

ADMINISTRATIVE INFORMATION

ADMINISTRATION

The plans are administered by the Plan Administrator. For Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment and Long Term Care, benefits are provided according to the provisions of the insurance policies issued to the Plan Sponsor. Certain administrative functions (including claims administration) are performed on behalf of the Plan Administrator according to administrative vendor contracts.

The HPHC POS and PPO medical plans, as well as Delta Dental, are self-funded health plans, with respect to which HMFP/ APHMFP/CAPHMFP has purchased stop loss insurance to minimize exposure to significant losses. The re-insurer is Humana.

PLAN YEAR

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

FUTURE OF THE PLAN

While the Plan Sponsor intends to continue the Plans indefinitely, it is difficult to predict the future. The Plan Sponsor reserves the right to terminate these Plans, or amend or eliminate benefits under these Plans at any time for any reason. Any amendment, however, may not deprive you of any benefits to which you are entitled at the time.

NO GUARANTEE OF EMPLOYMENT

These plans are not employment contracts. Nothing contained in this summary, the plan documents or the insurance contracts gives you the right to continue employment or interferes with the Plan Sponsor's right to discharge you or to terminate your service at any time.

ADDITIONAL INFORMATION

For additional information about these Plans, you should refer to the official plan documents and the full insurance contracts. Copies are available from the Plan Administrator upon request. If the terms of this summary conflicts with the Plan documents, the plan documents shall govern.

SOURCES OF PLAN CONTRIBUTIONS

Contributions for coverage may be made only by the Plan Sponsor or by participating employees. Some of the overages require joint contributions from participating employees and the Plan Sponsor. Contributions made by the Plan Sponsor include Benefit Dollars (i.e., departmental contributions to cover the costs of certain benefit dollars). Departments have the authority to allocate department expenses to individual Profit and Loss Statements. From time to time, this may include benefits.

PRIVACY OF HEALTH INFORMATION

A Federal Law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that health plans (e.g., medical, dental and medical reimbursement plans) protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in Plan's Privacy Notice, which is provided to you along with this benefits summary booklet and is also available from Human Resources.

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

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy your information, receive an accounting of certain disclosures of your information, have your information sent to an alternative location or by alternative means, and under certain circumstances, amend your information. You also have the right to file a complaint with the health plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

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The plan maintains a Privacy Notice, provided together with this benefits summary booklet that provides a complete description of your rights under HIPAA's privacy rules. For another copy of the Privacy Notice, questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact Human Resources at 617-632-8694, option 4. A copy of the Privacy Notice for the dental plan is available through Delta Dental.

Notice of Privacy Practices

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

The HPHC POS and PPO medical plans, and the Medical Reimbursement Plan (collectively referred to in this section as the "Health Plans") use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the Health Plan.

How Your Health Information May be Used or Disclosed

For Treatment. The Health Plans may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician nurse, or other person providing health services to you, will be recorded as it relates to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. The Health Plans may use and disclose your health information to others in order to pay for services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in course of treatment.

For Health Care Operations. The Health Plans may use and disclose health information about you for operational procedures. For example, your health information may be disclosed to members of Human Resources to:

- Evaluate the performance of the health plans
- Assess the quality of care and outcomes in your case and similar cases
- Learn how to improve services and
- Determine how to improve the quality of effectiveness of the provided health care.

Required by Law. The Health Plans may use and disclose information about you as required by law. For example, the health plans may disclose information for the following purposes:

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

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

Decedents – Your health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donations – Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research – The Health Plan may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

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

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

Workers' Compensation – Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation.

Your Health Information Rights – You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, the Health Plans are not required to agree to a requested restriction
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Amend your health record; however, the Health Plans are not required to agree to the amendment
- Request communications of your health information be sent by alternative means or to alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken and
- Receive an accounting of disclosures made of your health information.

Disclosure to You, a Family Member or Other Caregiver

Disclosures to you by telephone or email - In order to ensure that your privacy rights are protected, the Health Plans will require you to verify your identity by providing your Social Security Number and your date of birth before any disclosure to you of your protected health information over the telephone or via email.

Disclosure to relatives and caregivers - Upon your written authorization, only the health Plans may disclose your protected health information to a family member, other relative, or a caregiver identified by you. Only information that is believed to be directly relevant to the person's involvement with your health care or payment related to your health care will be disclosed to such person. Your protected health information may also be disclosed in order to notify such a person of your location, general condition or death. An authorized individual must verify his or her identity by Social Security Number and date of birth before any disclosure is made.

Disclosure to a parent or legal guardian - The protected health information of a child under the age of 19 will be disclosed to a parent or legal guardian upon such individual's request unless such child specifically requests that his or her information not be disclosed, either in general or in a specific instance. A parent or legal guardian must verify his or her identity by providing the child's Social Security Number and date of birth before any disclosure is made.

Complaints - You may make a formal complaint to the Director, HR Operations, c/o Human Resources, HMFP/APHMFP/CAPHMFP at Beth Israel Deaconess Medical Center, Inc., MASCO Building, 375 Longwood Avenue, 3rd Floor, Boston, MA 02215, 617-632-8694, option 4, and/or to the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of the Health Plans

The health plans are required to:

- Maintain the privacy of protected health information
- Provide you with this notice of its legal duties and privacy practices with respect to your health information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed

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- Accommodate reasonable requests you may make to communicate health information by alternative means or to alternative locations and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

The health plans reserve the right to change their information practices and to make the new provisions effective for all protected health information they maintain. Revised notices will be made available to you by email and in hard copy within 60 days of any change.

Contact Information

If you have questions or complaints, please contact HR Operations, HMFP/APHMFP/CAPHMFP at Beth Israel Deaconess Medical Center, Inc., MASCO Building, 375 Longwood Avenue, 3rd Floor, Boston, MA 02215 or 617-632-8694, option 4.

YOUR ERISA RIGHTS

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operations of the plan, including insurance and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this plan description and the documents governing the health plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have "creditable coverage" from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage ceases (if you request it before losing coverage), or if you request it up to 24 months after losing coverage. Without losing evidence of creditable coverage, you may be subject to preexisting condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage under the plan.

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

If your claim for a benefit under a plan is denied, in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such cases, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the plan's fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about a plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory (One Bowdoin Square, 7th floor, Boston, MA, telephone 617-424-4950) or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

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

AMENDMENT OF TERMINATION OF PLAN

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

FILING A CLAIM FOR BENEFITS – HEALTH PLANS

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

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

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