HARVARD
Human Resources

SUMMARY PLAN DESCRIPTION

Health and Welfare Plans

Effective January 1, 2017

This guide presents basic information about all the health and welfare benefits provided by Harvard University ("Harvard") under the Harvard University Flexible Benefits Plan (the "Plan"), as of January 2017, and your rights to benefits as a Plan participant. The Plan is maintained for you and your eligible dependents, as long as you meet the eligibility requirements

This is the Summary Plan Description (SPD) for your benefits under the Plan. This SPD and any separate Plan documents provided to you by Harvard or any of Harvard's insurance carriers and vendors are intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). Please refer to the applicable separate Plan documents for complete details on specific items such as benefits coverage, deductibles, copayments, definitions, coordination of benefits, waiting periods, exclusions, and limitations.

The SPD is based on a number of legal documents that may include policies, contracts, collective bargaining agreements, Plan documents, and trust agreements. Although the SPD is intended to be accurate, any differences between it and the legal documents will be governed by the legal documents.

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1. HOW DOES THE PLAN WORK?

Harvard provides a full range of benefits aimed at promoting your health and welfare.

1.1 Overview of Benefits

Some benefits are automatically provided to you, and others you must actively choose. Benefits are an important part of your total compensation package. Harvard provides generous subsidies for most benefits. Available benefits include:

- Medical and Prescription Drug
- Dental
- Vision Care
- Long Term Disability (LTD)
- Basic Life Insurance
- Contributory (Supplemental) Life Insurance
- Health Flexible Spending Account (FSA)
- Dependent Care FSA
- Limited Purpose FSA
- Health Savings Account (HSA) (if eligible)
- Harvard Global Plan (if eligible)
- Reimbursement Program
- Copayment Reimbursement Program
- Retiree Benefits

1.2 Paying for Benefits

As allowed by the Internal Revenue Service (IRS), your share of the costs for medical, dental, and vision care as well as contributions to FSAs or an HSA account may be deducted from your pay on a pre-tax basis (unless stated differently under eligibility requirements). This saves you significant money by reducing your taxable income. LTD and Contributory Life Insurance premiums are paid with after-tax dollars.

Please note: As required by law, premiums for (non-dependent) domestic partner or ex-spouse benefits coverage are deducted from your pay on an after-tax basis for federal income tax purposes and the value of any Harvard contribution toward the cost of coverage is subject to imputed income. If you have a domestic partner and are electing family coverage, please contact the Benefits Office at 617-496-4001 to speak with a representative about enrollment and tax implications.

2. AM I ELIGIBLE FOR BENEFITS?

Harvard offers benefits coverage to you and your eligible dependents, as long as you meet the eligibility requirements. Additional information and coverage requirements are available in the applicable Plan documents and on hr.harvard.edu.

2.1 Eligibility Requirements

Faculty and Staff Members

You are eligible to enroll in the Plan if you are on a regular Harvard payroll and you:

- Regularly work at least 17.5 hours a week; or
- Have an annual base salary of at least $15,000.

You are not eligible for the Plan if you:

- Are on a temporary payroll;
- Are a Harvard student employee enrolled in a full-time degree program; or
- Have a training status appointment.

Note: Specific eligibility requirements for hourly employees vary by collective bargaining agreement. Consult your applicable contract for eligibility requirements.

Teaching Assistants, Visiting Fellows, Coaching Assistants

If you regularly work at least 17.5 hours a week or are paid at an annual base rate of at least $15,000, you are eligible for the medical plan, vision care plan, and reimbursement program only.

Internal Postdoctoral Fellows

If you are performing Harvard research and regularly work at least 17.5 hours a week or are paid at an annual base rate of at least $15,000 and receive compensation from Harvard University, you are eligible for all health and welfare benefits.

External Postdoctoral Fellows (Stipendee)

If you are performing Harvard research and regularly work at least 17.5 hours a week or are paid at an annual base rate of at least $15,000 and you receive your stipend through Harvard University, you are eligible for all benefits except the High Deductible Health Plan, FSAs and the HSA. All premiums are paid with after-tax dollars.

Other Employees

In order to meet Affordable Care Act requirements, an individual not otherwise eligible for health care benefits under the Plan may, at the discretion of the employer, be treated as benefits-eligible for purposes of medical plan enrollment. Should you have questions about your eligibility for health care benefits, please contact the Benefits Office at 617-496-4001.

Dependent(s)

If you are a benefits-eligible employee who is enrolled in coverage under a medical, dental, or vision plan, you may enroll your eligible dependent(s) to the extent such coverage is available. As a benefits-eligible employee, your eligible dependents include your legal spouse, same-sex or opposite-sex domestic partner, and your dependent children, including the children of your domestic partner or spouse, provided they meet the requirements set forth in the applicable Plan documents.

Coverage is contingent on receiving required dependent documentation. To that end, you must provide the Benefits Office with all required documentation for each eligible dependent you wish to enroll in benefits as follows:

- Within 30 days of your hire date or the date you are first eligible for benefits
- Within 30 days of gaining an eligible dependent by marriage, birth, or adoption
- Within 30 days of an IRS-defined change in status (as defined in Section 3.2)

If you fail to provide the required dependent documentation within the 30-day enrollment period, any undocumented dependents you've already enrolled in coverage will be removed from all benefits plans retroactive to their first date of eligibility.

2.2 Benefit Election Requirements

You have 30 days from your hire date, the date you are first eligible for benefits, or the date of an IRS-defined change in status (see Section 3.2), to enroll in the Plan. Your benefit elections will be retroactively effective as of your hire date, the date you are first eligible for benefits, or the date of your IRS-defined change in status.

If you fail to make your benefit elections within 30 days of your hire date, the date you are first eligible for benefits, or the date of your IRS-defined change in status, you will not be able to enroll in coverage or make benefit changes until the next annual Open Enrollment period or, if earlier, within the 30-day period following an IRS-defined change in status.

3. HOW DO I ENROLL IN BENEFITS OR MAKE CHANGES?

You enroll in benefits online using PeopleSoft. Enrollment instructions are included in your enrollment packet or online at hr.harvard.edu. New hires and newly benefits-eligible employees who do not complete their enrollment within the 30-day enrollment period will not have any coverage except Basic Life Insurance and short term disability, if eligible. Review this section for important enrollment details.

3.1 Enrollment Time Frame

You have 30 days from your date of hire, the date you are first eligible for benefits, or the date of an IRS-defined change in status (see Section 3.2 below) to submit your elections, as well as all supporting documentation if you are electing family coverage. Supporting documentation includes a marriage certificate if you are enrolling a spouse; a birth certificate or adoption paperwork if you are enrolling a dependent child(ren); a Harvard Statement of Domestic Partnership, along with a Certificate of Registration from a municipality, if you are enrolling a domestic partner; and proof of change in status, if applicable.

What happens if I miss the 30-day enrollment period?

If you miss the 30-day enrollment period, you will not be able to enroll in or make changes to your benefit elections until the next annual Open Enrollment period (Open Enrollment is held annually in the fall; any changes are effective on January 1st of the following year), unless you experience an IRS-defined change in status. Enrollment changes must be consistent with your change in status.

3.2 Changing Benefits During the Year

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

For example, you may be allowed to make changes to your benefits if you:

- Get married or register a domestic partner
- Get divorced
- Have or adopt a child
- Experience a death
- Have a dependent who loses or gains eligibility
- Change in employment status—that is, you or your spouse/domestic partner begin or end employment, an unpaid leave of absence, or family medical leave
- Experience a significant change in medical coverage or cost for you or your spouse/domestic partner
- Move into or out of the HMO plan service area

4. WHEN DOES COVERAGE BEGIN AND END?

Benefits—for you and any eligible dependents—are generally effective on your eligibility date, the date of your IRS-defined change in status, or January 1 of the following year if elections are made during Open Enrollment. Review this section for details.

4.1 Coverage Start Dates

	Newly Eligible Employee	Open Enrollment	IRS-Defined Change in Status
Medical, Prescription Drug, Dental, and Vision Care	Hire date or date first eligible	January 1	Date of an IRS-defined change in status
LTD*	Hire date or date first eligible	Date coverage approved	Date coverage approved
FSAs	Hire date or date first eligible	January 1	Date of an IRS-defined change in status
HSA (if eligible)	First of month following eligibility date	January 1	First of month following eligibility date
Contributory* (Supplemental) Life Insurance	Hire date or date first eligible	Date coverage approved	Date coverage approved

* You may apply for LTD and Supplemental Life Insurance at any time during the year with Evidence of Insurability (EOI). Your coverage will begin once approved.

4.2 Coverage End Dates

Your coverage under the Plan ends at midnight on the earliest of following dates:

- You no longer meet the eligibility requirements to participate in these plans, or
- You fail to make the required payment, or
- Your employment with the University terminates, or
- The University cancels the benefit plan.

4.3 Loss of Benefits

The Plan Sponsor (Harvard), in its sole discretion, may at any time modify, amend, or terminate the provisions, terms, and conditions of the Plan without the consent of any participant or any beneficiary under the Plan. Any modification, amendment, or termination of the Plan will be by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate, and delivered to the benefits-specific Plan Administrator. No vested rights of any nature are provided by the Plan.

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefits are described in the separate Plan documents.

Note: If you or any of your eligible dependents lose coverage under the Plan, contact the Benefits Office at 617-496-4001 to determine what arrangements, if any, may be made to continue your group coverage or to convert to any available individual coverage. Certain rights to continue health care coverage are outlined in Section 10.

5. WHAT ARE MY BENEFITS?

As a member of the Harvard University faculty or staff, you are eligible for a wide range of valuable University-provided benefits as detailed in this section. For specific information on all of your benefits, please consult the separate Plan documents.

5.1 Health Coverage

Medical Coverage

When you enroll in a medical plan, you pay a portion of the total group premium, with Harvard paying most of the total premium. To see monthly rates, visit hr.harvard.edu.

Harvard faculty and staff (non-union) have a choice between three types of medical plan options:

1. Health Maintenance Organization (HMO)
2. Point of Service (POS)
3. High-Deductible Health Plan (HDHP) with Health Savings Account (HSA)

Employees covered by a collective bargaining agreement have a choice between two types of medical plan options:

1. Health Maintenance Organization (HMO)
2. Point of Service (POS)

If you are a member of HUPA, HUSPMGU or SEIU who resides outside of Massachusetts, you may also choose a Preferred Provider Organization (PPO).

The HMO, POS, and HDHP with HSA plans are offered through two provider networks: Harvard University Group Health Plan (HUGHP) and Harvard Pilgrim Health Care (HPHC). The PPO is offered through HPHC.

Harvard staff located in Washington, D.C. have other medical plan options found on pages 12 and 13. Note: DC plans are excluded from the prescription drug coverage provided by Catamaran/OptumRx, as this coverage is supplied under their medical plan.

Prescription Drug Coverage

Your prescription drug benefit is included as part of your medical plan premium and is administered by OptumRx, a pharmacy benefits manager. Upon initial enrollment in a Harvard-sponsored medical plan, you will receive instructions for prescription drug services. Prescription drug coverage has three copayment tiers, with most generic medications having the lowest copayment.

The following is a brief summary of the medical and prescription drug coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

Faculty and Non-Union Staff

Coverage for Eligible Expenses	In-Network (Authorized)	Out-of-Network (Unauthorized)	
	HMO and POS	HMO	POS
Deductible	$250 per individual/ $750 family maximum	N/A	$750 per individual/ $2,500 family maximum
Coinsurance after Deductible	10% paid by you/ 90% paid by Harvard	N/A	30% paid by you/70% paid by Harvard
Preventive Care	Covered at 100% (deductible does not apply)	No coverage	Deductible, then coinsurance
Office Visits			
Primary Care and Specialist	$30 copayment (deductible does not apply)	No coverage	Deductible, then coinsurance
Behavioral Health	$30 copayment (deductible does not apply)	No coverage	20% coinsurance (no deductible)
Emergency Room	$100 copayment (deductible does not apply)		
Hospital Admission (includes medical and behavioral health)	Deductible, then coinsurance	No coverage	Deductible, then coinsurance
Outpatient Diagnostic Labs/X-Rays	Covered at 100%	No coverage	Deductible, then coinsurance
High Tech Imaging	Deductible, then coinsurance	No coverage	Deductible, then coinsurance
Outpatient Surgery	Deductible, then coinsurance	No coverage	Deductible, then coinsurance
Maternity			
Routine Prenatal Care	Covered at 100%	No coverage	Deductible, then coinsurance
Inpatient Hospital	Deductible, then coinsurance	No coverage	Deductible, then coinsurance
Prescription Drugs			
Retail (up to 30-day supply)	$7 generic; $20 preferred brand; $45 non-preferred brand	No coverage	Member must submit receipt and will be reimbursed minus the applicable copayment for 30-day prescriptions at in-network cost
Mail Order (up to 90-day supply)	$14 generic; $50 preferred brand; $110 non-preferred brand	N/A	N/A
Out-of-Pocket Maximum (OOP) (includes deductible, medical and prescription costs)	$1,500 individual/ $4,500 family	N/A	$2,500 individual/ $7,500 family
Coverage after you reach your OOP Maximum	100% of eligible in-network expenses paid by Harvard	N/A	100% of eligible out-of-network expenses paid by Harvard

POS Plus Plan – Faculty and Non-Union Staff Only

Coverage for Eligible Expenses	In-Network	Out-of-Network
Deductible	None	$750 per individual/$2,500 per family maximum
Coinsurance after Deductible	None	30% paid by you/70% paid by Harvard
Office Visits		
Primary Care and Specialist	$30 copayment	Deductible, then coinsurance
Behavioral Health	$30 copayment	20% coinsurance, no deductible
Emergency Room	$100 copayment	$100 copayment
Hospital Admission (includes medical and behavioral health)	Fully covered	Deductible, then coinsurance
Diagnostic Testing	Fully Covered	Deductible, then coinsurance
Outpatient Surgery	Fully Covered	Deductible, then coinsurance
Maternity		
Routine Pregnancy Care	Fully Covered	Deductible, then coinsurance
Inpatient Hospital	Fully Covered	Deductible, then coinsurance
Prescription Drug		
Retail (up to 30-day supply)	$7 generic; $20 preferred brand; $45 non-preferred brand	Member must submit receipt and will be reimbursed minus the applicable copayment for 30-day prescriptions at in-network cost
Mail Order (up to-90 day supply)	$14 generic; $50 preferred brand; $110 non-preferred brand	N/A
Out-of Pocket Maximum (OOP) (includes deductible, medical and prescription costs)	$2,000 individual/$6,000 family	$2,500 individual/$7,500 family
Coverage after you reach your OOP Maximum	100% of eligible in-network expenses paid by Harvard	100% of eligible out-of-network expenses paid by Harvard

HDHP – Faculty and Non-union Staff

Coverage for Eligible Expenses	In-Network	Out-of-Network
	HDHP	
Deductible	$1,500 individual/$3,000 family In-network and out-of-network costs will be combined toward annual amount.	
Coinsurance after Deductible	15% paid by you/85% paid by Harvard	35% paid by you/65% paid by Harvard
Preventive Care	Covered at 100% (deductible does not apply)	Deductible, then coinsurance
Office Visits		
Primary Care and Specialist	Deductible, then coinsurance	Deductible, then coinsurance
Behavioral Health	Deductible, then coinsurance	Deductible, then coinsurance
Emergency Room	Deductible, then coinsurance	Deductible, then 15% coinsurance
Hospital Admission (includes medical and behavioral health)	Deductible, then coinsurance	Deductible, then coinsurance
Diagnostic Testing	Deductible, then coinsurance	Deductible, then coinsurance
Outpatient Surgery	Deductible, then coinsurance	Deductible, then coinsurance
Maternity		
Routine Prenatal Care	Covered at 100% (deductible does not apply)	Deductible, then coinsurance
Inpatient Hospital	Deductible, then coinsurance	Deductible, then coinsurance
Prescription Drugs		
Retail (up to 30-day supply)	Deductible, then $7 generic; $20 preferred brand; $45 non-preferred brand	
Mail Order (up to-90 day supply)	Deductible, then $14 generic; $50 preferred brand; $110 non-preferred brand	
Out-of-Pocket Maximum (OOP) (includes deductible)	$3,000 individual/$6,000 family	$6,000 individual /$12,000 family
Coverage after you reach your OOP	100% of eligible in-network expenses paid by Harvard	100% of eligible out-of-network expenses paid by Harvard

Union Employees Covered by ATC & HUCTW (Excluding Dumbarton Oaks and The Center for Hellenic Studies)

Coverage for Eligible Expenses	In-Network (Authorized)	Out-of-Network (Unauthorized)		
	HMO and POS	HMO	POS	PPO
Deductible	N/A	N/A	$500 individual/ $2,000 family	$250 individual/ $500 family
Coinsurance after Deductible	N/A	N/A	30% paid by you/70% paid by Harvard	
Preventive Care	Covered at 100%	No coverage	Deductible, then coinsurance	
Office Visits				
Primary Care and Specialist	$20 copayment	No coverage	Deductible, then coinsurance	
Behavioral Health	$20 copayment	No coverage	20% Coinsurance (deductible does not apply)	
Emergency Room	$100 copayment, waived if admitted			
Hospital Admission (includes medical and behavioral health)	$100 copayment	No coverage	Deductible, then coinsurance	
Outpatient Diagnostic Labs/X-rays	Covered at 100%	No coverage	Deductible, then coinsurance	
High Tech Imaging	$50 copayment	No coverage	Deductible, then coinsurance	
Outpatient Surgery	$20 copayment	No coverage	Deductible, then coinsurance	
Maternity				
Routine Prenatal Care	Covered at 100%	No coverage	Deductible, then coinsurance	
Inpatient Hospital	$100 copayment	No coverage	Deductible, then coinsurance	
Prescription Drugs				
Retail (up to 30-day supply)	$7 generic; $20 preferred brand; $45 non-preferred brand	No coverage	Member must submit receipt and will be reimbursed minus the applicable copayment for 30-day prescriptions at in-network cost	
Mail Order (up to 90-day supply)	$14 copayment generic; $50 preferred brand; $110 non-preferred brand	N/A	N/A	
Out-of-Pocket Maximum (OOP)				
Medical only	$2,000 individual/ $6,000 family	N/A	$2,500 individual/ $7,500 family	
Prescription only	$4,600 individual/ $7,200 family	N/A		
Coverage after you reach OOP	100% of eligible in-network expenses paid by Harvard	N/A	100% of eligible out-of-network expenses paid by Harvard	

Union Employees Covered by Local 26

Coverage for Eligible Expenses	In-Network (Authorized)	Out-of-Network (Unauthorized)		
	HMO, POS, and PPO	HMO	POS	PPO
Deductible	N/A	N/A	$500 individual/ $2,000 family	$250 individual/ $500 family
Coinsurance after Deductible	N/A	N/A	20% paid by you/80% paid by Harvard	
Preventive Care	Covered at 100%	No coverage	Deductible, then coinsurance	
Office Visits				
Primary Care and Specialist	$15 copayment	No coverage	Deductible, then coinsurance	
Behavioral Health	$15 copayment	No coverage	Coinsurance (deductible does not apply)	
Emergency Room	$40 copayment, waived if admitted			
Hospital Admission (includes medical and behavioral health)	Covered at 100%	No coverage	Deductible, then coinsurance	
Diagnostic Testing	Covered at 100%	No coverage	Deductible, then coinsurance	
Outpatient Surgery	$15 copayment	No coverage	Deductible, then coinsurance	
Maternity				
Routine Prenatal Care	Covered at 100%	No coverage	Deductible, then coinsurance	
Inpatient Hospital	Covered at 100%	No coverage	Deductible, then coinsurance	
Prescription Drugs				
Retail (up to 30-day supply)	$5 generic; $15 preferred brand; $40 non-preferred brand	No coverage	Member must submit receipt and will be reimbursed minus the applicable copayment for 30-day prescriptions at in-network cost	
Mail Order (up to 90-day supply)	$10 copayment generic; $35 preferred brand; $100 non-preferred brand	N/A	N/A	
Out-of-Pocket Maximum (OOP)				
Medical only	$2,000 individual/ $6,000 family	N/A	$2,000 individual/ $5,000 family	$1,000 individual/ $2,000 family
Prescription only	$4,600 individual/ $7,200 family	N/A	$4,600 individual/$7,200 family	
Coverage after you reach OOP	100% of eligible in-network expenses paid by Harvard	N/A	100% of eligible out-of-network expenses paid by Harvard	

Union Employees Covered by HUPA, HUSPMGU, & SEIU

Coverage for Eligible Expenses	In-Network (Authorized)	Out-of-Network (Unauthorized)	
	HMO, POS, and PPO	HMO	POS and PPO
Deductible	N/A	N/A	$750 individual/$2,500 family
Coinsurance after Deductible	N/A	N/A	20% paid by you/80% paid by Harvard
Preventive Care	Covered at 100%	No coverage	Deductible, then coinsurance
Office Visits			
Primary Care and Specialist	$20 copayment	No coverage	Deductible, then coinsurance
Behavioral Health	$20 copayment	No coverage	Coinsurance (deductible does not apply)
Emergency Room	$75 copayment, waived if admitted		
Hospital Admission (includes medical and behavioral health)	Covered at 100%	No coverage	Deductible, then coinsurance
Diagnostic Testing	Covered at 100%	No coverage	Deductible, then coinsurance
Outpatient Surgery	$20 copayment	No coverage	Deductible, then coinsurance
Maternity			
Routine Prenatal Care	Covered at 100%	No coverage	Deductible, then coinsurance
Inpatient Hospital	Covered at 100%	No coverage	Deductible, then coinsurance
Prescription Drugs			
Retail (up to 30-day supply)	$7 generic; $20 brand; $45 non-preferred brand	No coverage	Member must submit receipt and will be reimbursed minus the applicable copayment for 30-day prescriptions at in-network cost
Mail Order (up to 90-day supply)	$14 generic; $50 preferred brand; $110 non-preferred brand	N/A	N/A
Out-of-Pocket Maximum (OOP) (includes deductible)			
Medical only	$2,000 individual/ $6,000 family	N/A	$2,500 individual/ $7,500 family
Prescription only	$4,600 individual/ $7,200 family	N/A	$4,600 individual/ $7,200 family
Coverage after you reach your OOP	100% of eligible in-network expenses paid by Harvard	N/A	100% of eligible out-of-network expenses paid by Harvard

Dumbarton Oaks and The Center for Hellenic Studies—Includes HUCTW Union Members

Coverage for Eligible Expenses	Kaiser Permanente HMO Select	CareFirst BlueChoice HMO Open Access
Deductible	$0	$0
Coinsurance after Deductible	N/A	N/A
Preventive Care	Covered at 100%	Covered at 100%
Office Visits		
Primary Care	$10 copayment	$10 copayment
Specialist	$20 copayment	$20 copayment
Behavioral Health	$10 copayment/individual; $5 copayment/group	Covered at 100%
Emergency Room	$50 copayment	$50 copayment
Hospital Admission (includes medical and behavioral health)	Covered at 100%	Covered at 100%
Diagnostic Testing		
X-rays, blood work	Covered at 100%	Covered at 100%
CT/PET scans, MRIs	$50 copayment	Covered at 100%
Outpatient Surgery	$50 copayment	$20 copayment
Maternity		
Routine Prenatal Care	Covered at 100%	Covered at 100%
Inpatient Hospital	Covered at 100%	Covered at 100%
Prescription Drugs		Preferred preventive drugs covered at 100%
Retail Plan Pharmacy (up to 30-day supply)	$10 generic; $20 preferred brand; $35 non-preferred brand	N/A
Retail Network (up to 30-day supply)	$20 generic; $35 preferred brand; $50 non-preferred brand	Up to a 34-day supply: $10 generic; $20 preferred brand; $35 non-preferred brand
Mail Order	Up to a 90-day supply for two copayments	Up to a 90-day supply: $20 generic; $40 preferred brand; $70 non-preferred brand
Out-of-Pocket Maximum (OOP) (includes deductible where applicable)	$3,500 individual/$9,400 family	Medical only: $1,300 individual/ $2,600 family Prescription only: $4,500 individual/ $9,000 family
Coverage after you reach OOP	100% of eligible in-network expenses paid by plan	100% of eligible in-network expenses paid by plan

Dumbarton Oaks and The Center for Hellenic Studies—Includes HUCTW Union Members (cont.)

Coverage for Eligible Expenses	CareFirst BlueChoice HMO Opt-out + Open Access		CareFirst BluePreferred PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	N/A	$300 individual/ $600 family	N/A	$300 individual/ $600 family
Coinsurance after Deductible	N/A	20% paid by you/ 80% paid by Plan	N/A	20% paid by you/ 80% paid by Plan
Preventive Care	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Office Visits				
Primary Care	$10 copayment	Deductible, then coinsurance	$10 copayment	Deductible, then coinsurance
Specialist	$20 copayment	Deductible, then coinsurance	$15 copayment	Deductible, then coinsurance
Behavioral Health	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Emergency Room	$50 copayment		$50 copayment	
Hospital Admission (includes medical and behavioral health)	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Diagnostic Testing				
X-rays, blood work	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
CT/PET scans, MRIs	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Outpatient Surgery	$20 copayment	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Maternity				
Routine Prenatal Care	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Inpatient Hospital	Covered at 100%	Deductible, then coinsurance	Covered at 100%	Deductible, then coinsurance
Prescription Drugs				
Retail Plan Pharmacy (up to 30-day supply)	Preferred preventive drugs covered at 100%		Preferred preventive drugs covered at 100%	
Retail Network (up to 30-day supply)	Up to a 34-day supply: $10 generic; $20 preferred brand; $35 non-preferred brand		Up to a 34-day supply: $10 generic; $20 preferred brand; $35 non-preferred brand	
Mail Order	Up to a 90-day supply: $20 generic; $40 preferred brand; $70 non-preferred brand		Up to a 90-day supply: $20 generic; $40 preferred brand; $70 non-preferred brand	
Out-of-Pocket Maximum (OOP) (includes Deductible where applicable)	For medical only: $1,300 individual/ $2,600 family For Rx only: $4,500 individual/ $9,000 family	For medical only: $2,000 individual/$4,000 family For Rx only: $4,500 individual/$9,000 family	For medical only: $1,000 individual/ $2,000 family For Rx only: $4,500 individual/ $9,000 family	For medical only: $2,000 individual/$4,000 family For Rx only: $4,500 individual/$9,000 family
Coverage after you reach OOP	100% of eligible in-network expenses paid by plan	100% of eligible out-of-network expenses paid by plan	100% of eligible in-network expenses paid by plan	100% of eligible out-of-network expenses paid by plan

Dental Coverage

Harvard offers comprehensive dental coverage through the Delta Dental PPO Plus Premier plan, which includes dentists in the Delta Dental PPO and Delta Premier networks. You may also use out-of-network dentists, but this may increase your out-of-pocket costs.

The following is a brief summary of the dental plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

Faculty, Non-Union Staff, HUCTW & ATC Unions, Dumbarton Oaks and The Center for Hellenic Studies

Delta Dental Covered Services	
Deductible	
Level 1	$50 per person/$150 per family
Level 2	$500 per person
Coinsurance after Deductible	25% paid by you/75% paid by Harvard unless otherwise noted
Preventive Care	Covered in full
Basic Services	Deductible, then coinsurance
Periodontics, Endodontics, and Oral Surgery	Deductible, then coinsurance
Major Restorative Services	Deductible, then coinsurance
Orthodontics	50% coverage for children under age 19, no deductible; $1,500 Delta Dental lifetime limit
Maximum Annual Benefit	
Level 1	$3,000 per person
Level 2	No annual limit
Level 2 coverage begins when you reach the Level 1 maximum of $3,000. After paying the Level 2 deductible of $500, eligible costs and services are covered with no maximum. Coinsurance applies as noted above.	
Delta Dental provides coverage for services from non-participating providers. Although the benefit level is the same as participating providers, your out-of-pocket costs may be higher if the non-participating provider's fees are higher than Delta Dental's negotiated fees. As a result, you may be responsible for the difference.	

Union Employees Covered by Local 26

Delta Dental Covered Services	
Deductible	$25 per person/$75 per family
Coinsurance after Deductible	25% paid by you/75% paid by Harvard, unless otherwise noted
Preventive Care	Covered in full
Basic Services	Deductible, then coinsurance
Periodontics, Endodontics, and Oral Surgery	Deductible, then coinsurance
Major Restorative Services	Deductible, then coinsurance
Orthodontics	50% coverage for children under age 19, no deductible; $1,500 Delta Dental lifetime limit
Maximum Annual Benefit	$3,000 per person
Delta Dental provides coverage for services from non-participating providers. Although the benefit level is the same as participating providers, your out-of-pocket costs may be higher if the non-participating provider's fees are higher than Delta Dental's negotiated fees. As a result, you may be responsible for the difference.	

Union Employees Covered by HUPA, HUSPMGU, & SEIU

Delta Dental Covered Services	
Deductible	$50 per person/$150 per family
Coinsurance after Deductible	25% paid by you/75% paid by Harvard unless otherwise noted
Preventive Care	Covered in full
Basic Services	Deductible, then coinsurance
Periodontics, Endodontics, and Oral Surgery	Deductible, then coinsurance
Major Restorative Services	Deductible, then coinsurance
Orthodontics	50% coverage for children under age 19, no deductible; $1,500 Delta Dental lifetime limit
Maximum Annual Benefit	$3,000 per person
Delta Dental provides coverage for services from non-participating providers. Although the benefit level is the same as participating providers, your out-of-pocket costs may be higher if the non-participating provider's fees are higher than Delta Dental's negotiated fees. As a result, you may be responsible for the difference.	

Vision Care Coverage

Harvard's comprehensive vision care benefit provides coverage for vision exams and products at greatly reduced and/or discounted rates. Davis Vision, a leading provider of vision care benefits, is Harvard's vision care provider. Harvard's medical plans also offer coverage for routine vision screening and discounts on eyewear.

The following is a brief summary of the vision care plan coverage. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

	Davis Vision Covered Services
Eye Examination	$15 copayment; covered once per calendar year
Eyeglasses	
Spectacle Lenses (every calendar year)	$20 copayment for standard single-vision, lined bifocal, or trifocal lenses
Frames (every 24 months)	100% coverage for any fashion or designer frame from Davis Vision's collection or $140 retail allowance toward any frame from provider plus 20% off balance or $190 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations.
Contact Lenses (every calendar year)	
Evaluation, Fitting, and Follow-up Care	$20 copayment for standard contacts or collections contacts or $60 allowance with 15% off balance less $20 copayment for Specialty Contacts
Contact Lenses (in lieu of eyeglasses)	100% coverage for any contact lenses from Davis Vision's Contact Lens Collection or $150 retail allowance toward provider-supplied contact lenses, plus 15% off balance

5.2 Flexible Spending Accounts (FSA)

The following is a brief summary of the FSA coverage. For more detailed information, refer to your Plan documents or contact the Plan Administrator.

Harvard offers three FSA options:

1. Health FSA: Lets you pay for eligible medical, dental, and vision care expenses for you and your eligible dependent(s); you may enroll in a Health FSA even if you are not enrolled in a Harvard-sponsored medical plan. See "Limited Purpose FSA" below if you are enrolled in an HDHP.
2. Dependent Care FSA: Lets you pay for eligible dependent care expenses for a dependent child or adult so that you (and/or spouse/partner) may work, attend school, or look for a job.
3. Limited Purpose FSA: Lets you pay for dental and vision care expenses only, and is available if you are enrolled in an HDHP. Other eligible medical expenses may be covered by a Health Savings Account (HSA).

Each year you will need to make a new election in these accounts for the following calendar year. You may also be able to make changes during the year if you experience an IRS-defined change in status. Annual contribution amounts are limited by IRS regulations. However, the minimum annual contribution is $120.

5.3 Health Savings Account (HSA)

The following is a brief summary of the HSA plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

If you are enrolled in an HDHP, you can pay for medical expenses for you and your eligible dependent(s) using an HSA. If not spent, HSA funds can roll over and accumulate year to year. Annual contribution amounts are limited by IRS regulations.

5.4 Copayment Reimbursement Program (CRP) and Reimbursement Program (RP)

The CRP is available to employees covered by a collective bargaining agreement, employees enrolled in a medical plan at Dumbarton Oaks and The Center for Hellenic Studies and those enrolled in the Global Benefits Plan. The RP is available to employees not covered by a collective bargaining agreement. These programs assist employees who face high medical costs during the Plan Year. You do not have to enroll in the programs. If you are eligible, as described in the specific benefit documentation and noted below, you may be reimbursed for covered medical costs.

Eligibility for the Copayment Reimbursement Program

You must be an active union staff member, have an annual full-time equivalent (FTE) salary of $95,000 or less, and be enrolled in one of Harvard University's medical plans, other than the HDHP.

A certain threshold in qualifying reimbursement expenses must be met before reimbursement will be made. The threshold is determined by your FTE salary at the time you file for reimbursement and whether you have individual or family coverage in a Harvard medical plan:

Union Employees covered by HUPA, HUSPMGU, Local 26 & SEIU, and employees at Dumbarton Oaks and the Center for Hellenic Studies

Copayment Reimbursement Program Thresholds			
If My Medical Plan Enrollment Status Is:	And My Full-Time Equivalent (FTE)* Salary Is:	My Threshold For In-Network Office Visit Copayments Is:	My Threshold For In-Network Prescription Drug Copayments Is:
Individual	Less Than $70,000	$135	$500
	$70,000–$95,000	$270	$1,000
Family	Less Than $70,000	$330	$1,000
	$70,000–$95,000	$660	$2,000

* For those who work less than full-time, your full-time equivalent salary is the salary that would be earned working full-time at the same rate of pay.

Only in-network medical (includes behavioral health) office visit and prescription drug copayments are eligible for reimbursement.

Union Employees covered by HUCTW and ATC

Copayment Reimbursement Program Thresholds				
If My Medical Plan Enrollment Status Is:	And My Full-Time Equivalent (FTE)* Salary Is:	My Threshold For In-Network Office Visit Copayments Is	My Threshold For In-Network Prescription Drug Copayments Is:	My threshold for in-network hospital, high-tech imaging and ER copayments is:
Individual	Less Than $75,000	$180	$500	$300
	$75,000+	$360	$1,000	$600
Family	Less Than $75,000	$440	$1,000	$450
	$75,000+	$880	$2,000	$900

* For those who work less than full-time, your full-time equivalent salary is the salary that would be earned working full-time at the same rate of pay.

Eligibility for the Reimbursement Program

You must be an active faculty or non-union staff member, have an annual FTE salary of $110,000 or less, and be enrolled in one of Harvard University's medical plans, other than the HDHP.

A certain threshold in qualifying reimbursement expenses must be met before reimbursement will be made. The threshold is determined by your FTE salary at the time you file for reimbursement and whether you have individual or family coverage in a Harvard medical plan:

Reimbursement Program – Faculty and Non-Union Staff		
If your FTE salary is...	You can be reimbursed for out-of-pocket costs above...	
	Individual	Family
< $30,000	$600	$600
$30,000-$39,999	$800	$900
$40,000-$49,999	$900	$1,200
$50,000-$59,999	$900	$1,600
$60,000-$69,999	$900	$1,900
$70,000-$79,999	$1,250	$2,300
$80,000-$89,999	$1,250	$2,800
$90,000-$99,999	$1,500	$3,300
$100,000-<$110,000	$1,500	$4,000

* For those who work less than full-time, your full-time equivalent salary is the salary that would be earned working full-time at the same rate of pay.

Only in-network out-of-pocket medical and prescription expenses including deductible, co-insurance, emergency room copayments, office visit copayments, and prescription drug copayments are eligible for reimbursement.

5.5 Long Term Disability (LTD) Coverage

The following is a brief summary of Harvard's LTD plan. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

LTD insurance is a salary replacement benefit that helps you meet your financial commitments if you are unable to work for more than 180 days due to an injury or illness. Harvard's group LTD plan is offered through The Standard Insurance Company (The Standard). Enrollment is voluntary; however certain benefits-eligible employees who are members of a collective bargaining agreement must enroll as a condition of their employment.

LTD Highlights	
Monthly Benefit	60% of the first $25,000 of your monthly pre-disability earnings, reduced by deductible income (for example, Social Security and workers' compensation)
Maximum Monthly Benefit	$15,000
Minimum Monthly Benefit	$100 or 10% of your maximum monthly benefit
Waiting Period Before Benefits Become Payable	180 days from your date of disability

You may elect to enroll in coverage at any time with evidence of good health. If you enroll within 30 days of your benefits eligibility date or within 30 days of certain permitted election events, you will not need to provide evidence of good health.

Cost of the Plan

You pay for the full cost of the coverage via payroll deductions with after-tax dollars, so LTD benefits are tax-free.

Absence from Work

You must be actively at work on the day before the scheduled effective date of your LTD insurance coverage or your insurance will not become effective as scheduled. If you are not actively at work because of physical disease, injury, pregnancy, or mental disorder on the day before the scheduled effective date of your coverage, it will not become effective until the day after you complete one full day of active work.

When You Are Considered Disabled

You are considered disabled if you meet one of the following definitions of disability during the period it applies:

Own Occupation Definition of Disability—During the 180-day benefit waiting period and the first 24 months for which LTD benefits are payable (Own Occupation period), you are disabled from your own occupation if, as a result of physical disease, injury, pregnancy, or mental disorder you are unable to perform with reasonable continuity the material duties of your own occupation; or you are unable to earn 80% or more of your indexed pre-disability earnings when working in your own occupation.

Any Occupation Definition of Disability—During the Any Occupation period, from the end of the Own Occupation period to the end of the maximum benefit period, you are required to be disabled from all occupations. You are disabled from all occupations if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation that you are able to perform, whether due to education, training, or experience, and for which both of the following are true: the occupation is available at one or more locations in the national economy; and the occupation is one in which you can be expected to earn at least 80% of your indexed pre-disability earnings within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

Partial Disability Definition—During the 180-day benefit waiting period and the Own Occupation period, you are partially disabled when you work in your own occupation but, as a result of your disability (physical disease, injury, pregnancy, or mental disorder), you are unable to earn 80% or more of your indexed pre-disability earnings, in that occupation.

Maximum Benefit Period

The maximum benefit period is the longest period for which LTD benefits are payable for any one period of continuous disability, whether from one or more causes. The maximum benefit period begins at the end of the 180-day benefit waiting period. No LTD benefits are payable after the end of the maximum benefit period, even if you are still disabled.

The maximum benefit period is determined by your age when disability begins, as indicated below:

Maximum Benefit Period for LTD Benefits	
Your Age When Disability Began	**Maximum Benefit Period**
61 or younger	To age 65, or to Social Security Normal Retirement Age (SSNRA), or 3 years 6 months, whichever is longer.
62	To SSNRA, or 3 years 6 months, whichever is longer.
63	To SSNRA, or 3 years, whichever is longer.
64	To SSNRA, or 2 years 6 months, whichever is longer.
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Survivors' Benefit

If you die while LTD benefits are payable, and if on the date you die you have been continuously disabled for at least 180 days, a survivors' benefit equal to six times your unreduced monthly LTD benefit may be payable to eligible survivors.

Waiver of Premium

The Standard will waive payment of your premium for your LTD insurance coverage while LTD benefits are payable.

Impact on Other Harvard Benefits

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

Benefit Program	Impact While Receiving LTD Benefits
Basic and Contributory Life Insurance	Coverage will continue free of cost based on your pre-disability salary.
LTD Insurance	Premiums are waived while receiving LTD benefits.
Medical, Dental, and Vision Care	Coverage will continue at the lowest tier of the Harvard subsidized group rate and premiums will be deducted from your LTD payments.
FSAs	You may not contribute to an FSA while on LTD. If you have an existing account you can incur claims up to the start of LTD.
Reimbursement Program and Copayment Reimbursement Program	Not eligible while receiving LTD benefits

1973 LTD Program and 1965 Total Disability Plan

If you became disabled before June 1, 2007, the effective date of the University's LTD plan offered through The Standard, you are grandfathered under the University's 1973 LTD program. If you held a Harvard Corporation appointment as an Officer of Instruction or Administration before April 1, 1973, and you have not transferred to the University's current LTD plan, you are covered under the University's 1965 Total Disability Plan. The University's 1973 LTD program and 1965 Total Disability Plan are closed and no new enrollments will be accepted. If you participate in either of these programs and have any questions, contact The Standard or the Benefits Office at 617-496-4001.

5.6 Life Insurance

The following is a brief summary of Harvard's life insurance plans. For more detailed information, refer to the Plan documents or contact the Plan Administrator.

Basic Life Insurance

If eligible, Harvard provides you with Basic Life Insurance coverage when you become eligible for benefits. This free group term coverage is equal to one-half your annual benefit base rate (ABBR) rounded to the nearest $1,000. Your coverage amount will be adjusted to reflect any change in your ABBR during the year, effective on the date of the change. You will be automatically enrolled, if eligible. Basic Life Insurance is offered through the Metropolitan Life Insurance Company (MetLife).

Basic Life Insurance Reduction While Employed

If you are employed and turning age 67, your Basic Life Insurance coverage amount is reduced by 35% effective the January 1st following your 67th birthday. Your Basic Life Insurance coverage amount reduces another 35% at age 70, effective the January 1st after your 70th birthday. It reduces 35% every five years after age 70, effective January 1st following the calendar year in which you turn an age that triggers a further reduction in your benefit.

Contributory Life Insurance

You may purchase additional, optional coverage up to five times your ABBR ($1.25 million maximum), rounded to the nearest $1,000. Your coverage amount will be adjusted to reflect any change in your ABBR during the year effective the date of the change. You may elect to enroll in or alter your coverage amount at any time with evidence of good health. If you enroll within 30 days of your benefits eligibility date or date of marriage, you will not need to provide evidence of good health. Contributory Life Insurance is offered through MetLife.

Cost of the Plan

You pay for the full cost of your Contributory Life Insurance coverage via payroll deductions with after-tax dollars.

Absence from Work

If you are absent from work because of illness or injury or for any other reason on the date your Basic and Contributory Life Insurance coverage amount would otherwise increase, that increase will not take effect until you return to work.

Waiver of Premium

In the event you become disabled and you are approved for LTD benefits, MetLife will waive payment of your Contributory Life Insurance premium while LTD benefits are payable.

Beneficiaries

You must designate a beneficiary for your life insurance coverage. This ensures that the person(s) you choose will receive your insurance benefit in the event of your death. To designate a beneficiary, complete the Beneficiary Designation Form and return it to the Benefits Office.

You may change your beneficiaries at any time by submitting an updated Beneficiary Designation Form to the Benefits Office. For more information about how to designate a beneficiary for your Basic and/or Contributory Life Insurance benefit, contact the Benefits Office at 617-496-4001.

Accelerated Benefit Option

If you become terminally ill, and are diagnosed with less than 24 months to live, you have the option to receive an Accelerated Death Benefit. The benefit is up to 50% of your Basic and Contributory Life Insurance coverage amounts, not to exceed $250,000 for each. Requests to receive the Accelerated Death Benefit must be made while your life insurance is still in effect and proof of terminal illness is required.

Portability and Conversion Options

If your life insurance coverage ends you may continue coverage with one of two options:

Portability—With this option you are continuing your life insurance coverage as an individual term life policy through MetLife.

Conversion—With this option you are converting your life insurance from a term life policy to an individual whole life policy through MetLife.

You have 31 days from your coverage end date to port or convert your life insurance coverage. When you leave Harvard employment, you will receive information about your portability and conversion options for Basic and Contributory Life Insurance. Contact the Benefits Office at 617-496-4001 for more information or to request a Portability or Conversion Form.

5.7 Harvard Global Benefits Plan

The following is a brief summary of Harvard's Global Benefits Plan. For more detailed information, refer to your Plan documents or contact the Plan Administrator.

The Global Benefits Plan is for benefits-eligible faculty members and staff employees working abroad for six months or longer. The Global Benefits Plan offers benefits that are comparable to those available to benefits-eligible employees working in the U.S., with access to a network of participating providers, including a network of coverage for eligible dependents who remain in the U.S.

The Global Benefits Plan provides bundled health (i.e., medical, prescription drug, dental, and vision care), Basic and Contributory Life Insurance, and LTD coverage to benefits-eligible international expatriate employees under a group insurance policy issued to the University by Delaware American Life Insurance Company, an affiliate of Metropolitan Life Insurance Company (MetLife).

Eligibility

You are eligible for benefits under the University's Global Benefits Plan if you are not covered by a collective bargaining agreement and normally work at least 17.5 hours per week (excluding overtime) or your annual salary is at least $15,000 and you are:

- An active, full-time U.S.-based University employee on temporary assignment outside the U.S.; or
- An active, full-time non-U.S.-based University employee working on temporary assignment in the U.S.; or
- An active, full-time non-U.S.-based University employee working temporarily in an assignment country and you are neither a national of the assignment country nor the U.S.

Enrollment

You have 30 days from your hire date, the date you are first eligible for benefits, or the date of an IRS-defined change in status, to enroll in the Global Benefits Plan. Once you enroll in benefits under the Global Benefits Plan, you will receive MetLife's Expatriate Benefits Member Guide, which provides essential information about how to access your benefits and get assistance with questions. You and your covered dependent(s) will receive MetLife expatriate identification cards as well.

Cost of Coverage

The following chart outlines your cost share for the Global Benefits Plan:

Harvard Global Benefits Plan	
Benefit Program	**Cost**
Bundled Health Coverage	Harvard pays a portion of the premium for your bundled health (medical, prescription drug, dental, and vision care) coverage, and you must pay the remainder.
Basic Life Insurance	Coverage is free of cost to you. Harvard pays all of the premiums.
Contributory Life Insurance	If you elect coverage, you must pay all the premiums with after-tax dollars deducted from your University pay. Harvard does not pay any portion of the cost.
LTD Insurance	If you elect coverage, you must pay all the premiums with after-tax dollars deducted from your University pay. Harvard does not pay any portion of the cost. Because you pay your LTD premiums with after-tax dollars, any LTD benefits you may receive will be tax-free under current law.

Other Harvard Benefits

If you are a benefits-eligible expatriate employee of the University and are eligible for benefits under the University's Global Benefits Plan, you will not be eligible to participate in the University's other medical, dental, vision care, Basic and Contributory (supplemental) Life Insurance, or LTD plans unless you return to a position within the U.S. You will, however, be eligible to have a Health FSA or a Dependent Care FSA, but either FSA can be used only to cover qualifying expenses incurred in the U.S.

5.8 Harvard Retiree Coverage

Retired faculty and staff members and their eligible spouse/domestic partners (at time of retirement) and/or dependent(s) may be eligible for health care coverage, including medical, dental, and life insurance.

Eligibility for Medical, Dental, and Life Insurance Plans

Medical and Dental

If you are faculty, administrative/professional staff, or non-union support staff hired prior to January 1, 2014, you and your spouse/domestic partner and/or dependents are eligible for medical and dental benefits if, at the time of your retirement, you are at least age 55, have at least 10 years of participation service, and your age plus years of participation service total at least 75 years. If you have been continuously employed at Harvard since before January 1, 1986, you do not need to meet the age 55 minimum.

If you are faculty, administrative/professional staff, or non-union support staff hired on or after January 1, 2014, you and your spouse are eligible for medical and dental benefits if, at the time of your retirement, you are at least age 60, have at least 15 years of participation service, and your age plus years of participation service total at least 75 years.

If you are staff covered by a collective bargaining agreement, you and your spouse are eligible for medical and dental benefits if, at the time of your retirement, you are at least age 55, have at least 10 years of participation service, and your age plus years of participation service total at least 75 years. If you have been continuously employed at Harvard since before January 1, 1986, you do not need to meet the age 55 minimum.

Life Insurance

Upon retirement, your life insurance coverage will continue to be available to you until the June 30th following your 70th birthday if you satisfy at least one of the following conditions at the time you separate from the University:

- You meet the medical and dental eligibility rules outlined above.
- You are at least age 65.

If you retire as a faculty member or a non-hourly staff employee, your Basic Life Insurance coverage amount will be reduced by 35% effective on the July 1st following your 66th birthday.

If you retire as an hourly employee, your Basic Life Insurance coverage amount will be reduced by 35% effective on the July 1st after your 65th birthday.

If you are not eligible for retiree life insurance coverage, you have 31 days from your last day of employment to convert your University group Basic and/or Contributory Life Insurance coverage to individual coverage with MetLife, if you are eligible for such an individual policy. You will receive portability and conversion information soon after your retirement.

Enrollment

You should arrange to meet with a Harvard Benefits Consultant at least three months before your retirement date. You have a choice of medical plans after retirement, provided you meet the eligibility requirements.

Retiree Medical

As an eligible retiree or an eligible dependent of a retiree, you have several post-retirement medical plan options. Your coverage options depend on your age. The cost of your coverage depends on the date you retire from Harvard, the plan you are enrolled in, and your years of pension participation service.

Coverage

Eligible retirees can elect or drop coverage during the annual Open Enrollment period or as a result of an IRS-defined change in status. Contact the Benefits Office if you have questions on this.

If you elect family coverage at retirement, you may only cover yourself and the person who was your spouse or domestic partner at the time of your retirement and eligible dependent children.

Before Age 65

If you retire before age 65, you are offered the same medical plans that are available to active employees in your employee classification, and you share in the cost of the coverage.

If your spouse/domestic partner is also is under age 65, you remain in the Harvard active medical plan with a family membership.

Within three months of reaching age 65, you (or your spouse/domestic partner) should apply for Medicare Parts A and B. At the same time, Harvard will send you a letter requesting a copy of your Medicare card and asking you to select a senior medical plan. The letter contains information to assist you with your selection and additional information is available by contacting the Benefits Office at 617-496-4001.

Cost of Medical Coverage

The cost of coverage is based on the date you retire from Harvard, your years of pension participation service, and your employee classification at the time you retire.

Retired Faculty, Administrative/Professional Staff, and Non-Union Support Staff

If you retired before January 1, 1996, the University contributes the equivalent of the group Medex rate (100%) and applies that dollar amount to the cost of your coverage and your eligible spouse's/domestic partner's and/or dependent children's coverage.

If you retired on or after January 1, 1996, the University contributes a percentage of the group Medex rate (cost for that year) and applies that dollar amount to the plan you choose. The University's contribution percentage is based on your years of participation service, with the subsidy rate as follows:

If you meet eligibility requirements for post-retirement medical	The University contributes	Years of services required to receive the maximum subsidy
By December 31, 2018 (and have no breaks in service after January 1, 2014)	50% to 80% of the cost of Medex toward coverage for you and your eligible spouse/domestic partner and/or eligible dependent children	At least 20 years of service
Between January 1, 2019 and December 31, 2023 (and have no breaks in service after January 1, 2014)	40% to 70% of the cost of Medex toward coverage for you and your eligible spouse/domestic partner and/or eligible dependent children	A least 20 years of service
After January 1, 2024 (and have no breaks in service after January 1, 2014)	40% to 70% of the cost of Medex toward coverage for you and your eligible spouse/domestic partner and/or eligible dependent children	At least 30 years of service

Note: The same dollar amount is applied to each plan, so if you choose a plan that is less expensive than Medex, the University's subsidy will comprise a larger percentage of the cost.

Faculty, Administrative/Professional Staff, and Non-Union Support Staff Hired on or After January 1, 2014

The University contributes a percentage of the group Medex rate (cost for that year) and applies that dollar amount to the plan you choose. The University's contribution percentage is based on years of participation service.

Faculty, administrative/professional staff, and non-union support staff who leave Harvard before attaining post-retirement eligibility and subsequently become re-employed at the University will be credited with service earned before leaving, but will be covered under the rules for those hired after January 1, 2014.

Staff Covered by a Collective Bargaining Agreement

If you retired before January 1, 1996, the University contributes the equivalent of the group Medex rate (100%) and applies that dollar amount to the cost of coverage for you and your eligible spouse/domestic partner and/or eligible dependent children.

If you retire on or after January 1, 1996, the University contributes a percentage of the group Medex rate and applies that dollar amount to the plan you choose. The University contribution percentage is based on your years of participation service at the time you retire, ranging from 50% to 80% of the cost of Medex. Each year, Harvard recalculates the amount of the University subsidy.

Retirees and eligible spouses/domestic partners **under age 65** may choose from the plans offered to active employees and will pay the same rate as active employees, depending on their salary tier at the time of retirement.

If you worked a certain number of full years and less than six months, the months are dropped and the University's contribution is based on the full years only. If you worked a number of full years and six months or more, the number of months is rounded up and the University's contribution reflects the additional year.

If you are not eligible for Harvard medical coverage at retirement, you may have the option of continuing Harvard coverage through COBRA. For details, see Your Rights Under COBRA Continuation Coverage in Section 10.1.

Medical Plan Options

There are three plans available to retirees and spouses age 65 and older:

- Blue Cross Blue Shield Medex
- Harvard Pilgrim Health Care Medicare Enhance
- Tufts Medicare Preferred HMO

Prescription Drug Coverage

Your prescription drug benefit is included as part of your medical plan premium and is administered by Catamaran/OptumRx, a pharmacy benefits manager. Upon initial enrollment in a Harvard-sponsored retiree medical plan, you will receive instructions for prescription drug services. Prescription drug coverage has three copayments tiers, with most generic medications having the lowest copayment.

The Retiree Medical Plan Comparison Chart outlining plan details is available from the Benefits Office.

Retiree Dental

If you meet the eligibility requirements for post-retirement health, you and your spouse/domestic partner (and eligible dependent children, if any) may participate in the retiree Delta Dental Plan.

You have two opportunities to enroll in retiree dental coverage:

- You must enroll in the benefit at the time of retirement; or
- If you defer enrolling in retiree medical coverage at the time you retire, you may also defer your enrollment in retiree dental. At the time that you later enroll in medical coverage, you can also enroll in retiree dental coverage.

If you do not choose to enroll at one of these two times, you will not be able to do so later. You may cancel your dental coverage during any Open Enrollment period, with an effective date of the following January 1. Or, if you experience an IRS-defined change in status during the year, you may cancel your coverage within 30 days of the change in status. If you cancel retiree dental coverage, you will not be able to re-enroll at a later date.

6. HOW DO I FILE OR APPEAL A CLAIM?

For in-depth information on how to file or appeal a benefits claim, please review this section.

6.1 ERISA Claims Procedures for Health Claims

Claiming Benefits

A health plan benefits claim is a request for a Plan benefit or benefits, made by a covered employee/dependent or their representative that complies with the Plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a Plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30-day period if additional information is required to process the claim, and may request a one-time extension not longer than 15 days and put your claim on hold until all information is received.

Once notified of the extension, you have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will automatically be denied.

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 15 days of receipt of the Pre-Service Claim. You will be given at least 45 days from the receipt of this notice to correct your claim.

The Plan Administrator will notify you of its determination within 15 days after the claim is received, unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning on the earlier of (i) the date the missing information is received by the Plan Administrator or (ii) the end of the period afforded to you to provide the missing information. Otherwise, the extension shall not exceed 15 days from the end of the initial 15-day period.

If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims That Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided by the Plan Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan Administrator reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Plan Administrator shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Adverse Benefit Determination

If a claim is wholly or partially denied, or if a rescission of coverage occurs (each, an "Adverse Benefit Determination") the Plan Administrator will furnish the Plan participant with a written notice of the Adverse Benefit Determination. The written notice will contain the following information:

(a) the specific reason or reasons for the Adverse Benefit Determination;

(b) specific reference to those Plan provisions on which the Adverse Benefit Determination is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary;

(d) appropriate information as to the steps to be taken if a Plan participant wishes to submit the claim for review;

(e) In the case of an Adverse Benefit Determination by the Plan:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either (1) the specific rule, guideline, protocol, or (2) other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the participant upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request;

(f) In the case of an Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(g) In the case of an Adverse Benefit Determination, the Plan must:

- Ensure that any notice of Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and provide notice of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- Ensure that the reason or reasons for the Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim;
- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Appealing a Denied Claim

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Plan will identify, upon request to the Plan Administrator, any medical experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card,
- The date(s) of service(s),
- The provider's name,
- The reason you believe the claim should be paid, and
- Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

The review of your appeal shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which:

- You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the participant by telephone, facsimile, or other available similarly expeditious method.

The Plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

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

Timing of Notification of Benefit Determination on Review

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first-level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first-level appeal decision.

For appeals of Post-Service Claims (as defined above), the first-level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals That Require Immediate Action" below.

If you are not satisfied with the first-level appeal decision of the Plan Administrator, you have the right to request a second-level appeal from the Plan Administrator. Your second-level appeal request must be submitted to the Plan Administrator within 15 days of the receipt of the first-level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Plan Administrator's decisions are conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

Manner of Notification of Final Internal Adverse Benefit Determination

The Plan Administrator shall provide a participant with written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the participant:

(a) The specific reason or reasons for the Adverse Benefit Determination;

(b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(c) A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain the information about such procedures;

(e) A statement of the participant's right to bring an action under Section 502(a) of the Act; and

(f) The following information:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(g) In the case of an Adverse Benefit Determination the Plan must:

- Ensure that any notice of Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- Ensure that the reason or reasons for the Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim. This description must also include a discussion of the decision;

- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

External Review

In the case of an Adverse Benefit Determination, you may be entitled to request an independent, external review of our decision. If your situation is urgent, you may be entitled to an expedited external review.

More information about your external review rights, including the time frame and procedure for requesting an external review, will be provided to you in the Notice of Final Internal Adverse Benefit Determination.

6.2 ERISA Claims Procedures for Disability Claims

Manner and Content of Notification of Claims Decision

The Plan Administrator will provide a claimant with written or electronic notification of the Plan's claims decision. If a disability claim is wholly or partially denied, the Plan Administrator will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the extension is necessary due to matters beyond the control of the Plan. After the expiration of the first 30-day extension of time, an additional 30-day extension may be necessary due to matters beyond the control of the Plan. If an extension or an additional extension is required, the Plan Administrator will notify the claimant in writing or electronically prior to the commencement of the extension or additional extension. The notice to the claimant will state the reason for the extension and the date by which the Plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

In the case of an adverse claims decision, the notification will include:

(i) The specific reasons for the adverse decision;

(ii) Reference to the specific Plan provisions on which the decision is based;

(iii) A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why that material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action following an adverse claims decision on review;

(v) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol; or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon request; and

(vi) If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; or (2) a statement that an explanation will be provided free of charge to the claimant upon request.

Appeal of Adverse Claims Decisions

Upon receipt of an adverse claims decision, the claimant (or the claimant's authorized representative) has up to 180 days to file an appeal with the Plan Administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the Plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

Notification of Claims Decision on Review

The Plan Administrator will notify the claimant of the Plan's claims decision on review within a reasonable time period appropriate to the circumstances but not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse claims decision. The 45-day period may be extended for another 45 days if the reviewer finds that special circumstances warrant an extension of time. If an extension of time is required, notice of the extension will be furnished to the claimant prior to the commencement of the extension.

Manner and Content of Notification of Claims Decision on Review

The Plan Administrator will provide claimants with written or electronic notification of a Plan's benefit determination on review. If the disability claim is wholly or partially denied on review, the Plan Administrator will provide the claimant with a written notification that will include:

(i) The specific reasons for the adverse decision;

(ii) Reference to the specific Plan provisions on which the claims decision is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all records relevant to the claimant's claim for benefits; a statement of the claimant's right to bring a civil action following an adverse claims decision on review;

(iv) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol; or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon request;

(v) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (2) a statement that the explanation will be provided free of charge to the claimant upon request; and

(vi) The following statement: "The group policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance."

6.3 ERISA Claim Procedures for All Other Welfare Plans

If your claim is wholly or partially denied, the Plan Administrator will provide you with a written notification, which will include (i) the specific reasons for the denial, (ii) reference to the specific Plan provisions upon which the denial is based, (iii) a description of any additional information necessary for you to perfect your claim with an explanation of why the information is needed, and (iv) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of benefits on review.

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

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

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

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

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards within these claims procedures in making the benefits determination.

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

You may have representation throughout the review procedure.

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

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

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

7. HOW DO I GET IN TOUCH?

If you have any specific questions, please refer to the chart below for your benefit providers' contact information.

7.1 Benefits Contact Information

For all general benefits questions, please contact:

Harvard Human Resources, Benefits
617-496-4001
benefits@harvard.edu or
hr.harvard.edu > Compensation & Benefits

Plan Name and Number	Plan Sponsor and Identification Number	Plan Administrator and Agent for Legal Services	Plan Type, Administration, & Plan Year End	Contact Information for Individual Plans
MEDICAL				
Harvard University Flexible Benefits Plan (PN 501)	Harvard University 114 Mt Auburn St. Cambridge, MA EIN #: 04-2103580	Harvard University Harvard Human Resources 114 Mt Auburn St. Cambridge, MA 617-496-4001	Medical Self-Insured and Fully Insured plans December 31	**Harvard University Group Health Plan** 617-495-2008 hughp.harvard.edu **Harvard Pilgrim Health Care** 888-333-4742 harvardpilgrim.org **Tufts Medicare Preferred HMO** 800-936-1902 tuftshealthplan.com **Harvard Pilgrim Medicare Enhance** 877-679-5667 harvardpilgrim.org **Blue Cross Blue Shield Medex** 800-882-1093 bcbsma.com **Kaiser Permanente** 855-249-5018 **Care First/Blue Cross Blue Shield** 888-567-9155 **OptumRx** (Harvard's Pharmacy Benefits Manager) 844-265-1224 optumrx.com

Plan Name and Number	Plan Sponsor and Identification Number	Plan Administrator and Agent for Legal Services	Plan Type, Administration, & Plan Year End	Contact Information for Individual Plans
MEDICAL				
			Global Benefits Plan Fully Insured December 31	**Metropolitan Life Insurance Company (MetLife)** (contact the Regional Service Center shown on your MetLife Expatriate ID card)
DENTAL				
			Dental Self-Insured December 31	**Delta Dental of Massachusetts** 800-872-0500 deltadentalma.com
Retiree Association Dental Plan (PN 518)	Harvard University 114 Mt Auburn St. Cambridge, MA	Harvard University Harvard Human Resources 114 Mt Auburn St. Cambridge, MA 617-496-4001	HURA Dental Fully Insured December 31	**Delta Dental of Massachusetts** 800-872-0500 deltadentalma.com
VISION				
			Vision Plan Fully Insured December 31	**Davis Vision** 800-448-8245 davisvision.com/members enter Client Code 2556
LIFE AND DISABILITY				
			Basic and Contributory Life Fully Insured December 31	**Metropolitan Life Insurance Company (MetLife)** 800-638-6420 metlife.com
			Long Term Disability Fully Insured December 31	**The Standard Insurance Company** 855-758-4775 (toll-free Harvard-dedicated line for claims questions) standard.com

Plan Name and Number	Plan Sponsor and Identification Number	Plan Administrator and Agent for Legal Services	Plan Type, Administration, & Plan Year End	Contact Information for Individual Plans
COPAYMENT REIMBURSEMENT AND REIMBURSEMENT PROGRAMS				
Harvard University Medical Reimburse-ment Program (PN 506)	Harvard University 114 Mt Auburn St. Cambridge, MA EIN #: 04-2103580	Harvard University Harvard Human Resources 114 Mt Auburn St. Cambridge, MA 617-496-4001	Health Care Spending Account Self-Insured December 31	This benefit is administered by **Benefit Strategies**. For any questions, contact: (T) 855-HVD-FLEX (855-483-3539) (F) 603-647-4668 benstrat.com hvdflex@benstrat.com
SPENDING ACCOUNTS AND HEALTH SAVINGS ACCOUNT				
Benefit Strategies FSAs and HSA (PN 506)				**Benefit Strategies** (T) 855-HVD-FLEX (855-483-3539) (F) 603-647-4668 benstrat.com hvdflex@benstrat.com

8. WHAT ARE MY RIGHTS UNDER ERISA?

As a participant in the Plan, you are entitled to certain rights and protections under ERISA, which are detailed in this section.

8.1 Description of ERISA Rights

Receive Information About Your Plan and Benefits

If you participate in the Plan, ERISA provides that you shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operations of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The 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 the summary annual report.

Continue Group Health Plan Coverage

In certain instances, you will be entitled to continue health care coverage for yourself, spouse, domestic partner, or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event (as described in further detail in Section 10.1. You or your dependents may have to pay for such coverage. Harvard's group health plans include the medical/dental portions of the Harvard University Flexible Benefits Plan (Plan No. 501) and the Harvard University Medical Reimbursement Program (Plan No. 506).

Domestic Partners (same-sex and opposite-sex) are not considered qualified beneficiaries under COBRA. However, Harvard extends rights similar to COBRA to eligible Domestic Partners.

You should review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan 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 a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, contact the Benefits Office at 617-496-4001. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or on the U.S. Department of Labor's website (www.dol.gov/ebsa), or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA or visiting www.dol.gov/ebsa.

9. WHAT ELSE DO I NEED TO KNOW?

Review this section for important administrative information about the Plan.

9.1 Sources of Plan Contributions and Election of Benefits

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

9.2 Third-Party Liability

The Plan provides payment for covered expenses if you or your dependents are ill or injured. However, if a third party (person or organization) is at fault for the illness or injury and you or your covered dependents bring a claim against the third party, you must reimburse the Plan for any Plan-paid benefits immediately after you collect damages. The Plan will be reimbursed in full from any judgments, insurance policy proceeds, or settlement before any amounts from such judgment, proceeds, or settlements, including attorneys' fees you incur, are paid to any other person, regardless of the manner in which the recovery is structured.

The Plan may file a lien against the third party, or the third-party's agent or with the court, and you agree to consent to such lien. You must take any reasonable actions necessary to protect the Plan's subrogation and reimbursement rights, including notifying the Plan Administrator if and when you or your covered dependents file a lawsuit or other action or enter into a settlement negotiation with another party (including his or her insurance company) in connection with the conduct of such party. You must cooperate with the Plan's reasonable requests concerning its subrogation and reimbursement rights and must keep the Plan Administrator informed of any developments in any legal actions or settlement negotiations. You also agree that the Plan may withhold any future benefits paid by the Plan to the extent necessary to reimburse the Plan under its subrogation and reimbursement rights.

The Plan is subrogated to all the rights you may have against any third party, including an insurance company, liable for your injury or illness or for the payment for the medical treatment of such injury or illness up to the value of the benefits provided to you under the Plan. The Plan may assert its subrogation rights independently. You will cooperate with the Plan and its agents to protect these subrogation rights by, among other things, providing the Plan with relevant information that it requests, signing and delivering such documents as the Plan may reasonably require to secure its rights, and obtaining the Plan's consent before releasing any party from liability for payment. Any litigation or settlement negotiations will be undertaken so as to not prejudice, in any way, the Plan's subrogation rights.

Contact your insurer or consult your Harvard Pilgrim Health Care Benefit Handbook or your Blue Cross Blue Shield Benefits Description (Massachusetts only) for details on your medical plan's right to recover benefits on behalf of you or your dependent(s).

9.3 Additional Documentation

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

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

9.4 Agent for Service of Legal Process

Legal process may be served on the Plan Administrator.

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

Harvard University
Office of Human Resources
Smith Campus Center, 6th Floor
Cambridge, MA 02138
(617) 496-4001

10. REQUIRED NOTICES

10.1 Continuation of Health Care Benefits—COBRA

A federal law known as "COBRA" requires that most employers sponsoring group health plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of health coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.)

If you are an employee of Harvard or one of the participating employers (the "Employer") covered by a group health plan maintained by Harvard (the "Health Plan"), you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Health Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Health Plan for any of the following four reasons:

(1) The death of your spouse;

(2) Your spouse's separation from employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer;

(3) Divorce or legal separation from your spouse; or

(4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Health Plan, he or she has the right to choose continuation coverage if group health coverage under the Health Plan is lost for any of the following five reasons:

(1) The death of the employee;

(2) The employee's separation from employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the Employer;

(3) The employee's divorce or legal separation;

(4) The employee becomes entitled to Medicare; or

(5) The dependent ceases to be a "dependent child" under the Health Plan.

Rights similar to those described above may, in certain instances, apply to retirees, spouses, and dependents if Harvard is involved in a proceeding under Title 11, United States Code, and those individuals lose health coverage as a result of that proceeding.

Under the law, the employee or a family member has the responsibility to inform Harvard of a divorce, legal separation, or a child losing dependent status under the Health Plan within 60 days of the later of the date of such event or the date on which coverage would be lost because of such event. Failure to do so within the time limits will result in loss of eligibility for COBRA continuation. Harvard has the responsibility to notify the Plan Administrator of the employee's death, separation from employment, reduction in hours, or Medicare entitlement.

If you lose coverage because of a qualifying event, you have at least 60 days from the date you lost coverage to inform Harvard that you want to elect continuation coverage. If you do not elect continuation coverage on a timely basis, your group health coverage will end. If you elect continuation coverage, Harvard is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months from the date employment terminated or hours were reduced if a second event entitling you to choose continuation coverage (such as death, divorce, legal separation, ceasing to be a dependent child, or Medicare entitlement) occurs within that 18-month period.

The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration (for purposes of Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiariesdue to a termination in employment or reduction in hours. To benefit from this extension, the qualified beneficiary must notify Harvard of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18-month period of continuation coverage. The qualified beneficiary must also notify the Employer within 30 days of the date of any final determination by the Social Security Administration that the individual is no longer disabled. Furthermore, the monthly premium cost to such a qualified beneficiary during the 11-month extension will be increased to 150% of the applicable premium relating to continuation coverage.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Health Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator within 60 days of the birth or adoption.

However, the law also provides that your continuation coverage may be cut short for any of the following five reasons:

(1) Harvard no longer provides group health coverage to any of its employees;

(2) The premium for continuation coverage is not paid on a timely basis;

(3) The qualified beneficiary becomes covered—after the date he or she elects COBRA coverage—under any other group health plan (as an employee or otherwise);

(4) The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;

(5) The qualified beneficiary extends coverage for up to 29 months due to a disability and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

Failure to pay any required premium on a timely basis will result in the permanent termination of continuation coverage.

The law also says that, at the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if such an individual conversion health plan is otherwise generally available under the Health Plan.

Continuation coverage under COBRA is provided subject to the qualified beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

You also may have other options available to you when you lose group health plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's or domestic partner's plan), even if that plan generally does not accept late enrollees.

If You Have Questions About COBRA or the Marketplace

If you have questions about COBRA continuation coverage, you should contact the Benefits Office at 617-496-4001, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of any Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

Administration of COBRA/Contact Information

The Plan Administrator is responsible for administering COBRA. Notices that you are required to send to the Plan Administrator should be sent to Crosby Benefit Systems, PO Box 414944, Boston, MA 02241-4944, to whom the Plan Administrator has delegated this responsibility.

10.2 Genetic Information Nondiscrimination Act of 2008 (GINA)

Under GINA, an insurance provider or your employer may not discriminate against you on the basis of genetic information, including by adjusting premiums and contribution amounts.

10.3 Health Insurance Portability and Accountability Act (HIPAA) Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Harvard University Medical Plan or in the medical insurance coverage offered under the Harvard University Global Benefits Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). Generally, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage); however, if your or your dependents' other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends.

In addition, if you have a new dependent as a result of marriage, creation of a domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, creation of the domestic partnership, birth, adoption, or placement for adoption. To request special enrollment or to obtain more information, contact the Benefits Office at 617-496-4001.

10.4 HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. A copy of this notice can also be found on hr.harvard.edu.

You are receiving this Notice because you are a member of one or more of the following Plans: the Harvard University Medical Plan, the Harvard University Dental Plan, the Harvard University Vision Plan, and/or the Harvard University Medical Reimbursement Plan (each a "Plan" and collectively the "Plans").

Harvard University (the "Employer" or the "University") is committed to protecting the privacy of health information maintained by the Plans and by outside vendors who perform services for the Plans. The Plans are required by law to protect the privacy of certain health information that may reveal your identity ("protected health information" or "PHI"), and to provide you with a copy of this Notice, which describes the Plans' health information privacy practices. If you have any questions about this Notice or would like further information about this Notice, please contact the Harvard Benefits Privacy and Security Official named on page 58.

Generally, the term Protected Health Information (PHI) includes all individually identifiable health information concerning you that is maintained by the Plans, including genetic information. PHI does not include health information that is held by the University in its role as your employer (for example health information held for purposes of your employment records). "Unsecured PHI" is PHI that is not secured through the use of a technology or methodology that renders the PHI unusable, unreadable, or indecipherable.

PHI uses and disclosures by the Plans are regulated by a federal law called the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA") and the regulations that enforce HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). You may find these regulations at 45 Code of Federal Regulations Parts 160 and 164.

This Notice does not apply to certain information, which may be used and disclosed by the Employer and other third parties without notice and without your authorization. For instance, the Employer and the Employer's consultants and contractors may use and disclose information contained in your employment records held by the Employer in its role as employer, including information regarding pre-employment health testing. In addition, the Employer and the Employer's consultants and contractors may use and disclose information concerning benefits that are not part of the Plans, such as disability and life insurance, without notice and without your authorization. This information is not covered by HIPAA privacy regulations or this Notice.

SUMMARY OF PERMISSIBLE USES AND DISCLOSURES AND YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The following is a summary only, for your convenience. Please read the entire Notice for a more complete description of the Plans' privacy practices and your rights.

1. Requirement of Written Authorization

A Plan will obtain your written authorization before using your health information or sharing it with others outside the Plan except as otherwise described in this Notice or as otherwise permitted by law. In that regard, the Plans must obtain your written authorization for any use or disclosure of psychotherapy notes, except in some very limited circumstances (e.g., for the Plans to defend themselves in legal proceedings brought by you, for the U.S. Department of Health and Human Services to determine the Plans' compliance with HIPAA or to avert a serious and imminent threat to public health or safety). Also, without your written authorization, the Plans cannot receive direct or indirect financial remuneration for the sale of your PHI, unless an exception applies (such exceptions include certain public health activities, your treatment, services by a business associate on behalf of the Plans, or providing you with a copy of your PHI). If you provide a Plan with written authorization, you may revoke that authorization by notifying the Plans' Privacy and Security Official at any time, except to the extent that the Plan has already relied on it. To revoke an authorization, please write to the Privacy and Security Official named on page 58.

Except as otherwise permitted or required, as described in this Notice, the Plans may not use or disclose your PHI without your written authorization. Any use or disclosure of PHI pursuant to such authorization must be consistent with that authorization.

2. Exception to Written Authorization

As indicated above, there are some situations when a Plan will not require your written authorization before using your health information or sharing it with others. Some examples of those situations are:

- **Payment and Health Care Operations.** A Plan may use and disclose your health information in connection with paying claims or running the Plan's normal business operations. Payment and health care operations include a Plan's disclosures to business associates that perform certain services for the Plan, or act on behalf of the Plan. In connection with any disclosure to a business associate, a Plan will obtain an appropriate agreement from the recipient of your information in order to restrict further redisclosure to the extent required by law. The Plans' business associates are required to agree, in writing, to maintain the confidentiality of the health information to which they are provided access and to notify the Plans in the event of a breach of your Unsecured PHI. The Plans also may disclose PHI to employees of the Employer if those employees assist in carrying out treatment, payment, and health care operations, provided that the PHI is used for these purposes. Nonetheless, the Plan cannot use or disclose genetic information that is PHI for underwriting purposes.
- **Disclosures to the Employer.** A Plan may disclose certain aspects of your health information to the Employer as the sponsor of the Plan. A Plan, however, will restrict the Employer's uses of your information to purposes related only to the Plan's administration. The Plans prohibit the Employer from using your information for employment-related actions or decisions (e.g., for terminating your employment). The Employer or a Plan may also disclose your information to another party that assists the Employer in administering the Plan or performing other functions for the Employer in connection with the Plan, but only if the Employer obtains an appropriate confidentiality agreement from the person or organization receiving your health information.
- **Emergencies or Public Need.** A Plan may use or disclose your health information in an emergency or for important public needs. For example, a Plan may share your information if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Information That Does Not Identify You.** A Plan may use or disclose your health information if the Plan has removed any information that might reveal who you are (in which case the information is not covered by this Notice), or for certain limited purposes if the Plan has removed most information revealing who you are and obtained a confidentiality agreement from the person or organization receiving your health information.

3. Access and Control of Your Health Information

The Plans must provide you certain rights with respect to access and control of your health information. A substantial part of your health information is likely to be maintained by one or more business associates of the Plans, and not by the Employer. If your request pertains to information that is maintained by a business associate that is a third-party administrator of your benefits (for example, Crosby Benefit Systems, Inc.), you should make your request directly to such third-party administrator. The Benefits Office will provide you with contact information at your request and can help you determine to whom your request should be addressed. You have the following rights to access and control your health information:

- **Access.** You generally have the right to inspect and copy your health information in a designated record set (i.e., the group of records maintained by the Plans used to make decisions about you, such as records of enrollment, payment, claims adjudication, and case or medical management records). This right of access does not extend to psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act prohibits access or information held by certain research laboratories.
- **Amendments.** You have the right to request that a Plan amend your health information regarding Plan records (for example, billing records) if you believe it is inaccurate or incomplete.
- **Tracking the Ways Your Health Information Has Been Shared with Others.** You have the right to receive a list from a Plan, called an "accounting list," which provides information about how the Plan has disclosed your health information to outside persons or organizations during the relevant accounting period (see discussion below). Many routine disclosures a Plan makes, including certain disclosures to your Employer for the purposes of administering the Plan, will not be included on this list (but such disclosures made through electronic health records will be on the list).
- **Additional Privacy Protections.** You have the right to request further restrictions on the way a Plan uses your health information or shares it with others. A Plan or other HIPAA "covered entity" (including a health care provider) is not required to agree to the restriction you request (unless the requested restriction is for a health care provider not to disclose to a health plan information regarding health care services for which you (or someone on your behalf other than the Plans) have paid the full cost out of your own pocket), but if the Plan does agree the Plan will be bound by the agreement.
- **Confidential Communications.** You have the right to request that a Plan contact you in a way that is more confidential for you, such as at work instead of at home, if disclosure of your health information could put you in danger and you clearly state that in your request. A Plan will try to accommodate all reasonable requests.

4. To Have Someone Act on Your Behalf

Under certain circumstances, you may have the right to name a personal representative who can act on your behalf to control the privacy of your health information.

5. Copies of Notice

If you have received this Notice electronically, you have the right to a paper copy of this Notice if you have not already received one. You may request a paper copy at any time, even if you have previously agreed to receive this Notice electronically. A Plan will be required by law to abide by its terms that are currently in effect. However, a Plan also may change its privacy practices from time to time. If that happens, the Plan will revise this Notice so you will have access to an accurate summary of the Plan's privacy practices. The revised notice will apply to all of your health information maintained by the Plan. To request a paper copy of this Notice or any revised notice, please call the Privacy and Security Official named on page 58.

6. Complaints

If you believe your privacy rights with regard to a Plan have been violated, you may file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with a Plan, please contact the Privacy and Security Official. *No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED?

The Plans are committed to protecting the privacy of your protected health information. This Notice only covers health information that can identify you and that has been created or received by or for a Plan. Some examples of protected health information are:

- Information regarding payment for your health care;
- Information about your health condition (such as your diagnosis); and
- Information about health care services you have received or may receive in the future (such as surgery or prescriptions).

Identifying information includes any unique numbers or characteristics (such as your name, address, Social Security number, phone number, or health plan beneficiary number as listed on claims forms).

HOW A PLAN MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Payment and Health Care Operations

A Plan may use and disclose most health information about you to make payments and perform health care operations without your written authorization. Your information may also be disclosed to other persons or organizations outside a Plan so that they may perform certain types of payment activities and health care operations along with, or for, the Plan. In addition, a Plan may use or disclose protected health information for payment and health care operations that these persons or organizations have received or created about you. Below are further examples of how your information may be used and shared.

- **Payment**. A Plan may use and disclose your health information for payment purposes. For example, a Plan may use and disclose your health information for purposes of paying for your health care services or to obtain Plan contributions or premiums from you. Other examples include using and disclosing your health information to make determinations about your eligibility for benefits, to perform claims management (including, but not limited to, appeals of denied claims), to review the medical necessity or the appropriateness of the care you received, to obtain payment under a stop loss insurance policy, and to conduct utilization reviews such as pre-authorizations, or reviews, of services. In addition, a Plan may disclose your health information to the Employer for these purposes.
- **Health Care Operations**. A Plan may use and disclose your health information to conduct normal business operations. For example, a Plan may use your health information to evaluate performance in managing and providing you with health care benefits. A Plan also may use and disclose your health information to investigate the validity of benefits claims or in connection with obtaining stop loss insurance. In addition, a Plan may share your health information with another company that performs certain services, such as billing, compiling information, or performing audits or quality assessment to help the Plan determine how the Plan is doing relative to other health plans. Whenever a Plan has such an arrangement, it will have an appropriate agreement to ensure that the company that performs these services will protect the privacy of your health information, maintain its confidentiality, and limit the uses or further disclosures to the purpose for which the information was disclosed or to those required by law. In addition, the Employer may receive and disclose your health information to third parties for health care operations if the Employer has obtained an appropriate agreement from the person or organization receiving your health information.
- **Benefits and Services**. As part of health care operations, a Plan may use your health information to contact you regarding benefits or services that may be of interest to you where the Plan will not be receiving any direct or indirect financial remuneration in connection with such contact; receipt of such remuneration by a Plan will require your written authorization and you will have the right to opt out of receiving such contacts. Furthermore, you will have the right to opt out of receiving any fundraising communications (within the meaning of HIPAA) from the Plans.

2. Employer

- A Plan may disclose certain aspects of your health information to the Employer, as described above. Upon a request from the Employer, a Plan may disclose summary health information about you (information that identifies you only by zip code) to enable the Employer to modify, amend, or terminate the Plan. A Plan may also disclose to the Employer information on whether you are participating in, enrolled in, or disenrolled from the Plan. A Plan also may disclose health information about you, including information that identifies you, if it is necessary for the Employer to administer the Plan. For example, the Employer may need such information to process health benefits claims (including the review of denied claims), to audit or monitor the business operations of a Plan, to obtain stop loss insurance and stop loss insurance recoveries, or to ensure that the Plan is operating effectively and efficiently. A Plan, however, will restrict the Employer's uses of this information to purposes related only to Plan administration. The Plans prohibit the Employer from using protected health information received from the Plans for uses unrelated to Plan administration. Under no circumstances will a Plan disclose your health information to the Employer for the purpose

of employment-related actions or decisions (e.g., for employment termination) or for the purpose of administering any other plan that the Employer may offer (e.g., a plan that is not part of any Plan). The Employer may only allow this health information to be received by third parties, such as consultants or advisors, if the Employer has first obtained an appropriate agreement from the person or organization receiving your health information.

3. Emergencies or Public Need

A Plan may use your health information, and share it with others, in an emergency or to meet important public needs. A Plan will not be required to obtain your written authorization or any other type of permission before using or disclosing your information for these reasons:

- **As Required By Law.** A Plan may use or disclose your health information if the Plan is required by law to do so. A Plan also will notify you of these uses and disclosures if notice is required by law.
- **Emergencies or Public Need.** A Plan may use or disclose your health information in an emergency or for important public needs. For example, a Plan may share your information with public health officials authorized to investigate and control the spread of diseases. A Plan may also share information about you as necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. In such cases, a Plan will only share your information with someone able to help prevent the threat.
- **Public Health Activities.** A Plan may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, a Plan may disclose your health information to government officials who are responsible for controlling disease, injury, or disability. A Plan may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits the Plan to do so.
- **Health Oversight Activities.** A Plan may disclose your protected health information to government agencies authorized to conduct audits or investigations of the Plan.
- **Lawsuits and Disputes.** A Plan may disclose your health information if the Plan is ordered to do so by a court that is handling a lawsuit or other dispute. A Plan may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.
- **National Security and Intelligence Activities or Protective Services.** A Plan may disclose your health information to authorized federal officials who are conducting national security and intelligence activities, or providing protective services to the President of the United States or other important officials.
- **Military and Veterans.** If you are in the Armed Forces, a Plan may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. A Plan may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** A Plan may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries.
- **Other Uses and Disclosures.** While federal law allows health plans to use and disclose plan members' information for treatment purposes and for other purposes to benefit the public (e.g., for scientific research) without members' authorization, the Plans do not currently use or disclose their members' information in these ways.

4. Disclosures to Friends, Family, and Others Involved in Your Care and Payment for Your Care

- In the exercise of its professional judgment, a Plan may share information about your health benefits with those involved in your care or payment for your care unless you object. If you have provided your family members or friends with copies of your claim, your Harvard University ID number, or other relevant identifying information, a Plan will assume that you do not object unless you notify the Privacy and Security Official otherwise.

5. Completely De-Identified or Partially De-Identified Information

- A Plan may use and disclose your health information if the Plan has removed any information that has the potential to identify you so that the health information is "completely de-identified." A Plan may also use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, Social Security number, telephone number, fax number, electronic mail address, website address, or license number).

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

The Plans want you to know that you have the following rights to access and control your protected health information. These rights are important because they will help you make sure that the health information the Plans have about you is accurate. They may also help you control the way the Plans use or share your information, or the way the Plans communicate with you about benefits matters.

A substantial portion of your health information is maintained by one or more business associates of the Plans, and not by the Employer. If your request pertains to information that is maintained by a business associate that is a third-party administrator of your benefits (for example, Crosby Benefits Systems, Inc.), you should make your request directly to such third-party administrator. Harvard Human Resources, Benefits will provide you with contact information at your request and can help you determine to whom your request should be addressed. You have the following rights to access and control your health information:

1. Right to Inspect and Copy Records

You have the right to inspect and obtain a copy of your protected health information that may be used to make decisions about you and the provision of your health care benefits for as long as a Plan maintains this information in a designated record set. This includes records relating to payment of your health care benefits. As discussed above, certain exceptions apply to this right. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy and Security Official or contact the appropriate third-party administrator. If you request a copy of the information, a Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies the Plan uses to fulfill your request. If your protected health information is in an electronic health record, you may request that electronic health record be electronically sent in a readily producible form and format to you (or an individual you designate) and state where it is to be sent. Any costs to you for such electronic delivery will be limited to the labor costs for sending that record.

A Plan ordinarily will respond to your request within 30 days if the information is located at the Employer, and within 60 days if it is located off-site at another facility. If a Plan needs additional time to respond, the Plan will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain limited circumstances, a Plan may deny your request to inspect or obtain a copy of your information. If a Plan denies part or all of your requests, the Plan will provide a written denial that explains the reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The Plan will also include information on how to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. If a Plan has grounds to deny your access to part of the health information requested, the Plan will do its best to provide you with access to the rest of the information after excluding the parts the Plan cannot let you inspect or copy.

2. Right to Request to Amend Records

If you believe that the health information a Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept in the Plan's records. To request an amendment, please write to the Privacy and Security Official or contact the appropriate third-party administrator. Your request should include the reasons why you think the Plan should make the amendment. Ordinarily a Plan will respond to your request within 60 days. If a Plan needs additional time to respond, the Plan will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If a Plan denies part or all of your requests, the Plan will provide a written notice that explains the reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with a Plan's decision, you will have an opportunity to submit a statement explaining your disagreement, which the Plan will include in your records. A Plan will also include information on how to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice the Plan sends you.

3. Right to an Accounting of Disclosures

You have a right to request an "accounting of disclosures," which is a list detailing how a Plan has shared your protected health information during a relevant accounting period (six years before the date of that request for non-electronic PHI, three years before the date of that request for electronic PHI to carry out treatment, payment and health care operations) with others. An accounting list, however, will not include:

- Disclosures the Plan made to you;
- Disclosures the Plan made in order to provide you with benefits or conduct the Plan's normal business operations (i.e., Plan administration), including those disclosures made to business associates of the Plan, except for disclosures through electronic health records;
- Disclosures to the Employer for purposes related to administration of the Plan, except for disclosures through electronic health records;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures of information that only indirectly identifies you (for example, through dates but not by name); or
- Disclosures not made during the relevant accounting period.

To request an accounting list, please write to the Privacy and Security Official or contact the appropriate third-party administrator. Your request must state a time period within the past six years for the disclosures you want a Plan to include (but three years for electronic health records to carry out treatment, payment, and health care operations). You have a right to one accounting list within every 12-month period for free. However, a Plan may charge you for the cost of providing any additional lists in that same 12-month period. A Plan will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily a Plan will respond to your request for an accounting list within 60 days. If a Plan needs additional time to prepare the accounting list you have requested, the Plan will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting list. In rare cases, a Plan may have to delay providing you with the accounting list without notifying you because a law enforcement official or government agency has asked the Plan to do so.

4. Right to Additional Privacy Protections

You have the right to request that a Plan further restrict the way the Plan uses and discloses your health information to provide you with benefits or to run normal business operations. You may also request that a Plan limit how the Plan discloses information about you to those involved in your care where, absent such a limitation, the Plan may share your health information with family and friends involved in your care or payment for your care without your written authorization. For example, you could request that a Plan not disclose information about a prescription drug you are taking. To request restrictions, please write to the Privacy and Security Official or contact the appropriate third-party administrator. Your request should include (1) what information you want to limit; (2) whether you want to limit how a Plan uses the information, how the Plan shares it with others, or both; and (3) to whom you want the limits to apply.

A Plan is not required to agree to your request for a restriction in all cases (but see above for the Plan's obligation to agree to requested restrictions relating to services for which you or someone on your behalf other than the Plans have paid the full cost out of your own pocket), and in some cases the restriction you request may not be permitted under law. However, if a Plan does agree, the Plan will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once a Plan has agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, a Plan will also have the right to revoke the restriction as long as the Plan notifies you before doing so; in other cases, a Plan will need your permission before the Plan can revoke the restriction.

5. Right to Request Confidential Communications

You have the right to request that a Plan communicate with you about your benefits matters in a method or location that is more confidential for you if the disclosure of part or all of your health information could put you in danger and you clearly state that in your request. For example, you may ask that a Plan contact you at work instead of at home. To request confidential communications, please write to the Privacy and Security Official or contact the appropriate third-party administrator. A Plan will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if a Plan communicates with you through this alternative method or location.

6. Privacy and Security Official and Business Associates

Privacy and Security Official
Harvard University
Harvard Human Resources, Benefits
114 Mt Auburn Street, 4th Floor
Cambridge, MA 02138
617-496-4001

To find out how to contact any Plan business associates who may have your health information, please contact the Privacy and Security Official.

7. The Right to Receive Notification in the Event of a Breach

You have the right to be notified following a breach of your Unsecured PHI. If such a breach occurs, you will be notified within the time and in the manner required by HIPAA.

8. Limitation of Use and Disclosures to Minimum Necessary Standard

Until the Secretary of the U.S. Department of Health and Human Services releases further guidance regarding the minimum necessary standard, a Plan will limit disclosures and uses of PHI to the information contained in a limited data set. However, if it is not practicable for a Plan to limit its use or disclosure of PHI to a limited data set, then a Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment purposes;
- Uses or disclosures made to you;
- Uses or disclosures authorized by you;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required by the Plans' compliance with legal requirements.

9. De-Identified Information, Limited Data Sets, and Summary Information

This Notice does not apply to health information that has been de-identified. De-identified information is information that does not identify an individual (i.e., you) and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plans may use or disclose information in a limited data set, provided that the Plans enter into a data use agreement with the limited data set recipient that complies with the federal privacy regulations. A limited data set is PHI that excludes certain direct identifiers relating to you and your relatives, employers, and household members.

The Plans may disclose "summary health information" to the University without your authorization if the University requests the summary information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plans, or for modifying, amending, or terminating the Plans. "Summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the University has provided health benefits under the Plans, and from which most identifying information has been deleted. The Plans may also disclose to the University information on whether an individual is participating in the Plans and the coverage in which an individual has enrolled.

10. Your Protections Under Other Federal and State Law

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. This Notice does not address requirements under other federal laws or under state laws. However, if other federal laws and/or state laws are stricter than the HIPAA privacy laws, the other federal and/or state laws must be followed. To the extent this Notice is in conflict with the HIPAA privacy rules, the HIPAA privacy rules shall govern.

Harvard University
Harvard Human Resources, Benefits
114 Mt Auburn Street, 4th Floor
Cambridge, MA 02138
617-496-4001

10.5 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

If any medical insurance option under the Plan (1) provides for both medical and surgical mental health or substance use disorder benefit and (2) is not subject to an increased cost exemption (within the meaning of the MHPAEA):

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

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

10.6 Newborns' and Mothers ' Health Protection Act (NMHPA) Statement

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

10.7 Notice of Right to Designate a Primary Care Provider (PCP)

Certain coverage options under the Harvard University Medical Plan require the designation of a primary care provider. (The medical insurance coverage offered under the Harvard University Global Benefits Plan does not require the designation of a primary care provider.) If you enroll in one of those coverage options under the Harvard University Medical Plan, you will be required to designate a primary care provider for yourself and each enrolled family member at the time you enroll. If you elect any of these coverage options under the Harvard University Medical Plan, you have the right to designate any primary care provider who participates in the applicable provider network and who is available to accept you or your family members. Until you make this designation, the applicable coverage option designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact HUGHP (617-495- 2008), HPHC (888-333-4742), Kaiser Permanente (855-249-5018), CareFirst/BlueCross BlueShield (888-567-9155), BlueCross BlueShield/Medex (800-882-1093), or Tufts Health Plan (800-936-1902) for information, as applicable.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Harvard University Medical Plan or the Harvard University Global Benefits Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HUGHP (617-495-2008), HPHC (888-333-4742), Kaiser Permanente (855-249-5018), CareFirst/BlueCross BlueShield (888-567-9155), BlueCross BlueShield/Medex (800-882-1093), Tufts Health Plan (800-936-1902), or MetLife Expatriate Benefits (call the telephone number of the Regional Service Center shown on your MetLife Expatriate Benefits ID card), for information, as applicable.

10.8 Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA provides for continuation of health care coverage if you are called for active duty military service. Except to the extent greater benefits are provided by Harvard, the maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

10.9 Women's Health and Cancer Rights Act (WHCRA) Notices

The Harvard University Medical Plan and the medical insurance coverage offered under the Harvard University Global Benefits Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provide benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

The benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Harvard University Medical Plan or the medical insurance coverage offered under the Harvard University Global Benefits Plan, as applicable. Therefore, the deductibles and coinsurance described in the materials provided to you by HUGHP, HPHC, Kaiser Permanente, CareFirst/BlueCross BlueShield, BlueCross BlueShield/Medex, Tufts Health Plan, or MetLife Expatriate Benefits, as the case may be, apply. If you would like more information on WHCRA benefits, call HUGHP (617-495-2008), HPHC (888-333-4742), Kaiser Permanente (855-249-5018), CareFirst/BlueCross BlueShield (888-567-9155), BlueCross BlueShield/Medex (800-882-1093), Tufts Health Plan (800-936-1902), or MetLife Expatriate Benefits (call the telephone number of the Regional Service Center shown on your MetLife Expatriate Benefits ID card), as applicable.