2019

Your Benefits Guide

Benefits for Our Postdoctoral Scholars
Welcome to Tufts University!

Tufts University is pleased to offer our Postdoctoral Scholars a benefits package that supports you and your family’s physical, emotional, and financial health. The benefits described here apply to Postdoctoral Scholars who are regularly scheduled for half time (17.5 hours per week) or greater. In addition, some of the benefits require a twelve months or longer appointment. Please see the eligibility requirements of each benefit listed in this guide.

We encourage you to carefully assess the benefit options and costs before making decisions for yourself and your family members.

**Eligibility:** Half-time regularly scheduled at 17.5 hours per week  
**Plans Offered:** Health, Dental, Commuter, 403(b)

**Eligibility:** Half-time regularly scheduled at 17.5 hours per week and 12+ Month appointment  
**Plans Offered:** Health, Dental, Commuter, 403(b), FSA

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### Benefit Plan Year 2019

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Health Plan

The plan offered is the **Access Blue New England Enhanced Value Plan**, which is an HMO Plan. You will not need a referral in this plan, but you must choose a primary care provider. This Individual coverage on the health plan is provided at no cost to eligible Postdoctoral Scholars. Coverage for spouses, domestic partners, and dependent children is paid for in full by the Postdoctoral Scholar through payroll deduction. Full Plan information including the Summary of Benefits and Coverage (SBC) can be found here:


Health Plan Details

**Coverage Begins:**

**If you are currently a Post Doc:** September 1, 2019

**If you are a new hire just beginning at the university:** Date of Hire or date you become benefits eligible

**Enrollment Period:** You must enroll within 31 days of hire date or newly benefit eligible using eServe

If you do not enroll within the enrollment period noted above, your future participation will be limited to a Qualifying Status Change or the Annual Open Enrollment time period. Contact TSS Tss@tufts.edu within 31 days of your Qualifying Event which will occur in November for benefits effective January 1, 2020.
## BCBSMA Access Blue New England Enhanced Value Plan Summary

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Type</strong></td>
<td>HMO</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0 Individual / $0 Family</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$2,000 Individual / $4,000 Family</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>$0 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Office Visits</strong> (Primary Care &amp; Specialist)</td>
<td>$20 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Outpatient Therapy</strong></td>
<td>$20 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chiropractic</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal and Postnatal Care</strong></td>
<td>$0 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Laboratory and X-Ray</strong></td>
<td>$0 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>High Cost Imaging (CT/PET Scans/MRIs)</strong></td>
<td>$0 copayment (pre-authorization may be required)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Urgent Care Centers</strong></td>
<td>$20 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Emergency Room (Waived if Admitted)</strong></td>
<td>$100 copayment, then covered 100%</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td>$250 per admission copayment (pre-authorization required)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$250 per event copayment (pre-authorization required for some services)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mental Behavioral Health – Inpatient Services (Includes substance abuse disorder)</strong></td>
<td>$250 per admission copayment (pre-authorization required)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mental Behavioral Health – Outpatient Services (Includes substance abuse disorder)</strong></td>
<td>$20 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong> (30 Day Supply at Retail)</td>
<td>$10 / $30 / $45</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Mail Order</strong> (90 Day Supply by Mail)</td>
<td>$20 / $60 / $135</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**NOTES:** All care must be medically necessary to be covered. “Preventive” prescription drugs are covered at $0 copayment as defined by the IRS. This list is subject to change. Please refer to the Summary of Benefits and Coverage for full details.
About the Plan

Access
Access Blue New England gives you the option to go directly to any specialist or doctor in the HMO Blue New England network. No referrals needed. Just show your ID card and receive care. Some services require prior authorizations.

MyBlue
Accessing your health care plan and claims information

Register and login at bluecrossma.com/myblue

aHealthyMe Rewards
Earn up to $400 per year!

Visit ahealthymerewards.com for interactive tools and information on how to create a personalized action plan. You will get rewarded for the healthy things that you do – the more you do, the more points you earn, and the more you will get rewarded. Each quarter, your points will start fresh, giving you another chance to earn big for living healthy.

Fitness and Weight-Loss Reimbursements
You May Qualify For Up To $150 In Reimbursements

- **Fitness**: Reimbursement can be submitted once each calendar year.
- **Weight-Loss**: a qualified weight-loss program is a Weight Watchers program with in-person meetings or a hospital based weight-loss program. A qualified expense is participation fees for up to 3 months. Weight Watchers online does not qualify. Reimbursement can be submitted once year calendar year.

Contact BCBSMA to confirm if your fitness or weight-loss expenses qualify for reimbursement: https://myblue.bluecrossma.com/health-plan/fitness-reimbursement-weight-loss
Member Services: (800) 358-2227
Alternatives to the Emergency Room

The Emergency Room is a $100 copay for members. There are alternatives in situations that are not true emergencies such as:

Blue Care Line 24/7

Trained nurses are available 24 hours a day if you have questions. Calling the Blue Care Line is a quick way to find out if you need to see a doctor, go to an emergency room, or if you can treat yourself at home. There is No Cost for this service.

Blue Care Line: 1-888-247-2583

Well Connection (Telemedicine) 24/7

Live video consults with licensed doctors over your smartphone for minor medical and behavioral health care for a regular doctor’s office visit copay of $20. The doctors have an average of 15 years of experience and can diagnose and treat your symptoms and prescribe medication if necessary. Download the Well Connection App. Or visit wellconnection.com for more information on access.

Urgent Care

Visit your local Urgent Care facility or visit https://myblue.bluecrossma.com/health-plan/find-doctor-provider-dentist for treatment of conditions that are not life threatening but require immediate attention (examples: broken bones, minor injuries, stitches, etc.). Your copay for this visit will be $20.
Dental Plan - Voluntary

Postdoctoral Scholars are eligible to participate in the Delta Dental PPO Plus Premier Voluntary Plan. This plan includes in and out-of-network coverage for preventive care and for other basic and major restorative services. These Postdoctoral Scholars pay reasonable rates for this coverage.

Dental Plan Details

If you are currently a Post Doc: The next opportunity to enroll in the dental plan will be in November for January 1, 2020 – December 31, 2020.

If you are a new hire just beginning at the university: Date of Hire or date you become benefits eligible

Enrollment Period: You must enroll within 31 days of hire date using eServe.

If you do not enroll during your initial enrollment period, your future participation will be limited to a Qualifying Status Change or the Annual Open Enrollment time period during the month of November. Contact TSS Tss@tufts.edu within 31 days of your Qualifying Life Event.

Delta Dental’s mobile app is available for smartphones and tablets using iOS (Apple) or Android. To download and install, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental.

Features:
➢ Dentist search
➢ View claims and coverage
➢ ID card
➢ Dental care cost estimator
# Delta Dental PPO Plus Premier Plan Summary

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Providers</th>
<th>Premier Network and Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$0</td>
<td>$100 per person for all services</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td></td>
<td>$1,000 per person</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Restorative</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Prosthetic Maintenance</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Emergency Dental Care</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Major Restorative</strong></td>
<td>50%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**NOTES:** Please refer to the Summary of Benefits and Coverage for full details.
Dental Plan Extras

Delta Dental Rollover Max

A Delta Dental benefit feature that lets you roll over part of your unused spending in one year to increase your benefits for the following year, and beyond.

This valuable benefit feature allows you to roll over a portion of your unused spending to increase your maximum benefit limit next year, and beyond. So, you can save and accumulate part of your unused benefit dollars from a healthy year and use it for larger, more expensive procedures in the future—such as bridges, crowns, and root canals.

<table>
<thead>
<tr>
<th>Your plan’s annual maximum benefit amount</th>
<th>If your total yearly claims don’t exceed this threshold amount...</th>
<th>Then you can roll over this amount to use next year, and beyond.</th>
<th>Your accumulated rollover total is capped at this amount.</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$500</td>
<td>$350</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

How it Works

- To qualify for Rollover Max, you must receive at least one cleaning or one oral exam in the plan year. If you don’t receive a cleaning or exam, you won’t be eligible to roll over any of your benefit dollars to the following year.
- Annual maximum dollars are used first. Rollover Max dollars are used after the annual maximum is met.
- If you dis-enroll from your plan (for example, if you marry and enroll under your spouse’s plan), you will lose your current rollover balance/amount.
- Rollover Max amounts will be calculated during the plan year January – December.
- To check your Rollover Max balance online:
  - Log on to your account at [www.deltadental.com](http://www.deltadental.com) (you’ll need to register)
  - Click on Benefit Maximums
  - Rollover amount for each member will be listed under Rollover Maximums
Health Care and Dependent Care Flexible Spending Accounts

Health Care and Dependent Care Flexible Spending Accounts (FSAs) allow you to set aside a portion of your pay on a pre-tax basis to pay for eligible health, dental, vision, child care and adult/elder care expenses. The money you contribute to these plans reduces your taxable income, thereby reducing your overall income tax. Each year, employees must actively enroll in the Health Care and Dependent Care FSAs via eServe during the open enrollment period to participate for the next calendar year.

2019 IRS maximum limits are as follows:

- Health Care FSA: $2,700/calendar year per employee for health, dental and vision expenses
- Dependent Care FSA: $5,000/calendar year per family for dependent child(ren) (age 13 or younger) or adult/elder daycare expenses

These limits are subject to change by the IRS and are published in November of each year.

Once enrolled in a Health Care and/or Dependent Care FSA Account for the 2020 calendar year, you will receive an EBPA benefit debit card from our vendor, EBPA, and information on how to create an online account. This benefits debit card can be used for eligible expenses for the Health Care FSA, Dependent Care FSA, and Commuter Benefit for Transit/Parking. EBPA has a Mobile App available for iPhone and Android smartphones for FSA claim submission, account balances, and customer service – this is not required for FSA enrollment.

Important Notes:

*This benefit is only available for postdoctoral scholars who work 17.5 hours or more per week and have a twelve (12) months or longer appointment, along with a valid SSN

- Per IRS Rules, the FSA follows the “use it or lose it” rule, with the exception of the $500 rollover amount described below for health care expenses (minimum rollover is $100). Be cautious when selecting annual contribution amounts for health care and/or dependent care expenses.
- IRS guidelines permit employees to carry over up to $500 of unused contributions from your Health Care FSA to the following plan year. The amount carried over will not count against the $2,700 limit for the following year. The unused amounts that are carried over into the next plan year must be used to pay for or reimburse eligible health care expenses. Unused amounts under $100 and over $500 are forfeited under the “use it or lose it” rule described above.
- The IRS allows employees additional time after the calendar year ends (up to April 30th) to submit claim reimbursement requests for eligible expenses incurred during the prior calendar year.
- IRS allows separating employees 120 days from separation to submit expenses for reimbursement but which were incurred prior to separation.

Commuter Benefits for Transit and Parking

- This benefit is only available for postdoctoral scholars who work 17.5 hours or more per week and have a valid SSN.
- Employees will be able to pay for their transit / parking elections using the same debit card that is provided for Flexible Spending Accounts. Employees can access the EBPA commuter benefit enrollment website to make their monthly transit/parking elections. The enrollment deadline is the 4th of the month for the following month. Your debit card will be loaded on the 20th of the month with the funds you elect and you will be able to use this debit card to directly purchase the transit pass you need or pay for eligible transit parking expenses.
- If you work on any Tufts University campus in Massachusetts, you are eligible to receive a transit subsidy as an incentive to use public transportation. The Boston and Fenway subsidy is 35% up to a $50 maximum and the Medford and Grafton subsidy is 35% up to a $40 maximum. The subsidy is reflected in your payroll deduction and applied to the pre-tax amount of your commuter transit election.
- 2019 IRS maximum pre-tax limits are as follows: Transits: $265/month; Parking: $265/month. These limits are subject to change by the IRS and are published in November of each year.
Retirement Plans

Postdoctoral Scholars who have a Social Security Number (or ITIN) AND who pay FICA tax are allowed to contribute to the Self-Funded 403(b) Retirement Plan. Eligible Postdoctoral Scholars may sign up for the Self-Funded 403(b) Retirement Plan at any time throughout the year. Enrollment is available through eServe. When you log in and make your election or change your contribution, the election takes effect the next available payroll. You may elect to contribute an annual amount up to the current IRS deferral limit.

Tips For Updating Your Retirement Plan on eServe

The Self-Funded Retirement Plan is a key financial tool that allows you to save for retirement with pre-tax contributions.

1. To enroll in the 403(b) Plan, increase or decrease your contributions, or to change your investment vendor selections, please log into Employee Self Service at https://access.tufts.edu/software/eserve. For detailed instructions on how to make a change, please review the “Updating your 403(b)” Tip Sheet online. If you are paid on a semi-monthly basis, you will need to calculate your per pay period contribution amount by dividing the amount you want to contribute on an annual basis by 24 pay periods.

2. The investment options are offered through our record keepers, Fidelity and TIAA. However, if you do not make a fund selection, then your contribution will be directed to the same qualified default as described above with respect to the 401(a) Plan.

3. A loan provision is available under this Plan

4. Rollover options may be available from other qualified plans.

5. The annual IRS maximum amount you may contribute to the 403(b) Plan in calendar year 2019 is $19,000.

6. If you will be age 50 or older by December 31, 2019, you are eligible for the Age 50 Catch-Up Limit and may contribute an additional $6,000 for calendar year 2019; therefore, the IRS maximum amount for any employee who will be at least 50 years old by the end of 2019 is $25,000.

If you need help accessing your Employee Self-Service account, please contact Tufts Technology Services (TTS) at (617) 627-3376 or via email at it@tufts.edu.
Contact Information

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross of Massachusetts</td>
<td>(800) 358-2227</td>
<td><a href="http://www.bluecrossma.com">www.bluecrossma.com</a></td>
</tr>
<tr>
<td>Blue Cross of Massachusetts Well Connection Telehealth Service</td>
<td>N/A</td>
<td>Download Well Connection App or visit Wellconnection.com</td>
</tr>
<tr>
<td>Blue Cross of Massachusetts Blue Care Line (Nurseline)</td>
<td>(888) 247-2583</td>
<td>N/A</td>
</tr>
<tr>
<td>Delta Dental – Voluntary Plan</td>
<td>(800) 872-0500</td>
<td><a href="http://www.deltadentalma.com">www.deltadentalma.com</a></td>
</tr>
<tr>
<td>(For coverage or benefit questions contact Delta Dental and for billing or enrollment questions contact <a href="mailto:Tss@tufts.edu">Tss@tufts.edu</a>, see below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBPA (Flexible Spending Accounts and Commuter Benefits)</td>
<td>(888) 678-3457</td>
<td><a href="http://www.ebpabenefits.com">www.ebpabenefits.com</a></td>
</tr>
<tr>
<td>Fidelity Investments</td>
<td>(800) 343-0860</td>
<td><a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a></td>
</tr>
<tr>
<td>TIAA</td>
<td>(800) 842-2776</td>
<td><a href="http://www.tiaa.org">www.tiaa.org</a></td>
</tr>
<tr>
<td>Tufts Support Services</td>
<td>(617) 627-7000</td>
<td><a href="https://tuftstss.force.com/">https://tuftstss.force.com/</a></td>
</tr>
<tr>
<td>Tufts University Office of the Provost</td>
<td></td>
<td><a href="http://viceprovost.tufts.edu/postdoc/">http://viceprovost.tufts.edu/postdoc/</a></td>
</tr>
</tbody>
</table>

Benefits Questions & Answers

- **Who do I contact if I have additional benefit plan questions?**
  Your first resource is the benefit plan vendor. If you still need assistance, contact Tufts Support Services (TSS) at (617) 627-7000.

- **Who do I contact if I forgot my Tufts Username (User ID) and password information?**
  Your Tufts Username and password is the same as what you use to log into our Tufts University email account. To obtain your Username or to reset your password, please contact the Tufts Technology Services (TTS) at (617) 627-3376 or via email at it@tufts.edu.

- **May I enroll on my personal computer at home?**
  Yes, you can enroll from any computer with Internet access at any time during the Open Enrollment period. Internet Explorer or Firefox are the recommended browsers.

- **May I change my health and welfare benefits elections at any time?**
  No, you may only make changes during Open Enrollment or if you experience a Qualified Change in Status (i.e. marriage, birth, divorce, etc.). Please note that you must notify TSS of any changes within 31 days of the date of the event.

- **How do I find out if my doctors or hospitals participate in the Health Plan?**
  You can access the Blue Cross of Massachusetts provider directory using the website or telephone number listed on above.
Important Notice from Tufts University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tufts University and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Tufts University has determined that the prescription drug coverage offered by the university’s medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Tufts University coverage will be affected.

You may join a Medicare drug plan and keep your Tufts University coverage. Your Tufts University coverage will be coordinated with your coverage under the Medicare drug plan. You should compare your current coverage, including which drugs are covered and the amount you pay, with the coverage and cost of a Medicare prescription drug plan to determine if it makes sense for you to have both types of coverage. The University will NOT contribute to the cost of coverage under a Medicare drug plan, although the government may subsidize a portion of your premium. If you do decide to join a Medicare drug plan and drop your current Tufts University coverage, be aware that you and your dependents will not be able to enroll in a Tufts University Retiree Health Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Tufts University and do not join a Medicare drug plan within 63 consecutive days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 consecutive days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October, during the annual benefits open enrollment process, to join.
For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Tufts University Human Resources Benefits Office listed below for further information.

NOTE: You will receive this notice each year. You will also receive this notice before the next period you can join a Medicare drug plan, and/or if this coverage changes through Tufts University. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call Medicare at (800) 633-4227. TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213. TTY users should call (800) 325-0778.

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: August 2019

Name of Entity / Sender: Tufts University

Contact – Position / Office: Human Resources Benefits Office

Address: 200 Boston Ave., Suite 1600, Medford, MA 02155

Phone Number: (617) 627-7000
Important Information You Should Know...

Women's Health and Cancer Rights Act
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (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 lymphedemas.

These benefits will be provided subject to the same plan provisions applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Tufts Support Services at (617) 627-7000 or access the following website: http://www.dol.gov/ebsa/newsroom/fswhcra.html

Security of Health Information
HIPAA also includes security rules for electronic health information. The University has implemented safeguards to protect the confidentiality, integrity and availability of electronic protected health information, implement security measures to ensure adequate separation between the University and the benefit plans, and ensure that any agent to whom it provides electronic protected health information also agrees to implement security measures. The University will report to the benefit plans any security incident of which it becomes aware involving electronic protected health information.

Patient Protection Disclosure
Blue Cross of Massachusetts generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Cross of Massachusetts at 617-246-5000. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Blue Cross of Massachusetts 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 Blue Cross of Massachusetts at 617-246-5000.
Notice of Privacy Practices

Notice of Tufts University
Health Information 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.

This Notice of health Information Privacy Practices (the “Notice”) was updated as of August 29, 2019

Tufts University Postdoctoral Medical Benefit Plan (the “Plan”) provides health benefits to eligible employees of Tufts University (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words “you,” “your,” and “yours” refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure. Your “Protected Health Information” (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan’s duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan’s distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan. Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a diabetes management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies. The Plan’s use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

• Quality assessment and improvement activities
• Disease management, case management and care coordination
• Activities designed to improve health or reduce health care costs
• Contacting health care providers and patients with information about treatment alternatives
• Accreditation, certification, licensing or credentialing activities
• Fraud and abuse detection and compliance programs
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The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan’s use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
  - Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
  - Planning and development, such as cost-management analyses
  - Conducting or arranging for medical review, legal services, and auditing functions
  - Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers’ Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers’ compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product’s quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.
Notice of Privacy Practices

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director’s duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail. You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan’s agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan’s use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.
Notice of Privacy Practices

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan’s enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan’s records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan’s records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan’s records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan’s records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan’s records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law. indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Complaints
If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information
The Plan has designated Robbyn Dewar, Benefits Program and Compliance Director, as its contact person for all issues regarding the Plan’s privacy practices and your privacy rights. You can reach her at 200 Boston Ave, Suite 1600, Medford, MA 02155 or via phone at 617-627-6272.
This summary of the benefits plans has been designed to acquaint you with features of the plans. Every attempt has been made to summarize these programs and policies accurately.

There is a Summary Plan Description (SPD) for all benefits plans that contains more complete information.

In the event of a conflict between this document, the SPD, statements made by any person or the insurance contracts, the insurance contracts will be the prevailing authority on coverage questions.