Inside this Guide

- Choosing and Updating Your Benefits 1
- Vision Coverage 11
- Eligibility for Benefits Plans 3
- Disability Coverage 13
- Highlights 4
- Life and AD&D Insurance 14
- Medical Coverage 6
- Flexible Spending Accounts 16
- Prescription Drug Coverage 9
- Tax-Sheltered Annuity Contributions 18
- Dental Coverage 10
- Malpractice and CRICO Coverage 20

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, calling 1-833-AskMyHR (1-833-275-6947) or contacting your Benefits Consultant in the Professional Staff Benefits Office:

For MGH Residents
MGH/MGPO Professional Staff Benefits Office, Bulfinch 126, main campus (office phone number: 617-643-3071):
If your last name begins with A-L, call Susan Frain at 617-726-9264 or email sfrain@partners.org
If your last name begins with M-Z, call Virginia Rosales, CEBS at 617-724-9356 or email vrosales@partners.org

For BWH Residents call 857-307-7077 or email: bwhprofstaffbene@partners.org
Choosing and Updating Your Benefits

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

Each year, Partners 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.

3. On the Benefits Enrollment page click Select. An enrollment screen showing your benefits choices will appear. 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](http://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](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

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 $10,000 annually ($833.33 per month).

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 my HR 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 or your Benefits Consultant before their 26th birthday for details.

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
- Legal Guardianship paperwork that names the employee or the employee’s spouse as the Legal Guardian
Highlights

Partners Benefits for Residents is designed to allow you to meet the needs of you and your family.

Your Core Benefits

Partners provides you with basic group term life insurance and accidental death & dismemberment (AD&D) insurance at no cost to you. The insurance is equal to one times your annual salary (up to $500,000 in each program).

In addition to the core benefits, you can choose from a variety of other benefits:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can choose from two medical plans</td>
<td>to protect yourself and your family in the event of illness or injury.</td>
</tr>
<tr>
<td>Long-term disability insurance, with features for Residents.</td>
<td></td>
</tr>
<tr>
<td>A prescription drug benefit managed by CVS/caremark</td>
<td>offers a convenient mail service program</td>
</tr>
<tr>
<td>Optional group term life insurance options, including spouse and</td>
<td>dependent child(ren) coverage</td>
</tr>
<tr>
<td>Two dental plans providing different coverage choices</td>
<td></td>
</tr>
<tr>
<td>Optional accidental death &amp; dismemberment (AD&amp;D) insurance</td>
<td>to protect you, your spouse and dependent child(ren)</td>
</tr>
<tr>
<td>A vision care plan offering a cost-effective way</td>
<td>for you to get an annual comprehensive eye exam and corrective lenses</td>
</tr>
<tr>
<td>Health Care and Dependent Care Flexible Spending Accounts, to save you</td>
<td>to save tax dollars and reduce your out-of-pocket costs for health and</td>
</tr>
<tr>
<td>Four levels of coverage for medical, dental, and vision care, so that</td>
<td>dependent care expenses</td>
</tr>
<tr>
<td>A 403(b) Tax-Sheltered Annuity Plan offers you a tax-smart way to save</td>
<td>for the future.</td>
</tr>
<tr>
<td>Malpractice Insurance provides best-quality professional and general</td>
<td>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 special opportunities available to Partners Residents. See details on Ask myHR.
Determining Your Choice Pay Amount

The amount of your Choice Pay appears on your rate sheet.

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

<table>
<thead>
<tr>
<th>Medical and/or Dental Participation Choice Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td>Employee</td>
</tr>
</tbody>
</table>

Opt-Out Choice Pay

If you have medical coverage elsewhere, you may be eligible to receive an additional amount that you can use to help offset the cost of your benefits or take as additional taxable pay. 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.

Note: Actual Choice Pay amounts appear on your rate sheet.

If You Have Extra Choice Pay

If you have extra Choice Pay that you do not use for benefits, you will receive 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 the cost of the benefits that you choose is greater than your Choice Pay, 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.
Medical Coverage

Coverage Levels

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

Partners 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

Partners 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>
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<tbody>
<tr>
<td><strong>Partners Select</strong></td>
<td><strong>Partners Plus</strong></td>
</tr>
<tr>
<td><strong>Tier 1 (Preferred):</strong></td>
<td><strong>Tier 1 (Preferred):</strong></td>
</tr>
<tr>
<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>- 100% coverage for inpatient services</td>
<td>- 100% coverage for inpatient services</td>
</tr>
<tr>
<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>- $15 co-pay for specialist office visits</td>
<td>- $15 co-pay for specialist office visits</td>
</tr>
<tr>
<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>- 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><strong>Annual Medical Out-of-Pocket Maximum:</strong></td>
</tr>
<tr>
<td>$2,500 individual/$5,000 family.*</td>
<td>$2,500 individual/$5,000 family.*</td>
</tr>
</tbody>
</table>

| **Tier 2 (Non-Preferred):** | **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:** | **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 |  |
| - 70% coverage for most services after deductible |  |
| - 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.
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 $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 Partners 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></td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td></td>
<td>$20</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40</td>
</tr>
<tr>
<td></td>
<td>$80</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$70</td>
</tr>
<tr>
<td></td>
<td>$140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Salary Level</th>
<th>Out-of-Pocket Maximum Levels</th>
</tr>
</thead>
<tbody>
<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>

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 copay 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:
Dental Coverage

Your Dental Plan options:
- Basic Dental
- Major Dental

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

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.

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](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.

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.

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

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

<table>
<thead>
<tr>
<th>Employee</th>
<th>Employee and Spouse</th>
<th>Employee and Child(ren)</th>
<th>Family</th>
</tr>
</thead>
</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, 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 Partners 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. 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, 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.
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>One pair of eyeglasses</td>
<td>Reimbursement levels:</td>
</tr>
<tr>
<td></td>
<td><strong>Eyeglass frames</strong> from Davis Designer selection</td>
<td>Frames</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> a $45 wholesale credit towards the purchase of</td>
<td>$14</td>
</tr>
<tr>
<td></td>
<td>non-Davis frames</td>
<td>One pair of lenses</td>
</tr>
<tr>
<td></td>
<td><strong>Vision lenses:</strong></td>
<td>Single lenses $14</td>
</tr>
<tr>
<td></td>
<td>– Single lenses</td>
<td>Bifocal lenses $23</td>
</tr>
<tr>
<td></td>
<td>– Bifocal lenses</td>
<td>Trifocal lenses $32</td>
</tr>
<tr>
<td></td>
<td>– Trifocal lenses</td>
<td>One pair of contact lenses $45</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong></td>
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<td></td>
<td><strong>Contact lenses</strong> after you pay $25-$45 for standard,</td>
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<td></td>
<td>soft, daily-wear, disposable or plan replacement contact</td>
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<tr>
<td></td>
<td>lenses. If your provider feels plan-supplied contact</td>
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<td>lenses are not suitable for you, a $125 credit will be</td>
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<td></td>
<td>applied toward the cost of contact lenses.*</td>
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<tr>
<td></td>
<td><strong>Laser Vision Correction Surgery:</strong> You will be eligible</td>
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<tr>
<td></td>
<td>for $500 per eye. This benefit is available from any</td>
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<td>provider; however, if you use a Davis Vision participating</td>
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<tr>
<td></td>
<td>provider, you will get a discount and your $500 will go</td>
<td></td>
</tr>
<tr>
<td></td>
<td>further. A $1,000 lifetime maximum benefit applies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Optional Feature:</strong> These optional features are</td>
<td></td>
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<tr>
<td></td>
<td>available:</td>
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<tr>
<td></td>
<td><strong>$10 copay each</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Premier frames from “The Collection”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Polycarbonate lenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Anti-reflective coating (ARC) Standard ARC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Progressive multifocal lenses</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>
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<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>
<tr>
<td>Coverage Frequency</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>

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

**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 Only

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 a LTD insurance plan 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 PeopleSoft myBenefits, 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 (up to $8,000 maximum) every 12 months that you remain disabled, if applicable, subject to carrier approval.

- LTD 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 LTD benefit is adjusted to reflect 60% of the first year earnings for your specialty (up to $8,000 maximum).

- 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.
Life and AD&D Insurance

Employee Coverage

Partners provides you with basic employee life insurance and accidental death & dismemberment (AD&D) insurance of 1 times your annual base salary (up to $500,000 in each program) at no cost to you.

- Basic life insurance amounts in excess of $50,000 are subject to imputed 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.

- In addition, you can purchase optional group term life insurance and AD&D insurance:
  
  You may elect up to 8 times your annual salary, to a limit of $2 million in each program. Newly-eligible employees can elect up to 4 times base salary (up to $800,000) in supplemental life and/or AD&D coverage, without providing proof of good health for life insurance. 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 are electing more than 1 times your annual salary, or more than $800,000 of coverage, you will be required to 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 is required for life insurance if your spouse is 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.

- You may elect spouse coverage without electing optional life coverage for yourself.

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.
**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 is required.
- Dependent child(ren) are covered for life insurance from birth until the last day of the month in which they turn age 26.
- You may elect dependent child(ren) coverage without electing optional life coverage for yourself.
- The cost for coverage is not affected by the number of dependent children you have.

**Business Travel Accident Insurance**
- Most Partners employees are insured for 5 times base pay up to $2 million 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.

**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

Partners 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 nondiscrimination testing under federal regulations. Annual limits may be adjusted based on results of testing.

* Limits and eligible items are subject to change. See Ask myHR for 2019 contribution limits.

**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 Partners, 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)
Benefits for Residents | Flexible Spending Accounts

**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

<table>
<thead>
<tr>
<th>Partners offers two types of TSA contributions:</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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 retirement savings plan.</td>
</tr>
</tbody>
</table>

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.

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 Tier 1, 2, or 3 funds: Log in to your account at 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 Tier 4 TIAA Annuity Choice funds: Visit 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 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: 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: Two: Guided Choice</td>
<td>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>Three: 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: Four: Annuity Tier</td>
<td>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
1-855-999-1PHS (1747)
http://netbenefits.com/partners

TIAA (annuities only)
1-800-842-2776
https://www.tiaa.org
CRICO/Malpractice Insurance Coverage for Residents

House Officers, Residents and Interns (including Dental Residents)

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

Residents: must have at least a limited MA medical license

Any Residents or Interns (including Dental Residents) who are employed by a Member Institution or its subsidiary; or who are enrolled in a program of approved medical instruction by a Member Institution or its subsidiary; are eligible.

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 Resident moonlighting is required to have a full license.

When is an application required?
- All new Residents (Interns, including Dental Residents)
- 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-crico or contact the MGH CRICO Malpractice Coordinator, Providencia (Provy) Diaz at 617-724-9925 or by e-mail at pdiaz1@partners.org.
Important Note

The information contained in this Guide is only a summary of the benefit programs available under Total Choice. In the event of any discrepancy between this summary and the actual plan documents, the plan documents will always govern. Plan documents are available upon request from the HR Support Center.