payroll deductions will be lower. However, your out-of-pocket costs and co-pays are higher than with Partners Plus, and can be substantial.

**Partners Benefits for Residents also offers the following managed care plans:**
- Harvard Pilgrim
- Neighborhood
- Tufts

Your Networks of Coverage
Each medical plan offers you a choice of providers within several networks. Each network provides a different level of coverage:

- You receive the highest level of coverage when you use a specialist or facility within the **Partners Preferred Network**. This network includes Partners HealthCare specialists and facilities, along with providers at Children's Hospital Boston, Dana-Farber Cancer Institute, Emerson Hospital, Hallmark Hospitals (Lawrence Memorial and Melrose-Wakefield), and the Massachusetts Eye and Ear Infirmary. There is no annual deductible, and many types of care are covered at 100% with no or low co-pays.

- You will still receive comprehensive coverage, at somewhat higher costs, when you use specialists and facilities within the **Plan Network**. This network consists of non-Partners providers who are in the carrier’s network. For example, if you have Partners Plus or Partners Value, this would include all non-Partners specialists and facilities within the Blue Care Elect PPO network. There is an annual deductible. Co-pays tend to be higher in the Plan Network than in the Partners Preferred Network. For example, you will pay $40 for a visit to a non-Partners specialist covered under the Plan Network, vs. $15 for a visit to a Partners specialist covered under the Partners Preferred Network. Plan Network co-pays for physical, speech, and occupational therapy are $40 for the first 15 visits and $15 thereafter. Co-pays are higher under Partners Value.

- If you enroll in Partners Plus or Partners Value, you may also receive coverage when you use **Out-of-Network** specialists and facilities that don’t belong to either the Partners Preferred or the Plan Networks. However, your costs for out-of-network care will be substantially higher. In many cases, you will pay 30% or more of the medical bill for your care. Coverage for Out-of-Network specialists and facilities is not available in any of the managed care plans (Harvard Pilgrim, Neighborhood, or Tufts).

Regardless of which medical plan or network you choose:
You do not need to obtain an insurance referral when you need to see a specialist.

You will receive the same coverage for primary care, regardless of whether your primary care physician (PCP) is in the Partners Preferred or the Plan Network. Your plan does not require you to have a PCP of record, but we encourage you to have one.

Emergency Room visits have a $100 co-pay, regardless of whether you choose a Partners or non-Partners HealthCare facility. This co-pay will be waived if you are admitted as an inpatient to the hospital.

Coverage Levels:

You have the option of choosing medical coverage in the following categories:
- **Employee**
- **Employee and Spouse**
- **Employee and Children**
- **Family**

You may opt out of medical coverage if you provide proof that you are covered through an outside plan.
**Highlights of Coverage**

### Blue Cross Blue Shield Plans

**Partners Plus**

**Annual combined Out-of-Pocket Maximum for the Partners Preferred and Plan Networks:**

- $2,500 individual/$5,000 family.*

**Partners Preferred Network:**
- No annual deductible; Plan pays 100% of most covered expenses
- 100% coverage for inpatient services
- $15 co-pay for office visits and hospital outpatient visits
- No co-pay for routine physicals for adults and children

**Blue Care Elect PPO Plan Network:**
- $250 annual deductible per individual, $500 per family; plan pays 100% of most covered expenses, but your out-of-pocket expenses may be higher
- 100% coverage for inpatient services after deductible and payment of $250 co-pay per admission
- $40 co-pay for specialist office visits and hospital outpatient visits**
- $15 co-pay for primary care physician and mental health provider office visits
- No co-pay for routine physicals for adults and children

**Out-of-Network:**
- $500 annual deductible per individual, $1,000 per family
- 70% coverage for most services
- Maximum annual employee out-of-pocket cost: $4,000 per individual, $8,000 per family*

**Partners Value**

**Annual combined Out-of-Pocket Maximum for the Partners Preferred and Plan Networks:**

- $3,000 individual/$6,000 family (excludes $250 per person admissions co-payment).*

**Partners Preferred Network:**
- No annual deductible; Plan pays 100% of most covered expenses
- $250 co-pay per person for inpatient admissions
- 80% coverage for inpatient services
- $35 co-pay for office visits and hospital outpatient visits
- No co-pay for routine physicals for adults and children

**Blue Care Elect PPO Plan Network:**
- $500 annual deductible per individual, $1,000 per family; plan pays 100% of most covered expenses, but your out-of-pocket expenses may be higher
- 75% coverage for inpatient services after deductible and payment of $250 co-pay per admission
- $50 co-pay for specialist office visits and hospital outpatient visits**
- $35 co-pay for primary care physician and mental health provider office visits
- No co-pay for routine physicals for adults and children

**Out-of-Network:**
- $750 annual deductible per individual, $1,500 per family
- 65% coverage for most services
- Maximum annual employee out-of-pocket cost: $5,000 per individual, $10,000 per family* (excludes annual $250 per person inpatient co-payment)

### Managed Care Plans

**Harvard Pilgrim Health Care**

**Annual combined Out-of-Pocket Maximum for the Partners Preferred and Plan Networks:**

- $2,500 individual/$5,000 family.*

**Partners Preferred Network:**
- No annual deductible; Plan pays 100% of most covered expenses
- 100% coverage for inpatient services at affiliated hospitals
- No co-pay for routine physicals and preventive services for adults and children
- $15 co-payment for other office visits and outpatient visits

**Harvard Pilgrim Plan Network:**
- $250 annual deductible per individual, $500 per family
- 100% coverage for inpatient services at affiliated hospitals, after deductible
- No co-pay for routine physicals and preventive services for adults and children
- $40 co-payment for specialist office visits and outpatient visits**
- $15 co-pay for primary care physician and mental health provider office visits

**Neighborhood Health Plan**

**Annual combined Out-of-Pocket Maximum for the Partners Preferred and Plan Networks:**

- $2,500 individual/$5,000 family.*

**Partners Preferred Network:**
- No annual deductible; Plan pays 100% of most covered expenses
- 100% coverage for inpatient services at affiliated hospitals
- No co-pay for routine physicals for adults and children
- $15 co-payment for other office visits and outpatient visits

**Neighborhood Plan Network:**
- $250 annual deductible per individual, $500 per family
- 100% coverage for inpatient services at affiliated hospitals, after deductible
- No co-pay for routine physicals and preventive services for adults and children
- $40 co-payment for specialist office visits and outpatient visits**
- $15 co-pay for primary care physician and mental health provider office visits

**Tufts Health Plan**

**Annual combined Out-of-Pocket Maximum for the Partners Preferred and Plan Networks:**

- $2,500 individual/$5,000 family.*

**Partners Preferred Network:**
- No annual deductible
- 100% for authorized inpatient services at affiliated hospitals
- No co-pay for routine physicals for adults and children
- $15 co-payment for other office visits and outpatient visits

**Tufts Plan Network:**
- $250 annual deductible per individual, $500 per family
- 100% coverage for inpatient services at affiliated hospitals, after deductible
- No co-pay for routine physicals and preventive services for adults and children
- $40 co-payment for specialist office visits and outpatient visits**
- $15 co-pay for primary care physician and mental health provider office visits

* Co-pays for physical, speech, and occupational therapy in the Plan Network are $40 for visits 1-15, then $15 for visits 16+ ($50 and $35 respectively, for Partners Value).

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*Excludes prescription drug and hearing aid co-pays*
Additional Information About Your Medical Plans

While most medical plans have various deductibles and co-payments, there are some preventive services that are provided in full in all of the pre-tax medical plans.

- **There are no lifetime/annual limits on any Partners medical plans.**

- **Coverage without co-pays is provided for preventive care and routine care services, according to the recommended guidelines outlined in the Patient Protection and Affordable Care Act.** For example, covered services include age-related screenings such as a baseline mammogram for women ages 35-39, routine mammograms for women age 40 and older and colonoscopies (without surgery) for individuals age 50 and older, which are provided based on recommended guidelines. Such routine screenings will not normally be covered if you fall outside of these age guidelines, unless you have other risk factors.

Other routine preventive services that are covered when provided under recommended guidelines include:
- annual physicals
- immunizations
- routine gynecology visits and Pap smears
- Prostate-Specific Antigen (PSA) tests
- routine sigmoidoscopies
- well-child visits
- routine vision screenings (through your medical plan)
- routine hearing exam office visits and hearing tests
- preventive lab tests
- family planning services (including contraception)
- co-pays for prescription contraceptives

**Please note:** You must use providers in the Partners Preferred or Plan Networks to receive 100% coverage with no co-pays for routine and preventive screenings.

- **All of your dependent children, and your spouse’s dependent children, qualify for medical, dental, and vision coverage up to age 26, regardless of their student or marital status. See page 10.**

- **An appeals process is available.** If your claim is denied, in whole or in part, you will be provided with a written explanation of the denial that explains the reason for the denial, the specific Plan provision involved, an explanation of how claims are reviewed, how to request a review of the denied claim, and the information you will need to submit an appeal. If you have questions about a claim payment, you can contact your medical carrier, or call your Professional Staff Benefits Office at 617-726-8133.

If you do not agree with the reason why your claim was denied, in whole or in part, you can appeal the claim decision. To appeal an adverse benefit determination, or to review administrative documents relevant to the claim, you should send a written request to your medical carrier. Your appeal should include the reason why you think the claim should be reviewed, any data or documentation pertinent to the claim, copies of bills and claim forms, and any questions or comments you may have concerning the claim.

Generally, you have 180 days following the adverse benefit determination to appeal that decision.

- **In 2014, the medical costs of the health plans you participate in will be reported on your W-2 Form (2013 W-2).** Normally you receive this form each January.

**Please note:** This information will appear on your W-2 form for informational purposes only and will not be reported as taxable income.

Please see your Benefits Intranet site for the latest health care reform updates, including a notice with information on coverage available through the Health Insurance Marketplace:

http://is.partners.org/hr/New_Web/phs/phs_benefits.htm

If you are eligible for medical coverage through Partners but cannot afford the premiums, you may qualify for assistance through Medicaid and the Children’s Health Insurance Program (CHIP).

Please see the CHIP notice that is posted on your Benefits Intranet site for more information:

http://is.partners.org/hr/New_Web/phs/phs_benefits.htm

If you have any questions about health care reform or about your health benefits, contact your Professional Staff Benefits Office by phone at 617-726-8133 or via email at: ibenefits@partners.org
Mandatory Health Insurance Requirements

The Massachusetts Health Care Reform Act and the Patient Protection and Affordable Care Act ("PPACA") require all residents age 18 and older to have health coverage. If you qualify for medical insurance through Partners, you can enroll in a Partners-sponsored health plan when you are first eligible or during open enrollment. Health coverage you elect during open enrollment will take effect on January 1 of the next plan year. The only other time that you can enroll is when you have a qualifying change of status such as a birth, divorce or death (see page 6).

If you do not qualify for health coverage through Partners and are without access to other health insurance, consider enrolling in a state plan (check the Health Insurance Marketplace notice posted on your Benefits website for information on enrolling in state plans).

You may decline Partners-sponsored coverage by showing proof of other coverage. If you do not enroll in a Partners-sponsored health plan or provide proof of other health coverage, Partners will default you into our Partners Value health plan – Employee Only coverage and will subsidize a portion of the premiums for the medical plan. Coverage is effective on the first day of eligibility and deductions are taken retroactively. You will not be able to change your election or opt out of coverage until the following open enrollment, to be effective at the beginning of the following plan year – January 1.

Medical Coverage for Employees Living Out of Area

Employees who live in zip codes 02501 to 02799 or 01001 to 01699, or who live out of state, have different versions of our medical plans. Your plans provide the Partners Preferred Network level of benefits under the Network plan. You do not need to obtain an insurance referral to see a specialist. Emergency Room co-pays are $100, regardless of facility.

Details about the Out of Area medical plans are available in a special Out of Area Medical Plan Comparison Chart. You may request this chart from the Benefits Office, or download it at: http://is.partners.org/hr/New_web/phs/phs_benefits.htm

Extended Coverage for Children Under Age 26

Partners extends health, dental and vision insurance for your dependent children up to age 26, regardless of student or marital status or eligibility for other coverage. Your legal spouse’s children are also eligible for coverage up to age 26.

Coverage ends on your child’s 26th birthday. You can add your child on your medical, dental, and/or vision coverage during open enrollment by going into eBenefits. If you do not have access to eBenefits, call your Professional Staff Benefits Office.

You will see an increased deduction in your paycheck if you need to move from Employee Only insurance to a higher tier level – e.g., Family coverage – because you are adding your child to your health plan(s). There is no added cost if you already are in a tier level with dependents (such as Family).

Dependent Children with Disabilities:

Unmarried, dependent handicapped children age 26 and over qualify for medical, dental and/or vision insurance if coverage has been continuous and they have applied for and been approved by the carrier for coverage within 30 days of when they normally would have lost coverage. Contact your Professional Staff Benefits Consultant for details.

Michelle’s Law

In the case of a medically necessary leave of absence from school, coverage for unmarried, dependent full-time students ages 19-26 will be extended for up to one year, or the date on which coverage would otherwise end under the plan (whichever is earlier). *Medically Necessary Leave of Absence* means a leave of absence from a post-secondary educational institution or any other change in enrollment that:

1. commences while the child is suffering from a serious illness or injury;
2. is medically necessary; and
3. causes the child to lose student status under the terms of the plan

Written certification must be provided by the child’s treating physician stating the child is suffering from a serious illness or injury, and that the leave (or change in enrollment) is medically necessary.
Determining Your Medical Coverage Needs

Selecting medical coverage is one of the most important financial decisions you will make in designing your personal benefits program. Which medical plan is best depends on many factors.

- What are your anticipated medical expenses for the coming year?
- How much can you pay toward these expenses in deductibles, co-payments, and coinsurance?
- What is the most you could afford to pay if you or a dependent needed health care?
- Can you opt out of coverage because you have coverage elsewhere — for example, through your spouse’s employer or the Health Insurance Marketplace?
- If you do not have outside coverage, how do you plan to meet your obligations under federal and state laws that require you to have medical coverage?
- If you are seeing a specialist, is your doctor on the list of participating physicians available in Partners Plus, Partners Value, or one of the managed care plans? Check with your doctor or go online to find out (see page 14).
- Could you withstand unexpectedly high medical expenses if you were to elect a high out-of-pocket cost option such as Partners Value?

Once you have answered these questions, look at your Personal Benefits Summary and rate sheet, or go online to eBenefits.

- Choose your level of coverage (employee, employee and children, employee and spouse, or family).
- Look at the prices included with your enrollment materials.
- Review your medical plan comparison chart.
- Weigh the level of benefits against the prices.
- Make your decision within 30 days of the date you are first eligible.

Many of our employees find that a Preferred Provider Organization (PPO) such as Partners Plus or Partners Value offers them the right combination of coverage, freedom of provider choice, and affordability. Consider this: MGH and BWH have satellite locations in many communities. For the most cost-effective access to world-class specialists at MGH and BWH, choose Partners Plus or Partners Value.
Terms to Understand

**Coinsurance** — The plan’s share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan’s annual out-of-pocket maximum.

**Co-pay** — The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Co-pays range from $10 to $100.

**Deductible** — The amount you pay before a plan pays any benefits. For example, if you receive out-of-network services under Partners Plus, you would have to pay $500 (for an individual) or a maximum of $1,000 (for a family) before the plan would pay benefits.

**Health Insurance Marketplace** (also known as an "Exchange" under the Affordable Care Act) — A state resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage.

**Managed Care Plans** — Health plans that place an emphasis on preventive services, such as an annual routine physical, to promote good health. Managed care plans put together a network of hospitals, physicians, and other health care professionals to provide your care.

**Out-of-Pocket Maximum** — The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services. Under Partners Plus, for example, your combined out-of-pocket maximum for the Partners Preferred and Plan Networks is $2,500 per individual and $5,000 per family ($3,000/$6,000 for Partners Value) when you receive care in-network. After you reach your maximum, including your deductible and coinsurance (excluding prescription drug and hearing aid co-pays), the plan would pay 100% of all remaining covered, allowed charges you incur during the year.

**Preferred Provider Organization (PPO)** — A program in which a hospital or health care system contracts with a network of medical providers to offer care. You receive higher benefits and lower cost services when you use one of these "preferred" providers.

**Primary Care Physician (PCP)** — The doctor you select to provide your medical care and help you find a specialist. Each covered family member may select his or her own PCP.

---

**Voluntary Medical Management Program**

Depending on your choice of medical coverage, you may be able to participate in a proactive health management program. See your plan’s Web site. In some cases, you may be contacted by your insurance carrier to see if you wish to participate in a program.
Partners Preferred Network Providers, Health Centers and Provider Organizations

What hospitals and other organizations are part of the Partners Preferred Network?

The facilities and organizations comprising the Partners Preferred Network include:

- Boston Children’s Hospital
- Brigham & Women’s Hospital
- Brigham & Women’s Faulkner Hospital
- Brigham & Women’s/Physician Organization
- Brigham & Women’s/Mass General Health Care Center in Foxborough
- Brigham and Women’s Ambulatory Care Center in Chestnut Hill
- Brigham and Women’s at Newton Corner
- Brockton Neighborhood Health Center
- Brookside Community Health Center
- Codman Square Health Center
- Dana-Farber Cancer Institute
- Dana-Farber/Brigham and Women’s Cancer Center
- Dana-Farber/Brigham and Women’s Cancer Center in clinical affiliation with South Shore Hospital
- Dana-Farber/Brigham and Women’s Cancer Center in clinical affiliation with Milford Regional Medical Center
- Dimock Community Health Center, Inc.
- Dorchester House Multi-Service Center
- East Boston Neighborhood Health Center
- Emerson Hospital
- Fenway Community Health
- Geiger-Gibson Community Health Center
- Greater Lawrence Family Health Center
- Greater Roslindale Medical & Dental Center
- Hallmark Hospitals (Lawrence Memorial and Melrose-Wakefield)
- Harbor Health Services, Inc. (Neposet)
- Harvard Street Neighborhood Health Center
- Joseph M. Smith Community Health Center
- Lowell Community Health Center
- Lynn Community Health Center, Inc.
- Manet Community Health Center
- Martha’s Vineyard Hospital
- Mass General Hospital for Children
- Mass General Hospital for Children at North Shore Medical Center
- Mass General West
- Mass General/North Shore Center for Outpatient Care
- Massachusetts Eye and Ear Infirmary
- Massachusetts General Hospital
- Massachusetts General Physician’s Organization
- Mattapan Community Health Center
- McLean Hospital
- MGH Back Bay Health Center
- MGH Charlestown HealthCare Center
- MGH Chelsea HealthCare Center
- MGH Everett Family Care
- MGH Imaging – Chelsea, Chelmsford, Worcester
- MGH North End Waterfront Health
- MGH Revere HealthCare Center
- Nantucket Cottage Hospital
- Newton-Wellesley Hospital
- Newton-Wellesley Hospital Waltham Urgent Care Center
- Newton-Wellesley Physician Hospital Organization
- North End Community Health Committee, Inc.
- North Shore Community Health, Inc. (Salem Family Health Center)
- North Shore Physicians Group
- NSMC MRI – Peabody
- NSMC Salem Hospital
- NSMC Union Hospital
- NSMC Wellness and Integrative Medicine Center
- NSMC Women’s Center
- Partners Community HealthCare, Inc.
- Partners HealthCare at Home
- Roxbury Comprehensive Community Health Center, Inc.
- Sidney Borum Jr. Health Center (of Fenway)
- South Boston Community Health Center
- South Cove Community Health Center
- South End Community Health Center
- Southern Jamaica Plain Health Center
- Spaulding Hospital for Continuing Medical Care, Cambridge
- Spaulding Hospital for Continuing Medical Care, North Shore
- Spaulding Nursing & Therapy Center - North End & West Roxbury
- Spaulding Rehab Network Outpatient Centers
- Spaulding Rehabilitation Hospital Boston
- Spaulding Rehabilitation Hospital Cape Cod
- Uphams Corner Health Center
- Whittier Street Health Center
Selecting Your Primary Care Physician (PCP)

While you do not need to obtain insurance referrals from your PCP when you need specialty care, it is recommended that you use a PCP to serve as a "home base" for all of your medical care needs.

Resources are available if you would like help selecting a PCP or specialist. Check your medical carrier's online directory to find a provider in the Partners Preferred or Plan networks:

**Blue Cross Blue Shield (Partners Plus, Partners Value)**
http://www.bluecrossma.com/partners

**Harvard Pilgrim HealthCare**

**Neighborhood Health Plan**
http://nhp.spectralogix.com/partners.asp

**Tufts Health Plan**
http://www.tuftshealthplan.com/partners

Try the following resources if you would like to find a provider at a specific Partners entity:

**Partners HealthCare Web Site:**
www.Partners.org – “Find a Doctor” system-wide search options

**Brigham and Women’s Hospital Physician Referral Service**
Phone: 855-278-8010
Website: http://physiciandirectory.brighamandwomens.org

**Brigham and Women’s Faulkner Hospital Physician Referral Service**
Phone: 617-983-7500
Website: http://physiciandirectory.brighamandwomensfaulkner.org

**Massachusetts General Hospital Physician Referral Service**
Phone: 617-726-5800
Website: http://www.massgeneral.org/doctors

**McLean Hospital**
Main Phone Number: 617-855-2000

**Newton-Wellesley Hospital CareFinder Referral Service**
Phone: 866-694-3627
Website: http://nwh.org/docs

**North Shore Medical Center Physician Referral Service**
Phone: 877-676-2637
Website: http://nsmcphysicians.partners.org

**Partners HealthCare at Home**
Main Phone Number: 781-290-4200
Website: http://www.partnersathome.org

**Spaulding Rehabilitation Network**
Main Phone Number: 617-573-7000
Outpatient: 1-888-776-4330

If you find it more convenient to choose a physician close to home, you’ll find Partners affiliates and Partners Community HealthCare, Inc. (PCHI) affiliates in many Massachusetts communities.

**You can locate PCHI physicians on this referral website:** https://pchinet.partners.org/pchilite/internet/consumersearch/consumersearch.asp
Express Scripts

Express Scripts (formerly called Medco) provides you with prescription coverage, regardless of which medical plan you choose. When you enroll in a Partners medical plan, you will receive an Express Scripts identification card for your prescription drug coverage, and a kit with information about how to use the plan to obtain your prescription drugs. When you need to fill a prescription, you can go to any pharmacy that participates with the Express Scripts network and show your Express Scripts identification card.

Express Scripts prescription drug coverage is provided based on an open formulary (list of covered prescriptions). The vast majority of therapeutic drugs are included in the formulary. Non-therapeutic drugs, such as those used for cosmetic reasons, are not included.

Information is also available on the web at http://www.express-scripts.com and by phone at 1-800-711-4541.

Co-payments are designed to promote the use of equally-effective, less expensive medications where clinically appropriate. Co-payments are based on the drug’s designation in the formulary—generic, preferred, or non-preferred brand-name. This designation is based on the recommendations of the Drug Management Committee. The formulary list is reviewed and changed throughout the year.

Preferred brand-name drugs which have a generic equivalent will be covered at the non-preferred brand-name co-payment level—$50.

Be sure to advise your doctor that you belong to Express Scripts Prior Authorization Program. Certain classes of drugs require approval from Express Scripts before the prescription can be filled.

<table>
<thead>
<tr>
<th></th>
<th>Filled at retail pharmacy (Up to 30-day supply)</th>
<th>Filled through home delivery or online (Up to 90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>
Dental

**Partners Benefits for Residents offers two dental plans:**

- **Basic Dental**
- **Major Dental**

The plans offer different benefits, so be sure to review the two options carefully.

**Coverage Levels:**

- **You have the option of choosing dental coverage in the following categories:**
  - Employee
  - Employee and Children
  - Employee and Spouse
  - Family
  - No Coverage

**Determining Your Dental Coverage Needs**

Your need for dental coverage depends on several factors. Your family dental history and your costs for coverage are probably the most important factors.

Look at the benefits available under the two plans, then refer to your Personal Benefits Summary or rate sheet to find the prices.

To make the right decision, ask yourself these questions:

- Do you or your family only require routine checkups and cleanings? If so, Basic Dental coverage may be adequate to meet your needs.
- Do you or a family member need special or recurring treatment, such as orthodontia, periodontics, fillings, or crowns? If so, consider enrolling in Major Dental coverage.

**Highlights of Coverage**

Before you receive dental care, be sure that your dentist participates in one of the Delta Dental networks covered by your plan. You will have your best coverage with either the Delta Dental PPO or the Delta Dental Premier network.

Most Massachusetts dentists are part of the Delta Dental Premier network, so it is likely that your dentist participates. While fewer dentists participate in the Delta Dental PPO network, your share of the costs for dental care are less if you have a dentist in this network.

To find a dentist, go to http://www.deltadentalma.com, click "Find a Dentist" and choose Delta Dental PPO, then follow the instructions. Dentists listed as Delta Dental PPO are in both networks. Dentists listed under Delta Dental Premier are in the Premier network only.

**Basic Dental**

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning twice per calendar year. Then,

- After you pay a $50 annual deductible ($100 per family), the plan will pay:
  - 50% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $1,000 per person annually

**No orthodontia coverage is available under Basic Dental**

See the chart on the next page for specific age limitations for certain services.

**Major Dental**

The plan pays 100% of the charges for diagnostic and preventive care, which includes a checkup and cleaning twice per calendar year. Then,

- After you pay a $25 annual deductible ($50 per family), the plan will pay:
  - 80% of the charges for minor restorative treatment
  - 50% of the charges for major restorative treatment
- Maximum benefit: $2,000 per person annually

**Orthodontia coverage: 50%, no deductible; lifetime maximum $2,000**

For more information on dental plan coverage, call Delta Dental 1-800-872-0500.
### Eligible children covered up to age 26.

<table>
<thead>
<tr>
<th>Dental Services</th>
<th>Basic Dental</th>
<th>Major Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar-Year Maximum</td>
<td>$1,000 per person</td>
<td>$2,000 per person (excluding orthodontia)</td>
</tr>
</tbody>
</table>

#### Diagnostic/Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete initial exam and charting</strong></td>
<td>Once</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Periodic oral exams</strong></td>
<td>Twice per calendar year</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>X-Rays:</strong> full mouth</td>
<td>Every 60 months</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Bitewings</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Single tooth X-Rays as needed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive evaluation</strong></td>
<td>Every 60 months</td>
<td>100%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Preventive Services**

- **Teeth cleaning** — twice per calendar year
- **Fluoride treatment** — twice per calendar year for members under age 19
- **Space maintainers** — Required due to the premature loss of teeth.
  - For members under age 14 and not for the replacement of primary or permanent anterior teeth.
  - Sealants for unrestored permanent molars, once every 4 years per tooth per tooth for members through age 15.
  - Sealants are also covered for members aged 16 up to age 19 who have had a recent cavity and are at risk for decay.
- **Periodontal cleaning** — Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.

#### Minor Restorative

**Restorative Services**

- **Silver and white fillings** — once every 24 months per surface, per tooth
- **Temporary fillings** — once per tooth
- **Stainless steel crowns** — once every 24 months per tooth

**Oral Surgery**

- **Simple extractions** (non-surgical) in dentist's office
- **Surgical extractions**, (including impactions) in dentist's office
- (Oral surgical benefits not provided when rendered in a surgical day care or hospital setting)

**Periodontics**

- **Periodontal Surgery**
  - Periodontal surgery benefits not provided when rendered in a surgical day care of hospital setting
- **Scaling and root planning** — once every 24 months, per quadrant

**Endodontics**

- **Root canal therapy** — once per tooth
- **Vital pulpotomy** — limited to deciduous teeth

**Prosthetic Maintenance**

- **Bridge or denture repairs** — once every 12 months, same repair
- **Rebase of dentures** — once every 36 months
- **Recementing crowns and onlays** — once per tooth

**Emergency Dental Care**

- **Minor treatment of pain relief** — three occurrences in 12 months

**General Anesthesia** (only with covered surgical services)

#### Major Restorative

**Prosthodontics**

- **Dentures** — once within 60 months
- **Fixed bridges and crowns** (when part of a bridge) — once every 60 months
- **Implants** — once every 60 months per tooth

**Restorative Services**

- **Crowns and onlays** (when teeth cannot be restored with regular fillings) — once every 60 months per tooth

#### Orthodontia

- **Active orthodontic treatment** not available
- **Lifetime orthodontia maximum** N/A

- **50% coverage, no deductible**

- **$2,000 lifetime maximum benefit**

Eligible children covered up to age 26.
**Partners Benefits for Residents offers a vision plan:**

- Davis Vision Plan

**Coverage Levels:**

<table>
<thead>
<tr>
<th>You have the option of choosing vision care coverage in the following categories:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employee</td>
</tr>
<tr>
<td>• Employee and Spouse</td>
</tr>
<tr>
<td>• Employee and Children</td>
</tr>
<tr>
<td>• Family</td>
</tr>
<tr>
<td>• No Coverage</td>
</tr>
</tbody>
</table>

The Davis Vision Plan provides a way to pay vision expenses at a lower cost through a network of optometrists.

**Determining Your Vision Coverage Needs**

Ask yourself these questions:

- What are your anticipated vision care expenses for the coming year?
- Would you be willing to use a network of private optometrists for your vision care services?

**Highlights of Coverage**

Every 12 months, you may go to a participating provider to receive 100% coverage for:

- A comprehensive eye examination, after you pay a $10 co-payment
- One pair of eyeglasses with plain or tinted lenses, or contact lenses

To find the participating network provider nearest you, call Davis Vision at 1-800-999-5431 to access the Interactive Voice Response (IVR) unit. You may also find a provider by visiting [www.davisvision.com](http://www.davisvision.com), clicking "Members" and entering client code 7360 in the Open Enrollment Plan box. Don’t forget: Davis has providers conveniently located near work.

If you choose to go outside of the Davis Vision network for services other than LASIK, benefits are significantly less. You may want to consider setting aside money in a Health Care Flexible Spending Account instead to pay these expenses on a before-tax basis.

**How Do I Obtain Services?**

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision Plan participant or covered dependent.
- Provide the office with your employee ID number (the number on the back of your Partners ID badge) and the date of birth of any covered children needing services.

It’s that easy! The provider’s office will verify your eligibility for services, and no claim forms or ID cards are required!
Here is an overview of the Davis Vision Plan benefits.

<table>
<thead>
<tr>
<th>Plan Provisions</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Eye Exams</td>
<td>100% after you pay $10 co-payment</td>
<td>Covered up to $16</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses</td>
<td><strong>One pair of eyeglasses</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Eyeglass frames</strong> from Davis Designer selection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR a $45 wholesale credit towards the purchase of non-Davis frames</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Vision lenses:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Single lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Bifocal lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Trifocal lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Contact lenses</strong> after you pay $25-$45 for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>standard, soft, daily-wear, disposable or plan replacement contact lenses. If your provider feels plan-supplied contact lenses are not suitable for you, a $125 credit will be applied toward the cost of contact lenses.*</td>
<td></td>
</tr>
<tr>
<td>Lasik Vision Correction</td>
<td><strong>You will be eligible for</strong> $500 per eye. This benefit is available from any</td>
<td></td>
</tr>
<tr>
<td></td>
<td>provider; however, if you use a Davis Vision participating provider, you will get a discount and your $500 will go further. A $1,000 lifetime maximum benefit applies.</td>
<td></td>
</tr>
<tr>
<td>Optional Feature</td>
<td><strong>These optional features are available:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Premier frames from <strong>“The Collection”</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Polycarbonate lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Anti-reflective coating (ARC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standard ARC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Progressive multifocal lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$10 co-payment each</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $30 for intermediate vision lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $20 for scratch-resistant coating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $75 for polarized lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $30 for plastic photosensitive lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $30 for high-index (thinner and lighter lenses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- $60 for Anti-Reflective Coating (ARC) Ultra ARC</td>
<td></td>
</tr>
</tbody>
</table>

**Coverage Frequency**
- Once every 12 months

*Your Davis provider will give you specific co-payment information for the type of lenses you require or prefer.*
Life Insurance

**Partners Benefits for Residents** offers these programs:

- Employee Basic Life Insurance
- Employee Optional Group Term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance
- Spouse Term Life Insurance
- Dependent Term Life Insurance
- Business Travel Accident Insurance

### Coverage Levels:

<table>
<thead>
<tr>
<th>Basic Life Insurance</th>
<th>Optional Life and AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Employee</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td></td>
<td>Dependent Child(ren) (for Life only)</td>
</tr>
</tbody>
</table>

**Determining Your Needs for Optional Group Term Life Insurance Coverage**

Everyone has different needs for life insurance. For some, the basic benefit is enough. Others need more insurance to help their survivors. To determine how much life insurance you need, ask yourself these questions:

- Does someone besides yourself count on your income?
- Do you have children who will require your assistance to pay for their education?

If the answer to either of these questions is “yes,” consider your options to buy additional coverage at very attractive group rates.

**Keeping Your Beneficiary Designation Current**

Your beneficiary designations must be elected at initial eligibility and should be reviewed annually or when you have a major life event (marriage, divorce, arrival of a child, etc.). You can review and make changes to your current beneficiary designation on eBenefits at any time, for any reason, to make sure the right person will receive payment in the event of your death.

To view your current beneficiary, log on to eBenefits, go to Insurances and click **Insurance Beneficiary Summary**. If you wish to see more details (such as a list of your contingent beneficiaries) or would like to add or change your beneficiary listing, click **Insurance Summary**. Click **Edit** and follow the instructions to make changes.
Highlights of Coverage

**Partners provides you with life insurance:**
- Basic employee life insurance equal to 1 times your annual base salary (up to $500,000)
- Amounts in excess of $50,000 are subject to imputed income according to IRS rules

**In addition, Partners also offers:**

**Employee Coverage**
- Optional group term life insurance: 1, 2, 3, 4, or 5 times your annual base salary (maximum of $1,000,000). Newly-eligible employees can elect up to 3 times salary in optional life insurance, not to exceed $250,000, without providing proof of good health. During open enrollment or within 30 days of a Qualified Change of Status event, you may elect to increase your life insurance coverage by 1 times your annual base salary if your annual base salary is less than or equal to $150,000. If you are electing more than 1 times your annual base salary or more than $150,000 of coverage you will be required to provide proof of good health.
- Optional AD&D Insurance amounting to $100,000
- Living benefits rider — If you are diagnosed with a terminal illness, you may become eligible to receive a portion of your basic and optional life insurance benefit as a cash payment.

**Spouse Coverage**
- Term life insurance amounting to:
  - $10,000, $25,000, $50,000, $75,000 or $100,000
- Optional AD&D insurance amounting to $100,000
- No proof of good health required if elected within 30 days of initial eligibility or marriage, except for coverage over $50,000; otherwise, evidence of insurability will be required
- Eligibility for Spouse Life ends at divorce. You must contact your Professional Staff Benefits Office to discontinue premium deductions from your pay.

**Dependent Child(ren) Coverage**
- Term life insurance: $10,000/child no matter how many dependent children you have
- No proof of good health required
- Dependent child(ren) are covered from birth up to age 26, including your spouse’s dependent children.
- When dependent children are no longer eligible,* no benefits are payable, even if premiums are still being deducted from your paycheck. You must contact the Benefits Office when your dependents are no longer eligible.

**Business Travel Accident Insurance**
- Most Partners employees are insured for 5 times base pay up to $2,000,000 if accidental death or dismemberment occurs while traveling on Hospital business
- Partners pays the full cost of this coverage

*See “Dependent Eligibility” on page 3.

---

**If both you and your spouse work at Partners HealthCare System entities, you may insure each other as dependents and your qualified dependent children may be insured by both of you for life insurance coverage. You may not be covered both as an employee and as a dependent for accident insurance.**

**Reductions Due To Age:**

**Your basic Life Insurance will be reduced as follows:**

- At age 65, it reduces to 65%
- At age 70, it reduces to 50%
Long-Term Disability

**Partners Benefits for Residents offers two options:**

- Long-Term Disability (LTD) Plan — 60% of Pay (automatic coverage)
- Long-Term Disability (LTD) Plan — 80% of Pay

**Coverage Level:**

- Employee

Long-Term Disability (LTD) coverage can be essential to financial protection. Without income protection, a long-term disability can spell financial disaster for you and your family. For that reason, Partners offers a special LTD Program with features designed specifically for Residents.

**Highlights of Coverage**

- You will be automatically enrolled in LTD coverage that replaces 60% of your salary, within the first 30 days of benefits eligibility*. You may elect to increase coverage to 80% of your salary, or waive coverage within the first 30 days of benefits eligibility. To waive coverage, log on to eBenefits, navigate to your LTD benefits screen and select “Waive”.
- If you elect coverage after your initial 30-day eligibility, an Evidence of Good Health form must be approved before coverage can begin.
- After being disabled for 90 days, you’ll receive 60% or 80% of your pay with a 3% annual cost-of-living adjustment every 12 months that you remain disabled, if applicable, subject to carrier approval.
- Benefits continue for as long as you remain disabled or until you reach age 65 (if you are age 60 or older when you become disabled, benefits continue for up to five years or age 70, whichever comes first, but not less than one year).
- If you become disabled during your residency and remain disabled until the time you were scheduled to complete your residency, your benefit is adjusted to reflect 60% of the first year earnings for your specialty.
- Upon completing your residency, you may elect to convert your coverage.

**Determining Your Needs for Long-Term Disability Coverage**

If you were disabled and unable to work for a long period of time:

- How would you pay for food, housing, and current monthly bills?
- How would you pay for medical coverage, or continue benefits for dental and vision care?
- How would you continue to pay your student loan?

By enrolling for Long-Term Disability coverage, if you become disabled, you will receive a monthly income and you can continue your medical, dental, vision, and basic life insurance coverage at active Residents rates. The plan will also pick up the cost of required student loan payments while you’re disabled, subject to a $150,000 maximum.

Most Residents cannot afford to be without this excellent coverage.

* Guaranteed acceptance has two conditions: You must be actively at work and you must not have been previously declined by our Long-Term Disability insurance carrier, Unum. Otherwise, you must complete an Evidence of Insurability (EOI) form to apply for coverage.
Health Care Flexible Spending Accounts

Highlights of Participation

Health Care Flexible Spending Accounts (FSAs) allow you to save on taxes for certain health care expenses.

- You may set aside up to $2,500 pre-tax each year (divided over each paycheck) for your or your dependents’ eligible medical, dental, and vision expenses not paid for by your health plan.
- New elections must be made for each calendar year.
- Amounts not used by March 15 of the following year and filed by March 31 of the following year will be forfeited.

Determining Your Need for a Health Care Flexible Spending Account

To determine the level of expenses you are likely to incur, review what you have spent on medical expenses for the last two years. Consider how participation in a benefit plan, such as dental or vision coverage, may affect the amount you contribute.

Many non-cosmetic health care expenses (medical, dental, vision, hearing, etc.) can be reimbursed through your Health Care Account. **PLEASE NOTE:** Over-the-counter (OTC) products that are considered medicines do not qualify for reimbursement from your Health Care FSA, unless you have a prescription from your physician. OTC medicines include allergy or cold remedies, pain relievers, and antacids. In addition to submitting a prescription with your claim, you must provide a receipt from the store where you purchased the OTC medication.

Insulin and non-medicine OTC items such as bandages, contact lens solution and nasal strips do not require a prescription.

The IRS now recognizes a same-sex spouse and his/her children as dependents for tax purposes. As a result, their expenses are eligible for reimbursement through a Health Care FSA.

Internal Revenue Service Rules: Use It or Lose It

Be sure to estimate your health care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining in your account. You have the entire calendar year and up to March 15 of the subsequent year to incur expenses for reimbursement against money deferred in any calendar year. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 31 of the year subsequent to the deferral year to submit for reimbursable expenses from account balances for the prior year; otherwise, your balance will be forfeited.

Examples of Eligible Health Care Expenses

To the right you will find some examples of eligible health care expenses. You will find a comprehensive list of eligible and ineligible expenses at: http://hcet.ebia.com/partners

Remember! With the range of medical, dental, and vision plans available through Partners, some of these expenses may be partially or fully covered by your insurance provider, depending upon your personal selections. Any amount covered by your plans is not an eligible expense. In addition, insurance premium payments and long-term care expenses or premiums are not eligible for reimbursements. The Mental Health Parity Act eliminated graded co-payments and benefit limitations for mental health and substance abuse care. Due to this change, some of these expenses may be covered under your medical plan and are therefore not reimbursable from your FSA.

Eligible Expenses

- **Health Care** — deductibles, co-payments, coinsurance, treatment or services not covered by your medical plan, and other eligible expenses
- **Prescription Drugs** — expenses not covered by your plan, including co-payments
- **Hearing Care** — routine hearing exams, hearing aids and batteries not covered by your medical plan
- **Dental Care** — all uninsured dental care including deductibles, coinsurance, and amounts over maximums
- **Vision Care** — exam, and all vision aids not covered by your plan; laser vision correction treatment

Submitting Your Claims

Submit claims with receipts to the Benefits Office using the FSA Express online system. Log onto PeopleSoft at https://ibridge.partners.org and go to: HRMS Production > Main Menu > Self Service > eBenefits > FSA Express > FSA Claim Entry

**Instructions for using FSA Express are available at:** http://is.partners.org/hr/New_Web/phs/phs_Benefits.htm

If you do not have online access, you may request a claim form from the Benefits Office. Once approved, your reimbursement will be made automatically to your paycheck and indicated on your pay advice. You can track the status of your claims on eBenefits.
Determining Your Need for a Dependent Care Flexible Spending Account

A Dependent Care Flexible Spending Account allows you to set aside tax-free dollars to pay for dependent care expenses you incur so that you (and your spouse, if you are married) can work. You may also use a Dependent Care Account if your spouse is attending school full-time or is disabled and is unable to care for your dependents. You may set aside up to $5,000 each year if single or if married, filing jointly, or $2,500 if married, filing separately.

The IRS now recognizes a same-sex spouse and his/her children as dependents for tax purposes. As a result, their expenses are eligible for reimbursement through a Dependent Care Account.

Examples of Eligible Dependent Day Care Expenses

- Nursery schools, day care centers, and summer day camps for dependents, up to age 13. If you are caring for a family member who resides with you and who is physically or mentally incapable of caring for his/her own needs, regardless of age, and whom you claim as a dependent for income tax purposes, you may also submit those expenses to your Dependent Care FSA.

- Dependent care providers in or outside your home.

- Dependent care centers that provide day care (not residential care) for dependent adults.

The following dependent care expenses do NOT qualify for reimbursement from your account:

- General "babysitting", other than during work hours

- Care provided by a relative who is your (or your spouse's) dependent and will be under age 19 at the end of the year

- Expenses for programs at the kindergarten level or above

- Expenses for overnight camps

NOTE: Final determination on eligible expenses rests with the Internal Revenue Service. You may wish to refer to IRS Publication 503 "Child and Dependent Care Expenses" for more information. You can download this publication from the IRS website: www.irs.ustreas.gov
Advantage of Having Longer to Incur Expenses

Sharon elects to defer $1,000 in her Dependent Care Flexible Spending Account. On December 31, 2013, she has incurred $900 in eligible expenses. Under the old rules, she would forfeit $100.

In February 2014, Sharon incurs dependent care expenses. Sharon can now submit up to $100 of those expenses for reimbursement since claims can be incurred for an additional 2.5 months in the subsequent year.

*Please note that expenses can only be reimbursed from funds set aside in one plan year. The same 2014 incurred expenses cannot be reimbursed from 2013 and 2014 deferrals.
Tax-Sheltered Annuity Contributions

Partners gives you an opportunity to invest in your retirement through a Tax-Sheltered Annuity (TSA) program. You may contribute as much as $17,500 in 2013. TSA contribution limits for 2014 were not available at the time of this guide’s publication. More information about TSAs, including contribution limits for 2014, is available by contacting your Benefits Consultant or online at: http://is.partners.org/hr/New_Web/phs/phs_tsageninfo.htm

Your Savings

- You have two ways to save:
  - A flat dollar amount per pay period or
  - A percentage of pay each pay period

Partners offers two types of TSA contributions:

- **Traditional (pre-tax) contributions** are deducted from each paycheck before taxes are deducted. Because you use pre-tax dollars to fund your investments, you reduce the amount of federal and state income taxes you pay now. Balances and their investment earnings grow on a tax-deferred basis, and are taxable later when you take distributions.

- **Roth contributions** are deducted from the after-tax dollars in your paycheck — so your weekly take-home pay will be less than with traditional contributions if you choose this option. However, while you pay income taxes now, which reduces your net pay, you will pay no taxes later when you receive qualified distributions from your retirement savings plan.

- You may change the amount you save, or stop your contributions, at any time through PeopleSoft self-service.

Partners reserves the right to adjust your TSA deduction if your contribution exceeds IRS limits.

Updating Your TSA Beneficiaries

When you enroll in a TSA, you must name the person(s) you want to receive your proceeds in the event you should die. It is your responsibility to make sure that this information is accurate and up-to-date. Make sure to review your TSA beneficiaries at least once a year.

To name beneficiaries for your Fidelity Tier 1, 2, or 3 funds:
Log in to your account at http://www.netbenefits.com/partners. Click “Your Profile” at the top of the screen, then click “Beneficiaries” and follow the instructions.

To name beneficiaries for your Tier 4 TIAA-CREF Annuity Choice funds:
Visit http://www.tiaa-cref.org to designate beneficiaries for your annuities.
Choosing Your Investments

While it is important to begin early to save for your own retirement, it is also just as important to allocate your investments based on your individual goals and overall comfort level with making investment decisions.

Our investment lineup is designed to help you pick investments based on your goals, your other available retirement savings, and your comfort in making investment decisions. Each tier in the lineup includes a carefully researched, unique menu of investment options that targets different objectives and levels of engagement. **You may pick investments from a single tier or across multiple tiers and change them anytime during the year in order to meet all of your goals.** The tiers are:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Available Investment Options</th>
<th>May be right for you if…</th>
</tr>
</thead>
<tbody>
<tr>
<td>One: Easy Choice</td>
<td>Vanguard Target Retirement Date Funds</td>
<td>You want a diversified, low-cost retirement portfolio that utilizes the expertise of professional investment managers, and automatically rebalances funds to become more conservative as you approach retirement. Many employees may find this option is best for them. If you take no action, your funds will automatically be defaulted into the Vanguard Target Retirement Date Fund closest to the year in which you will turn age 65.</td>
</tr>
<tr>
<td>Two: Guided Choice</td>
<td>Five pre-screened mutual funds</td>
<td>You want to build a diversified retirement portfolio without having to sort through a large array of fund choices. These funds have been specifically selected for use by participants who wish to manage their own asset allocation to match their personal investment goals and risk level.</td>
</tr>
<tr>
<td>Three: Open Choice</td>
<td>Thousands of mutual funds from over 350 investment companies available through a brokerage window, via Fidelity BrokerageLink®</td>
<td>You want to build your own retirement portfolio through the thousands of mutual funds that are available through a brokerage account. Unlike Tiers 1, 2 and 4, these funds have not been selected by the plan managers and fund performance will not be monitored by your employer.</td>
</tr>
<tr>
<td>Four: Annuity Tier</td>
<td>Two TIAA-CREF annuities: TIAA Traditional Annuity and CREF Stock Account Variable Annuity</td>
<td>You want to invest in a vehicle that will provide the assurance of a lifetime income upon retirement.</td>
</tr>
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</table>

For questions about the lineup, please contact:

<table>
<thead>
<tr>
<th>Fidelity</th>
<th>1-855-999-1PHS (1747)</th>
<th><a href="http://netbenefits.com/partners">http://netbenefits.com/partners</a></th>
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<tr>
<td>TIAA-CREF (annuities only)</td>
<td>1-800-842-2776</td>
<td><a href="http://www.tiaa-cref.org/">http://www.tiaa-cref.org/</a></td>
</tr>
</tbody>
</table>
Tier I – Easy Choice. This “set it and forget it” option offers a diversified, index-based Vanguard Target Retirement Date fund that mixes stocks, bonds and cash, and corresponds to your expected retirement date. A professional manager updates your asset allocation over time. As your retirement date approaches, your investments will automatically transition from an allocation that focuses on growing your capital to one that focuses on preserving your capital. Many employees may find this option is best for them.

If you do not make an investment allocation your contributions will be automatically invested with the Vanguard Target Retirement Date fund that is closest to the year in which you will turn age 65.

Tier II – Guided Choice. The Guided Choice tier includes five actively managed funds: a money market fund, a global fixed income fund, a global equity fund, a real return fund and a global balanced fund. This range of funds allows you to construct an actively managed fund allocation that matches your goal and risk level. Tier II is appropriate if you feel well equipped to make your own asset allocation decisions.

— We chose the Vanguard Prime Money Market Fund because of its low fees and conservative nature, which is appropriate for the capital preservation option in the plan.

— The PIMCO Global Advantage Strategy Bond Fund was chosen because of PIMCO’s expertise in fixed income management, and its well diversified global bond portfolio.

— The MFS Global Equity fund was chosen for its strong track record in many different market environments as well as the skill and experience of the portfolio management team.

— We chose the JPMorgan Diversified Real Return Fund — R5 because of its strong base of inflation-protected bonds, which offers downside protection while other diversifiers such as real estate, infrastructure and natural resource related securities can help the fund achieve an expected long term return over inflation.

— The GMO Global Asset Allocation Fund — R6 was chosen for the strong macro-economic forecasting abilities of the team at GMO, which should help the fund navigate changing market environments.

Tier III – Open Choice. This tier includes access to thousands of mutual funds through Fidelity’s BrokerageLink platform. This tier is appropriate if you are very comfortable managing your own investments and want the most flexibility and choice. There are additional costs for some ongoing transactions in this tier, so please research the specifics before investing.

Tier IV – Annuity Tier. Ensuring adequate lifetime income is an important consideration for retirement planning. To help you in your planning, this tier has two annuity accounts:

— TIAA Traditional Annuity: a guaranteed annuity that offers a fixed rate of return

— CREF Stock Account Variable Annuity: a variable annuity whose rate of return will fluctuate with the market.

Annuities can help protect you from outliving your assets. And unlike mutual funds, an annuity offers the opportunity to receive the assurance of a lifetime income in retirement. By creating a portfolio utilizing both fixed and variable annuities, you can benefit from an income stream for life, while retaining some growth potential for your annuity payments.

For more information, please go to http://netbenefits.com/partners.
The Power of Tax-Deferred Savings

Experts tell us that to get by comfortably in retirement, we need at least 70% to 80% of the income that we earn the day before we retire. This is known as the income replacement ratio. Consider the advantages of tax-deferred savings over regular after-tax savings. Let’s say that this employee saves $29 a week, or $1,508 a year, in a traditional TSA account. For this illustration we will assume that she earns an annual return of 8% and is in the 28% tax bracket.

As you can see, over time, your savings can really benefit from the power of tax-deferred savings. A variety of investment options is available ranging from conservative fixed income funds to aggressive stock funds. For more information, call the Benefits Office or the vendors listed in the beginning of this guide.

Why Start Saving Now?

For many people, retirement seems like such a distant goal that they feel no urgency to plan so far ahead. After all, how much can it hurt to wait a few more years?

The chart on the next page shows the real cost of waiting. It compares two 29-year-old coworkers, Dana and Pat. Dana put away $2,000 a year for 10 years (earning a hypothetical 8% rate of return) and then never added another dime to her savings. Pat waited 10 years to start, and then invested $2,000 a year until she retired 27 years later at age 65. Dana invested a total of $20,000 while Pat contributed $54,000. Who came out ahead? You might be surprised.
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<th>Investment</th>
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</tbody>
</table>

Total Amount Invested: $20,000  $54,000
Account Value At Age 65: $249,953  $188,678

(For illustration purposes only. Your investment experience will differ.)

* Assumes return of 8% per year compounded annually.
Enrollment Information

See your Enrollment Statement or Rate Sheet for your benefit credits.

The amount of Choice Pay available to you is shown on your Personal Benefits Summary at open enrollment or on a Residents Rate Sheet, if you are newly eligible for benefits. Your Choice Pay will vary according to the Choice Pay formula (see page 2) and according to your benefit choices. You are encouraged to review this guide, which provides highlights of all available plans.

How the Enrollment Process Works

Enrollment Period

During open enrollment, use eBenefits on the Web to update your benefit choices. Please refer to your Personal Benefits Summary for specific open enrollment dates.

Newly-Eligible Residents

As part of your Residents' orientation you'll receive benefits enrollment materials, and have the opportunity to ask questions. Make sure to enroll in your benefits within 30 days of when you are eligible.

Enrollment Instructions

Using the Practice Worksheet

On the following page you will see a Practice Worksheet. Have your Personal Benefits Summary and rate sheet alongside the worksheet. Before enrolling, use a pencil to complete the Practice Worksheet. Enter your choices, the price tags for your selections, and the totals to consider a variety of scenarios.

When you have designed the coverage package that best meets your needs, you are ready to enroll.

At Work: Go online to your PeopleSoft Account. Click Start > Partners Applications > PeopleSoft HRMS > Main Menu > Self Service > eBenefits > Benefits Enrollment.

At Home: Go online to: https://ibrIDGE.partners.org

NOTE: Your Practice Worksheet is not an enrollment form. You must enroll via eBenefits within 30 days of your benefits eligibility date.

If we do not receive your response within 30 days of the date your appointment begins, you will be assigned employee-only medical coverage under Partners Value. You will not have an opportunity to change your coverage until the next annual open enrollment period for coverage effective the following January 1.

Benefits are effective on your first day of eligibility and deductions will be retroactive to that day.
On your Personal Benefits Summary, circle the plans and levels of coverage you want, and then enter the price tags on this worksheet.

Enter basic Choice Pay

Enter medical participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners medical coverage)

Enter dental participation Choice Pay based on level of coverage you choose (enter 0 if you are not electing Partners dental coverage)

**Enter Total Choice Pay**

Enter prices for options you choose

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<tr>
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<th>Column 1</th>
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Enter Flexible Spending Account Amounts:

|                          |
|--------------------------|----------|
| Health Care Account Contribution (monthly) | $________| $________|
| Dependent Care Account Contribution (monthly) | $________| $________|

**Add prices for total**

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<tr>
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<tr>
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</table>

If B is larger than A

- A $________

Your Costs $________

If A is larger than B

- B $________

Your Cash $________
When you or your covered dependents are no longer eligible for coverage under your Partners medical, dental, vision, or health care account under the Partners Benefits for Residents Plans, you or your covered dependents may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may also have other alternatives available to you through the Health Insurance Marketplace.

If you choose to continue coverage, you are generally entitled to be offered coverage identical to the coverage being provided under the plan to you and your family members on the day before the day you would otherwise lose coverage.

This law applies if you or your covered spouse or dependent children (referred to as “qualified beneficiaries”) are no longer eligible for coverage due to any of the following qualifying events:

- Termination of employment (for reasons other than gross misconduct)
- Reduction of work hours
- Divorce or legal separation
- Your death
- You enroll in Medicare (Part A, Part B, or both) or
- Your child no longer qualifies as an eligible dependent

A newborn infant, adopted child, or a child placed in your home for adoption will be entitled to receive COBRA continuation coverage as a qualified beneficiary if you have elected and are then receiving COBRA coverage. To cover your newborn or adopted child under COBRA, you must elect coverage within 31 days of the child’s birth, adoption, or placement for adoption.

The period of COBRA coverage begins with the date of your qualifying event and continues for up to 18 months from that qualifying event, in most cases. If you continue your coverage under COBRA due to divorce or loss of status as an eligible dependent, however, COBRA coverage is available for 36 months. You may continue your health care FSA participation only through the end of the calendar year in which the qualifying event occurred.

**More Information**

This notice summarizes the law and is general in nature. Consult the law itself and the actual plan provisions for detailed information about how COBRA may apply to your particular circumstance.

The Plan Administrator administers COBRA continuation coverage through your Professional Staff Benefits Office. If you have any questions about COBRA or if you would like more information about your COBRA coverage rights, you may contact your Professional Staff Benefits Office. The Plan Administrator will send all notices and other important information regarding COBRA to a qualified beneficiary’s last known address as shown in Plan records. In order to protect your family’s COBRA rights, you must notify the Plan Administrator in writing of any address change for you or any covered family member.

There are circumstances under which the coverage periods (excluding the FSA coverage period) may be extended:

- Coverage may be available for 29 months if at any time during the first 60 days of COBRA continuation coverage you or another covered family member is determined to be disabled by the Social Security Administration and you notify the Benefits Office within 60 days of such determination and before the end of the 18-month continuation coverage period. The disability extension is available only for as long as you or your family member remains disabled.
- In the case of a retiree or an individual who was a covered surviving spouse or dependent child of a retiree on the day before a Chapter 11 filing, coverage may continue until death and, in the case of the spouse or the dependent child of a retiree, for 36 months after the date of the death of the retiree.
- Additional qualifying events can occur while the continuation coverage is in effect. Such events may extend an 18-month continuation coverage period to 36 months, but in no event will coverage extend beyond 36 months after the initial qualifying event. The extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare, or gets divorced or legally separated. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child.

**Notification Rules**

Under the law, you or a family member must inform the Professional Staff Benefits Office of a divorce, legal separation, or a child’s loss of dependent status under the plan. The notice must be provided within 60 days of the date of the event. If you fail to provide the notice within the applicable 60 day notice period the right to elect COBRA coverage will be lost.

You must also notify your Professional Staff Benefits Office if a second qualifying event occurs, or of the Social Security Administration’s determination that a qualified beneficiary is disabled as explained above. You must provide this notice within 60 days following the second qualifying event or the Social Security’s determination, and before the end of the 18-month coverage period in order to be eligible for the extended coverage period. If you fail to provide the notice within the 60 day notice period, the COBRA coverage period will not be extended.
You must notify the Professional Staff Benefits Office if you (or a covered dependent) are determined by Social Security to no longer be disabled before the 29 months run out. This notice must be provided within 30 days of the determination.

You must provide these notices by calling the Professional Staff Benefits Office at 617-726-9267.

In the case of disability, a copy of the Social Security’s determination of disability must be provided.

How to Enroll for COBRA Continuation Coverage

To enroll for continuation coverage under COBRA, complete a COBRA election form which will be mailed to you. Return your completed election form to the address on the form within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return your completed form within the 60 day period, the right to elect continuation coverage will be lost, and you will not be allowed to continue your coverage in the plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of your mailed election form.)

You must pay the full cost of COBRA continuation coverage. Generally, the amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period, the Plan Administrator will terminate coverage retroactively to the beginning of the maximum coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. A premium payment that is mailed will be deemed made on the date of mailing. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

There may be other coverage options available to you and your family. Under the Affordable Care Act, you may be able to buy coverage through the Health Insurance Marketplace (the Health Connector, in Massachusetts). In the Marketplace, you might be eligible for tax credits that could lower your monthly premiums, and you can see what your costs and benefits would be under those plans, compared to the COBRA premium. Your COBRA eligibility does not affect your eligibility for Marketplace coverage or tax credits. You also might be eligible to enroll in a spouse’s plan if you contact that plan within 30 days of your loss of employer coverage.

When Your COBRA Coverage Ends

Your COBRA coverage will end when:

- You reach the maximum length of time allowed for your COBRA coverage (for example, 18 months or 29 months or 36 months from your qualifying event). (If you are continuing your coverage beyond 18 months due to disability, your coverage will end when you are no longer disabled.);
- Partners no longer provides group health coverage to any of its employees;
- The premium for coverage is not paid in a timely manner;
- After electing COBRA, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation for any preexisting condition that the individual may have; or
- After electing COBRA, the qualified beneficiary enrolls for Medicare.

HIPAA Provision

(Health Insurance Portability and Accountability Act of 1996)

If You Declined Medical Coverage Because You Have Coverage Elsewhere

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may have the opportunity to enroll yourself and your eligible dependents for medical coverage during the year if you previously declined coverage, as follows:

- You and/or your dependents have coverage from another source (such as your spouse’s medical plan or COBRA coverage) and you lose that coverage or
- You acquire a dependent through marriage, birth, adoption or placement for adoption

If you need to enroll for coverage as a result of one of the above events, you must do so within 30 days of the event. Otherwise, you may be required to wait until the next open enrollment period.
Brigham and Women’s Hospital and Massachusetts General Hospital are founding members of Partners HealthCare System, Inc.