### Inside this Guide

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing and Updating Your Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Eligibility for Benefits Plans</td>
<td>3</td>
</tr>
<tr>
<td>Highlights</td>
<td>4</td>
</tr>
<tr>
<td>Medical Coverage</td>
<td>6</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>9</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>10</td>
</tr>
<tr>
<td>Vision Coverage</td>
<td>11</td>
</tr>
<tr>
<td>Disability Coverage</td>
<td>13</td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance</td>
<td>14</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>16</td>
</tr>
<tr>
<td>Tax-Sheltered Annuity Contributions</td>
<td>18</td>
</tr>
<tr>
<td>Malpractice Insurance (CRICO Coverage)</td>
<td>20</td>
</tr>
<tr>
<td>Tuition Assistance</td>
<td>21</td>
</tr>
</tbody>
</table>

**TIP:** click on the button located on the bottom of each page to return to this page to navigate through the benefits listed above. Simply on the coverage and you will be redirected to the appropriate page.

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**Ask myHR**

There are several ways to get information about your benefits. You can find the answers to many of your benefits questions on Ask myHR, your one-stop HR and benefits information resource. Access Ask myHR at www.AskMyHRportal.com. If you need assistance, please contact the HR Support Center by submitting an online request, emailing askmyhr@partners.org or calling 1-833-AskMyHR (1-833-275-6947).

You can also contact your HR/Benefits Consultant in the MGH/MGPO Professional Staff Benefits Office, Bulfinch 126 (office phone number: 617-643-3071).

**Susan Frain, last names A-L**  
sfrain@partners.org  
617-726-9264

**Virginia C. Rosales, CEBS, last names M-Z**  
vrosales@partners.org  
617-724-9356
Choosing and Updating Your Benefits

Newly-eligible Fellows have 30 days from the date first eligible to enroll in the MGH Flex Benefits Program.

Each year, Massachusetts General Hospital (MGH) sponsors a fall benefits Open Enrollment period. During open enrollment, employees can make changes to their benefits for any reason. All choices become effective January 1 of the following year. Employees can change or stop contributions to a 403(b) Tax-Sheltered Annuity account at any time.

Enroll in Your Benefits using Ask myHR.

Within 30 days of becoming benefits-eligible, or during fall Open Enrollment:

1. Go to the Ask myHR portal at www.AskMyHRportal.com. If you are accessing Ask myHR from outside of work, you must log in with your username and password and enter a confirmation code, delivered via text message or phone call to a phone number you have pre-registered.

   You can register or update a phone number at: http://myprofile.partners.org

2. Once in Ask myHR, click myBenefits at the top of the screen. You will be redirected to PeopleSoft Self Service. If prompted, enter your username and password at the log in screen.


   Enroll in or update each benefit for which you are eligible. When you are done enrolling in your benefits, click Submit twice and then OK.

If you need assistance, please contact the HR Support Center.

You must enroll in your benefits via PeopleSoft myBenefits within 30 days of your benefits eligibility date (for most employees, your date of hire). If you do not enroll within 30 days of your benefits eligibility date, you will automatically be enrolled in Partners Select medical coverage for yourself only and will have to wait until the next annual Open Enrollment period to change your coverage. Benefits are effective on your first day of eligibility and deductions will be retroactive to that day.
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 can include:

- 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 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 and spouse within 30 days of the date of your marriage.

Making Your Change

1. Within 30 days of your change of status event, go to the Ask myHR portal at www.AskMyHRportal.com. If you are accessing Ask myHR from outside of work, you must log in with your username and password and enter a confirmation code, delivered via text message or phone call to a phone number you have pre-registered. You can register or update a phone number at: http://myprofile.partners.org

2. Once in Ask myHR, click my Benefits at the top of the screen. You will be redirected to PeopleSoft Self Service. Enter your username and password at the log in screen.

3. Click Life Events. Indicate the appropriate Life Event and follow the instructions.

If you need assistance, please contact the HR Support Center.
Eligibility for Benefits Plans

**Employee Eligibility**

Monthly-paid MGH Fellows are eligible for FLEX benefits if they have scheduled annual earnings of at least $10,000 (at least $833.33 per month) and are scheduled to work at least half time (87 hours per month). Coverage is effective on the date of eligibility (i.e. date of hire). Fellows are not eligible to participate in MGH retirement programs, other than the 403(b) Tax-Sheltered Annuities (TSA).

Your eligible dependents for medical, dental, vision, and life insurance are:

- your legal spouse,
- your dependent children under age 26, and
- your legal spouse’s dependent children under age 26.

**Adding Your Dependent Child to Your Benefits**

You can add your child who is under age 26 to your medical, dental, and/or vision coverage by going into Ask myHR during Open Enrollment, or if you experience a qualifying life event. If you are a permanent legal guardian, you may add the child for whom you are a permanent legal guardian to your coverage. Proof of your guardianship may be required.

**PLEASE NOTE:** In order to satisfy government reporting requirements, you must provide your spouse’s and all dependents’ Social Security numbers and dates of birth when enrolling them on your benefits plans.

**Children Age 26 and Older**

Coverage for your or your legal spouse’s dependent child will end automatically on the last day of the month in which the child turns age 26, at which time they will be offered COBRA. Dependent children with disabilities who are over age 26 are eligible for the medical, dental, vision plans, and child life 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 would normally lose coverage. Please contact the HR Support Center before their 26th birthday for details.

MGH 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
- Legal Guardianship paperwork that names the employee or the employee's spouse as the Legal Guardian
The FLEX benefits program is designed to allow you to meet the needs of you and your family.

<table>
<thead>
<tr>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FLEX benefit credits</strong> are provided to you to help pay a majority of your benefit costs. If you elect not to participate in the MGH program, you may be eligible to receive an Opt-Out Credit as taxable income. Please see the next page for details.</td>
</tr>
<tr>
<td>You can choose from <strong>two medical plans</strong> to protect yourself and your family in the event of illness or injury.</td>
</tr>
<tr>
<td>Long-term disability (LTD) insurance is available for financial protection in the event you cannot work due to an extended illness or injury.</td>
</tr>
<tr>
<td>A <strong>prescription drug benefit</strong> managed by CVS/caremark that offers a convenient mail service program.</td>
</tr>
<tr>
<td>Basic group life insurance and accidental death &amp; dismemberment (AD&amp;D) insurance are provided equal to 1 times your annual base salary.</td>
</tr>
<tr>
<td><strong>Two dental plans</strong> provide you the level of coverage that is right for your situation.</td>
</tr>
<tr>
<td>Optional group term life insurance allows you to purchase additional life insurance for yourself, your spouse or your dependents.</td>
</tr>
<tr>
<td>A <strong>vision care plan</strong> offers a cost-effective way for you to get an annual comprehensive eye exam and corrective lenses.</td>
</tr>
<tr>
<td>Optional accidental death and dismemberment (AD&amp;D) insurance is available to protect you, your spouse and dependents.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>A 403(b) tax-sheltered annuity (TSA) plan offers you a tax-smart way to save for the future.</td>
</tr>
<tr>
<td><strong>Two Flexible Spending Accounts</strong> save you tax dollars and reduce your out-of-pocket costs for health care and dependent day care.</td>
</tr>
<tr>
<td>Malpractice Insurance provides best-quality professional and general liability insurance to all eligible members of the Professional Staff.</td>
</tr>
</tbody>
</table>

In addition to the benefits in this guide, there are many perks available to MGH Fellows. Visit Ask myHR at www.AskMyHRportal.com for the latest discounts and specials.
**Benefit Credits**

The *FLEX* benefits program gives you a choice about how MGH's dollars are spent on your behalf. Each year MGH gives you a certain number of benefit credits, to reduce your benefits deductions.

There are two types of benefit credits available under *FLEX*.

### Medical Participation Credit

If you enroll in one of the medical plans offered under *FLEX*, you will receive credits based on the level of coverage you select:

- Employee
- Employee and Child(ren)
- Employee and Spouse
- Family

### Opt-Out Credit

If you have coverage elsewhere you may be eligible to receive a credit in your pay that can be used to pay for other benefits, or it will be added as taxable income. Make sure to select the Opt-Out option in PeopleSoft to receive the credit. Please note that you are not eligible for this credit if you have medical coverage through MassHealth, Medicare, ConnectorCare or other government-sponsored medical coverage.

**If you Have Extra Benefit Credits**

If you have extra benefit credits that you do not use for benefits, they are taken in cash as additional taxable pay (provided you are covered under another medical plan).

**If You Choose More Benefits Than You Have Credits**

If you choose more benefits than your credits will cover, you will pay the additional amount through payroll deduction.
Medical Coverage

Coverage Levels

You have the option of choosing medical coverage in the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Coverage Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Employee and Spouse, Employee and Child(ren), Family</td>
</tr>
</tbody>
</table>

MGH offers the following medical plans for employees who live in the Greater Boston area. Both plans are administered by AllWays Health Partners. If you live out of state, or outside the Greater Boston area, you are eligible to participate in an “Out of Area” medical plan. See Ask myHR for a map of towns that are considered out of area, and for details on our out of area medical plans.

- **Partners Select**: A medical plan that offers low-cost, high-quality care from providers within the Partners network, referred to as the Tier 1 (Preferred) Network. Coverage is available for non-Partners providers, referred to as Tier 2 (Non-Preferred), but at a higher cost.

- **Partners Plus**: A Preferred Provider Organization (PPO) plan that offers cost-effective, high-quality care. You will pay more per paycheck for coverage under Partners Plus than Partners Select, but lower point of care out-of-pocket costs when you receive care from providers outside of the Tier 1 (Preferred) Network.

**Your Networks of Coverage**

MGH health plans are designed to offer you the best health care, while maintaining the flexibility to receive care that is best for you and your family.

- You receive the highest level of coverage when you use health care providers and facilities within the Tier 1 (Preferred) Network. This network includes Partners HealthCare primary care physicians (PCPs), specialists and facilities, along with providers at the Dana-Farber Cancer Institute and Emerson Hospital. Services received at South Shore Hospital, but not South Shore affiliated providers, are Tier 1.

- You will still receive comprehensive coverage, at higher point of care costs, when you use a Tier 2 (Non-Preferred) PCP, specialist or facility within the AllWays Health Partners Network. AllWays Health Partners provides national coverage through the Aetna network.

- If you enroll in Partners Plus, you also may receive coverage when you use Out-of-Network specialists and facilities that don’t participate in either the Tier 1 (Preferred) or Tier 2 (Non-Preferred) Networks. However, your costs for Out-of-Network care will be substantially higher. In many cases, you will pay 40% or more of the medical bill for your care. Coverage for Out-of-Network specialists and facilities is not available under Partners Select.

**Starting January 1, 2019**: Before you receive your ID card in the mail, you can access the card electronically at www.allwaysmember.org.

Regardless of which medical plan you choose:

- You do not need to obtain an insurance referral when you need to see a specialist.

- Your plan does not require you to have a PCP of record, but we encourage you to have one.

- Emergency Room visits have a $150 co-pay. This co-pay will be waived if you are admitted as an inpatient to the hospital.

- Partners HealthCare On Demand telemedicine and non-Partners telemedicine services are fully covered without a co-pay. For more information on Partners HealthCare On Demand, see Ask myHR.

- When you join a Partners medical plan, you can receive coverage for one month of membership fees at a qualified health club for yourself and your covered family members. Contact AllWays Health Partners for details at 1-800-432-9449.
### Highlights of Coverage

<table>
<thead>
<tr>
<th>AllWays Health Partners Plans</th>
<th>Partners Select</th>
<th>Partners Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1 (Preferred):</strong></td>
<td>- No annual deductible: Plan pays 100% of most covered expenses</td>
<td>- No annual deductible: Plan pays 100% of most covered expenses</td>
</tr>
<tr>
<td></td>
<td>- 100% coverage for inpatient services</td>
<td>- 100% coverage for inpatient services</td>
</tr>
<tr>
<td></td>
<td>- $10 co-pay for primary care, pediatric primary care and outpatient mental health/substance use disorders visits</td>
<td>- $10 co-pay for primary care, pediatric primary care and outpatient mental health/substance use disorders visits</td>
</tr>
<tr>
<td></td>
<td>- $15 co-pay for specialist office visits</td>
<td>- $15 co-pay for specialist office visits</td>
</tr>
<tr>
<td></td>
<td>- No co-pay for routine physicals for adults and children</td>
<td>- No co-pay for routine physicals for adults and children</td>
</tr>
<tr>
<td></td>
<td>- No co-pay for Partners HealthCare On Demand telemedicine or other telemedicine services</td>
<td>- No co-pay for Partners HealthCare On Demand telemedicine or other telemedicine services</td>
</tr>
<tr>
<td><strong>Annual Medical Out-of-Pocket Maximum:</strong></td>
<td>$2,500 individual/$5,000 family.*</td>
<td>$2,500 individual/$5,000 family.*</td>
</tr>
</tbody>
</table>

| **Tier 2 (Non-Preferred):**   | - $4,000 annual deductible per individual, $8,000 per family | - $750 annual deductible per individual, $1,500 per family |
|                               | - 70% coverage for inpatient services after deductible and payment of $500 co-pay per admission | - 85% coverage for inpatient services after deductible and payment of $500 co-pay per admission |
|                               | - $70 co-pay for primary care physician** | - $45 co-pay for primary care and pediatric primary care visits |
|                               | - $10 co-pay for outpatient mental health/substance use disorders visits | - $10 co-pay for mental health/substance use disorders visits |
|                               | - $100 co-pay for specialist office visits*** | - $70 co-pay for specialist office visits*** |
|                               | - No co-pay for routine physicals for adults and children | - No co-pay for routine physicals for adults and children |
|                               | - No co-pay for Partners HealthCare On Demand telemedicine or other telemedicine services | - No co-pay for Partners HealthCare On Demand telemedicine or other telemedicine services |
| **Annual Medical Out-of-Pocket Maximum:** | $5,750 individual/$10,700 family.* | $4,000 individual/$8,000 family.* |

| Out-of-Network: | - $1,500 annual deductible per individual, $3,000 per family | - $1,500 annual deductible per individual, $3,000 per family |
|                | - 70% coverage for most services after deductible | - 70% coverage for most services after deductible |
|                | - Maximum annual employee out-of-pocket cost: $5,000 per individual, $10,000 per family* | - Maximum annual employee out-of-pocket cost: $5,000 per individual, $10,000 per family* |

* Excludes prescription drug co-pays. A separate Prescription Drug Out-of-Pocket Maximum applies, based your level of medical coverage (individual or family) and your salary as of January 1, 2019. See page 9 for details.

** Pediatric primary care office visits are covered at the Preferred level ($10 co-pay) for children 18 years of age and younger under Partners Select.

*** Co-pays for physical therapy, speech therapy, and occupational therapy in the Tier 2 (Non-Preferred) Network are $15 starting in 2019.
**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 $500.

**Deductible:** The amount you pay before a plan pays any benefits.

**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.

**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. A separate out-of-pocket maximum applies to your prescription drug plan, based on your annual salary and level of medical coverage (individual or family, for example).

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**Learn More About Your Medical Benefits on Ask myHR**

More information is available online, including:
- Rate sheets
- How to find a Partners network provider
- Preventative Care and Routine Care costs under the Patient Protection and Affordable Care Act, including covered services.
- Medical Opt-Out Credit
- Medical Coverage for Employees Living Out of Area
- The latest Health Care Reform Updates, including affordable coverage available under the Children’s Health Insurance Program (CHIP) and the Health Insurance Marketplace
- Your rights to appeal a denied claim
- Michelle’s Law
Prescription Drug Coverage

CVS/caremark provides prescription coverage for those enrolled in a MGH medical plan. You will receive one identification card to use for both your medical and prescription drug coverage.

Co-payments promote the use of medications that work just as well but cost less, where appropriate. The co-payment is based on whether the drug is designated generic, preferred, or non-preferred in the list of covered prescriptions, which is updated throughout the year.

<table>
<thead>
<tr>
<th>Filled at CVS/caremark Retail Pharmacy Network</th>
<th>Filled through Maintenance Choice (CVS Caremark Mail Service Pharmacy or CVS/pharmacy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 30 day supply</td>
<td>Up to 60 day supply</td>
</tr>
<tr>
<td>Up to 90 day supply</td>
<td>Up to 90 day supply</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$70</td>
</tr>
</tbody>
</table>

Your plan also includes a CVS ExtraCare Health Card, so you and your family can enjoy a discount on CVS Brand health-related products.

Retail Network for short-term medications

Fill short-term (30- or 60-day) prescriptions for medications such as antibiotics at a CVS/caremark network pharmacy. The network comprises more than 67,000 pharmacies nationwide, including chain pharmacies, independent pharmacies and CVS/pharmacy stores. Massachusetts General Hospital and Brigham and Women's Hospital pharmacies are also included in the network. To locate a participating pharmacy, visit www.caremark.com or download the CVS/caremark app at: www.caremark.com/mymobile.

Maintenance Choice® for long-term medications

Maintenance Choice® lets you choose how to get 90-day supplies of your maintenance medications: through the CVS Caremark Mail Service Pharmacy or at a CVS/pharmacy store (including CVS/pharmacy locations at Target retail stores). With Maintenance Choice, all long-term maintenance medications you take for chronic conditions need to be filled as 90-day supplies. This saves you one co-pay for each 90-day refill. View a list of Maintenance Choice medications at: http://www.caremark.com/portal/asset/CVS_Caremark_Maint_DrugList.pdf

Prescription Drug Out-of-Pocket Maximum

Your prescription drug plan includes an out-of-pocket maximum that limits how much you have to pay in prescription drug co-pay expenses during the calendar year. Your out-of-pocket maximum depends on your level of medical coverage (for example, individual or family) and your salary as of January 1, 2019:

<table>
<thead>
<tr>
<th>Salary Level</th>
<th>Out-of-Pocket Maximum Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Prescription Drug Out-of-Pocket Maximum</td>
<td></td>
</tr>
<tr>
<td>Under $50,000</td>
<td>$250 individual coverage/$500 for all other levels</td>
</tr>
<tr>
<td>$50,000 to $100,000</td>
<td>$800 individual coverage/$1,600 for all other levels</td>
</tr>
<tr>
<td>Above $100,000</td>
<td>$1,600 individual coverage/$4,000 for all other levels</td>
</tr>
</tbody>
</table>
Dental Coverage

Your Dental Plan options:
- Basic Dental
- Major Dental

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

<table>
<thead>
<tr>
<th>Coverage Levels</th>
<th>You have the option of choosing dental coverage in the following categories:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
</tr>
</tbody>
</table>

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 rate sheet to find the prices.

To make the right decision, ask yourself these questions:
- Do you or your family require only routine checkups and cleanings? If so, Basic Dental coverage may 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.

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 Ask myHR 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.

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.

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. Your share of the costs for dental care are less if your dentist participates in the Delta Dental PPO network.

Download the Delta Dental app, search for a dentist online, manage your dental claims, check coverage, and much more right from your mobile device. The app even has a built-in toothbrush timer!
Vision Coverage

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

### Coverage Levels

<table>
<thead>
<tr>
<th>You have the option of choosing vision 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 Child(ren)</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

### 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-pay
- 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 or visit [www.davisvision.com](http://www.davisvision.com), click “Member” and enter client code 7360 in the box.

If you choose to go outside of the Davis Vision network for services other than laser vision correction surgery, 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 and a MGH employee or covered dependent.
- Provide the office with your Davis Vision ID card when you show up for your appointment.

You can use your insurance benefits to buy eyewear or contact lenses online exclusively at [visionworks.com](http://visionworks.com). Look up your benefits, and see the savings on over 2,000 frames as you shop. When you find the eyewear or contact lenses you want, enter a valid prescription to complete your order.

1. At [visionworks.com](http://visionworks.com), click on the Insurance menu to get started.

2. In “Member Lookup,” enter the policyholder's employee ID, which you can find on the employee’s paycheck, and the name and birth date of the person who is shopping.

3. Verify your vision benefits in “Current Benefits”. This will show your current coverage and eligibility.

4. Once you're ready to shop, click on “Start Shopping” to browse frames, lenses and contacts that suit your style and prescription.

At checkout, your vision benefit will be applied to your eyewear purchase.

Download the Davis Vision app, available from the mobile app stores for iOS and Android. You can use the app to easily locate an in-network vision provider, check the status of a claim, or contact Davis Vision.
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-pay</td>
<td>Covered up to $16</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses</td>
<td><strong>One pair of eyeglasses</strong>&lt;br&gt;<strong>Eyeglass frames</strong> from Davis Designer selection&lt;br&gt;<strong>OR</strong> a $45 wholesale credit towards the purchase of non-Davis frames&lt;br&gt;<strong>Vision lenses:</strong>&lt;br&gt;  – Single lenses&lt;br&gt;  – Bifocal lenses&lt;br&gt;  – Trifocal lenses&lt;br&gt;<strong>OR</strong>&lt;br&gt;<strong>Contact lenses</strong> after you pay $25-$45 for 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.*&lt;br&gt;<strong>Laser Vision Correction Surgery:</strong> You will be eligible for $500 per eye. This benefit is available from any 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.&lt;br&gt;<strong>Optional Feature:</strong> These optional features are available:&lt;br&gt;  <strong>$10 copay each</strong>&lt;br&gt;  – Premier frames from “The Collection”&lt;br&gt;  – Polycarbonate lenses&lt;br&gt;  – Anti-reflective coating (ARC) Standard ARC&lt;br&gt;  – Progressive multifocal lenses&lt;br&gt;  – $30 for intermediate vision lenses&lt;br&gt;  – $20 for scratch-resistant coating&lt;br&gt;  – $75 for polarized lenses&lt;br&gt;  – $30 for plastic photosensitive lenses&lt;br&gt;  – $30 for high-index (thinner and lighter lenses)&lt;br&gt;  – $60 for Anti-Reflective Coating (ARC) Ultra ARC</td>
<td><strong>Reimbursement levels:</strong>&lt;br&gt;  Frames $14&lt;br&gt;  <strong>One pair of lenses:</strong>&lt;br&gt;  Single lenses $14&lt;br&gt;  Bifocal lenses $23&lt;br&gt;  Trifocal lenses $32&lt;br&gt;  One pair of contact lenses $45</td>
</tr>
</tbody>
</table>

| Coverage Frequency       | Once every 12 months                                                               | Once every 12 months                         |

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

**MGH offers a LTD option:**
- Long-term disability (LTD) plan

**Coverage Levels**
- Employee

**Determining Your Needs for Long-Term Disability Coverage**
Everybody needs income protection in the event they are seriously disabled and not able to work for a long period of time. MGH provides long-term disability insurance to MGH Fellows at no cost.

**Highlights of Coverage**
- After being disabled for 90 days, you’ll receive 60% of your pay reduced by any Social Security or Workers’ Compensation benefits you or your family are eligible to receive.
- You will need to apply for LTD benefits if you become disabled and you must be under the continuing care of a physician to remain eligible for benefits.
- 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).
- The maximum monthly benefit available from the plan is $10,000.
- Fellows receive LTD coverage as part of their benefits program. As a result, monthly LTD income is taxable.

Refer to the separate Long-Term Disability summary plan description for more details. The plan description is available on Ask myHR.
Life and AD&D Insurance

Coverage Levels

<table>
<thead>
<tr>
<th>Basic life and accidental death &amp; dismemberment (AD&amp;D) insurance</th>
<th>Optional life and AD&amp;D insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Employee, Spouse, Dependent Child(ren)</td>
</tr>
</tbody>
</table>

Highlights of Coverage

MGH provides you basic life and AD&D insurance:

- Basic employee life insurance and AD&D insurance equal to 1 times your annual base salary (up to $500,000 in each program)
- Basic life insurance amounts in excess of $50,000 are subject to imputed (taxable) income according to IRS rules. If you don’t need that much coverage and wish to avoid paying imputed income tax, you can elect basic life coverage equal to just $50,000.

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%.

Your supplemental life insurance does not decrease with age.

Will you be traveling soon? Your new, employer-paid travel assistance coverage through MetLife offers a downloadable app you can use for assistance with medical or other needs while you’re away from home for personal or business travel — including overseas teleconsultation and emergency services. See Ask myHR for details.
In addition, MGH also offers:

**Employee Coverage**

- Optional group term life insurance and AD&D insurance:
  
  You may elect up to 8 times your base annual salary, to a limit of $2 million in each program. Newly-eligible employees can elect up to 4 times their base salary (up to $800,000) in supplemental life and/or AD&D coverage, without providing proof of good health. Proof of good health is never required for AD&D coverage.
  
  During Open Enrollment or within 30 days of a Qualified Change of Status event, you may elect to increase your life and/or AD&D insurance coverage by 1 times your annual base salary. If you elect more than 1 times your annual base salary, or more than $800,000 of coverage, you must provide proof of good health for life insurance.

**Spouse Coverage**

- You may enroll your spouse in supplemental life and/or AD&D coverage of $10,000, $25,000, or any $25,000 increment up to $200,000.

- No proof of good health required for life insurance if enrolled within 30 days of initial eligibility or marriage, except for coverage over $50,000. Otherwise, evidence of insurability will be required for life insurance.

- Eligibility for Spouse Life ends if you become divorced. You must contact the HR Support Center to discontinue premium deductions from your pay.

**Dependent child(ren) Coverage***

- You may enroll your child(ren) under age 26 in supplemental life and/or AD&D coverage of $5,000, $10,000, $15,000 or $20,000.

- No proof of good health required

- Dependent child(ren) are covered from birth until the last day of the month in which they turn age 26, including your spouse’s dependent children.

**Business Travel Accident Insurance**

- Most MGH employees are insured for 5 times base pay up to $2 million if accidental death or dismemberment occurs while traveling on Hospital business

- MGH pays the full cost of this coverage

* See “Dependent Eligibility” on Page 3.

---

**Value-Added Services**

Your Supplemental MetLife coverage also includes these core services, included at no cost:

- Will Preparation/Estate Resolution Services
- Funeral Planning/Discounts
- Retirement Planning
Flexible Spending Accounts

MGH offers these two plans:

<table>
<thead>
<tr>
<th>Health Care Account</th>
<th>Dependent Care Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defer up to $2,650 (pre-tax) in 2018*</td>
<td>Defer up to $5,000 (pre-tax) in 2018*</td>
</tr>
<tr>
<td>For your or your dependents’ eligible medical, dental, and vision expenses not paid for by your health plan.</td>
<td>Eligible Dependent Care</td>
</tr>
<tr>
<td></td>
<td>Daycare for children up to age 13</td>
</tr>
<tr>
<td></td>
<td>Disabled Dependents</td>
</tr>
<tr>
<td></td>
<td>Adult Dependents</td>
</tr>
</tbody>
</table>

Highlights of the Plan

Submitting Your Claims

Benefit Strategies is the administrator for your Flexible Spending Account (FSA) claims. If you enroll in a FSA for 2019, you will submit claims to Benefits Strategies using a debit card, mobile app, online system or paper claim form. See Ask myHR for more information.

Internal Revenue Service Rules: Use It or Lose It

Be sure to estimate your health care and/or dependent care expenses carefully. Under IRS rules, you must forfeit any unused account balance(s) remaining in your account. Generally, you cannot change or stop contributing during the year unless you have a qualified change of status. You have until March 15 of the following year to incur expenses for reimbursement, and up to March 31 of the following year to submit your expenses for reimbursement; otherwise, you will forfeit your balance.

Flexible spending accounts are subject to yearly non-discrimination testing under federal regulations. Annual limits may be adjusted based on results of testing.

Determining Your Needs for the Health Care Flexible Spending Account

Review what you have spent on medical expenses for the last two years. Consider how participation in a health benefit plan may affect the amount you contribute. Remember! With the range of medical, dental, and vision plans available through MGH, some expenses may be partially or fully covered by your insurance provider. 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.

Examples of Eligible Health Care Expenses:

- **Health Care** – deductibles, co-pays, 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, contact lens solution

See a comprehensive list of eligible and ineligible expenses at: [https://www.benstrat.com/downloads/FSA_EXTENDED_Eligible_Expenses.pdf](https://www.benstrat.com/downloads/FSA_EXTENDED_Eligible_Expenses.pdf)

* Limits and eligible items are subject to change. See Ask myHR for 2019 contribution limits.
**Determining Your Needs for the Dependent Care 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 contribute up to $5,000 tax-free in a Dependent Care FSA in 2018* ($2,500 if married and filing separately).

**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 tuition at the kindergarten level or above
- Expenses for overnight camps

**NOTE:** Final determination on eligible expenses rests with the Internal Revenue Service. For more information, download IRS Publication 503 “Child and Dependent Care Expenses” from the IRS website: [www.irs.gov](http://www.irs.gov)

* Limits and eligible items are subject to change. See [Ask myHR](https://benstrat.com/downloads/DCA_Income_Tax_Credit_Comparison.pdf) for 2019 contribution limits.

**Dependent Care Flexible Spending Account**

Before you decide how much to contribute to your Dependent Care Account, consider:

- Holidays and vacations during which your dependent care needs might change;
- Whether one of your dependents will begin school during the year and need less dependent care; and
- Whether any of your dependents will become ineligible during the year (for example, by reaching age 13).

The federal government strictly limits the amount of expenses for which you may be reimbursed under a Dependent Care FSA. While reimbursements from your account are generally tax-free to you, federal law states that the amount excluded from your gross income cannot exceed the least of:

- $5,000 annually if single or if married, filing jointly ($2,500 if you are married and filing separate federal income tax returns); or
- Your annual income (if married, the annual earned income of the lesser earning spouse).

If your spouse is a full-time student for at least five months during the year or is physically and/or mentally handicapped, there is a special rule to determine his or her annual income: the amount is the greater of his/her actual earned income or the assumed monthly income amounts of either $250 or $500.

**Tax Credit or Dependent Care Flexible Spending Account?**

You cannot participate in the Dependent Care Account and utilize the Dependent Care tax credit for the same year. Before enrolling in the Dependent Care Account, evaluate whether the tax credit you can take on your federal income tax 1040 form will save you more money than the Dependent Care Account.

An information sheet is available for assistance in determining which approach is best for you: [https://benstrat.com/downloads/DCA_Income_Tax_Credit_Comparison.pdf](https://benstrat.com/downloads/DCA_Income_Tax_Credit_Comparison.pdf)
The 403(b) Tax-Sheltered Annuity (TSA) Plan offers a tax-deferred savings opportunity for your retirement. If you participate, contributions are deducted automatically from each paycheck and invested in funds offered through our retirement administrators, Fidelity and TIAA. As of 2018, the maximum amount that you contribute to a Tax-Sheltered Annuity is $18,500. Employees age 50 or older can contribute up to $24,500. Different maximum contributions may apply for 2019. See Ask myHR for the 2019 contribution limits.

Your Savings

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

Starting, changing, or stopping TSA contributions

- TSA changes are allowed throughout the year.*

If you are newly benefits-eligible:

- In Ask myHR, click myBenefits at the top of the screen. You will be redirected to PeopleSoft Self Service.
- Enter your username and password at the log in screen.
- Click Benefits Enrollment. On the Enrollment Summary page, scroll through your benefit plan options until you see your TSA options. Click on the Edit button to make a change. You may choose a flat amount or a percent.
- Click Continue, review your election and click on Continue again. You may also elect/change the Roth TSA at this time.
- Make any needed changes to your other employee benefits. When finished, scroll to the bottom of the page. You will be asked to click Submit twice and then OK.

To change your TSA contribution after 30 days of benefits eligibility

- In Ask myHR, click myBenefits. Log in to PeopleSoft Self Service, then click Retirement Contributions. Click the TSA account (traditional or Roth) for which you want to edit your contribution amount, then click Save.

* Employees cannot be reimbursed for contributions already deducted from paycheck(s).

MGH offers two types of TSA contributions:

1. **Traditional (pre-tax) contributions**: are deducted from each paycheck before taxes are deducted — so you reduce the 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.

2. **Roth contributions**: are deducted from the after-tax dollars in your paycheck. Because you pay income taxes now, your monthly take-home pay will be less than with traditional contributions. However, you will pay no taxes later when you receive qualified distributions from your retirements savings plan.

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

MGH 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 Easy Choice, Guided Choice, or Open Choice funds:

Log in to your account at [http://www.netbenefits.com/partners](http://www.netbenefits.com/partners). Click “Profile” at the top of the screen, then click “Beneficiaries” and follow the instructions.

To name beneficiaries for your TIAA Annuity Choice funds: Visit [https://www.tiaa.org](https://www.tiaa.org).
### 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 option 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 option or across multiple options and change them anytime during the year in order to meet all of your goals. The options are:

<table>
<thead>
<tr>
<th>Option</th>
<th>Available Investment Options</th>
<th>May be right for you if...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One:</strong></td>
<td><strong>Easy Choice</strong>&lt;br&gt;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><strong>Two:</strong></td>
<td><strong>Guided Choice</strong>&lt;br&gt;Several 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><strong>Three:</strong></td>
<td><strong>Open Choice</strong>&lt;br&gt;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 Options 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><strong>Four:</strong></td>
<td><strong>Annuity Choice</strong>&lt;br&gt;Three TIAA annuities: TIAA Traditional Annuity, CREF Stock Account Variable Annuity and TIAA Real Estate Account Variable Annuity</td>
<td>You want to invest in a vehicle that will provide the assurance of a lifetime income upon retirement. 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.</td>
</tr>
</tbody>
</table>

**For questions about the lineup, please contact:**

**Fidelity**<br>1-855-999-1PHS (1747)<br>[http://netbenefits.com/partners](http://netbenefits.com/partners)

**TIAA (annuities only)**<br>1-800-842-2776<br>[https://www.tiaa.org](https://www.tiaa.org)
Eligibility

Each physician covered by CRICO must participate through the sponsorship of a Founding Member institution and meet JCAHO and State credentialing regulations.

_Fellows:_ must have at least a limited MA medical license

Any **CLINICAL FELLOW** who is employed by a Member Institution or its subsidiary; or is enrolled in a program of approved medical instruction by a Member Institution or its subsidiary.

The CRICO Medical Professional Liability policy provides limited **claims-made coverage with tail for all professional services of a medical nature.**

- The current limits of liability for physicians are $5,000,000 per claim/$10,000,000 annual aggregate.

**Note:** Per the Board of Registration of Medicine, any Fellow moonlighting is required to have a full license.

When is an application required?

- All new **CLINICAL FELLOWS**
- Any existing physicians changing their specialty classification
- Any existing physicians changing their sponsoring institutions and/or primary employer
- Any existing physicians changing their status (e.g. Resident to Fellow, Fellow to Staff)

**Note:** Name changes do **NOT** require a new application. Please submit a written request along with a copy of the marriage certificate or court order outlining the name change.

For more information about CRICO or to print your verification of coverage (facesheet), log on to [www.rmf.harvard.edu/my-c rico](http://www.rmf.harvard.edu/my-crico) or contact the MGH CRICO Malpractice Coordinator, Provy Diaz, at 617-724-9925, **pdiaz1@partners.org.**
Tuition Assistance

We encourage Fellows to take advantage of educational and training opportunities to increase their knowledge and skill in their present jobs, or prepare them for a position within another area of the hospital. MGH tuition assistance benefits are based on the following schedule:

<table>
<thead>
<tr>
<th>Completed Service</th>
<th>Hours Worked Per Week</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months of continuous service</td>
<td>36-40 hours</td>
<td>$2,000</td>
</tr>
<tr>
<td></td>
<td>20-35 hours</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

A $750 maximum reimbursement applies to certificates.

Fellows who are regularly scheduled to work at least 20 standard hours per week are eligible to apply for this benefit.

- To submit a Tuition Assistance request, go to PeopleSoft, click the myBenefits tile, then click Request Tuition Assistance.
- First-time applicants are required to submit a letter of acceptance or certificate enrollment at time of request.
- Requests must be approved by your manager and the tuition administrator prior to the start of class.
- Once you have completed your pre-approved request, submit a copy of your grade report, along with a receipt for tuition and laboratory fees you have paid, to the Training Department. You must earn a passing grade to receive reimbursement.
- You will be reimbursed according to the established limits for the cost of tuition and lab fees. Expenses for books, activity, registration, or other non-academic fees are not covered.

Tuition assistance payments are not taxable income under current law.

Employees with questions about Tuition Assistance should visit Ask myHR.