New Employee Information Check List
Permanent Full Time Employees

Please check appropriate box indicating that you received each item.		
	Description of Form	**Action**
☐	Intake Form	**To be signed in Human Resources**
☐	Anti-Nepotism Review Request Form	**Complete and return if applicable, if not applicable indicate N/A on form and return**
☐	CORI (Criminal Offense Record Inquiry)	**Complete and return**
☐	Employee Network Use Policy (If applicable)	**Sign and return**
☐	Employee Orientation Booklet	For your information
☐	Employee Withholding Allowance Certificate Form W-4 (Federal Income Tax)	**Complete and return**
☐	Massachusetts Employee Withholding Exemption Certificate Form M-4 (State Income Tax)	**Complete and return**
☐	EEO Self-Identification Form	**Complete and return (Optional)**
☐	Housing Rehab Information	For your information
☐	Background Information Form	**Complete and return**
☐	U.S. Department of Justice Form I-9 Employment Eligibility Verification	**Complete section 1 and return with 2 forms of I.D. from List B & C or 1 form of List A**
☐	New Member Enrollment Memo for the Waltham Retirement Board	Must make an appointment with the Retirement Board and bring required documentation
☐	OPEB	For your information
☐	Social Security Statement	**Sign and return**
☐	Sexual Harassment Policy and Procedures	**Sign and return signature page**
☐	Direct Deposit Authorization Form (Optional)	**If selected**, complete and return with a VOIDED check and attached it to application.
☐	Payroll (email direct deposit slip)	For your information
☐	Flexible Spending Program (Optional)	**Complete the Enrollment form and return**
☐	Deferred Compensation (Optional)	Andrew Wilson, Retirement Plan Advisor (Request forms from HR) 339-221-2770 andrew.wilson@empower.com
☐	Drug and Alcohol Policy	**Sign and return**
☐	Emergency Contact Info	**Complete and return**
☐	Fair Labor Standards Act	For your information
☐	Vehicles Can Be Dangerous (for employees who drive City vehicles)	**If applicable, complete and return**
☐	Laborers' Union Clothing Form	**If applicable, complete and return**
☐	Release of Information Form-CDL drivers	**Sign and return**
☐	Hands Free Law	For your information
☐	Life Insurance Boston Mutual **Must provide Social Security Numbers for beneficiaries listed.**	**If selected, complete application form and return If declining, complete blue waiver and return**
☐	Permanent Life Insurance (Optional)	Contact LifePlus Insurance Agency 781-837-9222
☐	Heritage Cancer Insurance Coverage (Optional)	Contact LifePlus Insurance Agency 781-837-9222 Must be pre-approved before you can sign up

New Employee Information Check List
Permanent Full Time Employees

Please check appropriate box indicating that you received each item.	
Description of Form	**Action**
☐ Osha Fact Sheet	For your information
☐ Right to Know Workplace Notice	For your information
☐ Delta Dental If you select Harvard or Tufts you are eligible to enroll	**If selected, you must complete enrollment form and return**
☐ Overview of Health Insurance	For your information
☐ Gen.Notice of Cobra Cont.of Coverage Rights	For your information
☐ Open enrollment information	For your information
☐ Waiver of Group Health Insurance Coverage	**If you do not participate in a Health Insurance plan you must complete this form and return**
☐ Blue Cross and Blue Shield PPO **Must provide copy of marriage certificate if adding a spouse and birth certificate for each dependent**	**If selected, you must complete enrollment form and return**
☐ Tufts Health Plan **Must provide copy of marriage certificate if adding a spouse and birth certificate for each dependent**	**If selected, you must complete enrollment form and return**
☐ Harvard Community Health Plan **Must provide copy of marriage certificate if adding a spouse and birth certificate for each dependent**	**If selected, you must complete enrollment form and return**
☐ Receipt of Employment Information	**Complete this form and return**
☐ State Ethics Form	**Sign Signature Page and return** ****You must complete on-line training and turn in the certificate to the Human Resources Office*****
☐ Credit Union	For your information
☐ Pregnant Workers Fairness Act	For your information
☐ Parental Leave Act	For your information
☐ Employee Rights under the FMLA	For your information
☐ USERRA	For your information
☐ EEO	For your information
☐ Employee Assistant Program (EAP)	For your information
☐ Domestic Violence Leave Act	For your information
☐ No Smoking	For your information
☐ Unemployment Information	For your information
☐ Workers Compensation	For your information

_____ _____

Employee Signature **Date**

City of Waltham

ANTI-NEPOTISM REVIEW REQUEST FORM

The Anti-Nepotism Review Request Form must be reviewed by the Personnel Department prior to any employee assignment or employment offer.

PROPOSED PLACEMENT

Name: _____
First Middle Last

Soc.Sec.Number: _____

Being Considered for: _____ _____
Posting Number Position Title

DEPARTMENT CERTIFICATION (If additional listings are necessary, attach on a separate sheet.)

Department: _____ _____
Name

The person proposed for placement listed above is related to:

Name: _____
First Middle Last

Position: _____ _____
Position Number Classification Title

Relationship (specify): _____

The person proposed for placement listed above is related to:

Name: _____
First Middle Last

Position: _____ _____
Position Number Classification Title

Relationship (specify): _____

This placement will not result in a relative (or closely identified person) supervising or having any influence over the other relative's employment, promotion, salary administration, or other related management or personnel considerations, or in any other violation of the subject policy.

Signature: _____ _____
Department Head or Authorized Department Representative Date

Return complete form to: Personnel Department

CERTIFICATION REVIEW (to be completed by Personnel Department)

Signature: _____ _____ _____
Personnel Department Title Date

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

This form is not to be faxed. Please return form to organization .

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment or licensing purposes.

City of Waltham is registered under the
(Organization)
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to City of Waltham
(Organization)
to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing City of Waltham
(Organization)

with written notice of my intent to withdraw consent to a CORI check.

I also understand, that City of Waltham may conduct
(Organization)
subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____
Signature of CORI Subject *Date*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ___ ___ -- ___ ___ ___ ___ ☐ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____
Print Name of Verifying Employee

_____ _____
Signature of Verifying Employee *Date*

CITY OF WALTHAM

EMPLOYEE NETWORK USE POLICY

General Policies and Procedures

Effective Date: May 31, 2004

1. PURPOSE

1.1 To outline the proper use of City's computer network including, but not limited to, use of the Internet.

2. POLICY

2.1 Waltham's data network access to the Internet is provided for City business purposes only.

2.2 City Private, City Most Private and City Sensitive Information, including technical business proprietary data may not be communicated via an Internet connection without additional security protective mechanisms being implemented as approved by the MIS Department and the appropriate clearances and approvals being obtained from the City Solicitor.

2.3 Transmission of government-classified information via the Internet is strictly prohibited. Contact the City Solicitor for more information.

2.4 All files downloaded from the Internet must be scanned using a City approved virus-scanning program prior to executing on a City of Waltham computer. It is recommended that source code be retrieved and reviewed as opposed to binary formats.

2.5 Attempts to gain unauthorized access to any computer or communications system on the Internet are prohibited.

2.6 Any suspected compromise of a City's computer or communications resource or information via an Internet connection shall be immediately reported to the MIS Department.

3. APPLICABILITY

3.1 This policy applies to all municipal employees using Waltham's computer network.

4. EMPLOYEES' RESPONSIBILITIES

4.1 Department managers and supervisors are responsible for promoting and monitoring compliance with this policy.

4.2 Acceptable Use - The use of the City's computer network must be related to City business. All laws pertaining to copyrighted material and material protected by trade secret must be obeyed.

4.3 Privileges - The use of the computer network is a privilege, not a right. Inappropriate use will result in cancellation of this privilege and disciplinary action by the City.

4.4 Network Etiquette - Users are expected to abide by the generally accepted rules of network etiquette including, but not limited to, the following:

A) Do not use profane, vulgar or other inappropriate language.
B) Do not reveal personal information about yourself or your coworkers.
C) Use electronic mail (email) with the knowledge that it is not private.
D) All electronic data transfers promoting, aiding, furthering or otherwise in support of illegal activities are prohibited.
E) Do not use the network in any way that would disrupt other users.
F) Remember that the information you create, transmit and receive on the City's computer network may be public record and could be disclosed in response to a public records request.

4.4 Disclaimer - Access to information via the computer network can mean access to materials that are not useful and may even be offensive. It is impossible to control access to all such materials and users may unintentionally confront them. However, it is the City's position that the value of the useful information generally available via the City's computer network outweighs the inconvenience that users may occasionally experience as a result of unintentionally accessing or being exposed to material that has little value and may be offensive. The City of Waltham makes no warranties of any kind for its computer network service. Neither the City of Waltham, nor the MIS Department will be liable for damages resulting from the use or misuse of the City's computer network services.

4.5 Vandalism - Vandalism will result in cancellation of privileges. Vandalism is defined as any attempt to intentionally and maliciously alter or destroy computer equipment and/or data or to intentionally and adversely interfere with the on-line services provided by the computer network.

5. DEFINITIONS

5.1 Internet--A public global network of networks connecting commercial, government, and educational organizations.

5.2 World Wide Web (WWW)--A hypertext-based system for finding and accessing Internet Resources.

5.3 City Private - Contact your City Solicitor for more information.

5.4 City Most Private - Contact your City Solicitor for more information.

5.5 City Sensitive Information - Contact the City Solicitor for more information.

_____	_____
Jeannette A. McCarthy - Mayor	**Kristin Murphy** - Personnel Director
_____	_____
Date	Date

_____
Donald Aucoin – Director of MIS

_____
Date

Please continue to next page for the Policy Acceptance and Network Activation Form.

POLICY ACCEPTANCE AND NETWORK ACTIVATION FORM

Your signature below indicates that you have read the terms and conditions of the City of Waltham Employee Network Use Policy carefully, understand their significance, and accept your responsibilities as stated.

_____ _____

Employee Name (please print) Employee signature / Date

Employee: When you have signed above, give this form to your department head/supervisor.

Department Head/Supervisor: Complete the information below and return to the Personnel Department promptly. When this form has been reviewed and approved by the Personnel Department, it will be forwarded to the MIS Department for Its final review and network activation.

This is a request for a new network account for:

Employee Name:_____

Position: _____

Department:_____

Please check all that apply:

☐ Full Time ☐ Part Time
☐ Permanent ☐ Student

☐ Network Access
☐ Email Account

Duration: From _____ to _____

A copy of this form, upon its completion, will be kept in the Personnel File of the employee noted above.

Department Head/Supervisor: _____ _____ _____
Print *Signature* *Date*

Personnel Representative: _____ _____ _____
Print *Signature* *Date*

MIS Representative: _____ _____ _____
Print *Signature* *Date*

WELCOME

Congratulations and welcome. The City of Waltham is an Equal Opportunity employer. Each and every individual is considered and treated solely on the basis of qualifications and performance of the job that they hold, without regard to race, color, sex (including gender identity, sexual orientation, and pregnancy), national origin, ancestry, veteran status, age (over 40), religion, disability or genetic information.

What follows is information to familiarize you with the benefits and options you will receive as an employee of the City of Waltham. The Orientation Guide has been prepared to provide employees with a brief summary of those benefits offered by the City of Waltham. This booklet provides details of each benefit, the benefit's eligibility requirement and any pertinent enrollment information.

Employees should refer to any collective bargaining agreements (if applicable) for detailed information on any of the benefits listed in this guide. If at any time there should be a conflict between the description contained within this guide and a statute or a collective bargaining agreement (CBA), the terms of the statute or (CBA) will supersede. If applicable, please contact your union representative for a copy of the CBA.

The City has prepared this book as a guide to policies, benefits, and general information that should assist you during your employment. It is not intended to be a complete guide to employee benefits. However, neither this guidebook, nor any other City communication or practice, creates an employment contract. The City reserves the right to amend, modify or delete any policy or provision that is included in this guidebook.

Should any employee have further questions or desire a more detailed explanation of any of the benefits featured within the packet, please contact the Human Resources Department at 781- 314-3355.

Please review and familiarize yourself with the ENTIRE orientation package to ensure that you have accessed all of the benefits available to you. COMPLETE AND RETURN THE BOLDED items on your checklist to guarantee the prompt activation of your payroll.

GENERAL INFORMATION

Appearance

The City expects all of its employees to dress professionally and use good judgment regarding appearance. Department heads and office related positions should have business dress or business casual appearance. Outside or maintenance personnel should have safety footwear as well as uniforms or appropriate clothing.

Attendance

Please take pride in a good attendance record. Your absence or tardiness is a hardship to others and places an unfair burden on your fellow employees. If you must be absent or late, you must notify your department before your regular reporting time. You must contact your department each day that you are absent. The main telephone number is 781-314-3000.

The standard workweek for most employees is Monday through Friday, 8:30 a.m. to 4:30 p.m., with a one-hour lunch period. Some departments may have different schedules.

Safety Belts

The City of Waltham has an utmost concern for the safety of its employees. According to **Massachusetts General Laws, Chapter 90, Section 13A,** "no person shall operate a private passenger motor vehicle or ride in a private passenger motor vehicle, a vanpool vehicle or truck less than eighteen thousand pounds on any way unless such person is wearing a safety belt which is properly adjusted and fastened." Because it is law, we require the use of seat belts in city-owned vehicles. For a copy of MGL Chapter 90; Section 13A please visit http://www.state.ma.us/legis/laws/mgl/90-13A.htm.

Notification of Available Positions

All Non-Civil Service vacant positions will be posted on the Human Resources Department website http://www.city.waltham.ma.us. Announcements will also be distributed by email to each department for posting. Civil Service positions will be posted according to civil service law and collective bargaining agreements.

Personal Data

It is required that each employee notifies his/her department head of any changes in personal data. Employees who change an address, telephone number, educational accomplishments, marital status, or individuals to be contacted in event of emergency, must submit a written notification of these changes to their department and to the Human Resources Department.

To change information with insurance providers you must contact the provider directly.

Background Check

The City of Waltham conducts background checks on candidates' post-offer (contingency offer). The type of information that can be collected by the City includes, but is not limited to, a criminal background check, education, employment history, credit, web based available information, public information, former employers and professional and personal references. This process is conducted to verify the accuracy of the information provided by the candidate and determine his/her suitability for employment. Any offer of employment is contingent upon the successful results of the background check.

CORI

The City endeavors to ensure the safety of the public which it serves, while protecting the civil rights of its employees, volunteers and contractors. Criminal Offender Record Information (CORI) checks are part of a general background check for City employment and volunteer work. City departments will proceed in accordance with the rules set forth by the Criminal History Systems Board.

Pre-employment Physical

The City of Waltham requires that all permanent employees undergo a pre-employment physical at the City's expense.

PAYROLL INFORMATION

Mandatory Deductions from Paycheck

The City of Waltham is required by law to make certain deductions from your pay each time one is prepared. Among these are your federal and state income taxes. These deductions will be itemized on your check stub. The amount of the deductions will depend on your earnings and on the information, you furnish on your W-4 form regarding the number of exemptions you claim. If you wish to modify this number, please request a new W-4 form from the Human Resources office or the person who completes your payroll. Only you may modify your W-4 form. Verbal or written instructions are not sufficient to modify withholding allowances. We advise you to check your pay stub to ensure that it reflects the proper number of withholdings. The W-2 form you receive annually reflects how much of your earnings were deducted for these purposes. Any other mandatory deductions to be made from your paycheck, such as court-ordered garnishments, or child support, will be itemized on your pay stub whenever the City of Waltham is ordered to make such deductions.

Credit Union

Merrimack Valley Credit Union (formerly RTN Credit Union) serves the financial needs of the City of Waltham employees and their families and is committed to helping members achieve financial well-being through quality products and services with personalized service. If you need assistance or have questions, please contact Mike Davis at 781-736-9902, mdavis@rtn.org or the RTN Business Development Team at BizDevelopment@rtn.org or
781-736-9945.
600 Main Street
Waltham, MA 02452
For Waltham branch hours and more information, go to www.rtn.org.

Direct Deposit

Paychecks are dispersed each Wednesday for the previous week (with the exception of Board Members and Traffic Supervisors). Employees have the opportunity to have their net pay automatically deposited into an account at the bank of their choice. The bank must be a member of the Automated Clearing House. The forms are available at the Human Resources Department. Once enrolled, if you change banks, please advise your department payroll clerk.

Deferred Compensation Plan

The plan permits you, on a voluntary basis, to authorize a portion of your salary to be withheld and invested for payment to you at a later date. Neither the deferred amount nor earnings on the plans are taxable until they are actually distributed to you. Further information can be obtained by contacting the plan client account managers identified in the orientation material.

The City of Waltham offers one plan:

Great West
SMART Plan-1-877-457-1900 x20084
www.mass-smart.com

Union Dues
If applicable, the City is required to deduct union dues from your paycheck, those deductions are then forwarded directly to the union. Please contact your union representative for further details.

INSURANCE

Annual Health Fair
The City of Waltham holds an Annual Health Fair every spring. Open enrollment for Health insurance is in May and takes effect July 1st. During this time of Open enrollment, employees may make changes to their health plans. This is the **ONLY** time changes are allowed, with the exception of qualifying events.

In the event of a loss of health insurance, birth, marriage or divorce, it is the responsibility of the employee to notify the Payroll Department within **30 days of the event**. Birth certificate, marriage certificate and/or divorce decrees will also need to be provided at this time. Failure to meet this timeline will result in waiting until the next open enrollment period.

Health insurance is paid one month in advance. In the event that an employee switches from an individual plan to family plan, the employee will be responsible for paying the difference in cost back to the event date.

Health Insurance Plans
The City of Waltham offers its permanent employees working at least 20 hours per week three health plan options from which to choose*:

- Harvard Community Health Plan (HMO) w/Delta Dental
- Tufts Health Plan (HMO) w/Delta Dental
- Blue Cross/Blue Shield: PPO w/No Delta Dental

The City's contributions to the plans are: 89% of the cost of HMO, and 87.5% of the cost of Blue Cross/Blue Shield PPO. New employees may select one of these plans. An open enrollment every May provides employees with an opportunity to change coverage. Employees with a qualifying event may change coverage during the year for the following reasons:

- Change in number of dependents
- Change in employment status that affects your eligibility for benefits
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change of residence that puts you within the enrollment area
- Judgment, decree or order pertaining to child or spouse
- Change in legal marital status

In order to enroll a spouse and/or dependents to your health plan, the City requires a copy of your marriage license and birth certificates for dependents. As of January 1, 2014, dependent children are eligible up to their 26th birthday.

Complete information on all health plans and enrollment forms are provided in your orientation package.

HEALTH AND LIFE INSURANCE PREMIUMS

***See Attached Rate Sheet**

DELTA DENTAL: (Available with Harvard Pilgrim Health Plan HMO and Tufts Health Plan HMO only)

- Preventative dental services are covered at 100% with no deductible.
- Restorative services covered at 80% after a $50.00 per person deductible.
- Prosthodontics and Major Restorative are covered at 50%.
- Braces are not covered.

There is no additional cost for the dental coverage with the Harvard Pilgrim or Tufts coverage. There is no dental coverage offered with Blue Cross Blue Shield. For more information on coverage, please consult the Delta Dental information included in your Orientation Package.

*If you choose not to select the Health Insurance benefit, you must complete the *Waiver of Group Health Insurance Coverage Form* included in your Orientation Package.

Contact information for these health plans is as follows:

- Harvard Community Health Plan: 1-800-848-9995 TDD: 1-800-637-8257
  www.harvardpilgrim.org
- Tufts Health Plan: 1-800-462-0224 TDD: 800-868-5850
  www.tuftshealthplan.com
- Blue Cross/Blue Shield: 1-800-262-BLUE (2583) TTY: 1-800-522-1254
  www.bluecrossma.com
- Delta Dental: 1-800-451-1249
  www.deltamass.com

WHEN COVERAGE BEGINS:
If you begin your employment between the first of the month and the twenty-third of the month, then your health insurance coverage will begin on the first day of the following month. If your employment begins between the twenty-fourth and the last day of that month, then your health insurance will begin on the first day of the second full month.

WHEN COVERAGE ENDS:
If your employment ends between the first and the twenty-third of the month, then your health insurance coverage will end on the last day of that month. If your employment ends between the twenty-fourth and the last day of that month, then your health insurance coverage will end on the last day of the next month.

HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits exclusions for pre-existing conditions; prohibits discrimination against employees and their dependents based on health status; guarantees renew-ability and availability of health coverage to certain

employees and individuals; and protects many workers who lose health coverage by providing better access to individual health insurance.

The special enrollment rights apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. Special Enrollment periods apply to you and/or your dependents, if you have a new dependent as a result of marriage, birth, adoption or the placement for adoption (qualifying event). Under these rules, a group health plan is required to provide the opportunity for special enrollment. These individuals should make the request within 30 calendar days of the date the qualifying event occurred.

If you decline enrollment under the City of Waltham plan for yourself or your dependents (including your spouse) and state in writing that you and/or your dependents have coverage under another group health plan or health insurance coverage as the reason for declining to enroll you may also have special enrollment rights. Special enrollment rights may apply to you and/or your dependents in the event that you and/or your dependents are no longer eligible for this other coverage.

Your plan offers an Annual Open Enrollment in May which is effective July 1st of each year, giving you the opportunity to enroll yourself and /or your dependents if you have previously declined/waived coverage for you and your dependents.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA requires employers to offer employees and their families the opportunity to continue their group health care coverage for 18 to 36 months following termination, depending upon the "qualifying event" that leads to the ultimate termination of coverage. The City will notify you of your COBRA rights in writing. If you do choose continued coverage, you have 60 days from the date you would lose coverage to inform the Human Resources Department. If you elect coverage, you will have 45 days from the date of the election of coverage to pay premiums due from the date of your loss of coverage. If you do not choose continued coverage, your group coverage will end and cannot be reinstated.

Life Insurance Plan:

Boston Mutual Life Insurance Company
120 Royall St., Canton, MA. 02021-9968
1-800-669-2668 ext. 700

The City of Waltham offers its permanent employees working at least 20 hours per week basic life insurance in the amount of $15,000*. To be eligible for the additional optional coverage, employees must first be enrolled in the basic program. On the enrollment form, Plan A is the basic plan and Plan B is the optional plan.

Permanent employees working at least 20 hours per week, under age 75 who desire additional optional coverage are entitled to purchase life and accidental death and dismemberment insurance in $5,000 denominations up to the amount of the employee's salary.

Permanent employees working at least 20 hours per week, under the age of 75 are entitled to purchase dependent coverage. Dependent coverage includes only life insurance. Accidental death and dismemberment are not included.

In order to be eligible for dependent coverage, you must first purchase at least $5,000 in additional optional coverage. The entire optional premium for coverage is paid by the employee through payroll deductions.

When an employee is terminated, resigns, reduces their hours to less than 20, or reaches age 75, all additional optional coverage ends. The employee has the right to convert the full amount of additional coverage to an individual policy.

When an employee under age 75 retires, he/she may take his/her additional coverage with them until age 75.

For more information see your orientation package, contact the Human Resources Department, or visit the Boston Mutual webpage at: http://www.bostonmutual.com/
*The City contributes 50% of the premium.

Permanent Life/Cancer Insurance Coverage
The orientation package includes additional information on permanent life and cancer insurance coverage provided by LifePlus Insurance Agency. Enrollment for this coverage is available upon hire and in May during benefit open enrollment for July implementation. For more information contact the LifePlus Insurance Agency client service representative, at 1-781-837-9222 or http://www.lpins.com

Workers' Compensation
Workers' compensation benefits are provided for injuries arising out of and in the course of your employment. **Employees must report all work-related injuries and illnesses to their supervisor immediately, no matter how minor they may appear.** Worker's Compensation Informational booklet must be filled out, regardless of the nature of the injury, and returned to the Human Resources Department forthwith. If medical attention is required, the City of Waltham has the right to send you to the provider of their choice for the initial visit. Follow-up care provided as needed. If it is a medical emergency, 911 should be called.

Unemployment Compensation
Depending upon the circumstances, employees may be eligible for Unemployment Compensation upon termination of employment or a reduction in hours of work with the City of Waltham. The Department of Employment and Training determines eligibility for Unemployment Compensation. The City pays the entire cost of this insurance program.

EMPLOYEE BENEFITS

Flexible Spending Account Program
A Flexible Spending Account (FSA) plan allows employees to pay for certain unreimbursed healthcare and dependent care expenses with before-tax dollars. For many participants, the FSA plan provides a better tax benefit than is available to an individual taxpayer. The flexible spending

account program permits each employee to set aside up to $5000 pre-tax dollars for dependent care expenses and up to $3050 for medical expenses not reimbursed. Money that is reimbursed to you for paid expenses is tax-free. You pay no state, federal, social security, or Medicare taxes on that money. You may only enroll during open enrollment (usually each December) or if you have a "change in status/qualifying event" the following are considered changes in status/qualifying event:

- Change in number of dependents
- Change in employment status that affects your eligibility for benefits
- Dependent satisfies or ceases to satisfy eligibility requirements
- Significant change of residence or work-site
- Judgment, decree or order pertaining to child or spouse
- change in legal marital status

For additional information, contact the City of Waltham account representative with Sentinel Benefits at 1-888-762-6088, or visit their website at: www.sentinelgroup.com

Bereavement Leave

Non-union employees are entitled to one to three (1–3) days up to a maximum of five (5) days for the death of immediate family members, including: spouse, mother, father, grandmother, grandfather, daughter, son, sister, brother, aunt, uncle, grandchild, stepfamily of the employee or spouse of step family. Union employees will follow Bereavement Leave under current CBA Agreement The department head may grant additional days to employees under extenuating circumstances.

Family Medical Leave Act

The City's policy for the Family and Medical Leave Act of 1993 (FMLA) covers basic procedures governing leaves taken under FMLA so as to ensure compliance with the federal statute which allows eligible employees an unpaid leave for up to 12 weeks in one 12-month period, or in the case of certain family military leave, up to 26 weeks in one 12-month period. Eligible employees must (1) have worked at least 1,250 hours (approximately 25 hours per week) for the City within the last twelve months, and (2) have been employed by the City at least 12 months prior to the request for such leave. Please contact the Human Resources Department for detailed benefit information and a copy of the Act.

Domestic Violence Leave Act

All full-time, part-time, seasonal and temporary employees are eligible for Domestic Violence Leave. The City is committed to the protection of employees that provide service to the City from domestic violence by giving them the necessary tools to deal with domestic violence issues. This policy, along with the efforts of our EAP (Employee Assistance Program), can be utilized if the need arises to take time off to deal with a domestic violence issue. Please contact the Human Resources Department if you should have any questions regarding this Act.

Small Necessities Leave Act

Massachusetts enacted the Small Necessities Leave Act (SNLA) in 1998, expanding upon the rights granted by the federal Family and Medical Leave Act (FMLA). The SNLA grants eligible employees a total of 24 hours of unpaid leave during any 12-month period, *over and above* the

leave granted under the FMLA. To be eligible, an employee must (1) have been employed for at least 12 months by the employer from whom the leave is requested, and (2) have provided at least 1,250 hours of service to the employer during the previous 12-month period. Please contact the Human Resources Department if you should have any questions regarding this Act.

Parental Leave Act Policy

In accordance with MGL 149 the City grants up to 8 weeks of Parental Leave to both male and female eligible employees for the purposes of birth, adoption or placement pursuant a court order. Unless combined in accordance with other leave practices, parental leave is unpaid leave. Employees shall not be required to exhaust all time off prior to taking the leave. The Act provides that 2 employees of the same employer shall only be entitled to eight weeks of leave in the aggregate for the birth or adoption of the same child. Eligible employees are defined as employees who have completed their initial probationary period, not to exceed three months, or if there is no such probationary period, employees who have been employed for at least 3 consecutive months as a full-time employee. For additional information please contact the Human Resources Department.

Pregnant Workers Fairness Policy

The City of Waltham provides accommodations to allow pregnant employees or prospective employees or those with conditions related to their pregnancy to perform the essential functions of their jobs. In addition, the City will not discriminate against employees or prospective employees who are pregnant or have a condition related to pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child.

Holidays

The following holidays shall be allowed for permanent employees and in the event, one occurs within the working week, each employee shall be paid for a full day as if working:

- New Year's Day
- Memorial Day
- Veterans' Day
- Columbus Day
- Christmas Day
- Presidents' Day
- Martin Luther King Day
- Independence Day
- Thanksgiving Day
- Patriots' Day
- Labor Day
- Juneteenth

Whenever one of the foregoing holidays occurs on a Saturday or Sunday, the employee shall be given an additional day off. If the additional day off cannot be given because of personnel shortage or other cause, the employee shall be entitled to an additional day's pay.

Those who are required, to work on a holiday due to an emergency, shall be paid time and one half (1.5 hours) for the hours worked in addition to regular holiday pay.

Educational Incentive Program

The City of Waltham Educational Incentive Program is intended to encourage employees to improve their job competence, and helps prepare them for greater responsibilities within their present job assignments. The City shall reimburse eligible employees for tuition cost in accordance with the program guidelines. Please contact the Human Resources Department for

more complete information about this program. Reimbursement is subject to funds being available.

Jury Duty

The City's obligation to pay employees called for jury service is set forth in MGL Chapter 234A, Section 48, which states in pertinent part – "Each regularly employed trial or grand juror shall be paid regular wages by his employer for the first three days, or part thereof, of juror service. Regular employment shall include part-time, temporary and casual employment. As long as the employment hours of a juror reasonably may be determined by a schedule or custom and practice established during the three-month period preceding the term of service of such juror." If you have questions regarding pay for jury service, please ask your supervisor or contact the Human Resources Department.

Permanent Part Time Employees Policy

Permanent part-time employees are eligible for vacation, sick and holiday benefits on a prorated basis. Permanent employees working 20 hours per week or more are eligible for health benefits. Please contact the Human Resources Department should you have any questions regarding this policy.

Vacations

Applicable to non-union wage and salary grade classifications.
Years of service:

- Less than 1 year — At the discretion of the Dept. head
- More than 1 year, but less than 5 — 10 Days
- At least 5 years, but less than 10 — 15 Days
- At least 10 years, but less than 15 — 20 Days
- At least 15 years, but less than 20 — 25 Days
- At least 20 years — 30 Days

In all cases, vacation shall be taken during the calendar year unless the employee is given permission in writing by their department head with the approval of the mayor to carry the vacation time into the succeeding calendar year.

All vacation rights arising out of creditable service accumulated in any department of the City shall be transferable by an employee to any other department.

Every employee who has worked thirty (30) work weeks in the aggregate during the twelve months preceding the first day of June in the current year shall be eligible for a vacation up to 2 weeks with pay at the discretion of the department head. This provision shall not apply to employees in the Police and Fire Departments.

Sick Time

Sick time for non-union employees shall be used at the discretion of the department head. All employees must submit a doctor's note upon the usage of five concurrent sick days.

Longevity

Each non-union employee shall receive longevity pay which will be added to base compensation upon completion of each five (5) year increment of service with the City, but not commencing until completion of the tenth (10) year as follows:

a) A total of 8% of annual base salary per year for each employee who has completed at least 10 years but less than 15 years;
b) A total of 9% of annual base salary per year for each employee who has completed at least 15 years but less than 20 years;
c) A total of 10% of annual base salary per year for each employee who has completed at least 20 years but less than 25 years;
d) A total of 11% of annual base salary per year for each employee who has completed at least 25 years or more;

For the purposes of longevity, services with the City shall be defined as actual service in the employ of the City for which an employee is entitled to credit pursuant to the provisions of MGL Ch. 32. Service credit an employee may have, but which is not attributable to City employment, shall not be used as a basis for awarding longevity pay.

RETIREMENT BENEFITS

Social Security and Medicare Tax

The City of Waltham does not deduct Social Security from your wages. The City has a retirement program under General Laws Chapter 32, Sections 1-28 and other special acts of the Commonwealth of Massachusetts. Full-time and benefit eligible part-time employees must be members of the City's retirement program. All other non-benefitted employees must participate in the OBRA program.

Employees hired or re-hired after March 31, 1986 are required to pay Medicare tax and the City matches that contribution.

OBRA

If you are a part-time, seasonal or temporary employee of the Commonwealth of Massachusetts or a Massachusetts local government employer, you are required to contribute at least 7.5% of your gross compensation per pay period in the Massachusetts Deferred Compensation SMART Plan (SMART Plan). The SMART Plan is an alternative to Social Security as permitted by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA). This contribution is deducted on a pre-tax basis, reducing your current taxable income. This means that you will not pay any tax on this money until it is distributed from your account. Upon termination you may request a disbursement of funds or roll over the funds to another employer sponsored plan or traditional Individual Retirement Account (IRA). You may contact the SMART Plan at 877-457-1900.

Retirement Plan Membership

Membership in a contributory retirement system is mandatory for nearly all public employees who are regularly employed and working at least 20 hours per week. The Retirement Board exercises full jurisdiction to determine an employee's eligibility for membership in cases involving part-time, provisional, temporary, seasonal or intermittent employment or service.

Contributions:
Employees who become members:

Prior to-January 1, 1975, must contribute	(5%)
On or after January 1, 1975 and	
Prior to January 1, 1984, must contribute	(7%)
On or after January 1, 1984 but prior to July 1, 1996, must contribute	(8%)
After July 1, 1996, must contribute	(9%)

If membership began after January 1, 1979, and if your annual rate of regular compensation is $30,000 or more, the governmental unit for which you work will withhold 2% of that portion of your rate of regular compensation that is in excess of $30,000.

Employees hired after April 2, 2012 contribution rate decreases 3% once they have attained 30 years of creditable service.

A new employee is required to make an appointment with the Retirement Board to review and complete the retirement forms before the end of his/her first week of work. You should bring the following documentation:

- **Photo ID (Driver's license, Passport, Mass ID)**
- **Copy of your birth certificate**
- **Copy of DD214 if applicable**
- **Copy of beneficiary's birth certificate or Social Security Number**
- **Copy of marriage certificate if applicable**

Retirement Office/Location
The Retirement Office is located at 25 Lexington Street, Waltham. If you have questions, please call 781-314-3230. They have available a retirement guide booklet that can be mailed to you upon request.

CITY POLICIES AND PRACTICES

Non-Discrimination and Equal Employment Opportunity
Non-discrimination and equal employment opportunity are the policies of the City in all of its employment programs and activities. The City recognizes the right of individuals to work and advance on the basis of merit, ability, and potential, without regard to race, color, sex (including gender identity, sexual orientation, and pregnancy), national origin, ancestry, veteran status, age (over 40), religion, disability or genetic information. The City and its employees will take affirmative measures to ensure equal opportunity in the areas of recruitment, hiring, promotion, demotion or transfer, layoff or termination, rates of compensation, training programs, and all terms and conditions of employment. This applies equally in relations with the public and all persons or organizations doing business with the City.

Americans with Disabilities Act
The City complies with requirements of the regulations contained in the U.S. Americans with Disabilities Act of 1990, including reasonable accommodation to the known physical or mental

limitations of a qualified applicant or employee unless such accommodation will impose undue hardship on the City.

Discriminatory & Sexual Harassment

It is the goal of the City of Waltham to promote a workplace that is free of discriminatory harassment of any type, including sexual harassment. Discriminatory harassment consists of unwelcome conduct, whether verbal or physical, that is based on a characteristic protected by law, such as race, color, sex (including gender identity, sexual orientation, and pregnancy), national origin, ancestry, veteran status, age (over 40), religion, disability or genetic information.

The City of Waltham will not tolerate harassing conduct that affects employment conditions, that interferes unreasonably with an individual's performance, or that creates an intimidating, hostile, or offensive work environment.

Harassment of employees occurring in the workplace, in connection with work-related travel, and/or work-sponsored events will not be tolerated. Further, any retaliation against an individual who has complained about harassment or retaliation against individuals for cooperating with an investigation of a harassment complaint is similarly unlawful and will not be tolerated.

Anti-Nepotism Policy

It is the policy of the City of Waltham not to discriminate in its employment and personnel actions with respect to employees and applicants on the basis of marital or familial status. Notwithstanding this policy, the City of Waltham retains the right to refuse to hire or appoint a person or permit an existing supervisory relationship involving family members to continue, where the family members would be in the same department or division and where their familial and supervisory relationship has the potential for creating or in fact has created an adverse impact on supervision, safety, security or morale, or involves a potential conflict of interest. The Department Head shall have the authority and responsibility for determining if such a potential for adverse impact exists or does not exist. All new or prospective employees must complete an Anti-Nepotism form.

Drug and Alcohol Policy

It is the position of the City of Waltham that the use of illegal drugs and misuse of legal drugs, including alcohol, are sources of danger in the workplace and threaten the maintenance of a productive and safe work environment. The City of Waltham discourages users of illegal drugs and miss-users of legal drugs, including alcohol, from seeking employment with the City and encourages very forcefully the rehabilitation of such persons already in its employ.

Employees of the City of Waltham are visible and active members of the communities in which they live and work. They are inescapably identified with the City and are expected to represent it in a responsible and creditable fashion. While the City of Waltham has no intention of intruding into the private lives of its employees, the City does expect employees to report for work in a condition to perform their duties competently. Use of illegal drugs and misuse of legal drugs, including alcohol, can have a negative impact on the workplace and is contrary to the City's goal of providing a workplace that is a safe, alcohol and drug-free environment.

Employees who engage in drug and/or alcohol abuse, either on or off the job, have the potential to adversely affect the job performance and safety of themselves and others. Use of illegal drugs and misuse of legal drugs, including alcohol, is proper cause for disciplinary action up to and including termination of employment. A complete copy of the policy is provided in your orientation package.

Conflict of Interest Law

The conflict-of-interest law, Chapter 268A of the General Laws, requires that municipal employees give undivided loyalty to the municipality and act in the public interest rather than for private gain. This law sets a minimum standard of ethical conduct for all municipal employees and officials. The law and the Ethics Commission, which enforces the law, were established to foster integrity in government and promote public trust. The purpose of the law is to ensure that public employee's private financial interests and personal relationships do not conflict with their public obligations. The law governs what you may do on the job, what you may do after hours or what you may do after you leave public service.

All City of Waltham employees must complete the online State Ethics Commission training. This training is available on the website www.mass.gov/ethics. Scroll down to education and training resources, click on mandatory training requirements, click online training program and follow the instructions provided. Once the training is completed, print the last page of the training and return that to the City Clerk's office within 30 calendar days of date of hire and every two years thereafter. A complete copy of the policy is provided in your orientation package.

Progressive Discipline Policy

It is the primary goal of the City of Waltham to provide effective and efficient services to the public. Accordingly, it is the responsibility of all managers and supervisors in the employee of the City to attempt to improve the performance of employees under their supervision in order that services are delivered effectively and efficiently to the public. Discipline is one tool for affecting the performance of employees and for achieving the goal of providing effective and efficient municipal services.

The City's Progressive Discipline Policy provides guidelines that will assist managers in the counseling and disciplining of their employees. It also outlines various techniques and methods to help managers prevent and handle performance problems by dealing with situations fairly, consistently, progressively, and professionally.

This policy does not waive, modify, or diminish any managerial rights, rights that the management or appointing authority has by law, and rights that the management or appointing authority has with respect to provisional appointees. For a complete copy of this policy, contact the Human Resources Department.

Right to Know Law

The purpose of the Right to Know Law is to create a mechanism for providing and obtaining information about toxic and hazardous chemicals in the workplace. It is designed to afford employees and community residents opportunities to gain, through their employers and public officials, information regarding such chemicals. Further, it places a responsibility upon employers, to provide such information to employees.

The statute covers both public and private employers who manufacture, use, process or store toxic or hazardous substances, and who have employees who are or may be exposed under normal working conditions or under foreseeable emergencies, to toxic or hazardous chemicals contained on the Massachusetts Substance List. There are no exclusions for employers based on number of employees or size or nature of operation. Research laboratories are exempt but school laboratories are not exempt.

The law is two-fold. First, it places upon employers the responsibility of providing to all of its employees' information regarding the identity and effects of toxic and hazardous chemicals. Second, it affords employees the right and opportunity to obtain such information from and through their employers. For a complete copy of this law, contact the Human Resources Department.

Public Records Law

Under the Massachusetts Public Records Law, any person has the right of access to public information. Administrative information typically contained in a municipal employee's personnel file such as an employee's name, home address and date of birth is considered public information and may be disclosed in response to a public records request. Administrative information regarding public safety employees may not be disclosed under the Public Records Law.

Municipal employees who are victims of domestic violence, sexual assault or stalking may have their home address protected from public disclosure through a special program known as "The Address Confidentiality Program (ACP)" administered by the Secretary of the Commonwealth. For information on the ACP call 1-866-SAFE-ADD. For more complete information on the Massachusetts Public Records Law, contact the Human Resources Department.

Polygraph Protection Act

Employers are generally prohibited from requiring or requesting any employee or job applicant to take a lie detector test, and from discharging, disciplining, or discriminating against an employee or prospective employee for refusing to take a test or for exercising other rights under the Act.

Smoking Policy

Per MGL Chapter 270, Section 21 & 22 smoking is prohibited in all public buildings, or in a vehicle or vessel owned, leased or operated by the City of Waltham.

The City of Waltham encourages a spirit of cooperation, courtesy and mutual respect among employees in the workplace.

Police & Fire: The rule has been adopted under the authority of the Pension Reform Act, Ch. 697 of the Acts of 1987. Section 117 of the Act adds the following to Chapter 41 of the General Laws:

"Section 101A. Subsequent to January first, nineteen hundred and eighty-eight, no person who smokes any tobacco product shall be eligible for appointment as a police officer or firefighter in

a city or town and no person so appointed after said date shall continue in such office or position if such person thereafter smokes any tobacco products. The personnel administrator shall promulgate regulations for the implementation of this section."

Alcohol and Drug Free Workplace

The City realizes that the misuse of drugs and alcohol impairs employee health and productivity. Drug and alcohol problems result in unsafe working conditions for all employees and customers. The City is committed to maintaining a productive, safe, and healthy work environment, free of unauthorized drug and alcohol use, in compliance with the Drug Free Workplace Act. Any employee who seeks assistance through the Human Resources Department may be confidentially referred to drug and alcohol rehabilitation programs. Employees seeking assistance may also contact the Employee Assistance Program.

Any employee involved in the unlawful use, sale, manufacturing, dispensing or possession of controlled substances, illicit drugs and alcohol on City premises or work sites, or working under the influence of such substances or who is impaired at work as a result of the use of lawful substances, will be subject to disciplinary action up to and including dismissal and referral for prosecution.

In addition, the City has developed and maintains a comprehensive Drug and Alcohol Policy and CDL drug testing policy in accordance with the Department of Transportation 1991 Omnibus Transportation Employee Testing Act, as amended. For a complete copy of this law, contact the Human Resources Department.

Employee Assistance Program

The City of Waltham offers an Employee Assistance Program to help employees who may be experiencing personal problems that may impact their job performance. The purpose of the Employee Assistance Program is to help employees address these problems before they impact their job performance. There is no cost to employees, household members or dependents for EAP sessions and one 30-minute consultation for each legal or financial matter. This is a completely confidential program.

Employees may access the program by contacting an EAP representative at 1-800-451-1834, their department head or the Director of Human Resources or at www.emiia.org

Employee Network Use Policy

The Employee Network Use Policy outlines the proper use of Internet access. This policy applies to all Municipal Employees using Waltham's Network. All Waltham data network access to the Internet is provided for **CITY BUSINESS ONLY**.

All electronic data transferred, promoting, aiding, furthering or otherwise in support of illegal activities are prohibited. Attempts to gain unauthorized access to any computer or communications system on the Internet are also prohibited. The use of the Internet through your Waltham account is a privilege not a right and inappropriate use or vandalism of any kind may result in a cancellation of this privilege and disciplinary action. A complete copy of this policy is provided in your orientation package.

Whistleblower Protection Act
The Whistleblower Protection Act protects whistleblowers that are responsible for disclosing, threatening to disclose, providing information, or objecting to any activity, practice, or policy that the employee reasonably believes is in violation of law, rule, or regulation, or poses a risk to public health, safety, or the environment. An employer violates the Whistleblower Protection Act if the employer takes (or threatens to take) retaliatory personnel action against any employee or applicant because of disclosing said information.

Fair Labors Standard Act
The Fair Labor Standards Act (FLSA) establishes standards for minimum wages, overtime pay, recordkeeping, and child labor. Fair Labor Standards Act of 1938 was enacted to establish fair labor standards in the workforce. This regulation applies to all departments except Fire and Police personnel.

The City is hereby establishing a seven-day work period commencing at 12:01 a.m. on Sunday for all departments with the exception of employees engaged in law enforcement and fire protection activities.

The Act allows for certain employees to be exempt under the Act for its overtime provisions. Some of the exemptions, among others, are elected officials, executive, administrative, professional personnel, etc. The Human Resources Department will notify department heads which of their employees, if any, are exempt from the Act.

The Act calls for overtime payment for hours worked over 40 in a work period. Vacation leave and sick leave time not actually worked during a call back period may not be counted as hours worked under the Act. Compensatory time off may only be provided under the provisions of a labor contract or for employees not included in bargaining units, under a written memorandum of understanding arrived at before the performance of the work.

This Act also establishes standards for minimum wage and child labor. Please contact the Human Resources Department for a complete copy of the Fair Labor Standards Act.

Vehicles Can Be Dangerous Policy
The prevention of injuries is a major responsibility of employers and employees. Therefore, it is the policy of the City of Waltham that no employee shall ride outside the passenger compartment of a City-owned vehicle. All individuals in city-owned vehicles must be seated within the passenger compartment and wearing seatbelts. There will be NO exceptions to this policy. This policy will be rigorously enforced. Failure to comply may result in disciplinary action. A complete copy of this policy is provided in your Orientation Package.

USERRA
The Uniformed Services Employment and Reemployment Rights Act protects the job rights of individuals who voluntarily or involuntarily leave employment position to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of uniformed

services, and applicants to the uniformed services. Please contact the Human Resources Department should you have any questions regarding this Act.

Closing

The contents of this booklet are for your reference. If you have questions or require additional information regarding the contents of this booklet, please ask your supervisor or contact the Human Resources Department at 781-314-3355.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

Print full name ..... Social Security no. .....

Print home address..... City..... State..... Zip .....

Employee:

File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C..... .....
3. Write the number of your qualified dependents. See Instruction D..... .....
4. Add the number of exemptions which you have claimed above and write the total..... ☐
5. Additional withholding per pay period under agreement with employer $_____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

CONFIDENTIAL

EEO Self-Identification Form

Notice -Completion of this form is voluntary.

We are an Affirmative Action, Equal Opportunity Employer. Our employment decisions are made without regard to race, color, religion, gender, national origin, age, disability, marital status, veteran or military status, or any other legally protected status. The purpose of this Employee *EEO Self-Identification Form* is to comply with federal government record-keeping and reporting requirements. Periodic reports are made to the government on the following information. The data you provide on this form will be kept confidential and used solely for analytical and reporting requirement purposes. This form is processed and maintained separately from your personnel file and is not used to make decisions about the terms and conditions of employment. Completion of this form is optional and voluntary. We appreciate your assistance.

1. Date Completed: ☐
2. Name: ☐
3. Position Applying: ☐
4. Social Security Number: Last 4 Digits: ☐

Voluntary Self-Identification of Ethnicity, Race and Gender

5. Race/Ethnic Code: (Please Select One)

Ethnicity:

☐ **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race;

Race:

☐ **White (not Hispanic or Latino)** – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East;

☐ **Black or African American (Not Hispanic or Latino)** – A person having origins in any of the Black racial groups of Africa;

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands;

☐ **Asian (Not Hispanic or Latino)** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam;

☐ **American Indian or Alaskan Native (Not Hispanic or Latino)** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community recognition; and

☐ **Two or More Races (Not Hispanic or Latino)** – All persons who identify with more than one of the above five races.

6. Sex/Gender Code: (Please Select One)

☐ **Male** ☐ **Female** ☐ **Non-Binary** ☐ **Prefer Not to Disclose**

Signature: ☐ **Date:** ☐

THANKS FOR YOUR ASSISTANCE!

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM, MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL – KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
Human Resources Director
Workers' Compensation Agent

Housing Rehabilitation Program Guidelines

City of Waltham
Planning Department
Housing Division

January 13, 2022

Applying for Funding Assistance:

Applications for assistance are accepted by mail or in person in the Housing Department, 25 Lexington St., Waltham, MA. 02451.

Applications may be downloaded by going to the City web site at www.city.waltham.ma.us/housing

Application are accepted on a first-come, first-serve basis. For more information call the Planning Department Housing Division at 781-314-3380.

CITY OF WALTHAM
Background Information Form & Verification of Employment

Instructions: This form must be clearly printed in ink. **All questions must be answered completely.**

Applicants must submit copies of all certification or licenses required or related to employment with their background check form <u>if requested by the Human Resources Department.</u>

PERSONAL HISTORY

1. Name in full (Last, First, Middle Name) _____

2. Social Security Number _____

3. List all other names you have used. If you have ever used any surnames other than your true name, during what period and under what circumstances were these names used? If you have ever legally changed your name, give date, place and court.

_____ _____

4. Are you at least 18 years of age? Yes ☐ No ☐

5. Are you eligible to work in the United States? Yes ☐ No ☐

VERIFICATION OF EMPLOYMENT

6. Please provide the name and contact information of your supervisor or Human Resources Department in order to verify current or most recent employment. **<u>The City of Waltham must be able to verify employment.</u>**

Supervisor Name and/or Human Resources	Telephone Number

RESIDENCE

7. Present Residence Address (Street, Apartment #, City, State, Zip Code):

_____

_____

8. Residence # ( )_____Business # ( )_____Cell phone # ( )_____

9. List chronologically all past residences. Be as accurate as possible. (Include addresses while attending school if away from home and all military addresses).

From Month/Day Year	To Month/Day Year	Number & Street	City	State

EDUCATION

10. List all educational institutions that you have attended starting with high school:

Name of School	Location	Dates Attended From Month/Year To Month/Year	Degree Or Diploma

11. Were you ever dismissed from school for any reason during your scholastic career?

Yes ☐ No ☐

If YES, explain in detail. School: _____ Date: _____

_____

_____

MILITARY EXPERIENCE

12. Have you served in the United States Military? Yes ☐ No ☐

From	To	Branch	Rank	Active Reserve	Retired

PROFESSIONAL LICENSES

11. Please provide any professional licensure you currently hold or have held in the past.

Issuing Authority	Profession	License Number	Expiration Date

13. Has your professional license to ever been revoked or suspended in this state or any other?
Yes ☐ No ☐

If YES, explain in detail:

_____

_____

DRIVING RECORD

14. Provide your Massachusetts Driver's License number, and if requested, your driving record from the Registry and Expiration Date:

License Number: _____ Expiration Date: _____

15. Did you ever possess a Driver's License from another state? Yes ☐ No ☐

If YES, give dates State and license number (if known): _____

16. Has your license to operate motor vehicles ever been revoked or suspended in this state or any other? Yes ☐ No ☐

If YES, explain in detail:

_____

_____

EMPLOYMENT

17. List chronologically all employment beginning with the most recent. Include summer and part time employment while attending school, any period of unemployment and any military service.

ALL time must be accounted for and ALL employment must be provided.
CLEARLY STATE THE REASON FOR LEAVING (excluding medical reasons).

Employment History (Every section must be completed in full)	
Company	Type of Business

Telephone	Address		
Position	Department	Hours per WK	Supervisor
Start Date	Date Left	Reason for Leaving	
Duties/Major Accomplishments			

Company	Type of Business

Telephone	Address		
Position	Department	Hours per Wk	Supervisor
Start Date	Date Left	Reason for Leaving	
Duties/Major Accomplishments			

Company	Type of Business

Telephone	Address		
Position	Department	Hours per Wk	Supervisor
Start Date	Date Left	Reason for Leaving	
Duties/Major Accomplishments			

Company	Type of Business

Telephone	Address		
Position	Department	Hours per Wk	Supervisor
Start Date	Date Left	Reason for Leaving	
Duties/Major Accomplishments			

Company	Type of Business

Telephone	Address		
Position	Department	Hours per Wk	Supervisor
Start Date	Date Left	Reason for Leaving	

The City of Waltham is an AA/EEO Employer.

Duties/Major Accomplishments

18. Have you ever been dismissed, terminated or asked to resign from any position or employment you have held? YES □ NO □

19. Have you ever quit any job or position without giving notice? YES □ NO □

If YES, explain in detail. Employer's name: _____ Date _____
Reason: _____

_____

PROFESSIONAL/TRADE ASSOCIATIONS

20. Do you hold membership in any professional or trade organizations(s)? YES □ NO □

Organization	Address	Type	Member position Held

INVESTIGATION RECORD

21. Has the Commonwealth of Massachusetts, the United States Government, any State, Municipality, or other Police Agency investigated your background? YES □ NO □

If YES, provide the information below:

Month/Year	Investigating Agency

OUTSIDE ACTIVITIES

22. List any activities, which you may wish to have considered as reflecting favorably on your reputation for leadership, responsibility, honesty, and integrity. (**Response is Optional)**

From: To: (month/year)	Activity	Location (City/State)

PRIOR EMPLOYMENT APPLICATIONS (All employment)

23. Have you ever provided false information on any application for employment?
YES ☐ NO ☐

24. Have you ever withheld information on any application for employment? YES ☐ NO ☐

25. Have you ever misrepresented your qualifications on any application for employment?
YES ☐ NO ☐

Employee Authorization to Release Records

Read Carefully Before Signing

I certify that the above information is true and complete to the best of my knowledge; any misrepresentation of information on this application may be reason for immediate dismissal. I authorize you to review my character and ability to perform the job for which I am applying. I understand that in carrying out the review, reports may be solicited from previous employers, schools, credit bureaus, Registry of Motor Vehicles, personal and other references, but that no attempt will be made to contact my present employer or law enforcement agencies to see if I have been convicted of a felony unless specifically authorized by me to do so. I hereby release them from all liability for damages for providing this information. I also recognize that I will be required to complete the City's employment forms, complete and pass a pre-employment physical and complete and pass pre-employment drug/alcohol testing as well as a probationary period. It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

Note: Labor Service registration is valid for five years and is subject to all provisions of Civil Service Law and Rules. If you wish to renew your registration for one five year extension, you must notify the City of Waltham Human Resources Department in writing no earlier than six months before, or no later than six months after the fifth anniversary of your registration. Failure to provide such notification will result in removal from the Labor Registration List.

Applicant's Full Name (Print Legibly): _____

Applicant's Signature: _____

Date: _____

It is unlawful in Massachusetts to require or administer a polygraph test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability. (MGL c149, s 19b)

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Waltham Contributory Retirement System

25 Lexington Street 2nd Floor, WALTHAM, MA 02452 | 781.314.3230 | FAX 781.314.3236

MEMORANDUM

TO: NEW EMPLOYEE APPLICATION FOR MEMBERSHIP IN THE WALTHAM CONTRIBUTORY RETIREMENT SYSTEM

FROM: ANDREW B MALIS
EXECUTIVE DIRECTOR

Please make an appointment with the Waltham Retirement Board at 781-314-3230 to complete an application for Membership in the WCRS on or before your hire date.

Please bring the following items with you for your appointment.

1. *Bring a Photo ID.*
2. *Copy of yours and your Beneficiaries Birth Certificates.*
3. *Bring a copy of your Marriage Certificate.*
4. *You must have your Social Security number and those of your Beneficiaries.*
5. *You must bring a copy of your DD214 documents for Veterans Status.*

Thank you

CITY OF WALTHAM
MASSACHUSETTS

119 SCHOOL ST., WALTHAM, MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL – KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
Human Resources Director
Workers' Compensation Agent

To: Non-union Employees
From: City of Waltham
Re: OPEB Contribution
Date: May 1, 2023

Permanent employees who are eligible for the City's health insurance program, incur a liability referred to as Other Post-Employment Benefits (OPEB). Below is an explanation of OPEB. Each permanent full-time employee will have $10/week deducted from their paycheck to be deposited into the OPEB Trust Fund to help reduce the liability. Permanent part-time employees working over 20 hours/week, but less than full-time will contribute $4/week.

Other Post Employee Benefits (OPEB)
What is OPEB?
OPEB is the benefit offered to retirees other than their pension. It is mainly health insurance, which includes medical, dental, Medicare Part B premiums and drugs.

What is the OPEB liability?
The OPEB liability is the present value of the City's cost of health insurance for retirees. This includes current retirees and those employees who have a right to retire at a future date (vested employees). The OPEB liability is reduced by the amount of assets the City has set aside to date. The net amount is the unfunded OPEB liability. The current unfunded OPEB liability for the City of Waltham is $698.9 million.

What are the drivers of the City's OPEB liability?
*Level of Benefits
*Health care costs
*Eligible population

The City of Waltham is self-insured and offers benefit rich health plans consisting of low co-payments and $0 deductibles. The employee contribution is 12.5% for the PPO and 11% for the HMO plans. Under a special act for the City of Waltham, the contribution percentage paid by the employee at the time of retirement is guaranteed for the duration of their retirement.

Total annual rates for the City's plans as of July 1, 2023 are as follows:

BCBS PPO	Family $46,350/Individual $19,967
Tufts HMO	Family $32,013/Individual $11,930
HPHC HMO	Family $31,124/Individual $12,464

All permanent benefit eligible employees, their spouses and dependent children up to the age of 26 are eligible to participate. Additionally, surviving spouses of deceased employees and retirees are eligible to participate.

Why is the City's OPEB liability significant?
Health care costs are generally rising at a faster rate than the reserves.

A Mass Municipal Association (MMA) survey shows the average employee contribution for municipalities is 30%. The City is 11% or 12.5% and a contribution guarantee provided by a special act.

The OPEB liability in the near future will need to be included in the City's audited financial statements. This will have a significant unfavorable impact of the City's overall financial position and could potentially impact its bond rating.

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name City of Waltham **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
DIRECTOR OF PERSONNEL
WORKERS' COMPENSATION AGENT

CITY OF WALTHAM
SEXUAL HARASSMENT POLICY

The City of Waltham, as an employer, has as its goal the elimination of sexual harassment from the workplace. It is destructive of morale and teamwork and it can lead to poor job performance. Both the Massachusetts General Laws, Chapter 151B and 151C and Title VII of the Civil Rights Act of 1964 include sexual harassment as a form of unlawful sex discrimination. The City strongly disapproves of such conduct by or toward its' employees. It shall be the City's policy that all employees of the City, at all levels, elected or appointed, must avoid offensive and/or inappropriate sexual and/or sexually harassing behavior at work and will be held responsible for insuring that the workplace is free of sexual harassment. Sexual harassment, retaliation against an individual filing a claim, or retaliation against an individual cooperating in an investigation is against the law and will not be tolerated by the City of Waltham.

I. Definition of Sexual Harassment

Conduct which constitutes prohibited sexual harassment includes unwelcome sexual advances; requests for sexual favors; and other verbal or physical conduct of a sexual nature when:

(a) Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; or

(b) Submission to or rejection of such conduct by an individual is used explicitly or implicitly as the basis for employment decisions affecting such individuals; or

(c) Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance by creating an intimidating, hostile, or sexually offensive working environment.

The following behaviors are examples of what the City would consider to be sexual harassment:

(a) requests for sexual favors in exchange for actual or promised job benefits such as favorable reviews, salary increases, promotions, increased benefits or continued employment;

(b) coerced sexual acts;

In certain circumstances, the following conduct may also constitute sexual harassment:

(c) use of sexual epithets; gossip regarding one's sex life; comments about an individual's sexual activity;

(d) unwelcome brushing against the body of an individual; unwelcome sexual gestures or suggestive comments;

(e) displaying sexually suggestive objects, pictures, cartoons;

(f) inquiries into a person's sexual experiences;

(g) discussion of one's own sexual activities.

II. Considerations

Sexual harassment is not, by definition, limited to prohibited conduct by a male employee toward a female or by a supervisory employee toward a non-supervisory employee. The City's view of sexual harassment includes, but is not limited to, the following considerations:

(a) A man as well as a woman may be the victim of sexual harassment; a woman as well as a man may be the harasser.

(b) The harasser does not have to be the victim's supervisor. The harasser may also be a supervisory employee who does not supervise the victim, a non-supervisory employee (co-worker), or, in some circumstances, even a non-employee.

(c) The victim does not have to be the opposite sex from the harasser.

(d) The victim does not have to be the person at whom the unwelcome sexual conduct is directed. The victim may also be someone who is affected by such conduct when it is directed toward another person. For example, the sexual harassment of one employee may create an intimidating, hostile, or offensive working environment for another co-worker or unreasonably interfere with the co-worker's work performance.

III. Complaint Procedures

Complaints of sexual harassment may be made to: any Supervisor, any Department Head, the Director of Human Resources, Kristin Murphy, 119 School Street, Waltham, MA 02451, 781-314-3360.

(a) Complaints of sexual harassment or retaliation will be accepted verbally or in writing. All complaints will be taken seriously and investigated. Anyone may make such a complaint whether it be the victim or any other individual who has witnessed acts of sexual harassment or retaliation. The City expects individuals who witness such acts to report this conduct.

(b) Upon the occurrence of an initial act of harassment or upon repetition of such acts, the victim should report the incident to his/her immediate supervisor or the Department Head. The immediate supervisor or Department Head should then, in turn, immediately report the incident

to the Director of Personnel. In the event the immediate supervisor or Department Head is the offending person, or in the event the victim prefers to notify someone outside of the victim's department, the victim should report the incident directly to the Director of Personnel and/or the Administrative Assistant to the Mayor to handle and investigate sexual harassment complaints.

(c) The City will make every effort to investigate in a professional manner as expeditiously as possible and as confidentially as it is able to. The City will make every reasonable effort to limit information to those individuals who have an immediate need to know, including but not limited to, the Director of Personnel, the other person designated to handle sexual harassment complaints, the investigating officer (if someone other than the person designated to handle sexual harassment complaints), the alleged target of harassment or retaliation, the alleged harasser, and any possible witnesses or others who may be able to provide information necessary to the investigation.

(d) Upon completion of the investigation, the investigating officer will prepare a written report to be submitted to the Director of Personnel for appropriate action. A general summary of the investigation results will be shown by the Director of Personnel to the complainant within ten business days after the investigation has been concluded, if possible. The findings of the investigation will also be communicated to the alleged harasser.

(e) The Director of Personnel, irrespective of whether there is evidence that sexual harassment or retaliation has occurred, must advise the complainant that (s)he has the right to pursue other legal avenues which may be available.

IV. Sanctions

(a) Any employee found to have engaged in sexual harassment in violation of this policy is subject to disciplinary actions up to and including termination of employment. Disciplinary actions short of termination may include withholding of promotions and/or suspension.

(b) All employees are encouraged to contact their Supervisors, Department Heads, or the Director of Personnel if they have any questions as to whether or not they are or may be victims of sexual harassment. No employee will be punished for making such inquiries.

(c) If an employee is found to have made a knowingly false report for the sole purpose of harming another person, then such employee will be subject to disciplinary action.

V. State and Federal Remedies

In addition to filing a complaint with the City, if you believe you have been subjected to sexual harassment, you may file a formal complaint with either or both of the government agencies

listed below. Each of the agencies has a short time period for filing a claim (EEOC - 180 days; MCAD - 6 months):

1. The Massachusetts Commission Against Discrimination (MCAD)
   One Ashburton Place Room 601
   Boston, MA 02108-1518
   (617) 727-3990 (Admin. Services)
   (617) 720-6054 (TTY)

2. The United States Equal Employment Opportunity Commission (EEOC)
   One Congress Street
   10th Floor, Room 1001
   Boston, MA 02114
   (617) 565-3200 (To file complaints)
   1-800-669-3362 (Toll free)

Jeannette A. McCarthy City of Waltham Mayor	Kristin Murphy Director of Personnel Workers' Compensation Agent
Date_____	Date_____

Created by the City of Waltham Personnel Department

Receipt Form - Sexual Harassment Policy

I, _____, have received, read, and accept the City of Waltham Sexual Harassment Policy.

SIGNATURE_____

DATE_____

CITY of WALTHAM

- Office of the City Treasurer & Collector -

Thomas J. Magno
Treasurer & Collector

Dear Fellow Employee,

As you know, all City Departments are looking for ways to reduce operation costs. All of us in government have been making every effort to insure that the taxpayer's dollars are spent wisely. Those of us in the Treasurer's Office are constantly being faced with increased banking costs just as you are experiencing increases in service charges in your own personal checking and savings account.

The Treasurer's Office has reviewed the cost of payroll check processing and we have been exploring options to reduce banking costs without increasing any costs, or causing any inconvenience, to the employee. The Treasurer's Office processes over 80,000 payroll checks annually.

In talks with several local banks we are proposing a direct deposit program that will provide both the City of Waltham and the Employee substantial savings. Your participation in this program by having your payroll check deposited directly into your bank account is essential to reducing administrative costs. This program could save the City of Waltham $15,000 annually in and could save each employee $60.00 annually in banking services.

This program is simple and efficient. While other people are waiting in long lines at banks your earnings will be in your account at 9:00 a.m. on payday (except on Monday holidays). You will be under no obligation to stay in the program. If you are not completely satisfied you can notify us to return you to check processing. You may select any bank as your depository as most banks participate in this direct deposit network.

Complete the enclosed form marked "Direct Deposit Authorization Form" and return it to your payroll clerk for processing. If you have any questions, please call Patty Keefe at extension 3272 and we will be glad to help you in any way we can.

Your participation is essential to the success of this cost savings program.

Respectfully yours,

Thomas J. Magno
Treasurer & Collector

TJM/kc

610 Main Street • Waltham, Massachusetts 02452 • Tel: 781-314-3250 • Fax: 781-314-3260 • Email: tmagno@city.waltham.ma.us

Direct Deposit Authorization Form

PLEASE PRINT:

Name: _____

Address: _____

_____

_____

SS#: _____

Bank Name: _____

Bank Address: _____

Account #: _____

Type of Account (Please circle) Checking Savings

_____ _____

Signature Date

BANK ROUTING #: _____

PLEASE ATTACH A SAMPLE PERSONAL CHECK
AND WRITE **VOID** ACROSS THE CHECK

RETURN THIS FORM WITH YOUR CHECK TO THE HUMAN RESOUCE DEPARTMENT OR YOUR PAYROLL CLERK. THANK YOU.

NOW AVAILABLE
DIRECT DEPOSIT EMAIL

The City now has the ability to email direct deposit slips directly to the employees. You can sign up by going to the case following case sensitive link:
http://payroll.city.waltham.ma.us/cow1/eadvice.php

**You may use any email address but you must use a computer or device logged onto the City network to enroll

Upon completion you will receive a verification email, you must reply to finalize the process. It may take up to two pay periods to take effect.

Any questions please contact

Payroll Department at ext. 3270

Timely receipt of pay stub

Ability to store in a computer file for easier access

Less paper clutter

Better Privacy / Security

CITY OF WALTHAM
610 Main Street
Waltham MA 02452

FlexChoice

Reimbursement Account Overview

Sentinel Benefits
& FINANCIAL GROUP

A simple plan for ensuring your family's well-being

A flexible spending account (FSA) is one of the most valuable employee benefits your employer can offer you. It allows you to pay for qualified healthcare, dependent care and certain transportation expenses with pre-tax dollars.[1]

How Does FlexChoice Work?

Participation in your FlexChoice plan is easy. You decide how much to contribute and to which accounts: Healthcare, Dependent Care or Transportation *(if available)*. Contributions to your account(s) are made conveniently through payroll deduction on a pre-tax basis. When you incur an eligible expense, you may use one of the following methods to be reimbursed:

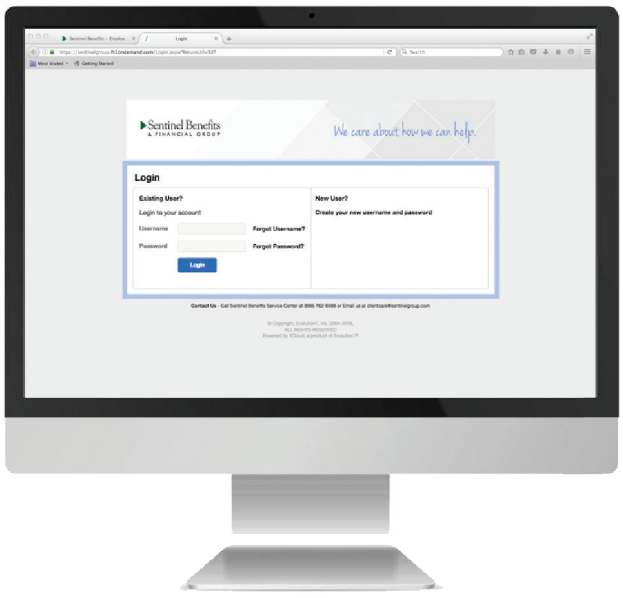
Benny Debit Card – The Benny Prepaid VISA makes it fast and convenient to access the money you have in your account. The Benny Card contains the value of your annual election and tracks it by account type – healthcare or dependent care. You can use the Benny Card to pay for qualified medical and dental expenses not covered by your insurance plan(s) or you can pay your childcare provider directly. You can also use it to pay for parking and transit expenses *(refer to the transportation benefits at sentinelgroup.com)*. The Benny Card automatically deducts the cost of your eligible expenses from your account. Just swipe and go. It is that easy!

Online Claim Submission – If you do not have a Benny Debit Card or you are not able to use your Benny Card for a particular purchase, you may request reimbursement by using Sentinel's online system. Simply enter your claim online, attach your scanned receipts to your online request, and press "submit." That's it, you're done! Sentinel reimburses you every Friday and your payment can be automatically deposited into your bank account.

How To Register Online

When you register online with Sentinel Benefits, you will be able to gain access to your plan account(s).

Go to sentinelgroup.com and hover over ACCOUNT ACCESS in the upper right corner. Select "FlexChoice" in the "For You" category of the dropdown menu. Once you are on the Login web page, click "Create your new username and password." Enter the required information and press "Next."



How you can save with an FSA

What FlexChoice Covers

The FlexChoice FSA plan covers an extensive range of out-of-pocket expenses. The list of expenses includes, but is not limited to:

- Prescription drug co-payments
- Non-covered dentist or other provider fees
- Health plan deductibles and coinsurance
- Doctor and emergency room co-payments
- Contact lenses, eyeglasses, and LASIK surgery
- Mail service and online prescription co-payments and deductibles
- A variety of over-the-counter items (per current regulations)
- Dependent care expenses

Dependent care expenses include day care and summer day camp for children as well as the cost for a caregiver to assist an elderly parent while you and your spouse are working or seeking gainful employment. For a comprehensive list of eligible healthcare and dependent care expenses, please visit: sentinelgroup.com/SentinelBenefits/media/Sentinel-Benefits/Documents/Eligible-Expenses.pdf.

FlexChoice helps you better prepare and manage unavoidable out-of-pocket costs while reducing your taxes. Refer to the examples on the right to see how quickly health and dependent care expenses can add-up and how much a FlexChoice plan can save you in taxes.

LISA ADAMS, age 26, unmarried

Lisa has medical and dental insurance at work. She learned very quickly that even with insurance, she still has significant out-of-pocket expenses.

Healthcare Related Expenses

Co-pays for Doctor Visits	$75
Optician Visit	$100
New Eyeglasses	$235
Dental Cost for Root Canal	$400
Prescription Co-Pay	$30
Total Eligible Expenses	**$840**

Tax Savings with an FSA

Healthcare FSA Expenses	$840
Marginal Tax Rate	28%

Estimated Tax Savings $235.20

ROGER & SUSAN COLLINS, ages 35 & 36, two children, ages 2 & 3

As their family grows, the Collins are finding that their insurance leaves them vulnerable to significant out-of-pocket costs. The children are in daycare while Roger and Susan work and the annual cost for this care exceeds $5,000.

Healthcare Related Expenses

Well Baby Visit Co-pays	$50
Children Sick Visit Co-pays	$75
Roger's Prescription	$100
Susan's Contact Lenses	$350
Roger's Extensive Dental Work	$225
Family Prescriptions	$235
Total Eligible Expenses	**$1,035**

Tax Savings with an FSA

Healthcare FSA	$1,035
Dependent Care FSA	$5,000
Total Expenses	$6,035
Marginal Tax Rate	33%

Estimated Tax Savings $1,991.50

HENRY & MEREDITH BRINKER, ages 57 & 56

Meredith's aging mother, Olivia, who is a qualified dependent, lives with them and needs help at home while Henry and Meredith are at work. While the Brinkers are insured at work, Olivia is covered only through Medicare. The annual cost for Olivia's care at the Brinker's home is $3,500.

Healthcare Related Expenses

Henry's Prescription	$350
Meredith's Annual Exam	$250
Family Dental Visits	$250
Olivia's Medication *(not insured)*	$750
Total Eligible Expenses	**$1,600**

Tax Savings with an FSA

Healthcare FSA	$1,600
Dependent Care FSA	$3,500
Total Expenses	$5,100
Marginal Tax Rate	35%

Estimated Tax Savings $1,785.00

See more tax savings with a reimbursement account

How To Participate in FlexChoice

You may only elect to participate in this program during your company's annual open enrollment period – unless you are new to your company or have experienced a "change in family status." Contact your Human Resources department for information about your company's open enrollment dates.

The Benny Card

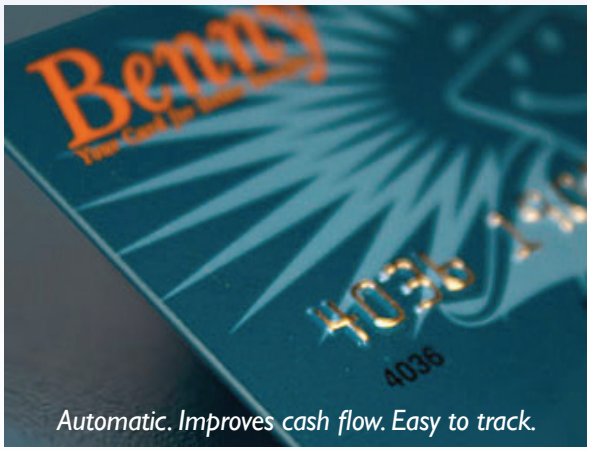
The Benny Debit Card[2] helps you save time, money and paperwork. Using the Benny Card helps you keep cash in your wallet. You will never "pay twice" – first from your paycheck into your FSA and then again at the time of purchase. You will have no claim forms to complete and will not have to wait to be reimbursed. Also, when you request a Benny Debit Card, you will receive a complimentary card for your spouse or dependent to use. For important information and details regarding the Benny Card, log onto our website. You can also check your balance and other account details online at any time at www.sentinelgroup.com.

Get The Answers You Need

Visit www.sentinelgroup.com or for answers to all your specific questions, email us at flexhelp@sentinelgroup.com, or call toll-free at (888) 762-6088, 8:00 a.m. to 6:00 p.m. ET.

sentinelgroup.com
(888) 762-6088

Sentinel Benefits & FINANCIAL GROUP



Automatic. Improves cash flow. Easy to track.

IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT FLEXIBLE SPENDING ACCOUNT PLANS

Carefully estimate your FSA contributions as money not spent during the plan year is often forfeited. Some plans do allow for a carryover of up to $500 of Healthcare funds, so please consult your Summary Plan Description for additional information on the carryover rules.

Only expenses incurred during the plan year are eligible for reimbursement from your account. (Some plans offer a 2 ½ month grace period that would allow you to submit claims incurred during the first 2 ½ months following the plan year to be included in the prior plan year's limit.)

You may only join a flexible spending account plan during your company's open enrollment period, when you first become eligible or experience a change in family status.

Once you elect to join the plan, you may not cancel or change your election during the plan year unless you have a change in family status.

If you are a partner or Sub-Chapter S shareholder employee, you may not participate in an FSA plan.

The maximum that you may contribute to the dependent care account is the lesser of $5,000 per family or 100% of the lowest paid spouse's income.

The maximum that you may contribute to the healthcare account is limited by the IRS and/or your plan. Please refer to the Summary Plan Description or contact your Human Resources department.

To protect your privacy, your claim records are kept confidential by Sentinel Benefits.

[1] The amount that you save in taxes with a reimbursement account will vary depending on the amount you set aside in the account, your annual earnings, whether or not you pay Social Security taxes, the number of exemptions and deductions you claim on your tax return, your tax bracket and your state and local tax regulations. Check with your tax advisor for information on how participation will affect your tax savings.

[2] Always save receipts for qualified purchases made with the Benny Card. You may be asked to submit some receipts to verify that your expenses comply with IRS guidelines. Your receipt must show the merchant or provider name, service received or item purchased, date and amount of the expense.

First use: 4/14/2016

City of Waltham

City of Waltham Section 125 Cafeteria Plan

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) lets you set aside a certain amount of each paycheck into an account - before paying income taxes. During the year, you will have access to this account for reimbursement of eligible medical expenses not covered by insurance. You may also have the option to set aside pre-tax dollars to reimburse eligible dependent care and commuter expenses (if allowed in the Plan).

How Does It Work?

You can contribute up to your plan's maximum for each benefit offered in the FSA. To do so, simply make your annual elections during your Plan's Open Enrollment Period. As a reminder, you must actively enroll in your FSA each Plan Year.

Benefit Options	Benefit Maximum	Deadline to Incur Expenses	Deadline to Submit Claims
Dependent Care	$5,000	3/15	3/31
Health FSA	$2,550	3/15	3/31

What is the Sentinel Benny Card?

The Benny Card is a Pre-Paid VISA card that allows you to pay for eligible FSA expenses at the point-of-sale. These cards can be used wherever VISA is accepted. Your Benny Card is valid for 3 years. If you continue to participate in the FSA, simply keep your card and your new balance is reloaded each year!

It's simple: The card eliminates out-of-pocket expenses and reduces the need to file a claim. And the best part - it's free!

How Do I Establish My Online Account at www.sentinelgroup.com?

Setting up your secure online account is simple! Log onto **www.sentinelgroup.com** and hover over ACCOUNT ACCESS in the upper right corner. Select "Login to your FSA, HRA, HSA and Retirement accounts" in the "For You" category of the dropdown menu. Once you are in the Account Access web page, click **Register Online** and follow the online instructions. Your online account allows you to submit claims, review account activity and manage your information.

Your temporary Plan Access Code to register is **22502501.**

Manage your account
www.sentinelgroup.com

Call the Member Service Center at
1-888-762-4088

Download our app at iTunes App Store or Google Play.

Sentinel Benefits
& FINANCIAL GROUP
Custom Solutions for Life and Wealth

Important Information Regarding Health Care and Dependent Care Flexible Spending Accounts

To learn more about FlexChoice, please visit our website at www.sentinelgroup.com. You will find everything you need, including:

- Claim forms
- Information on eligible expenses, including over-the-counter items
- Status information on claims and outstanding balances
- Everything you need to know about benefits debit card

... and much more!

You can only elect to participate in this program during your company's open enrollment period – unless you are new to your company or have experienced a qualified status change. Only the following events will be considered a qualified change in status under IRS guidelines:

- Change in legal marital status
- Change in number of dependents
- Change in employment status
- Change in work schedule which changes your eligibility requirements
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change of residence or work-site
- Judgment, decree or order pertaining to child or spouse

You must provide the appropriate documents for a Change in Status, e.g. marriage or birth certificate.

Any change in your annual election due to a qualified status change is only valid for expenses incurred from the date of the status change through the end of the plan year.

For answers to specific questions, email us at flexhelp@sentinelgroup.com or call the Sentinel Benefits member Service Center at 888-762-6088 Mon. - Fri., 8:00 AM to 6:00 pm ET (excluding holidays).

Know Your FSA: What's Eligible & What's Not

Eligible Health Care Expenses

Caring for the Handicapped
- Service dog
- Special education for the blind
- Tuition at special school for handicapped

Child Birth & Well-Being
- Breast pumps & lactation supplies
- Birthing/Lamaze
- Childbirth expenses (physician, hospital, etc.)
- Midwife services

Dental
- Bridges
- Crowns (non-cosmetic)
- Dentures and care products
- Exams and teeth cleaning
- Fillings
- Gum treatment
- Implants
- Occlusal guards
- Oral surgery
- Orthodontia
- Root canals
- X-Rays

Family Planning
- Condoms
- Fertility treatments
- Oral contraceptives
- Pregnancy test kit
- Tubal ligation
- Vasectomy

Hearing
- Hearing aid devices and batteries
- Hearing exams
- Telephone for the hearing impaired

Lab Exams & Tests
- Blood tests
- Body scans
- Cardiographs
- Cholesterol testing
- Laboratory fees
- Mammograms
- Radiology
- Urine/stool analysis
- X-Rays

Medical Equipment
- Artificial limb/prosthetics
- Asthma flow meters
- Autoette/wheelchair
- Blood pressure monitors
- Blood sugar test kit/strips
- Custom orthotic
- Diabetic Supplies
- Glucose kits, monitors and testers
- Heart rate monitors
- Medic-alert bracelet
- Nebulizers/Vaporizers
- Prosthesis
- Syringes

Medical Procedures
- Acupuncture
- Breast reconstruction surgery (following mastectomy due to disease)
- Operations (non-cosmetic)
- Organ donor's medical expenses
- Surgical fees

Medicines & Drugs
- Insulin
- Prescription Drugs

Miscellaneous
- Ambulance service
- Co-insurance and co-pays
- Deductible eligible expenses
- Hospital services
- Transportation expenses incurred for the rendering of medical services

Routine or Preventative Care
- Flu shots
- Immunizations/Vaccinations
- Physical exams

Specialists
- Chiropractor
- Dermatologist
- Osteopath
- Psychiatrist
- Psychologist

Therapy
- Alcoholism treatments
- Drug dependency treatments
- Physical therapy
- Smoking cessation programs
- Speech therapy

Vision
- Artificial eyes
- Contact lenses & cleaning solutions
- Eye examinations
- Eye surgery
- Eyeglasses
- Laser eye surgery/LASIK
- Prescription sunglasses
- Seeing eye dog and its upkeep

Over-the-Counter
- Bandages
- Callous and corn removers
- Crutches
- Cushions, pads, arch supports
- First-Aid kits
- Gauze and gauze pads
- Heating pads
- Hot/cold packs
- Hydrogen Peroxide
- Incontinence supplies for adults
- Medical tape
- Pedialyte for child's dehydration
- Rubbing alcohol
- Sunscreen (SPF 15+)
- Supports and braces
- Thermometers

Prescriptions for OTC drugs and medicines must be submitted to Sentinel Benefits along with a request for reimbursement.

Note: This list is not meant to be all-inclusive. For a full list please refer to IRS Code Section 213(d).

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Ineligible Health Care Expenses

- Christian Science practitioner*
- Compression hosiery* (for treatment of varicose veins)
- Cosmetic Surgery/Procedures
- Dancing/Exercise/Fitness Programs*
- Diaper Service
- Doula*
- Electrolysis
- Exercise Equipment/Personal Trainers
- Fiber supplements*
- Glucosamine/Chondrotin*
- Hair Loss Medication
- Hair Transplant
- Handicap automobile modifications*
- Health Club Dues*
- Herbal supplements*
- Humidifier*
- Insurance Premiums and Interest
- Lactation consultant*
- Language training for disabled child*
- Laser hair removal
- Lead-based paint removal*
- Long-Term Care Premiums
- Marriage Counseling
- Massage*
- Maternity Clothes
- Mentally handicapped or disabled person's cost for special home*
- Nutritionist*
- Orthopedic shoes* (to the extent the cost exceeds that of normal shoes)
- Prenatal vitamins*
- Psychoanalysis*
- Special food/beverage* (cost difference from regular food purchase)
- Special formula*
- Stem cell harvesting*
- Swimming Lessons
- Teeth Bleaching or Whitening
- Vitamins or nutritional supplements*
- Weight-loss program*
- Wig*

**Expenses marked with an asterik (*) are "potentially eligibile expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement.*

Note: This list is not meant to be all-inclusive. For a full list please refer to IRS Code Section 213(d).

Eligible expenses under a Dependent Care FSA are defined as those that enable the participant or the participant's spouse to work or to look for work. For purposes of a Dependent Care FSA plan, a "qualified dependent" must be under the age of 13, unless mentally or physically handicapped. Per IRS regulations, the service provider cannot be an individual under the age of 19 whom a personal tax exemption may be claimed and/or a child of the participant or spouse.

Eligible Dependent Care Expenses

- After-school care or extended day programs
- Babysitters (not for social events)
- Caregivers for a disabled spouse or dependent who lives with the participant
- Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center
- Day camps
- Household expenses provided that a portion of such expenses is incurred to ensure a qualifying dependent's well-being and protection
- Nursery schools
- Transportation services provided by the dependent care provider

Ineligible Dependent Care Expenses

- Babysitting for social events
- Educational expenses
- Expenses deducted from personal income tax return (dependent care)
- Kindergarten
- Overnight camps

For more information call (888) 762-6088, or visit **www.sentinelgroup.com**

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Health Care and Dependent Care Flexible Spending Account Enrollment/Change Form

General Information

Employer Name
City of Waltham

Department

Participant Name (Last Name, First Name, Middle Initial)

Date of Birth

Social Security Number

Street Address

City

State

Zip Code

Phone

Email Address

Date of Hire

Pay Frequency: ☐ Weekly (52 Pays) ☐ Bi-Weekly (26 Pays) ☐ Bi-Weekly (22 Pays) ☐ Monthly (12 Pays)

Health Care Spending Account

☐ I choose to participate in the FlexChoice Health Care Spending Account. I authorize my employer to make the following payroll deductions:

$_____ per pay period for _____ pay periods for an annual amount of $_____.

Dependent Care Spending Account

☐ I choose to participate in the FlexChoice Dependent Care Spending Account. I authorize my employer to make the following payroll deductions:

$_____ per pay period for _____ pay periods for an annual amount of $_____.

If enrolling during the plan year, be sure to calculate your annual election based on the remaining pay periods in the plan year.

Authorization to Participate

I understand that I may not increase or decrease the amount of my income reduction until the next plan Year, except to reflect a change in my family status (e.g. marriage, birth of a child, divorce or death). In making contributions to the spending accounts, I understand that I may forfeit any amounts in my account if I do not incur eligible expenses by the end of the plan Year. In addition, I understand that my Social Security benefits may be slightly reduced because I will pay less Social Security taxes. This election replaces any previous elections and will terminate on the earlier of (1) the end of the plan Year; (2) when I am no longer being compensated in an amount at least equal to my total salary reduction; (3) termination of the plan. My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I certify that: (i) I understand that pre-tax funds deposited into my FlexChoice account via payroll deductions as authorized by me upon enrollment in the FlexChoice program, (ii) I will only use the debit card to pay for any and all qualified expenses as defined under Sections 105, 125, 129, 132, and 213 of the Internal Revenue Code and as permitted by my Employer's plan, (iii) I understand that qualified expenses will be deducted directly from my FlexChoice account and that any non-qualified expenses or qualified purchases that exceed the available funds in my FlexChoice account may be declined by the merchant, (iv) I will only use the debit card for qualified expenses which have not been and will not be reimbursed under any other plan (v) I understand that if my Employer later identifies a reimbursed claim as a non-qualified expense, I will be responsible to repay the amount. my Employer may withhold the amount from my wages, my Employer may offset amounts reimbursed for non-qualified expenses against future claims for reimbursement, or my Employer may deny access to the debit card until the amount is repaid, (vi) I will retain receipts and other documentation for the expenses paid with the debit card. If the debit card fee is paid for by the employee, Sentinel will automatically deduct the annual fee from your FlexChoice Account when your enrollment form is processed.

Signature _____ Date _____

Employer Verification (to be completed by HR)

Qualifying Event Date: _____ Qualifying Event: _____

Benefit Effective Date: _____ Verified by: _____ Date: _____

This form must have an employer verification signature in order to be processed.

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL STREET, WALTHAM MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
Email kmurphy@city.waltham.ma.us

Kristin Murphy
Human Resources Director
Workers' Compensation Agent

The City of Waltham offers a deferred compensation plan.

What is a 457 Deferred Compensation Plan?

Under Section 457 of the Internal Revenue Code, Deferred Compensation Plans were established to permit you, on a voluntary basis, to authorize your employer to withhold a portion of your salary and invest it, on a tax-deferred basis, for payment to you and a later date. Neither your contributions nor any investment earnings are subject to current federal and (in most cases) state income taxes. Taxes become payable when your account assets are distributed to you, generally at retirement, when you may be in a lower income tax bracket. As you withdraw assets from the plan, they will be taxed as ordinary income.

Currently, the Internal Revenue Service (IRS) does not impose a tax penalty on assets withdrawn from a 457 Plan regardless of your age, but certain withdrawal restrictions may apply.

Andrew Wilson, CFP®, Retirement Plan Advisor
Massachusetts SMART Plan

255 Bear Hill Road, Waltham, MA 02451
Plan Support: 877.457.1900 | Direct: 339.221.2770 |
Email: andrew.wilson@empower.com
www.mass-smart.com

CITY OF WALTHAM - DRUG AND ALCOHOL POLICY

I. PURPOSE AND SCOPE:

The purpose of this policy is to outline the responsibilities of employees, supervisors and managers with regard to drug and alcohol use in the workplace and the testing of employees in safety sensitive positions in accordance with U.S. Department of Transportation regulations, issued under the Omnibus Transportation Employee Testing Act of 1991.

II. APPLICABILITY:

This policy applies to all safety-sensitive employees employed by the City of Waltham.

III. DEFINITION:

Safety Sensitive - For the purposes of this policy, safety-sensitive shall refer to all employees required by the City to obtain and retain a Commercial Drivers License.

IV. GENERAL POLICY REGARDING DRUGS AND ALCOHOL IN THE WORKPLACE:

A. The City of Waltham firmly believes that the use of illegal drugs and misuse of legal drugs, including alcohol, is a source of danger in the workplace and a threat to the City's goal of maintaining a productive and safe work environment. The City of Waltham discourages users of illegal drugs and misusers of legal drugs, including alcohol, from seeking employment with the City and encourages very forcefully the rehabilitation of such persons already in its employ.

B. Employees of the City of Waltham are visible and active members of the communities where they live and work. They are inescapably identified with the City and are expected to represent it in a responsible and creditable fashion. While the City of Waltham has no intention of intruding into the private lives of its employees, the City does expect employees to report for work in a condition to perform their duties. The City recognizes that employee off-the-job as well as on-the-job involvement with drugs and alcohol can have an impact on the workplace and on our ability to accomplish our goal of providing an alcohol and drug-free environment.

1. In accordance with the Federal Drug Free Workplace Act, the illegal use, sale or possession of narcotics, drugs or controlled substances while on the job or on City property is an offense warranting disciplinary action up to and including termination.

2. Employees who are under the influence of alcohol, either on the job or when reporting for work, or who possess or consume alcohol during work hours, have the potential for interfering with their own as well as their co-workers safe and efficient job performance. Consistent with City practice, such conditions will be proper cause for disciplinary action up to and including termination of employment.

3. Off-the-job illegal drug activity which could adversely affect an employee's job performance, or which could jeopardize the safety of other employees, the public or City property or equipment, is proper cause for disciplinary action up to and including termination of employment.

4. Employees who are involved with off-the-job drug activity may be considered in violation of this policy. In deciding what action to take, management will take into consideration the nature of the charges, the employee's present job assignment, the employee's record with the City and other factors relative to the impact of the employee's arrest upon the conduct of City business.

5. Employees are expected to follow any directions of their health care provider concerning prescription medications, and must immediately notify their supervisor if any prescription drug is likely to have an impact on job performance. In addition, notification must be given at the time of any testing or screening as to any drugs or medicine being taken.

6. Any employee, while on City property or during the employee's work shift, including without limitation all breaks and meal periods, consumes or uses, or is found to have in his or her personal possession, in his or her locker or desk or other such repository, alcohol or drugs, which are not medically authorized, or is found to have used or to be using such alcohol or drugs, will be suspended immediately pending further investigation. If use or possession is substantiated, disciplinary action, up to and including termination will be imposed.

7. Any employee who voluntarily requests assistance in dealing with a personal drug addiction or alcohol problem, prior to being found to be in violation of this policy, may participate in a rehabilitative program (such as an Employee Assistance Program) without jeopardizing his/her continued employment with the City of Waltham.

V. POLICY REGARDING DRUG AND ALCOHOL TESTING:

A. It is the policy of the City of Waltham to comply fully with the regulations mandating pre-use, random, reasonable suspicion and post-accident drug and alcohol testing in accordance with regulations issued by the U.S. Department of Transportation, (DOT).

B. Performance of safety-sensitive functions is prohibited by employees having a breath alcohol concentration of 0.04 percent or greater as indicated by an alcohol breath test; by employees using alcohol or within four hours after using alcohol; and by employees in the possession of any medication containing alcohol unless the package seal is unbroken.

C. Use of illicit drugs by safety-sensitive drivers is prohibited on or off duty.

VI. PROCEDURES:

A. Types of Tests The following tests are required:

1. Pre-employment - (Pre-use) All applicants for employment in positions requiring Commercial Drivers License, or candidates for transfer or promotion to such a position are subject to screening for improper use of alcohol or controlled substances.

2. Post-Accident - Conducted after accidents on drivers in City vehicles whose performance could have contributed to the accident, as determined by a citation for a moving traffic violation, and for all fatal accidents even if the driver is not cited for a moving traffic violation. An accident is defined as an incident involving a commercial motor vehicle in which there is either a fatality, an injury treated away from the scene, or a vehicle is required to be towed from the scene. Alcohol tests should be conducted within 2 hours, but in no case more than 8 hours after the accident. Employees must refrain from all alcohol use until the test is complete. Post-accident drug tests must be conducted within 32 hours.

3. Reasonable Suspicion - Conducted when a trained supervisor or manager observes behavior or appearance that is characteristic of alcohol or illicit drug misuse. If a driver's behavior or appearance suggests alcohol or drug misuse, a reasonable suspicion test must be conducted. If a test cannot be administered, the driver must be removed from performing safety sensitive duties for at least 24 hours. Testing for alcohol abuse must be based upon suspicion which arises just before, during or just after the time when the employee is performing safety-sensitive duties. Testing for substance abuse may occur at any time upon suspicion.

4. Random - Conducted on a random, unannounced basis just before, during or after performance of safety sensitive functions for alcohol or at any time for drugs. Each year, the number of random alcohol tests conducted by the City must equal at least 25% of all the safety-sensitive drivers. Random drug tests conducted by the City must equal at least 50% of all safety-sensitive drivers.

5. Return to Duty and Follow-up - Conducted when an individual who has violated the prohibited alcohol or drug standards returns to performing safety sensitive duties. Follow-up tests are unannounced and at least six (6) tests must

be conducted in the first 12 months after a driver returns to duty. Follow-up testing may be extended for up to 60 months following the return to duty.

B. Conduction Tests

1. Alcohol

DOT rules require breath testing using evidential breath testing (EBT) devices. Two breath tests are required to determine if a person has a prohibited alcohol concentration. A screening test is conducted first. Any result less than 0.02 alcohol concentration is considered a "negative" test. If the alcohol concentration is 0.02 or greater, a second, confirmation test must be conducted.

2. Drugs

a. Drug testing is conducted by analyzing a driver's urine specimen, and must be conducted through a U.S. Department of Health and Human Services (DHHS) certified facility. Specimen collection procedures and chain of custody requirements ensure that the specimen's security, proper identification and integrity are not compromised.

b. DOT rules require a split specimen procedure. Each urine specimen is subdivided into two bottles labeled as primary and split. Both bottles are sent to the laboratory. Only the primary specimen is opened and used for the urinalysis. The split specimen remains sealed at the laboratory. If the analysis of the primary specimen confirms the presence of illegal controlled substances, the driver has 72 hours to request that the split specimen be sent to another DHHS certified laboratory for analysis.

c. All urine specimens are analyzed for the following drugs:

Marijuana (THC metabolite)
Cocaine
Amphetamines
Opiates (including heroin)
Phecyclidine (PCP)

Testing is conducted using a two-stage process. First, a screening test is performed. If the test is positive for one or more of the drugs, a confirmation test is performed for each identified drug. Sophisticated testing requirements ensure that over-the-counter medications or preparations are not reported as positive results.

All drug tests are reviewed and interpreted by a physician designated as a Medical Review Officer (MRO) before they are reported to the employer. If the laboratory reports a positive result to the MRO, the MRO will

contact the driver and conduct an interview to determine if there is an alternative medical explanation for the drugs found in the urine specimen. For all the drugs listed above, except PCP, there are some limited, legitimate medical uses that may explain a positive test result. If MRO determines that the drug use is legitimate, the test will be reported to the City as a negative result.

3. Refusal to Participate

Any refusal to participate in any of the types of alcohol and or drug tests authorized in this policy will be treated as indicative of a positive result.

C. **Consequences of Alcohol/Drug Misuse**

1. Safety sensitive employees who have any alcohol concentration (defined as 0.02 or greater) who tested just before, during or just after performing safety sensitive functions must be removed from performing such duties for 24 hours, and will be suspended without pay for any lost work time.

2. Drivers who engage in prohibited alcohol or drug conduct (that is, who test positive for alcohol use greater than 0.04 or drug use) must be immediately removed from safety sensitive functions.

3. Drivers who wish to continue employment with the City of Waltham must be evaluated by a substance abuse professional and comply with any treatment recommendations to assist them with an alcohol or drug problem. The payment for any recommended treatment will be strictly at the expense of the employee (or his/her health insurance program, if applicable). Employees will be placed on non-occupational sick leave or leave without pay status during the treatment period, whichever is appropriate.

4. Drivers who have been evaluated by a substance abuse professional, who comply with any recommended treatment, who have taken a return to duty test with a result less than 0.02, and who are then subject to unannounced follow-up tests may return to work.

5. Drivers who have returned to work under these conditions and who subsequently test positive for alcohol or drug in accordance with this policy during the next five years will be terminated immediately.

D. **Information/Training**

1. All current and new employees, classified as safety sensitive, will receive written information about the testing requirements and how and where they may

receive assistance for alcohol or drug misuse. These employees must receive a copy of this policy.

2. All supervisory and management personnel employed by the City of Waltham must attend at least two hours of training on alcohol and drug misuse symptoms and indicators used in making determinations for reasonable suspicion testing.

3. This policy will be posted on employee bulletin boards and will be available to all employees.

4. Educational information will be made available periodically which will focus on the potentially dangerous effects of drug and alcohol use and abuse, the procedures associated with pre-employment drug screening and "reasonable suspicion" testing, the effects on job performance measured in loss of productivity, and the potential safety hazards presented to the individual employee, other employees and the public.

5. All recruitment advertising must include the statement "Drug/alcohol screening is a condition of employment" at the bottom of the advertisement/posting with the EEO statement.

6. All final candidates for employment must be given a copy of this policy, and be given opportunity to read the policy in its entirety.

E. **Record Keeping:**

1. The City is required to keep detailed records of its alcohol and drug misuse prevention program.

2. Driver alcohol and drug testing records are confidential. Test results and other confidential information may only be released to the employer, the substance abuse professional, the MRO, and any arbitrator of a grievance filed in accordance with this policy. Any other release of this information may only be made with the driver's consent.

F. **Pre-employment References:**

1. The City must obtain and review the following information from each employer that the prospective driver worked for, in a safety-sensitive position, during the previous two years: information about a test in which the employee's blood alcohol was 0.04 or greater; information about a positive drug test; and information about any refusal to participate in the alcohol and drug testing program.

2. The prospective employee must provide the former employer with a written release allowing the release of this information or he/she will not be hired.

3. If the previous employer indicates that a positive result was received, or that the employee refused to participate when selected for an alcohol or drug test, the applicant may not be appointed unless he/she has already consulted with a substance abuse professional, already received recommended treatment, and subsequently tested negative in a return to duty test for the former employer.

4. The City of Waltham must provide the same information to subsequent employers of current City employees when provided with a written release.

G. **Questions:**

Questions about this policy should be referred to the employee's Department Head and/or the Personnel Director.

Jeannette A. McCarthy City of Waltham Mayor	Brenda D. Capello Director of Personnel Workers' Compensation Agent
Date_____	Date_____

ATTACHMENT A

Pre-placement Consent to Drug and Alcohol Screening

I, _____, _____, understand
(Name) (Social Security)

That the medical examination that I am about to receive includes:

[ ] A blood test for the presence of drugs and/or alcohol

[ ] A urine test for the presence of drugs and/or alcohol

I hereby give my consent to _____ to perform these tests. I understand that if I decline to sign this consent, and thereby decline to submit a sample for the test, the test will not be completed. The Personnel Department will be notified and my application for employment will be rejected.

I further consent to the release of the results to the Waltham Personnel Department.

I have taken the following drugs or substances within the last 96 hours:

Identify	Name & Amount	Prescribing Physician
[ ] Sleeping Pills	_____	_____
[ ] Diet Pills	_____	_____
[ ] Pain Relief Pills	_____	_____
[ ] Cold Tablets	_____	_____
[ ] Anti-malarial	_____	_____
[ ] Other	_____	_____

[ ] CONSENT GIVEN [ ] CONSENT REFUSED

Specimen Number: _____ Signed: _____
Date: _____ Witness: _____

Attachment B

Employee Confirmation of Receipt

I hereby certify that I have received a copy of the Waltham Drug and Alcohol Policy and testing requirements and have been given the opportunity to ask questions about the content of the policy.

Employee's Name (please print)	Department
Employee's Signature	Date

Emergency Contact Form

Please provide the following information for notification in case of an emergency.

Employee name:_____Date of Birth:_____

Home address:_____

Email address:_____

Home telephone :_____ Cell phone:_____

I give my permission to contact the following people in case of emergency:

_____
Employee Signature

Next of Kin/Emergency Contact:

#1

Name:_____Relationship:_____

Home address:_____

Email address:_____Work telephone:_____

Home telephone :_____ Cell phone:_____

#2

Name:_____Relationship:_____
Home address:_____

Email address:_____Work telephone:_____

Home telephone :_____ Cell phone:_____

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL – kmurphy @city.waltham.ma.us

Kristin Murphy
Director of Personnel
Workers' Compensation Agent

January 3, 1989
(Revised November 22, 2002)

Personnel Department Regulation Number 1989-1

FAIR LABOR STANDARDS ACT

1. General

On November 13, 1985, President Ronald Reagan signed the "Fair Labor Standards Act Amendments of 1985." The implementation date is April 15, 1986; however, payment of monetary overtime compensation due under the Act may be deferred until August 1, 1986.

2. Applicability

This regulation applies to all departments except Fire and Police personnel who are covered under Personnel Department Regulation dated March 16, 1987.

3. Work Period

The City is hereby establishing a seven-day work period commencing at 12:01 a.m. on Sunday for all departments with the exception of employees engaged in law enforcement and fire protection activities.

4. Exemptions

The Act allows for certain employees to be exempt under the Act or its overtime provisions. Some of the exemptions, among others, are elected officials, executive, administrative, professional personnel, etc. The Personnel Department will notify Department Heads which of their employees, if any, are exempt from the Act.

5. Overtime Requirements

The Act calls for overtime payment for hours worked over 40 in a work period. Vacation leave, sick leave, time not actually worked during a call back period are not counted as hours worked under the Act.

6. Compensatory Time

Compensatory time off may only be provided under the provisions of a labor contract or for employees not included in bargaining units, under a written memorandum of understanding arrived at before the performance of the work.

Compensatory time off must be computed at the rate of 1-½ hours off for each hour of employment for which overtime compensation is required by the FLSA, i.e., for hours actually worked in excess of 40 hours in the workweek. Employees engaged in public safety, emergency response, or a seasonal activity may not accrue more than 480 hours of compensatory time for hours worked during the first work week beginning after April 15, 1986 or later. Other employees may not accrue more than 240 hours of compensatory time. Additional overtime hours of work must be paid by overtime pay. Employees must be permitted to use compensatory time off within a reasonable period after requested provided that the use would not unduly disrupt operations. Unused compensatory time off must be paid for on termination.

7. Occasional or Sporadic Employment

The hours of an employee who on an occasional or sporadic basis solely at his/her own option works part-time, in a different capacity than the one in which he/she is regularly employed, are excluded from hours worked for determination of overtime.

8. Suffer and Permit Time

Employees are not to commence work before the starting time, work during their lunch periods, not work beyond the quitting time of their shift unless written prior approval has been obtained from the supervisor.

9. Responsibilities

Every Department Head will be responsible for implementing this regulation and for calling this regulation to the attention of every current and new employee under his/her jurisdiction.

The Department Head will be responsible for maintaining and determining by work periods what overtime, if any, the City has incurred under the Act for those employees who are nonexempt.

The Data Processing Department will be responsible for developing and maintaining within its data processing system procedures which will determine the compensation and/or compensatory time due an employee.

The City Auditor will be responsible for maintaining and preserving records of the persons employed by the City, and of the wages, hours and other conditions and practices or employment of such employees as required by the Act.

The Personnel Department will be the liaison between the City and the U.S. Department of Labor and will be responsible for furnishing advice and guidance to conform with the Act. Personnel will also be responsible for notifying Department heads which of their employees, if any, are exempt from the Act.

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL – KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
Human Resources Director
WORKERS' COMPENSATION AGENT

CITY OF WALTHAM
VEHICLES CAN BE DANGEROUS POLICY

The prevention of injuries is a major responsibility of employers. Therefore, it is the policy of the City of Waltham that no employee shall ride outside the passenger compartment of a city owned vehicle. **All individuals in city-owned vehicles must be seated inside, wearing seatbelts**. There will be NO exceptions to this policy. This policy will be rigorously enforced. Failure to comply may result in disciplinary action.

_____ _____

CITY OF WALTHAM
Kristin Murphy
Director of Personnel
Worker's Compensation Agent

Date

This is to acknowledge that I, *(print name)* _____, have read the *City of Waltham Vehicles Can Be Dangerous Policy* and that I will abide by the rules set forth in this policy.

_____ _____

Employee Signature

Date

City of Waltham
Laborers' Union – Clothing
Size/Style Election Form

Employee Name _____

Department _____

SHIRT SIZE (circle one) S M L XL 2XL 3XL 4XL 5XL

SHIRT STYLE (Select up to 10 in total)

Short Sleeve – T shirt style ☐

Short Sleeve – Collar style ☐

Long Sleeve – T shirt style ☐

SWEATSHIRT (Choose one style)

Hooded with full zippered front style S M L XL 2XL 3XL 4XL 5XL

Crew neck style S M L XL 2XL 3XL 4XL 5XL

_____

Employee Signature

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM, MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358

Release of Information Form -- 49 CFR Part 40 Drug and Alcohol Testing

I, _____ (Driver Name), hereby provide consent to the City of Waltham, Massachusetts (hereinafter "the City") or its agent to conduct a limited query of the FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse (hereinafter "Clearinghouse") to determine whether drug or alcohol violation information about me exists in the Clearinghouse. This consent is valid during the period of my employment by the City and the City or its agent may make inquiries of the Clearinghouse as needed during my employment.

I understand that if the limited query conducted by City or its agent indicates that drug or alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose that information to the City or its agent without first obtaining additional specific consent from me.

I further understand that if I refuse to provide consent for the City or its agent to conduct a limited query of the Clearinghouse, the City must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations.

_____ _____

Employee Signature Date

Release of Information Form -- 49 CFR Part 40 Drug and Alcohol Testing

Section I. To be completed by the new employer, signed by the employee, and transmitted to the previous employer:

Employee Printed or Typed Name: _____

Employee SS or ID Number: _____

I hereby authorize release of information from my Department of Transportation regulated drug and alcohol testing records by my previous employer, listed in *Section I-B*, to the employer listed in *Section I-A*. This release is in accordance with DOT Regulation 49 CFR Part 40, Section 40.25. I understand that information to be released in *Section II-A* by my previous employer, is limited to the following DOT-regulated testing items:

1. Alcohol tests with a result of 0.04 or higher;
2. Verified positive drug tests;
3. Refusals to be tested;
4. Other violations of DOT agency drug and alcohol testing regulations;
5. Information obtained from previous employers of a drug and alcohol rule violation;
6. Documentation, if any, of completion of the return-to-duty process following a rule violation.

Employee Signature: _____ Date: _____

I-A.

New Employer Name: _____

Address: _____

_____

Phone #: _____ Fax #: _____

Designated Employer Representative: _____

I-B.

Previous Employer Name: _____

Address: _____

_____

Phone #: _____

Designated Employer Representative (if known): _____

Section II. To be completed by the previous employer and transmitted by mail or fax to the new employer:

II-A. In the two years prior to the date of the employee's signature (in Section I), for DOT-regulated testing ~

1. Did the employee have alcohol tests with a result of 0.04 or higher? **YES ____ NO ____**
2. Did the employee have verified positive drug tests? **YES ____ NO ____**
3. Did the employee refuse to be tested? **YES ____ NO ____**
4. Did the employee have other violations of DOT agency drug and alcohol testing regulations? **YES ____ NO ____**
5. Did a previous employer report a drug and alcohol rule violation to you? **YES ____ NO ____**
6. If you answered "yes" to any of the above items, did the employee complete the return-to-duty process? **N/A ____ YES ____ NO ____**

NOTE: If you answered "yes" to item 5, you must provide the previous employer's report. If you answered "yes" to item 6, you must also transmit the appropriate return-to-duty documentation (e.g., SAP report(s), follow-up testing record).

II-B.

Name of person providing information in *Section II-A*: _____

Title: _____

Phone #: _____ Date: _____

SAFETY ALERT – PLEASE POST

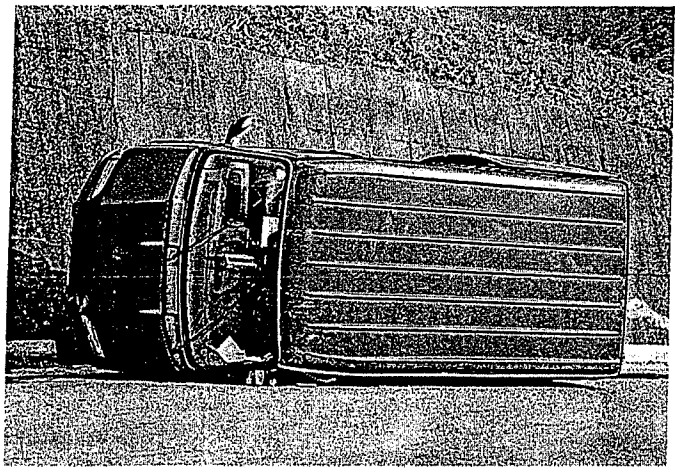
Keep employees in motor vehicles safe by preventing distracted driving and ensuring seat belts are worn!

What happened in Massachusetts?

Lots of people drive as a part of their job – some more than others. Motor vehicle crashes continue to be a leading cause of work-related death in Massachusetts and across the country. In the past four years (2013-2016), 36 workers have died in motor vehicle crashes while driving for work in Massachusetts. It's not just truck drivers who are dying in these crashes. Only 11 of these 36 victims were truck drivers. Many different jobs require employees to drive or be a passenger in a vehicle while at work. Some examples are: home health aides, landscapers, sales representatives, and police officers.

Food delivery crash

In 2016, a 22-year-old employee of a sandwich shop died while driving his own car to make a food delivery. He crashed into the rear of a truck that was making a left turn. Witnesses reported the driver was speeding before the crash. After the crash, police recovered the driver's cell phone from the car and a game was running on the screen. It was unknown if the victim was wearing a seatbelt.



Construction van crash

In 2016, two employees of a construction company, a 20- and a 52-year-old, died while riding in a company van. The van was in the left lane of a highway when a tire lost air and the van overturned. The van had only two front seats, but there were six employees in the vehicle. The employees in the back of the van were sitting on the floor or on supplies. Only the driver was wearing a seat belt. The worker in the front passenger seat, who was not wearing a seatbelt, and one of the workers in the back were ejected from the van when it crashed.

WHAT CAN BE DONE? SEE REVERSE FOR RECOMMENDATIONS →

SAFETY ALERT – PLEASE POST

How can employers keep workers safe while driving or riding in motor vehicles?

Prevent distracted driving by:

- Banning texting and hand-held phone use while driving for work (both work and personal phones).
- Requiring employees to pull over in a safe location if they must text, look up directions, or make/answer a call. This includes texts or calls from management.
- Preparing employees before implementing these policies by communicating:
  - How distracted driving puts them at risk of a crash;
  - That driving requires their full attention while they are on the road; and
  - What action the company will take if they do not follow the policies.
- Ensuring that employees program navigation devices (e.g., GPS, phones) before they start driving, and that these cannot be operated manually when the vehicle is in motion. Also, make sure a vehicle mount is used to secure the device and eliminate the need to hold it while driving.

Require the use of seat belts at all times by all vehicle occupants.

- Ensure that there are enough seats for each passenger and that each seat has a functioning seat belt.
- Require more than one trip or an additional vehicle if there are more passengers than seats.

Develop a Motor Vehicle Safety Program that includes policies on:

- Training employees on the importance of being attentive while driving.
- Routinely reminding employees that while behind the wheel, driving is their primary job.
- Schedules that allow employees to obey speed limits, follow applicable hour-of-service regulations, and prevent drowsy driving.
- Zero tolerance for speeding and aggressive driving practices.
- Procedures for reporting and investigating crashes and vehicle breakdowns.
- Routine maintenance procedures for employer provided vehicles.

IN ADDITION, AS A REMINDER:

In Massachusetts and many other states, anyone under 18 years old cannot drive as part of their work duties.

Resources

Preventing work-related motor vehicle crashes, NIOSH
www.cdc.gov/niosh/docs/2015-111/pdfs/2015-111.pdf

Distracted Driving At Work web page, NIOSH
www.cdc.gov/niosh/topics/distracteddriving/

Guidelines for Employers to Reduce Motor Vehicle Crashes, OSHA, NHTSA, NETS
www.osha.gov/Publications/motor_vehicle_guide.pdf

Motor Vehicles, Safe Driving Practices for Employees, OSHA
www.osha.gov/Publications/Safe_Driving_Practices.pdf

Distracted Driving for Employers, National Safety Council
www.nsc.org/learn/NSC-Initiatives/Pages/distracted-driving-for-employers.aspx

Network of Employers for Traffic Safety, Road Safety Resources
http://trafficsafety.org/road-safety-resources/#open-access

About FACE Facts | MA FACE: MA FACE (Massachusetts Fatality Assessment and Control Evaluation) seeks to prevent work fatalities by identifying and investigating these incidents and developing prevention strategies for those who can intervene in the workplace. MA FACE is supported by cooperative agreement # U60OH008490 from CDC-NIOSH. This document may be copied freely and found online at **www.mass.gov/dph/FACE**. If you have comments or questions, call the MA FACE Project at **1-800-338-5223**.

Group Basic Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of City of Waltham, MA

The following information is a summary of benefits; this summary is not your Certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the group policy will be resolved by the language issued in the master policy. Please contact your benefits administrator for policy provisions.

Eligibility
All Eligible Active Employees working a minimum of **20** hours per week are eligible. *If you are not actively at work on the effective date then insurance will not become effective until you return to active employment.*

Employee Basic Life and AD&D Benefit

- Flat $15,000.
- Upon retirement, Basic Life and AD&D coverage continues at $5,000.

Cost of Coverage
You, the employee, currently contribute to the cost of the Basic Group Life and AD&D coverage. Please consult your Benefits Administrator for specific contribution percentage.

Portability
If you leave your employment prior to age **60**, the coverage is "portable" for you. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium.

Conversion
Employees have 31 days from the date of termination to convert their Basic Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium.

Waiver of Premium
If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit
This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit
We will pay a percentage of an employee's life insurance benefit to a maximum of $2,500 per year, for up to four years of education, to each qualifying dependent if the employee's death is the result of an accident while covered under Group AD&D.

Seat Belt Benefit
We will pay an additional 50% of the AD&D benefit, not to exceed $10,000, in the event of an insured's death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit
If an employee dies as a result of an Accident while insured for AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to $5,000.

Exclusions
Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries, suicide or attempted suicide, riot or war, diseases, ptomaine or bacterial infection, drug and/or alcohol abuse, commission of an assault or felony by an employee, accident while serving on active duty, travel or flight in any aircraft or device which can fly above the earth's surface (does not apply to commercial flights) or injury which occurred before the Employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

Also available to you...

Bereavement Counseling*
This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

**Services provided by Health Management Systems of America – a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.*

Insurance products from the people you trust

James A. Flynn
Licensed Insurance Adviser

LifePlus™ Insurance Agency, Inc.

475 School Street, Suite 5, Marshfield, MA 02050
Tel: 781.837.9222 • Fax: 781.837.9227
Toll Free: 866.511.9222 • Cell: 781.789.8859
Jim@lpins.com • www.lpins.com

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x700

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Please refer to your Administration Kit for enrollment and mailing instructions

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

City of Waltham
Employer/Policyholder

Dept. ID

Employee Name *(Last, First, Middle)*

Social Security Number

Home Address *(Street, City, State, Zip)*

( ) Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age

PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $

Average Hours Worked | Date of Hire | or Date of Full Time Employment if different | Effective Date | State | Class

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # G-25763 Div. 1

	YES	NO	Insurance Amount
LIFE & AD&D	X	❑	$15,000

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # G-25763 Div. _____

It is the responsibility of the employee to notify the City of Waltham of changes in spouse or dependent eligibility for coverage.

	YES	NO	Insurance Amount
LIFE & AD&D Units of $10,000	❑	❑	$
SPOUSE Units of $5,000 Max 50% of Employee's Voluntary Amount	❑	❑	$
DEPENDENT LIFE:			
CHILD(REN) $1,000 14 days to 1 year; $10,000 age 1 year to 19 or 25 if full time student	❑	❑	$

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on separate sheet**

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit

Contingent Beneficiary(ies):

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

ACCEPTANCE OF INSURANCE - *Employee Signature Required*

SIGNATURE

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ **Date** _____

REFUSAL OF INSURANCE

Employee Name *(Last, First, Middle)* _____ Employee/Policyholder City of Waltham Group No. G-25763

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

CITY OF WALTHAM VOLUNTARY TERM LIFE AND AD&D RATES

Must have Basic Life to sign up for Optional Life

ISSUE AGE OPTION Rates Do Not Increase

GUARANTEED ISSUE AMOUNTS			
AGE	Under 60	60-69	70 & Over
Employee	$ 100,000	$ 50,000	$ 10,000
Spouse	$ 30,000	$ 20,000	Not Eligible
Dependent	$ 10,000		

MONTHLY PREMIUM

Age	Monthly Premium Rate per 1,000	10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	**100,000**
<35	$0.11	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
35-39	$0.15	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00
40-44	$0.22	$2.20	$4.40	$6.60	$8.80	$11.00	$13.20	$15.40	$17.60	$19.80	$22.00
45-49	$0.32	$3.20	$6.40	$9.60	$12.80	$16.00	$19.20	$22.40	$25.60	$28.80	$32.00
50-54	$0.41	$4.10	$8.20	$12.30	$16.40	$20.50	$24.60	$28.70	$32.80	$36.90	$41.00
55-59	$0.74	$7.40	$14.80	$22.20	$29.60	$37.00	$44.40	$51.80	$59.20	$66.60	$74.00
60-64	$1.22	$12.20	$24.40	$36.60	$48.80	$61.00	$73.20	$85.40	$97.60	$109.80	$122.00
65-69	$2.01	$20.10	$40.20	$60.30	$80.40	$100.50	$120.60	$140.70	$160.80	$180.90	$201.00
70-74	$3.35	$33.50	$67.00	$100.50	$134.00	$167.50	$201.00	$234.50	$268.00	$301.50	$335.00
75+	$6.27	$62.70	$125.40	$188.10	$250.80	$313.50	$376.20	$438.90	$501.60	$564.30	$627.00

****EMPLOYEE MUST HAVE COVERAGE IN ORDER TO INSURE SPOUSE AND/OR CHILDREN****

- EMPLOYEE LIFE & AD&D = $10,000 TO A MAXIMUM OF $500,000 (NOT TO EXCEED 5 TIMES SALARY)
- SPOUSE LIFE & AD&D = $5,000 TO A MAXIMUM OF $100,000 (NOT TO EXCEED 50% OF EMPLOYEE BENEFIT)
- DEPENDENT (LIFE ONLY) = $1,000 AGE 14 DAYS TO 1 YEAR; $10,000 AGE 1 YEAR TO AGE 19 OR 25 IF FULL TIME STUDENT ($1.90/MONTH)
- DEPENDENT CHILD(REN) - (LIFE ONLY) COVERAGE ALL GUARANTEE ISSUE

Applicants requesting insurance amounts over the guaranteed issue amount will require an Evidence of Insurability Form and Authorization to Release Medical Information. These forms will need to accompany the application .

City of Waltham
PERMANENT LIFE

When can I sign up?

You are eligible to sign up for permanent life insurance within the first 30 days of employment or during an enrollment period.

What is permanent life insurance?

Permanent Life Insurance is a cash value insurance policy. You are eligible to get coverage for yourself, a spouse or dependent(s). The permanent life policy offers guaranteed level premiums, cash values and fixed death benefits. The permanent life option is yours to keep at the rates you are offered when your policy is accepted.

Why shouldn't I just buy the Term Life Option?

While the City of Waltham offers you a basic amount even when you are retired, it may not be enough to cover funeral costs and term insurance ends at some point. The permanent life option is yours for as long as you continue to pay premiums.

What are the costs for permanent life insurance?

Rates are based upon your age and gender. Once your policy is issued your rates are to remain level.

Should I wait until I'm older to sign up for this coverage?

When you get older and are in more need of the insurance you may not be medically capable of qualifying. The younger you sign up the less the premium will cost.

Can this policy be deducted from my paycheck as other benefits?

Yes, the Permanent Life Insurance also includes convenient payroll deductions.

Can I keep this policy if I leave employment?

Yes, this policy is portable (YOU OWN IT). You can take your policy with you at the same rate as when you were an employee.

Please contact LifePlus Insurance Agency, Inc. with any enrollment questions.
781-837-9222 – fax 781-837-9227

City of Waltham
CANCER EXPENSE PLAN

When can I sign up?

Within the first 30 days of employment or during an enrollment.

Why do I need the Cancer Expense Plan if I have health insurance?

The American Cancer Society estimates that 30% of the cost of fighting cancer is "Direct" costs which are paid for by your health plan; doctor visits, prescriptions, surgeries, etc. The other 70% "Indirect" costs come out of the patient's pocket; lost income, co-pays, transportation, hotel, child care, special diets, etc.

How much does it pay?

The first occurrence benefit is $7,000. There is a $5,000 Radiation/Chemotherapy benefit and a maximum benefit of $3,000 for surgery.

Do I have to use the money for things related to medical expenses?

No benefits are paid directly to the insured with no questions asked.

Can my whole family be covered?

Yes, family and individual policies are available.

Are there benefits for having cancer screenings?

Yes, each insured person is eligible for an annual $50.00 Wellness Benefit available for most cancer screenings such as mammography, Pap smear, PSA test and sigmoidoscopy. This benefit is paid regardless of the test results.

Can the benefit be pre-taxed, like my health insurance?

Yes, the premiums can be pre-taxed without affecting the benefit received.

How much does it cost?

There are two options: Individual Plan is $4.89/week, Family Plan is $8.37/week.

Can I keep this policy if I leave employment?

Yes, this policy is portable (YOU OWN IT) at the same rates as when you were an employee.

Please contact LifePlus Insurance Agency, Inc. with any enrollment questions.
781-837-9222 – fax 781-837-9227

This form is for informational purposes only, please refer to the contract for specific language.

Allstate BENEFITS

Protection for the treatment of cancer and 29 specified diseases

Cancer Insurance

Receiving a cancer diagnosis can be one of life's most frightening events. Unfortunately, statistics show you probably know someone who has been in this situation.

With Cancer insurance from Allstate Benefits, you can rest a little easier. Our coverage pays you a cash benefit to help with the costs associated with treatments, to pay for daily living expenses, and more importantly, to empower you to seek the care you need.

Here's How It Works

You choose the coverage that's right for you and your family. Our Cancer insurance pays cash benefits for cancer and 29 specified diseases to help with the cost of treatments and expenses as they happen. Benefits are paid directly to you unless otherwise assigned. With the cash benefits you can receive from this coverage, you may not need to use the funds from your Health Savings Account (HSA) for cancer or specified disease treatments and expenses.

Meeting Your Needs

- Includes coverage for cancer and 29 specified diseases
- Benefits are paid directly to you unless otherwise assigned
- Coverage available for dependents
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts (employee only)
- Coverage may be continued; refer to your certificate for details
- Additional benefits have been added to enhance your coverage

With Allstate Benefits, you can protect your finances if faced with an unexpected cancer or specified disease diagnosis. **Practical benefits for everyday living.**[SM]

DID YOU KNOW?

Early detection, improved treatments and access to care are factors that influence cancer survival[1]

20.3 million

The number of cancer survivors in the U.S. is increasing, and is expected to jump to nearly 20.3 million by 2026[2]

[1]Life After Cancer: Survivorship by the Numbers, American Cancer Society, 2017.
[2]Cancer Treatment & Survivorship Facts & Figures, 2016-2017

Meet TJ

TJ is like anyone else who has been diagnosed with cancer. He is concerned about his wife and how she will cope with his disease and its treatment. Most importantly, he worries about how he will pay for his treatment.

Here is what weighs heavily on his mind:

- Major medical only pays a portion of the expenses associated with my treatment
- I have copays I am responsible for until I meet my deductible
- If I am not working due to treatments, I must cover my bills, rent/mortgage, groceries and other daily expenses
- If the right treatment is not available locally, I will have to travel to get the treatment I need

Here's how TJ's story of diagnosis and treatment turned into a happy ending, because he had supplemental Cancer Insurance to help with expenses.

CHOOSE

TJ chooses benefits to help protect himself and his wife if diagnosed with cancer or a specified disease

USE

TJ undergoes his annual wellness test and is diagnosed for the first time with prostate cancer. His doctor reviews the results with him and recommends pre-op testing and surgery.

Here's TJ's treatment path:

- TJ travels to a specialized hospital 400 miles from where he lives and undergoes pre-op testing
- He is admitted to the hospital for laparoscopic prostate cancer surgery
- TJ undergoes surgery and spends several hours in the recovery waiting room
- He is transferred to his room where he is visited by his doctor during a 2-day hospital stay
- TJ is released under doctor required treatment and care during a 2-month recovery period

TJ continues to fight his cancer and follow his doctor recommended treatments.

CLAIM

TJ's Cancer claim paid him cash benefits for the following:

Wellness
Cancer Initial Diagnosis
Continuous Hospital Confinement
Non-Local Transportation
Surgery
Anesthesia
Medical Imaging
Inpatient Drugs and Medicine
Physician's Attendance
Anti-Nausea

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits

An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Wellness Benefit

Biopsy for skin cancer; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer), PSA (prostate cancer); Bone Marrow Testing; Chest X-ray; Colonoscopy; Doppler screening for carotids or peripheral vascular disease; Echocardiogram; EKG; Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening for abdominal aortic aneurysms.

Benefits (subject to maximums as listed on the attached rate insert)

HOSPITAL CONFINEMENT AND RELATED BENEFITS

Continuous Hospital Confinement - inpatient admission and confinement

Government or Charity Hospital - confinements in lieu of all other benefits, except Waiver of Premium

Private Duty Nursing Services - full-time nursing services authorized by attending physician

Extended Care Facility - within 14 days of a hospital stay; payable up to the number of days of the hospital stay

At Home Nursing - private nursing care must begin within 14 days of a covered hospital stay; payable up to the number of days of the previous hospital stay

Hospice Care Center or Team - terminal illness care in a facility or at home; one visit per day

RADIATION/CHEMOTHERAPY AND RELATED BENEFITS

Radiation/Chemotherapy for Cancer - covered treatments to destroy or modify cancerous tissue

Blood, Plasma and Platelets - transfusions, administration, processing, procurement, cross matching

Hematological Drugs - boosts cell lines for white/red cell counts and platelets; payable when Radiation/Chemotherapy for Cancer benefit is paid

Medical Imaging - initial diagnosis or follow-up evaluation based on covered imaging exam

SURGERY AND RELATED BENEFITS

Surgery* - based on Certificate Schedule of Surgical Procedures

Anesthesia - 25% of Surgery benefit for anesthesia received by an anesthetist

Bone Marrow or Stem Cell Transplant - autologous, non-autologous for treatment of cancer or specified disease other than Leukemia, or non-autologous for treatment of Leukemia

Ambulatory Surgical Center - payable only if Surgery benefit is paid

Second Opinion - second opinion for surgery or treatment by a doctor not in practice with your doctor

MISCELLANEOUS BENEFITS

Inpatient Drugs and Medicine - not including drugs/medicine covered under the Radiation/Chemotherapy for Cancer or Anti-Nausea benefits

Physician's Attendance - one inpatient visit by one physician

Ambulance - transfer to or from hospital where confined by a licensed service or hospital-owned ambulance

Non-Local Transportation - obtaining treatment not available locally

Outpatient Lodging - more than 100 miles from home

Family Member Lodging and Transportation - adult family member travels with you during non-local hospital stays for specialized treatment. Transportation not paid if Non-Local Transportation benefit is paid

Physical or Speech Therapy - to restore normal body function

New or Experimental Treatment - payable if physician judges to be necessary and only for treatment not covered under other policy benefits

Prosthesis - surgical implantation of prosthetic device for each amputation

Hair Prosthesis - wig or hairpiece every two years due to hair loss

Nonsurgical External Breast Prosthesis - initial prosthesis after a covered mastectomy

Anti-Nausea Benefit - prescribed anti-nausea medication administered on outpatient basis

Waiver of Premium -** must be disabled 90 days in a row due to cancer, as long as disability lasts

OPTIONAL/ADDITIONAL BENEFITS

Cancer Initial Diagnosis - for first-time diagnosis of cancer other than skin cancer

Wellness Benefit - once per year for one of 23 exams. See left for list of wellness tests

SPECIFIED DISEASES

29 Specified Diseases Covered - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis, Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease, Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or C), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis

*Two or more surgeries done at the same time are considered one operation. The operation with the largest benefit will be paid. Outpatient is paid at 150% of the amount listed in the Schedule of Surgical Procedures. Does not pay for other surgeries covered by other benefits **Premiums waived for employee only

Cancer Insurance (GVCP3)

Includes coverage for 29 Specified Diseases

from **Allstate Benefits**

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 1
Continuous Hospital Confinement (daily)	$200
Government or Charity Hospital (daily)	$200
Private Duty Nursing Services (daily)	$200
Extended Care Facility (daily)	$200
At Home Nursing (daily)	$200
Hospice Care Center (daily) or	$200
Hospice Care Team (per visit)	$200
RADIATION/CHEMOTHERAPY/RELATED BENEFITS	**PLAN 1**
Radiation/Chemotherapy for Cancer[1] (every 12 months)	$5,000
Blood, Plasma, and Platelets[1] (every 12 months)	$5,000
Hematological Drugs[1] (every 12 months)	$100
Medical Imaging[1] (every 12 months)	$250
SURGERY AND RELATED BENEFITS	**PLAN 1**
Surgery[2]	$3,000
Anesthesia (% of surgery benefit)	25%
Bone Marrow or Stem Cell Transplant (once/year)	
1. Autologous	$1,000
2. Non-autologous (cancer or specified disease treatment)	$2,500
3. Non-autologous (Leukemia)	$5,000
Ambulatory Surgical Center (daily)	$500
Second Opinion	$400
MISCELLANEOUS BENEFITS	**PLAN 1**
Inpatient Drugs and Medicine (daily)	$25
Physician's Attendance (daily)	$50
Ambulance (per confinement)	$100
Non-Local Transportation[1]	
(coach fare or amount shown per mile*)	0.40/Mile
Outpatient Lodging (daily; limit $2,000/12 mo. period)	$50
Family Member Lodging (daily per trip; max. 60 days)	$50
and Transportation (coach fare or amount shown per mile**)	0.40/Mile
Physical or Speech Therapy (daily)	$50
New or Experimental Treatment[3] (every 12 months)	$5,000
Prosthesis[3] (per amputation)	$2,000
Hair Prosthesis (every 2 years)	$25
Nonsurgical External Breast Prosthesis[1]	$50
Anti-Nausea Benefit[1] (once per calendar year)	$200
Waiver of Premium (employee only)	Yes
OPTIONAL/ADDITIONAL BENEFITS	**PLAN 1**
Cancer Initial Diagnosis (one-time benefit)	$7,000
Wellness Benefit	$50

[1]Pays actual cost up to amount listed. [2]Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. [3]Pays actual charges up to amount listed. *At least 70 miles away, up to 700 miles. **Transportation up to 700 miles per continuous hospital confinement.

PLAN 1 PREMIUMS

MODE	EE	F
Weekly	$4.89	$8.37
Monthly	$21.17	$36.26

Issue ages: 18 and over if actively at work

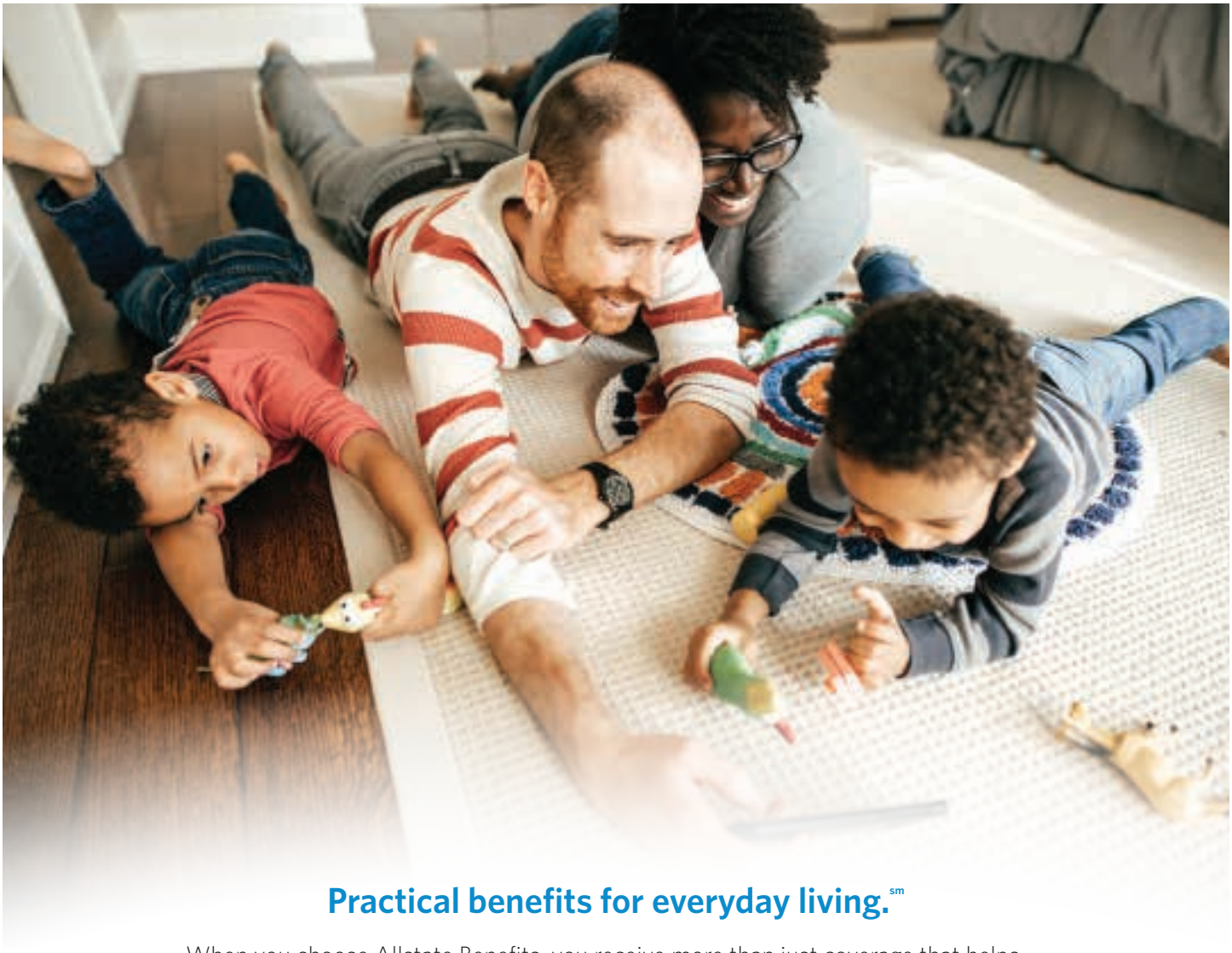
EE=Employee; F-Family

FOR HOME OFFICE USE ONLY - GVCP3

Opt 1-2Hosp; 2Rad; 2Surg; 1Misc; 7Init; 0ICU; 2Well; 0Prog

V.2019.11.22 FA Rate Insert Creation Date: 12/17/2019

For use in enrollments situsedin: MA. This rate insert is part of the approved brochure for form ABJ30590-3; it is not to be used on its own.



Practical benefits for everyday living.℠

When you choose Allstate Benefits, you receive more than just coverage that helps you protect your finances when faced with life's uncertainties; you also get the support of the Good Hands® promise.

We've been insuring and protecting families for over 50 years with the name that America knows and trusts. Our affordable and valuable coverage options help empower hard-working individuals and their families to make the best decisions for their care and finances.

After you've elected coverage, register with our website, MyBenefits, for anytime access to your coverage and benefit information. Plus, MyBenefits allows you to file fast and easy claims that we'll deposit right into your bank account (direct deposit authorization required).

Allstate Benefits. We can help give you and your family financial peace of mind.
Are you in good hands?®

DEFINITIONS

Actual Charges vs. Actual Cost

Actual Charge – Amount billed for a treatment or service before any insurance discounts or payments.

Actual Cost – Amount actually paid by or on behalf of you, accepted as full payment by the provider of goods or services.

CERTIFICATE SPECIFICATIONS

Eligibility

Coverage may include you, your spouse or domestic partner, and children under age 26.

Termination of Coverage

Coverage under the policy ends on the date the policy is canceled; the last day premium payments were made; the last day of active employment, unless coverage is continued due to Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence; the date you or your class is no longer eligible.

Spouse/domestic partner coverage ends upon divorce/termination of partnership or your death. Coverage for children ends the earlier of when the child reaches age 26 or 2 years following loss of dependent status under the Internal Revenue Code, unless he or she continues to meet the requirements of an eligible dependent.

Portability Privilege

Coverage may be continued under the Portability Provision when coverage under the policy ends. Refer to your Certificate of Insurance for details.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation

We do not pay benefits for a pre-existing condition during the 12-month period beginning on the date that person's coverage starts. A pre-existing condition is a disease or condition for which symptoms existed within the 12-month period prior to the effective date, or medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date. A pre-existing condition can exist even though a diagnosis has not yet been made.

Exclusions and Limitations

We do not pay for any loss except for losses due to cancer or a specified disease. Benefits are not paid for conditions caused or aggravated by cancer or a specified disease. Treatment and services must be needed due to cancer or a specified disease and be received in the United States or its territories.

Hospice Care Team Limitation: Services are not covered for food or meals, well-baby care, volunteers or support for the family after covered person's death.

Blood, Plasma and Platelets Limitation: Does not include immunoglobulins or blood replaced by donors.

For the **Surgery, New or Experimental Treatment** and **Prosthesis** benefits, we pay 50% of the applicable maximum when specific charges are not obtainable as proof of loss.

For the **Radiation/Chemotherapy for Cancer** benefit, we do not pay for: any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; treatment planning, consultation or management; the design and construction of treatment devices; basic radiation dosimetry calculation; any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; the diagnostic tests related to these treatments; or any devices or supplies including intravenous solutions and needles related to these treatments.

Allstate BENEFITS

This brochure is for use in enrollments sitused in MA and is incomplete without the accompanying rate insert.

This material is valid as long as information remains current, but in no event later than December 19, 2022.
Group Cancer benefits are provided under policy form GVCP3, or state variations thereof.

The coverage provided is limited benefit supplemental cancer and specified disease insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. There may be instances when a law requires that benefits under this coverage be paid to a third party, rather than to you. If you or a dependent have coverage under Medicare, Medicaid, or a state variation, please refer to your health insurance documents to confirm whether assignments or liens may apply.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

U.S. Department of Labor

OSHA®
Occupational Safety and Health Administration

Job Safety and Health
IT'S THE LAW!

All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request a confidential OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

This poster is available free from OSHA.

Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Notify OSHA within 8 hours of a workplace fatality or within 24 hours of any work-related inpatient hospitalization, amputation, or loss of an eye.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

On-Site Consultation services are available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.

Contact OSHA. We can help.

1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov

OSHA 3165-04R 2019

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF LABOR STANDARDS

Massachusetts Workplace Safety and Health Protection for Public Employees

454 CMR 25.00 requires all public sector employers to comply with OSHA regulations.

Employers: Employers are required to provide procedures, equipment, and training to prevent work-related injuries and illnesses.

Employees: Employees are required to comply with the policies and procedures established in their workplace to reduce work-related injuries and illnesses.

Inspection: The Department of Labor Standards (DLS) may conduct an on-site inspection to evaluate workplace conditions and make recommendations for the prevention of work-related injuries and illnesses. See **Inspection Summary** at mass.gov/dols/wshp.

Enforcement: DLS may issue a *Written Warning* which contains an *Order to Correct* when an inspection reveals a condition which could cause a work-related injury or illness. DLS may issue a *Civil Citation with Civil Penalty* when an employer fails to abate a *Written Warning*, or repeats conditions identified in a previous *Written Warning*.

Voluntary Assistance: Public sector workplaces may request technical assistance by contacting DLS at safepublicworkplacemailbox@mass.gov or (508) 616-0461 and choose option #1. There are no written warnings or penalties issued for voluntary assistance.

Complaints: Public employees or their representatives may file a complaint about safety and health conditions at their workplace by contacting DLS at safepublicworkplacemailbox@mass.gov or (508) 616-0461 and choose option #1.

Safety and Health Management: Sample safety programs and technical bulletins are available at mass.gov/dols/wshp.

mass.gov/dols/wshp **(508) 616-0461 and choose option #1**

Rev. 06-21-21

RIGHT TO KNOW WORKPLACE NOTICE

The Commonwealth of Massachusetts
Department of Labor and Workforce Development
Division of Occupational Safety

The **RIGHT TO KNOW LAW, Chapter 111F** of the Massachusetts General Laws, provides rights to Public Sector employees* regarding the communication of information on toxic and hazardous substances. These rights include:

WORKPLACE NOTICE- A notice must be posted in a central location in the workplace informing employees of their rights under the law. The notice must be in the English language. In workplaces where employees' first language is other than English, the notice must be posted in that language.

TRAINING- Employers must provide an annual training program to employees who work with toxic or hazardous substances. New employees must receive training within thirty days from date of hire. The training program must be conducted by a competent person and may be in the form of verbal and/or written instruction. At a minimum, training must include an explanation of employee rights, information on how to read an MSDS, the specific hazards of the chemicals used, handled or stored in the workplace, the type of personal protective equipment to be worn, and information on labeling of hazardous substances. This training must be done with pay during the employee's normal work shift or work hours. A record of this training must be maintained by the employer.

MATERIAL SAFETY DATA SHEET (MSDS)- The Material Safety Data Sheet is the document that provides information on each toxic or hazardous substance used or stored in the workplace. An employee or his or her designated representative has the right to obtain and examine the MSDS for any toxic or hazardous substance to which the employee "is, has been, or may be", exposed, if the employee's request is made to the employer in writing. After four working days from the date the request is made, an employee can refuse to work with the substance under two circumstances:

1. The employer fails to (a) furnish the employee with MSDA and (b) furnish the employee with proof that the employer has exercised diligent effort to obtain the MSDS, wither through the manufacturer or through the Deputy Director of the Division of Occupational Safety, or,

2. The MSDS provided by the employer is incomplete or outdated.

LABELING- All containers in the workplace of more than five pounds or more than one gallon, containing toxic or hazardous substances, must be labeled with the chemical name of the substance. Containers of mixtures must be labeled with the chemical name of each toxic or hazardous constituent when the constituents comprise one percent or more of the

mixture. Containers must also be labeled with the appropriate National Fire Prevention Association (NFPA) symbol if available. Labels must be clear, prominent, in English and weather resistant. There are some exceptions to the labeling requirements for containers, which are labeled in accordance with certain Federal laws.

NON-DESCRIMINATION- An employee who believes he or she has been discharged, disciplined, or in any other manner discriminated against by an employer for exercised rights granted under the Law, has one hundred eighty (180) days following the violation of the Law or following the date on which he or she obtained knowledge that a violation occurred, to file a complaint with the Deputy Director of the Division of Occupational Safety. A copy of the complaint must be sent to the employer at the same time by certified mail.

NOTE- The employee rights listed above are further defined in Chapter 111F of the Massachusetts General Laws and the Code of Massachusetts Regulations 454 CMR 21.00. Copies of the law and regulation can be obtained at the Statehouse Bookstore (617-727-2834).

All Right-to-Know Inquiries should be addressed to:
Paul Aboody, Program Manager
Division of Occupational Safety
1001 Watertown Street
West Newton, MA 02465
(617-969-7177
(Fax 617-727-4581)

*Private sector employees in Massachusetts are covered by a similar regulation, the Hazard Communication Standard (29 CFR 1910.1200), enforced by the Federal Occupational Safety and Health Administration (OSHA 616-565-9860).

DELTA DENTAL®

ENROLLMENT FORM

PLEASE PRINT OR TYPE

BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

Delta Dental of Massachusetts
PO Box 9695
Boston, Massachusetts 02114

1. SOCIAL SECURITY NO.*	2. LAST NAME*	3. MIDDLE INITIAL	4. FIRST NAME*	5. DATE OF BIRTH* (MM/DD/CCYY)

6. GENDER	7. SUBGROUP NUMBER (10 digits)*	8.SUBGROUP NAME*	9. EFFECTIVE DATE* (MM/DD/CCYY)
	009132-7401	City of Waltham - Active Employees	

10. HOME ADDRESS*	11. CITY*	12. STATE*	13. ZIP*

14. HOME PHONE	15. CELLULAR PHONE	16. WORK PHONE	17. EMAIL ADDRESS

18. RACE	19. LANGUAGE

* THIS FIELD IS REQUIRED

PLAN SELECTION

20. PLAN: Select plan you are enrolling in:

☑ **Delta Dental Premier** ☐ **Delta Dental PPO** ☐ **Delta Dental PPO** *Plus Premier* ☐ **DeltaCare** ☐ **The Value Plan** ☐ **EPO**

If DeltaCare or the Value Plan is selected, each subscriber & dependant must choose a DeltaCare Primary Care Dentist (PCD)

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

21. FIRST NAME	22. LAST NAME	23. DATE OF BIRTH (MM/DD/CCYY)	24. GENDER M/F	25. FULL TIME STUDENT Y/N	26. FACILITY # (DELTACARE)	DELTACARE OR VALUE PLAN ONLY		
						27. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	28. PROVIDER #	29. DO YOU CURRENTLY USE THIS DENTIST
SPOUSE								
CHILDREN								

30. REASON FOR SUBMISSION (CHECK ONE)

☐ NEW ADD ☐ TERMINATION ☐ DEMOGRAPHIC CHANGE ☐ SUBGROUP TRANSFER

SUBSCRIBER SIGNATURE _____ DATE _____

BENEFIT ADMINISTRATOR AUTHORIZATION _____ DATE _____

Visit **deltadentalma.com** for detailed benefit information

Coverage Summary for City of Waltham Group #009132

Deductible: $50 per individual / $150 per family. Deductible waived for Diagnostic and Preventive categories.

Calendar Year Maximum: $1,000 per person.

Category / Procedure	Qualifications	Co-Insurance In Network	Co-Insurance Out of Network
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Exam	Once every 6 months.		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Once every 6 months.		
Single Tooth X-rays	As needed.		
Preventive		100%	100%
Teeth Cleaning	Once every 6 months.		
Fluoride Treatments	Once every 6 months for members under age 19.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings (Front Teeth)	Once every 24 months per surface per tooth.		
Inlays and White Fillings (Back Teeth)	Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery		80%	80%
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).		
Periodontics (on natural teeth only)		80%	80%
Periodontal Surgery	One surgical procedure per quadrant in 36 months.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings.	100%	100%
Bone Grafts/GTR	No more than 2 teeth per quadrant per 36 months on natural teeth.	80%	80%
Endodontics		80%	80%
Root Canal Treatment	Once per tooth.		
Root Canal Retreatment	Once per tooth after 24 months have elapsed from initial treatment		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance		80%	80%
Bridge or Denture Repair	Once per bridge/denture per 12 months, after 24 months of initial insertion.		
Crown or Onlay Repair	Once per tooth per 12 months after 24 months of initial placement		
Rebase or Reline of Dentures	Once per denture within 36 months.		
Recement of Crowns & Onlays, Bridges	Once per crown, onlay or bridge.		
Emergency Dental Care		80%	80%
Palliative Treatment	Three occurrences in 12 months.		
Prosthodontics		50%	50%
Dentures	Once within 60 months (age 16 and older).		
Fixed Bridges	Once within 60 months (age 16 and older).		
Implants (only in lieu of a 3-unit bridge)	Endosteal Implant: Only when replacing one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimate recommended).		
Implant Abutments	Once per implant only when surgical implant is benefitted.		
Major Restorative		50%	50%
Crowns or Onlay	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).		
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.		

Dependent Eligibility: Eligible dependents are covered until the last day of the month of the member's 26th birthday.

Additional Benefit Information

Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out –of-pocket expenses you may incur and will confirm that this services are covered under your dental coverage.

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental Premier

DELTA DENTAL®

Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental Premier subscriber, you have access to the most extensive dental network in Massachusetts, with more than 11,000 participating dentist locations.

With Delta Dental Premier, you enjoy the greatest savings in out-of-pocket expenses when visiting a dentist who participates in the Delta Dental Premier network. Participating dentists typically accept discounted fees for their services, and since your co-payments are based on these fees, you pay lower out-of-pocket costs for your care. You will still receive coverage if you visit a non-participating dentist, but your benefit will be at the out-of-network level shown in the right-hand column of this coverage summary.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at http://www.deltadentalma.com/members/discounts-on-covered-services/

To find a dentist, simply visit **www.deltadentalma.com** (click on the Find a Dentist link and select Delta Dental Premier) or call Delta Dental customer service at 1-800-872-0500.

Learn more at deltadentalma.com

Visit the member area of **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

SP565 (9.17)

Delta Dental Premier

NONDISCRIMINATION NOTICE

Delta Dental of Massachusetts complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, and accessible electronic formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, visit: http://www.deltadentalma.com or call the number on your member ID card.

If you believe that Delta Dental of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu
Civil Rights Coordinator
Compliance Department
465 Medford Street
Boston, MA 02129
Fax: 617-886-1390
Phone: 617-886-1683
Email: FairTreatment@greatdentalplans.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc. Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered DSM Massachusetts Insurance Company, Inc.

DELTA DENTAL®

Talk to a Dentist Online With Virtual Visits

Delivered by TeleDentistry.com

Delta Dental of Massachusetts members can now schedule a virtual visit with a dentist 24/7 using their smartphone, tablet or computer

Virtual visits are available to Delta Dental of Massachusetts members for urgent dental problems through their existing Delta Dental coverage. A virtual visit is an effective way to receive care and avoid the emergency room.

You can schedule a virtual visit when you:

- Are having a dental emergency or an urgent dental concern.
- Need access to a dentist after hours and your dentist isn't available.
- Need to consult with a dentist while traveling.

TeleDentistry.com dentists diagnose the problem and provide treatment options. You will be referred to a Delta Dental dentist for follow-up care.

The TeleDentistry.com dentist will email you consultation notes and direct you to follow up with your provider. If you have not established care with a Delta Dental network dentist, TeleDentistry.com will provide you with a list of local Delta Dental network dentists for follow-up care.

This service supplements Delta Dental's current plan coverage and should be used after business hours, holidays and weekends, or when your regular dentist is unavailable.

TeleDentistry.com services are only available to current Delta Dental of Massachusetts members. A TeleDentistry.com consultation counts as a problem-focused exam under your dental plan.

IT'S EASY TO SCHEDULE A VIRTUAL VISIT

Delta Dental has partnered with TeleDentistry.com to provide virtual visits.

Here's how it works:

Step 1 – Go online to teledentistry.com/ddma.

Step 2 – Complete a brief registration and health questionnaire.

Step 3 – You'll be connected with a TeleDentistry.com dentist to begin your visit.

TeleDentistry.com is backed by the power of Preventistry™, Delta Dental of Massachusetts' groundbreaking and unique approach to transforming the oral health care system. Preventistry combines clinical innovation, actionable data and digital engagement to provide a higher level of care and improve the health of our members.

For additional information on the City of Waltham's Insurance Plans please visit:
Htps://www.city.waltham.ma.us/human-resources-department/pages/insurance

WALTHAM
MASSACHUSETTS
"The Watch City"

Published on *walthamma* (https://www.city.waltham.ma.us)

Insurance

Health Insurance Plans

The City of Waltham offers it's full-time, permanent employees three health options from which to choose:
(click the links for enrollment forms / plan & Benefit overview)

- Harvard Pilgrim Health Care (HMO) / Delta Dental Premier
- Tufts Health Plan (HMO) / Delta Denta Premier
- Blue Cross/Blue Shield: Blue Care Elect Preferred (PPO) / No Delta Dental

** See Health Insurance Monthly Premium Rates for payments/deductions in June 2021 - May 2022 for coverage July 1, 2021 - June 30, 2022.*

Retiree Over 65 Medicare Senior Supplement Plans 2020-21:

- BCBS Waltham Medex3 Senior Over 65 Medicare A & B
- Harvard Enhanced Senior Over 65 Medicare A & B
- Tufts Complement Senior Over 65 Medicare A & B
- City of Waltham Benefit Comparison Chart of Medicare Plans

If you have questions related to Social Security or Medicare please contact those agencies directly:

www.ssa.gov or find your local office by searching Social Security Office Locator or call 1-800-772-1213

www.medicare.gov/ or 1-800-633-4227.

The City's contributions to the plans are: 89% of the cost of HMO and 87.5% of the cost of Blue Cross Blue Shield. New employees may select one of these plans. An open enrollment every May provides employees with an opportunity to reselect.

The effective date of health care coverage depends on your date of hire. If date of hire is between the 1st-23rd day of the month, your insurance is effective the 1st day of the following month. Note: employees contributions are pre-paid 1 month , so payment of 4 weeks is required. If your hire date is the 24th-last day of the month, insurance coverage becomes effective five weeks from hire. July1 if the employee transfers, depending on the plan. Dependent children are eligible up to their 26th birthday.

In order to enroll a spouse and/or dependents to you health plan the City requires a copy of your marriage license and birth certificates for dependents.

In the event of a loss of health insurance, birth, marriage or divorce, it is the responsibility of the employee to notify the Payroll Department within **30 days of the event.** Birth certificate, marriage certificate and/or divorce decrees will also need to be provided at this time. Failure to meet this timeline will result in waiting until the next open enrollment period.

Complete information on all health plans and enrollment forms are provided in your orientation package.

Delta Dental

(Available with Harvard Pilgrim Health Plan HMO and Tufts Health Plan HMO only)

- Preventative dental services are covered at 100% with no deductible.
- Restorative services covered at 80% after a $50.00 per person deductible.
- Prosthodontics and Major Restorative are covered at 50%
- Braces are not covered.

There is no additional cost for the dental coverage with the Harvard Pilgrim or Tufts coverage, there is no coverage offered with Blue Cross Blue Shield. For more information on coverage, please consult the Delta Dental information included in your Orientation Package.

*If you choose not to select the Health Insurance benefit, you must complete the Waiver of Group Health Insurance Coverage Form included in your Orientation Package.

Contact information for these health plans is as follows:

- **Harvard Pilgrim Health Care:** 1-888-333-4742 / TDD: 1-800-637-8257 / Mental Health: 1-888-777-4742
- **Tufts Health Plan:** 1-800-462-0224 / TDD: 1-800-815-8580
- **Blue Cross/Blue Shield:** 1-800-782-3675

- **Delta Dental:** 1-800-872-0500

Life Insurance Plan

The City offers full-time, permanent employees basic life insurance in the amount of $15,000. To be eligible for the Additional Optional Coverage employees must first be enrolled in the basic program. On the enrollment form, Plan A is the basic plan and Plan B is the optional plan.

Full-time, permanent employees under age 75 who desire additional coverage are entitled to purchase life and accidental death and dismemberment insurance in $5,000 denominations up to the amount of the employee's salary.

Full-time, permanent employees under the age of 75 are entitled to purchase dependent coverage. Dependent coverage includes only life insurance. Accidental death and dismemberment's not included.

In order to be eligible for dependent coverage, full-time permanent employees must first purchase at least $5,000 in additional optional coverage. The entire premium for any additional coverage is to be paid by the employee through payroll deductions.

When an employee is terminated, resigns, retires or reaches age 75, all additional coverage ends. The employee has the right to convert the full amount of additional coverage to an individual policy. When an employee under age 75 retires, he/she may take his/her additional coverage with them until age 75.

Once you have applied for life insurance you will receive an Insurance Certificate of Coverage from the City of Waltham Payroll Department by mail within 30 days of enrollment. If you do not receive this certificate please contact the Payroll Department at 781-314-3270.

For more information see your orientation package or contact the Human Resources Department.

Allstate Cancer Insurance

The City of Waltham offers full-time, permanent employees the opportunity to enroll in Allstate Cancer Insurance. Coverage may include you, your spouse and children under age 26.

Pre-Existing Condition Limitation:
We do not pay benefits for a pre-existing condition during the 12-month period beginning on the date that person's coverage starts. A pre-existing condition is a disease or condition for which symptoms existed within the 12-month period prior to the effective date, or medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date. A pre-existing condition can exist even though a diagnosis has not yet been made.

Coverage under the policy ends on the date the policy is canceled; the last day premium payments were made; the last day of active employment, unless coverage is continued due to Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence; the date you or your class is no longer eligible. Spouse coverage ends upon divorce or your death. Coverage for children ends the earlier of when the child reaches age 26 or 2 years following loss of dependent status under the Internal Revenue Code, unless he or she continues to meet the requirements of an eligible dependent. Coverage may be continued under the Portability Provision when coverage under the policy ends. Refer to your Certificate of Insurance for details or contact LifePlus Insurance 781-837-9222

* See Allstate Cancer Brochure for more

COBRA (Competitive Omnibus Budget Reconciliation Act)

Cobra requires employers to offer employees and their families the opportunity to continue their group health care coverage for 18 to 36 months dependent upon the "qualifying event" that leads to the ultimate termination of coverage. If you do choose continued coverage, you have 60 days from the date you would lose coverage to inform the Human Resources Department. If you do not choose continued coverage, your group coverage will end and cannot be reinstated.

Newborn Coverage

See overview here

CITY OF WALTHAM
MASSACHUSETTS

CITY AUDITOR
Paul G. Centofanti

ASSISTANT CITY AUDITOR
Virginia A. Bergin

TO: City Department Heads
School Administrators/Principals
FROM: Paul G. Centofanti, City Auditor
RE: Health Insurance Enrollment
DATE: January 7, 2016

Other than salaries, health insurance is the single largest budget item for the City of Waltham. For the fiscal year ended June 30, 2015, the total cost of providing health care to employees, retirees and their dependents was in excess of $45 million, of which $40 million was directly subsidized by the taxpayers of the City of Waltham.

To ensure that coverage is fairly provided to all eligible employees and their eligible dependents, the City's policy is to have all new enrollment or changes to enrollment overseen by the Benefits Office located at City Hall. This allows employees to receive accurate information about each of the plan offerings, including benefit coverage and cost. It also allows the City to collect the required documentation to verify each individual's eligibility for enrollment so they may have timely access to benefits.

Employees and/or their family members should not contact any of the City's health care providers (Blue Cross/Tufts/Harvard/Delta Dental) directly for new enrollment or changes to enrollment. Each of the City's health care providers have been instructed to not allow or accept any new enrollment or changes to enrollment from anyone other than an authorized individual from the City's Benefits Office.

Generally, any new enrollment or changes to enrollment are only permitted during the City's annual enrollment period during the month of May. The only other time a new enrollment or a change to an enrollment is allowed is the occurrence of a *qualifying event*. Examples of a *qualifying event* are employment, birth/adoption of a child, marriage/divorce or change in employment status that results in the loss of coverage. Also, there are limited time periods to elect coverage under a qualifying event situation.

610 MAIN STREET • WALTHAM, MASSACHUSETTS • 02452-5580
TEL: (781) 314-3220 • FAX: (781) 314-3228 • E-MAIL: pcentofanti@city.waltham.ma.us

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM, MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL - KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
HUMAN RESOURCES DIRECTOR
WORKERS' COMPENSATION AGENT

Continuation Coverage Rights Under COBRA

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health 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 plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be the Human Resources Department at 781-314-3355. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

CITY OF WALTHAM
119 SCHOOL STREET
WALTHAM MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL – KMURPHY@CITY.WALTHAM.MA.US

MEMORANDUM

DATE: **NOVEMBER 8, 2021**

FROM: **KRISTIN MURPHY, HUMAN RESOURCES DIRECTOR**

SUBJECT: **OPEN ENROLLMENT**

The City of Waltham holds our annual Open Enrollment period the first two weeks of May for plan changes effective July 1st. During the Open Enrollment period, employees may make changes to their Health and Benefit plans. This is the **ONLY** time changes are allowed with the exception of Special Enrollment Periods due to a qualifying event.

It is the responsibility of the employee to notify the Human Resources Department **within 30 days of the qualifying life event.** Examples of these events are birth/adoption, marriage/divorce or loss of coverage. Documentation such as birth/marriage certificates, divorce decrees or proof of loss of coverage must be submitted with enrollment forms. Failure to meet this timeline will result in waiting until the Open Enrollment Period.

Health insurance is paid one month in advance. In the event of moving from an individual to family plan the employee will be responsible for paying the difference in cost between an individual and family plan back to the event date.

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL STREET, WALTHAM MASSACHUSETTS 02451
781.314.3355 FAX 781.314.3358
E-MAIL kmurphy@city.waltham.ma.us

Kristin Murphy
Director of Human Resources
Workmans' Compensation
Agent

WAIVER OF GROUP HEALTH INSURANCE COVERAGE

Employee Name: _____ Emp#: _____

Employee Address: _____

Department: _____

I hereby certify that I have been given an opportunity to participate in a Group Health Insurance Plan offered by my employer, the City of Waltham, and that I have declined to do so with respect to all health insurance coverages.

I further understand that if I desire to participate in a health insurance plan offered by the City of Waltham at a later date, this can only be done so during open enrollment in May of each year, for effective coverage as of July 1st.

_____ _____
Signature of Employee Date

CITY OF WALTHAM WEEKLY RATES FOR

HEALTH AND LIFE INSURANCE PREMIUMS

As of July 1, 2023

HEALTH INSURANCE:

1. Blue Cross/Blue Shield Blue Care Elect PPO (12.5%)
Individual Rate: Employee Weekly Rate = $48.00
Family Rate: Employee Weekly Rate = $111.42

2. Harvard Community Health Plan HMO/Delta Dental (11%)
Individual Rate: Employee Weekly Rate = $26.37
Family Rate: Employee Weekly Rate = $65.84

3. Tufts Health Plan HMO/Delta Dental (11%)
Individual Rate: Employee Weekly Rate = $25.24
Family Rate: Employee Weekly Rate = $67.72

There is no dental insurance with Blue Cross/Blue Shield Blue Care Elect

Delta Dental is included at no additional cost w/either Harvard Community Health Plan HMO OR Tufts Health Plan HMO

LIFE INSURANCE: Life Plus Insurance Agency, Inc.

$15,000 Basic Life Insurance Employee Weekly Share $1.28

When you purchase $15,000 Basic Life Insurance you are eligible to purchase up to $100,000 additional life insurance at reduced rates. Please see cost grid included in packet.

Cancer & Permanent Life policies are also available by contacting LifePlus Insurance Agency directly. Toll Free: 866-511-9222

DEPENDENT COVERAGE

If you purchase the $15,000 Basic Life Insurance plan, you are eligible to purchase life insurance for your spouse and/or children.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:
City of Waltham		002330957 - Active Employees

Current BCBS ID #, If any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Current Dental Group #:	Dental Group # Transferring To
			N/A	N/A

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)
❒ Open Enrollment ❒ New Hire ❒ COBRA
Change to Family ❒ Add Spouse ❒ Add Dependent
❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
❒ Other: _____

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ■ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family
Membership Type (Dental) N/A ❒ Individual ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered) Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **HSA: Health Savings Account**			
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

MASSACHUSETTS

Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please carefully read the instructions below.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298
Fax: 1-617-246-7531

163537 36-3630 (11/17)

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **bluecrossma.com**, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

Note: If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account..

Section 6 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shieldof Massachusetts.

Please mail to:

P.O. Box 986001
Boston, MA 02298
or fax to 1-617-246-7531

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see **www. .com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **bluecrossma.org/sbcglossary** or call **1-800-782-3675** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 in-network; $250 member / $500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room and emergency transportation.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$0 in-network; $1,000 member / $2,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$15 / visit; $15 / chiropractor visit; $15 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / acupuncture visit	Deductible applies first for out-of-network; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	$15 / visit; No charge for related routine lab tests and x-rays	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 / retail or mail order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail or mail order supply	Not covered	
	Non-preferred brand drugs	$45 / retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$15 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 100 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	20% coinsurance	Deductible applies first for out-of-network
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Deductible applies first for out-of-network; limited to members under age 18

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

■ The plan's overall deductible	$0
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ Primary care visit copay	$15
■ Diagnostic tests copay	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	$0
■ Specialist visit copay	$15
■ Emergency room copay	$50
■ Ambulance services copay	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MASSACHUSETTS

MCC COMPLIANCE

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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55-1487 (6/21)

BlueCross® BlueShield®

SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

$15 OFFICE VISIT COPAYMENT

City of Waltham

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

Download the app, or create an account at **bluecrossma.org.**

The Plan Sponsor believes that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered means the plan may not include certain consumer protections of the Act that apply to other plans, such as providing preventive health services without any cost sharing. However, a grandfathered plan must comply with certain other consumer protections of the Act, such as the elimination of annual and lifetime limits on most benefits.

Questions about which protections do or do not apply, and what causes a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at **1-781-314-3268**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a summary of the protections which do and do not apply to grandfathered health plans.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CHOICE

When You Choose Preferred Providers
You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider
To find a preferred provider:

- Look up a provider on Find a Doctor at **bluecrossma.com/findadoctor**. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.

- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**

When You Choose Non-Preferred Providers
You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. See the charts for your cost share.

You must pay a calendar-year deductible before you can receive coverage for most out-of-network benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is **$250** per member (or **$500** per family).

Your out-of-pocket maximum is the most that you could pay during a calendar year for out-of-network coinsurance for covered services. Your out-of-pocket maximum is **$1,000** per member (or **$2,000** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Utilization Review Requirements
Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • One visit per calendar year for age 2 to 11 • One visit every two calendar years for age 12 to 18	$15 per visit (no cost for related routine lab tests and X-rays)	20% coinsurance after deductible
Routine adult physical exams, including related tests, according to age-based schedule as follows: • One exam every five calendar years from age 19 through age 29 • One exam every three calendar years from age 30 through age 39 • One exam every two calendar years from age 40 through age 54 • One exam per calendar year for a member age 55 or older	$15 per visit (no cost for related routine lab tests and X-rays)	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	$15 per visit (no cost for related routine lab tests)	20% coinsurance after deductible
Routine hearing exams, including routine tests	$15 per visit (no cost for routine tests)	20% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	$15 per visit	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$15 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$15 per visit	20% coinsurance after deductible
Outpatient telehealth services with a covered provider	Same as in-person visit	Same as in-person visit
Chiropractors' office visits	$15 per visit	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$15 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$15 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	Nothing	20% coinsurance after deductible
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $15 per visit** Nothing	 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing	20% coinsurance after deductible
Rehabilitation hospital care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	$10 for Tier 1 $25 for Tier 2 $45 for Tier 3	Not covered
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$10 for Tier 1 $25 for Tier 2 $45 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

EMPLOYER SECTION

PLEASE WRITE IN YOUR 8 DIGIT GROUP NUMBER BELOW

Group/Company Name City of Waltham Group Number 14172-000 Active Employees

Office Location _____ Date of Hire _____ Effective Date of Coverage _____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date _____

SUBSCRIBER SECTION

PRODUCT (Select corresponding letter from the list on the front page) _____ **Other** _____

Last Name _____ First Name _____ Middle Initial _____

Employee Social Security Number (required) _____ – _____ – _____ Date of Birth (MM/DD/YYYY) _____ / _____ / _____ Gender: ❑ Male ❑ Female

Residential Address (required) _____ City _____ State _____ ZIP _____

P.O. Box (optional) _____ City _____ State _____ ZIP _____

Email Address _____ Home/Work Telephone (_____) _____ Cell Phone (_____) _____ Primary Language _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other _____

Primary Care Provider First Name _____ Last Name _____ PCP/ NPI # _____ Is this your current PCP? ❑ Yes ❑ No

Members Enrolling First Name / Last Name (if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP NPI #
❑ Spouse			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan _____ Name of Plan Holder _____ Health Plan Number _____ Effective Date _____

Names of Family Members Covered _____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Subscriber Signature _____ Date _____ **Employer Signature** (required) _____ Telephone _____ Date _____

TUFTS Health Plan

This is a Massachusetts Large Group Plan

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2010. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.

This health insurance issuer believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, restrictions on annual limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 800-462-0224. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

Please fill in the "subscriber" sections of this membership application completely so we do not delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. Please select a primary care provider (PCP). Be sure to fill out this section for all members, including dependents.
- Product Code: Please be sure to fill in the correct product code for the plan you have selected. (Please use chart on the right.)
- **Primary Care Provider: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are a current patient of the PCP you have listed. (You are a current patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam.**
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employer mails the form to:
  Tufts Health Plan
  P.O. Box 9186
  Watertown, MA 02471-9186

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present a claim that contains a false statement, you may lose your health care coverage and can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan. Tufts Health Plan does not directly provide health care services.

We collect email addresses and cell phone numbers ("your information") as part of the registration process. We may use your information to notify you of online activity related to the security and privacy of your accounts, such as, retrievals of username, etc. In addition we may use your information to send you health and wellness information and other updates that might be of interest to you as members of Tufts Health Plan. On certain occasions we may also share your information with providers in our network so that they may send you information that describes health-related products and/or services offered by the provider and included in your plan of benefits, enhancements to your plan, and/or benefits and services available to you as a health plan member that add value to, but are not part of, your plan of benefits. Each time we or any such provider sends health and wellness information and other updates, you will be given the opportunity to opt-out of receiving similar emails or cell phone communications in the future. Please note that you cannot opt-out of receiving emails that notify you of online activity since these are necessary to protect the privacy and security of Web accounts.

Product Codes

Write the corresponding letter in the product box in the subscriber section of the enrollment application.

- **A.** HMO Premium
- **B.** HMO Value
- **C.** HMO Basic
- **D.** HMO Choice Copay
- **E.** Advantage HMO
- **F.** Advantage HMO Saver
- **G.** POS
- **H.** POS Choice Copay
- **I.** EPO
- **J.** EPO Choice Copay
- **K.** PPO
- **L.** Advantage PPO
- **M.** Advantage PPO Saver
- **N.** Navigator by Tufts Health Plan
- **O.** CareLink
- **P.** Select HMO
- **Q.** Select Advantage HMO
- **R.** Rhode Island HEALTHPact
- **S.** Your Choice HMO
- **T.** Your Choice PPO
- **U.** Steward Community Choice
- **LPC.** Lifespan Premier Choice

We speak over 200 languages.
Call Member Services.

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
เรือ อิชาย ภาสาไธย

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the Doctor Search feature. If you need help filling out this form, call a Member Services Representative.

Member Services:

800.462.0224

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see https://www.tuftshealthplan.com or call 800-462-0224. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 800-462-0224 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0; per plan year.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://www.tuftshealthplan.com, "Find a doctor, hospital…" or call 800-462-0224 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not covered	None
	Specialist visit	$15 copay/visit	Not covered	Prior authorization may be required.
	Preventive care/ screening/ immunization	$15 copay/visit	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$10 copay/fill (retail); $10 copay/fill (mail order)	Not covered	Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	Tier 2 - Preferred brand and some generic drugs	$25 copay/fill (retail); $25 copay/fill (mail order)		
	Tier 3 - Non-preferred brand drugs	$45 copay/fill (retail); $45 copay/fill (mail order)		
More information about prescription drug coverage is available at www.tuftshealthplan.com **This is a Massachusetts Large Group Plan**	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	Not covered	Limited to a 30-day supply. Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you need immediate medical attention	Emergency room care	$50 copay/visit		Cost share waived if admitted.
	Emergency medical transportation	No charge		Some emergency transportation requires prior authorization to be covered
	Urgent care	$15 copay/visit		Services with non-participating providers are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	Not covered	Prior authorization may be required.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office Visits	No charge for routine outpatient office visits	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization is required.
	Rehabilitation services	$15 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	Habilitation services	$15 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	Skilled nursing care	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.
	Durable medical equipment	No charge	Not covered	Prior authorization may be required.
	Hospice services	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Not covered	Limited to one visit every 12 months with an EyeMed vision care provider.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care/custodial care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Treatment that is experimental or investigational, for educational or developmental purposes, or does not meet Tufts Health Plan Medical Necessity Guidelines (with limited exceptions specified in your plan document)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery	• Chiropractic care (spinal manipulation) • Hearing aids (age 21 or younger only)	• Infertility treatment • Routine eye care (Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or https://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.HealthCare.gov or call 1-800-318-2596. If you are a Massachusetts resident, contact the Massachusetts Health Connector at https://www.mahealthconnector.org.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Tufts Health Plan Member Services at 800-462-0224. Or you may write to us at Tufts Health Plan, Appeals and Grievances Department, 705 Mt. Auburn St., P.O. Box 9193, Watertown, MA 02471-9193. Additionally, a consumer assistance program can help you file your appeal. Contact: MA: Health Care for All, One Federal Street, Boston, MA 02110, 1-800-272-4232, https://www.hcfama.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-462-0224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-462-0224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-462-0224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-462-0224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800-462-0224.
To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change".*

Please note that if you have complaints regarding provider directory inaccuracies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services:
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

tuftshealthplan.com | 800.462.0224

TUFTS Health Plan

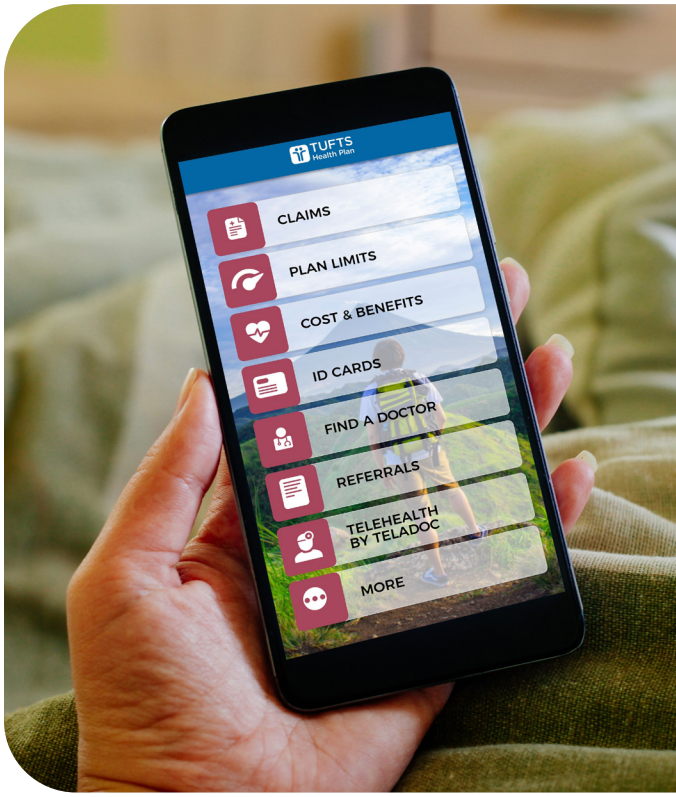
TUFTS Health Plan

MEMBER PORTAL + MOBILE APP

Quickly Access Your Benefits

Login or activate your secure online account at **mytuftshealthplan.com** or via Tufts Health Plan mobile app[1], to quickly and securely access your health plan benefits information.

- Understand your coverage and costs
- Check your claims, referrals, and authorization
- View plan limits, including your out-of-pocket costs
- Find a doctor or a hospital
- Select or change your Primary Care Provider (PCP)
- Estimate your costs
- **NEW!** Talk to a Teladoc® doctor 24/7 at no cost
- Access health and wellness resources
- View your ID card and tax forms



ACTIVATE YOUR SECURE ACCOUNT NOW

- Visit **mytuftshealthplan.com** OR
- Download the "Tufts Health Plan" mobile app

Download on the App Store | GET IT ON Google Play

[1]Does not apply to Tufts Health RITogether plans. Telehealth virtual health care services (provided by Teladoc®) are available to Tufts Health Plan commercial members (not including Tufts Health Direct). There will be no cost share or copay for Teladoc services to employer-sponsored groups that have this benefit and have not opted out; cost share may apply to some self-insured groups. Cost share will apply to Saver plan members starting 1/1/2022. If you're not sure whether your plan includes Telehealth by Teladoc please ask your employer. Your regular health care providers may also offer virtual health care services to you – please contact them directly for additional details. Cost share applies.

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TUFTS Health Plan

DIGITAL TOOLS

Access Your Health Plan Benefits Anywhere

Member Portal + Mobile App

Login or activate your secure online account at **mytuftshealthplan.com** OR download the "Tufts Health Plan" mobile app to access all of your health plan benefits information.

Download on the App Store | GET IT ON Google Play

Telehealth VIrtual Health Care

Set up your account at **tuftshealthplan.com/teladoc**
Access a U.S. based, board-certified doctors 24/7, by phone or mobile app worldwide for everyday care, confidential therapy and dermatology services.

Treatment Cost Estimator + Provider Search

Login to your secure online account to find a doctor, compare costs, and estimate your out of pocket cost.

MyRewards

Sign up for MyRewards when you shop for services like mammograms and MRIs, and earn up to $100 per each service.*

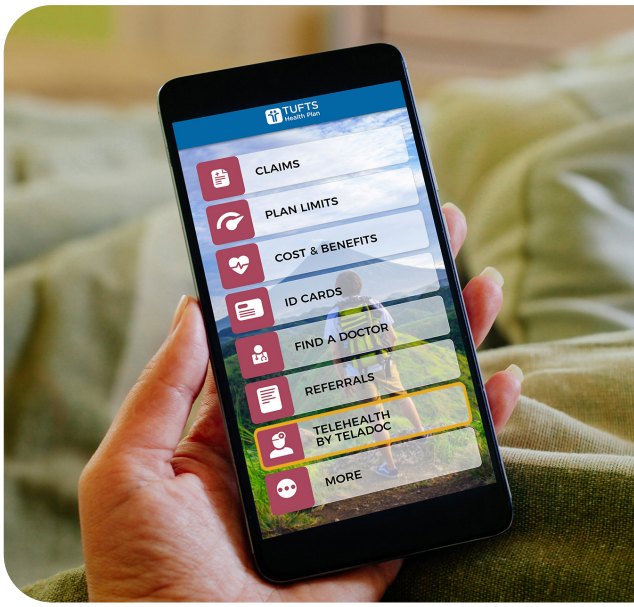
MyWire

Text "THP" to 73529 to enroll, and stay informed with secure, personalized text messages.

Simplicity, Security & Savings

LEARN MORE

Visit **tuftshealthplan.com/DigitalTools** or ask your employer



*Up to $500 per covered member per year. MyRewards is available to commercial fully-insured members (not including tiered products, CareLink and Tufts Health Direct) in Massachusetts and Rhode Island. Telehealth virtual health care services (provided by Teladoc®) are available to Tufts Health Plan commercial members (not including Tufts Health Direct). There will be no cost share or copay for Teladoc services to employer-sponsored groups that have this benefit and have not opted out; cost share may apply to some self-insured groups. Cost share will apply to Saver plan members starting 1/1/2022. If you're not sure whether your plan includes Telehealth by Teladoc please ask your employer.

TUFTS Health Plan

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TUFTS Health Plan

TALK TO A DOCTOR FOR FREE

Use Teladoc® Virtual Health Care Services from Tufts Health Plan

Just Follow These 5 Easy Steps:

1. Set up an account with your member ID:
   - Visit tuftshealthplan.com/Teladoc on a computer/tablet. Or
   - Download the Teladoc® app. Or
   - Call 1-800-TELADOC (835-2362)
2. Choose your preferences for language (over 200) and provider's gender
3. Choose an appointment time
4. Select text and/or email notifications
5. Connect with a U.S based and board-certified doctor by phone or video

The doctor will diagnose your symptoms and provide treatment, which may include a prescription, that can be sent to your nearest pharmacy. With your permission, the doctor can share a report about your visit with your primary care physician.

Protect You and Your Family From COVID-19

Use Teladoc® to get screened at no cost for COVID-19 – and avoid visiting a medical office where the risk of exposure to the disease may be higher. The doctor can answer your questions about symptoms or treatment. They'll also work with your state's local public health department to get you the care you need.

To expedite your visit during the COVID-19 crisis be sure to:

- Set up your account and complete your medical history in advance
- Select "phone session" and "as soon as possible" for the appointment time
- Turn on all notifications in the app, and keep your phone near you so you don't miss the doctor's call

Teladoc® is available to Tufts Health Plan Commercial members (not including Tufts Health Direct) for plans issued or renewed in 2020 at $0 copay. Members can contact a Teladoc® doctor 24/7 if they're concerned about their symptoms or have questions about Covid-19. Until further notice, there will be no member cost for this service to our employer-sponsored groups, including self-funded groups that have this benefit and have not opted out. Members of high-deductible health plans may be billed for deductible at a later date if the visit is unrelated to Covid-19

TELADOC.

TUFTS Health Plan

TELEHEALTH

No Driving, No Waiting Room, No Cost

Telehealth Virtual Health Care Provided by Teladoc® is Available 24/7 Worldwide — by Phone, Web or Mobile App

When you or your dependents need non-emergency care, use Telehealth to save time and money. You can even receive your prescription at your local pharmacy when medically necessary.

- Connect with a U.S. board certified doctor for everyday care, anywhere in the world in less than 15 minutes
- Schedule a session with a therapist or psychiatrist to get confidential support that fits your needs and schedule
- Access a dermatologist in less than 48 hours for common skin conditions such as psoriasis or eczema

Set Up Your Account With Your Member ID Card at

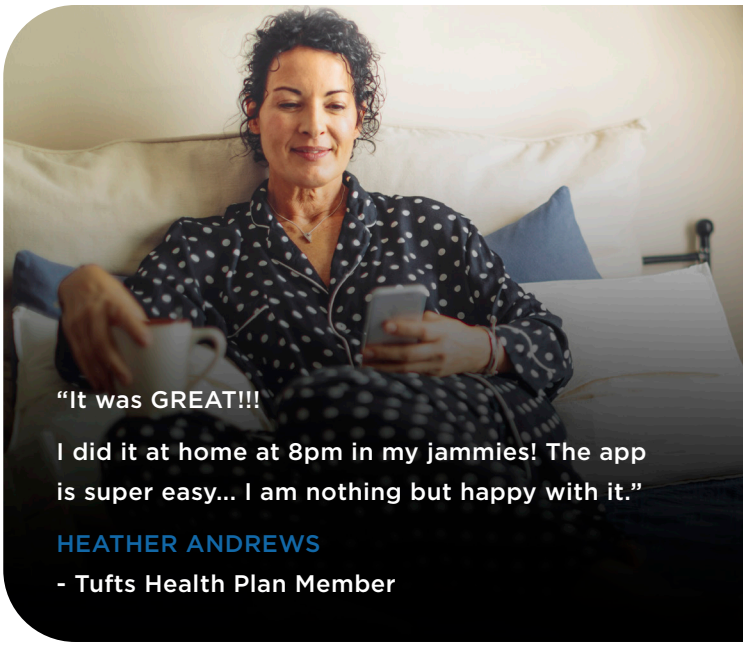
tuftshealthplan.com/Teladoc

Our Members Love Telehealth

- Worldwide 24/7 Access to care
- 92% of patients' visits are resolved the 1st visit
- 95% member satisfaction
- Over 40 million members

NEW! Access Telehealth Right from Our Mobile App

With the push of a button, our Tufts Health Plan mobile app now connects you directly to Teladoc doctors. Download the app and Tap "Telehealth by Teladoc" on the app home screen to request a 24/7 visit with a Teladoc doctor.



"It was GREAT!!!

I did it at home at 8pm in my jammies! The app is super easy... I am nothing but happy with it."

HEATHER ANDREWS
- Tufts Health Plan Member

In the case of an emergency, please call 9-1-1 or visit the nearest emergency department. Telehealth virtual health care services (provided by Teladoc®) are available to Tufts Health Plan commercial members (not including Tufts Health Direct). There will be no cost share or copay for Teladoc services to employer-sponsored groups that have this benefit and have not opted out; cost share may apply to some self-insured groups. Cost share will apply to Saver plan members starting 1/1/2022. If you're not sure whether your plan includes Telehealth by Teladoc please ask your employer. Your regular health care providers may also offer virtual health care services to you – please contact them directly for additional details. Cost share applies. This testimonial reflects this individual's experience and experiences may vary. Statistics are provided by Teladoc® and not verified by Tufts Health Plan.

TUFTS Health Plan

EYE CARE BENEFITS

Access to 61,000 Eye Care Providers

Coverage Through the EyeMed Vision Care Network

Tufts Health Plan offers coverage for routine eye exams and other vision services through the EyeMed Vision Care network.

EyeMed

You're Covered
Coverage through our EyeMed Vison Care Providers

LensCrafters

OPTICAL℠

Pearle Vision EST. 1961

Access Routine Eye and Vision Care Services

1. Use tuftshealthplan.com or our mobile app and click on "Find a Doctor" to find an eye care provider in the EyeMed network. (Or to check if your eye doctor is in the network).
2. Visit a provider in the EyeMed network to receive the highest level of coverage for routine eye exams.

Discounts on Glasses and Contacts

When you use eye care providers in the EyeMed network:

- **Save 35%** on the price of frames and get discount prices on lenses when you buy a pair of glasses.[1]
- **Save 20%** on the price of nonprescription sunglasses.
- **Save 5%-15%** on the price of LASIK and PRK laser vision correction. For a location near you and approval for the discount, please call 877.5LASER6.
- Order contact lenses for less than the retail price and have them shipped to your home or office. Visit contactsdirect.com, lenscrafterscontacts.com or targetoptical.com to purchase contact lenses online.[2]

[1] Discounts may not apply to some frames. Prices may vary by retail store.
[2] The cost of a contact lens evaluation and fitting is not covered by your eye care benefit, so you will need to pay for these services.

What Is Typically Covered?

Routine eye exams may include some or all of the following services:

- A review of the history of your eyes and vision, along with a general health history
- A discussion of any vision problems
- An exam of the inside and outside of your eyes and of the areas around your eyes
- A measure of the pressure in your eyes
- Dilation to make your pupils larger so that your eye care provider can see and check the entire inside of your eye
- A measure of how well you see close up and at a distance
- A test of your vision to see if you need prescription glasses and whether or not you can use contact lenses
- A treatment plan, follow-up eye exams, and eye health advice

Eye Care Providers

- **Optician:** An eye care provider who reads vision prescriptions and helps you choose the glasses, contact lenses, and other eye aids that are right for you
- **Optometrist (O.D.):** A licensed eye care provider who performs eye exams and other eye care services, and prescribes glasses, contacts, and other vision aids
- **Ophthalmologist (M.D.):** An eye doctor who performs eye exams, treats eye disease, conducts surgery, and prescribes glasses, contacts, and other vision aids

Important: Providers within the EyeMed network are able to meet your routine eye care and certain medical optometry needs. However, if you need to see an ophthalmologist to treat or monitor an eye disease or condition, be sure to confirm that the ophthalmologist is in the Tufts Health Plan network. If your plan requires a referral for specialty care, you will need to get one from your Primary Care Provider.

TUFTS Health Plan

Acupuncture Benefit

Tufts Health Plan Offers Alternative Care Options with Unlimited Acupuncture Coverage

With a network of local acupuncturists, you have access to unlimited acupuncture coverage with no prior authorization or referrals required. This acupuncture benefit was designed to help you receive the holistic care you need and deserve.

An alternative treatment for pain, acupuncture is commonly used to relieve discomfort associated with a variety of conditions, including: tension, migraines, neck pain and osteoarthritis.

How it Works

- Your visits are subject to your plan's specialist or primary care physician cost share.
- If your plan allows for out-of-network benefits, your visit will be subject to your out-of-network deductible and or coinsurance. You will need to pay the provider out of pocket and submit a reimbursement[1] form.
- If you're on advantage plans your visits may be subject to deductible cost share.

How to Find an Acupuncturist

- Visit **tuftshealthplan.com** and click on "Find a Doctor or Hospital" OR
- Login to your secure member account at mytuftshealthplan.com

[1]Reimbursement applies only to plans that have out-of-network benefits. For in-network only plans, members must visit a contracting provider within the Tufts Health Plan network.

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MEMBER DISCOUNTS AND PERKS

TUFTS Health Plan

DISCOUNTS & PERKS

HELP YOU SAVE AND STAY HEALTHY

Tufts Health Plan wants to help you reach your wellness goals with discounts on nutrition, mind and body, fitness, and other services related to good health.[1]

START LIVING WELL TODAY!

Log into **mytuftshealthplan.com**. If you don't have an account, choose "Register here" to create one. Once logged in, select "Get Started" on the Health & Wellness tile.

- Take your Wellbeing Assessment
- Connect with a Health Coach
- Participate in monthly challenges and activities to build health habits
- Earn points towards rewards

FITNESS AND EXERCISE

Get discounts at over 14,000 health and fitness facilities across the U.S. through the International Fitness Club Network. Tufts Health Plan members can even try before you join with a FREE one-week trial membership at any facility you like.[2] Members can learn more at preventure.com/ifcn-tufts with password "Fit4You".

Fitness Together

Fitness Together pairs you with a personal trainer in a private setting and a workout plan tailored to you![3]

- New members pay no fitness evaluation fee
- New members get 10% off the purchase price of any personal training package
- Existing members get 10% off the purchase price of personal training packages of 36 sessions or greater. To get the discount, show your Tufts Health Plan Member ID card when joining any participating Fitness Together location

Rather Work Out at Home?

- Save 10-40% on a wide array of fitness products

Rather Race to Get Your Workout?

- Save up to 15% off registrations to a variety of races

Other Discounts Include:

- Save up to 25% off online workout subscriptions
- Save 10% off home swim lessons and life guard services
- Save up to 90% off magazine subscriptions

Fitness Membership Rebate

Get money back on your fitness membership! Reimbursement details vary by plan – you may confirm your fitness rebate by viewing your health plan coverage in your secure member account, visit mytuftshealthplan.com.

HEALTHY EATING AND WEIGHT MANAGEMENT

The Dinner Daily

Save 25% on any Dinner Daily subscription, visit thedinnerdaily.com/thp and use code "THP25" to sign up. The Dinner Daily provides members with customized meal plans that fit members' dietary restrictions and a shopping list that maximizes savings with local grocery store specials.

[1] This information has been provided by the vendors and has not been independently confirmed by Tufts Health Plan. Available to Tufts Health Plan commercial members, excluding Tufts Health Direct. Confirm details with your employer, and check with your health care provider regarding any health or medical condition before beginning any new treatment, exercise, or nutrition regimen. Discounts are subject to change at any time.

[2] Specialty clubs and studios, such as martial arts, yoga, spin and personal training centers may offer different "trial" offers. Please inquire with the owner or membership department at these centers to verify offer.

[3] At participating facilities only. Discounts cannot be combined with any other promotion offered by the fitness location or trainer.

Jenny Craig®

Accelerate Your Weight Loss with Rapid Results Max by Jenny Craig.[4]

Rapid Results Max is a groundbreaking, science-based program that leverages intermittent fasting to accelerate weight loss and promote health benefits.

Special Offer from Tufts Health Plan: Save $120 on Jenny Craig weight loss plan[5]

Here's how the Jenny Craig program works:

- **Delicious Food:** Enjoy a customized meal plan, which includes delicious, chef-crafted meals, snacks and desserts, including the Jenny Craig Recharge Bar.
- **Dedicated Personal Consultant:** Jenny Craig provides personal one-on-one coaching with flexible by phone and in-person options.

3 Convenient Delivery Options:

- Contactless curbside pickup at a Jenny Craig center near you.
- Delivery from your local Jenny Craig center.
- Flexible shipping wherever you are![6]

Get Started Today!

Visit jennycraig.com/THP OR call 877.536.6970 to schedule an appointment for a FREE consultation.

MIND AND BODY

Ompractice

Access Ompractice virtual yoga and meditation at a discounted rate. Using two-way video via laptop or phone, Ompractice allows members to participate in live yoga and meditation classes with instruction and direction from a teacher, bringing the support, personal interaction and accountability of a studio session wherever you are.

Learn more: ompractice.com/tuftshealthplan.

Brain Fitness

Save 17% on the price of a subscription to BrainHQ™, an online cognitive training program. Stay sharp and visit brainhq.com/thp.

Cambridge Health Alliance Center for Mindfulness and Compassion Discount

Save 15% on Mindfulness and Self-Compassion courses, which can reduce stress and improve your overall wellbeing. Visit chacmc.org/courses and use access code "THP15" when you register.

Discounts on ChooseHealthy.com

Free shipping and up to 40% discount on wellness products on the site, ChooseHealthy.com. For details on how to get this discount, call Customer Relations or visit choosehealthy.com/public.

Massage Therapy and Acupuncture

Reconnect your body, mind, and spirit with massage therapy or acupuncture. **Massage therapy:** save 25% off the provider's usual fee, or pay $15 per 15 minutes of massage therapy, whichever is less. **Acupuncture:** save 25% off the provider's usual fee. For a list of providers near you, call ChooseHealthy customer service at 1-877-335-2746.

Meditation 101 Audio Series

The Meditation 101 Series is designed for those who are new to meditation. Meditation 101 consists of 10 short audio lessons that provide you with everything you need to know to begin meditating. To access this free tool, visit app.wellable.co/meditation101, and enter the access code "THP".

The Center for Mindfulness at UMass Memorial Health

Attend the 8-week, online Mindfulness-Based Stress Reduction (MBSR) or Mindfulness-Based Cognitive Therapy (MBCT) programs with the Center for Mindfulness at UMass Memorial Health and receive 15% off the cost of tuition. Participants have found an increased ability to relax, an enhanced ability to cope with chronic pain and stressful situations, and improved self-confidence. For more information send an email to mindfulness@umassmemorial.org, or visit ummhealth.org/umass-memorial-medical-center/services-treatments/center-for-mindfulness/mindfulness-classes.

MORE SAVINGS

Eye Glasses, Contacts + Corrective Vision Discounts

Save up to 35% on the price of frames, lenses and sunglasses when you see an EyeMed network provider. EyeMed Vision Care also offers a replacement contact lens program, and 5-15% off the cost of LASIK and PRK laser vision correction. Learn more at tuftshealthplan.com/eyemed.

Home Instead Senior Care®

Get a one-time $100 credit toward charges for non-medical support services at participating offices. Home Instead Senior Care enables seniors to live safely and comfortably wherever they call home. You can also receive a free home safety inspection once you have contracted for services with Home Instead Senior Care.

[4] Average weight loss in study was 13 lbs. for those who completed the program.

[5] Savings redeemed as 12 weeks with full planned menu purchase (avg. $182) each week. Active program enrollment and eligibility status required. Valid only for new members and former members who haven't had an active visit (in-person or remote) within the past 60 days. Valid at participating centers and Jenny Craig Anywhere. No cash value.

[6] Time and transit restrictions in certain zip codes prevent shipping frozen foods to those areas. See jennycraig.com/shipping-policy for more information.

For more information, please contact Home Instead at homeinstead.com or by phone at 888-580-6676 (toll-free). To get the discount, just show your Tufts Health Plan Member ID card.

You Can Save When You Use the CVS Caremark® ExtraCare Health Program

You receive 20%[7] off regular-priced CVS Health Brand,[8] health-related items valued at $1 or more. The ExtraCare card can be used at CVS Pharmacy® stores nationwide and new members can attach the discount to their card.

• How to Get Your 20% Discount: Just show your card at the time of purchase to receive your discount

• If you are a new member and have a CVS ExtraCare card: Link your CVS ExtraCare card to your Tufts Health Plan Member ID number to start receiving your discount. Just visit tuftshealthplan.com/extracarehealth to start the activation process. Provide your Tufts Health Plan Member ID number and your ExtraCare card number when prompted

• If you don't already have an ExtraCare card, you'll be able to get one on the website. You can also pick one up at any CVS Pharmacy or call 1-800-SHOP-CVS to request a card before you get started with the linking process

• If you already have a Tufts Health Plan CVS ExtraCare Health card: Continue to use your existing Tufts Health Plan CVS ExtraCare Health card to get your 20% discount[9]

Hearing Care Solutions

Hearing Care Solutions (HCS) provides you[10] with cost-effective hearing care services and products offered by today's leading manufacturers. The HCS program streamlines the hearing care process for members and their dependents by offering discounted prices, as low as $500, on a wide array of digital hearing aids with varying levels of technology and features.[11]

Along with competitive pricing, you get access to services including:

- A complete hearing exam, hearing aid evaluation and fitting[12]
- The choice of over 5,000 locations nationwide for an appointment
- Access to HCS Doctor of Audiology and Product Specialists for questions and product support
- 9 brands and multiple levels of hearing aid technologies to choose from
- 3-year manufacturers' warranty on hearing aids, including loss, damage, and repair[13]
- Battery supply that covers 3 years of use[14]

Get started by requesting an appointment and visiting one of the nationwide providers most convenient to you.

Visit hearingcaresolutions.com/tufts to learn more.

LEARN MORE:

tuftshealthplan.com/Discounts-Perks

800.462.0224

[7] The 20 percent discount is restricted to items purchased for the health care of the cardholder only and applies to regularly priced CVS Health Brand health-related items valued at $1 or more. Your ExtraCare Health discount may not be used in Target stores, including those with a CVS Pharmacy in them. Excludes alcohol, lottery, money orders, prescriptions and copays, pseudoephedrine/ephedrine products, postage stamps, pre-paid cards, gift cards, newspapers and magazines, milk (where required by law or regulation), sale/promotional merchandise, bottle deposits, bus passes, hunting and fishing licenses, not valid on any imposed governmental fees, or items reimbursed by a government health plan. Check with your plan administrator for more details.

[8] All CVS Pharmacy Brand products are 100% satisfaction guaranteed or your money back. If you're dissatisfied for any reason, you can return the CVS Pharmacy Brand product (opened or unopened) along with your receipt or invoice to any CVS Pharmacy store. We'll refund the full purchase price — no questions asked! To return the item by mail, call Customer Care at 1-888-607-4CVS (1-888-607-4287). Other pharmacies are available in our network. You are not obligated to fill your prescriptions at CVS Pharmacy by using the ExtraCare Health benefit.

[9] Members with an existing Tufts Health Plan CVS ExtraCare Health Card should not try to use the link tuftshealthplan.com/extracarehealth. This site is only for new members. If you need to replace your existing physical card or transfer ExtraCare rewards, call 1-888-543-5938 and select option 2.

[10] Programs described are for all Tufts Health Plan commercial members, excluding Tufts Health Direct.

[11] HCS does not place any restrictions on members utilizing the discount program, however, health plan coverage for such products and services may vary by plan. Members not eligible for plan coverage may leverage favorable HCS discounts for hearing care services and products.

[12] Hearing care services and products coverage varies by plan. If covered, copay or other cost-share may apply and referrals may be required.

[13] Hearing care services and products coverage varies by plan and may include frequency limitations. If covered, copay or other cost-share may apply.

[14] Up to 64 cells per ear, per year. A supply of batteries is only available for non-rechargeable hearing aid models.

TUFTS Health Plan

Clear Form

Harvard Pilgrim Health Care

REASONS FOR SUBMISSION (PLEASE CHECK ONE)
☐ NEW ENROLLMENT/CONTRACT
☐ CHANGE TO CONTRACT
☐ TERMINATE CONTRACT

QUALIFYING EVENT DATE: ________________
☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ COBRA ☐ LOSS OF INSURANCE ☐ COURT ORDER ☐ BIRTH/ADOPTION ☐ P/T TO F/T ☐ MARRIAGE/DIVORCE ☐ MOVED IN/OUT OF SERVICE AREA ☐ DEATH ☐ VOLUNTARY CANCELLATION

REASON FOR CHANGES (CHECK ALL THAT APPLY)
☐ CHANGE COVERAGE TYPE ☐ ADD DEPENDENT LISTED ☐ TERMINATE DEPENDENT LISTED ☐ TRANSFER/RE-ENROLL TO COBRA
☐ OTHER: ____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE
City of Waltham	0 9 4 0 7 8 0 0 0 0		

SUBSCRIBER INFORMATION

HP ID	PRODUCT: ☒ HMO ☐ PPO ☐ POS ☐ ACCESS AMERICA	PLAN NAME: Harvard HMO

SUBSCRIBER FIRST NAME	MI	LAST NAME	DOB	GENDER ☐ M ☐ F

SSN REQUIRED	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL

STREET ADDRESS (NO PO BOX)	APT #	CITY	STATE	ZIP

PRIMARY LANGUAGE (OPTIONAL)	PCP FULL NAME REQUIRED	PCP TOWN REQUIRED	CURRENT PATIENT ☐ YES ☐ NO	PCP ID #

SPOUSE INFORMATION

SPOUSE FIRST NAME	MI	LAST NAME	DOB	GENDER ☐ M ☐ F

SSN REQUIRED	MAILING ADDRESS (IF DIFFERENT)	RELATION CODE

PCP FULL NAME REQUIRED	PCP TOWN REQUIRED	CURRENT PATIENT ☐ YES ☐ NO	PCP ID #

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER ☐ M ☐ F	RELATION CODE

MAILING ADDRESS (IF DIFFERENT)	SSN REQUIRED

PCP FULL NAME REQUIRED	PCP TOWN REQUIRED	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER ☐ M ☐ F	RELATION CODE

MAILING ADDRESS (IF DIFFERENT)	SSN REQUIRED

PCP FULL NAME REQUIRED	PCP TOWN REQUIRED	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER ☐ M ☐ F	RELATION CODE

MAILING ADDRESS (IF DIFFERENT)	SSN REQUIRED

PCP FULL NAME REQUIRED	PCP TOWN REQUIRED	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

☐ PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐ YES. PLEASE COMPLETE ☐ NO

NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINSTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, IMCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPLANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

_______________________ EMPLOYEE SIGNATURE ____________ DATE _______________________ EMPLOYER SIGNATURE ____________ DATE

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Schedule of Benefits

HMO
MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and the Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742**.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	None
Deductible Rollover	
	None
Out-of-Pocket Maximum	
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$2,000 per Member per Calendar Year $4,000 per family per Calendar Year

Benefit	Member Cost Sharing:
Acupuncture Treatment for Injury or Illness	
	Not covered

Benefit	Member Cost Sharing:
Ambulance Transport	
Emergency ambulance transport	No charge
Non-emergency ambulance transport	No charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Not covered
Chemotherapy and Radiation Therapy	
	No charge
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Extraction of teeth impacted in bone (performed in a physician's office)	$15 Copayment per visit
Pediatric Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Calendar Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays.	No charge
Dialysis	
	$15 Copayment per visit
Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge
Durable Medical Equipment	
Durable medical equipment	No charge
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention Services	
	$15 Copayment per visit
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Room Care	
	$50 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
Hearing Aids (for Members up to the age of 22)	
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge
Home Health Care	
	No charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	No charge

Benefit	Member Cost Sharing:
Hospital – Inpatient Services	
Acute hospital care	No charge
Inpatient maternity care	No charge
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Calendar Year	No charge
Skilled nursing facility – limited to 100 days per Calendar Year	No charge
Infertility Services and Treatments (see the Benefit Handbook for details)	
The Plan covers the following diagnostic services for infertility: – Consultation – Evaluation – Laboratory tests	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."
Infertility treatment (see the Benefit Handbook for details)	$15 Copayment per visit
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	No charge
Genetic testing	No charge
Radiology	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	No charge
Other diagnostic services	No charge
Low Protein Foods	
– Limited to $5,000 per Calendar Year	No charge
Maternity Care - Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	No charge
Medical drugs received in the home	No charge
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.	
Medical Formulas	
	No charge

Benefit	Member Cost Sharing:
Mental Health and Substance Use Disorder Treatment	
Inpatient services	No charge
Intermediate services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge
Outpatient group therapy	$10 Copayment per visit
Outpatient individual therapy	$15 Copayment per visit
Outpatient treatment, including outpatient detoxification and medication management	$15 Copayment per visit
Outpatient methadone maintenance	Not covered
Outpatient psychological testing and neuropsychological assessment	$15 Copayment per visit
Observation Services	
	No charge
Ostomy Supplies	
	No charge
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)	
Routine examinations for preventive care, including immunizations	$15 Copayment per visit
Consultations, evaluations, sickness and injury care	$15 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures	No charge
Administration of allergy injections	$5 Copayment per visit
Prosthetic Devices	
	No charge
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	$15 Copayment per visit

(Continued on next page)

Benefit	Member Cost Sharing:
Rehabilitation and Habilitation Services - Outpatient (Continued)	
Pulmonary rehabilitation therapy	$15 Copayment per visit
Speech-language and hearing services	$15 Copayment per visit
Occupational therapy – limited to 60 visits per Calendar Year Physical therapy – limited to 60 visits per Calendar Year	$15 Copayment per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Endoscopy and sigmoidoscopy	No charge
Colonoscopy	No charge
Spinal Manipulative Therapy (including care by a chiropractor)	
	Not covered
Surgery – Outpatient	
	No charge
Telemedicine — Outpatient	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."
For inpatient hospital care, see "Hospital — Inpatient Services" for cost sharing details.	
Urgent Care Services	
Convenience care clinic	$15 Copayment per visit
Urgent care center	$15 Copayment per visit
Hospital urgent care center	$15 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Vision Services	
Routine eye examinations – limited to 1 exam per Calendar Year	$15 Copayment per visit
Vision hardware for special conditions	No charge
Voluntary Sterilization in a Physician's Office	
	$15 Copayment per visit
Voluntary Termination of Pregnancy	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	No charge

Notice of Grandfathered Plan Status

Harvard Pilgrim Health Care, Inc. believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer's benefits office or human resources department. For plans governed by the Employee Retirement Income Security Act (ERISA), (generally these are plans purchased by an employer, other then a governmental entity or a church) you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1–866–444–3272** or **www.dol.gov/ebsa/healthreform**. This web site has a table summarizing which protections do and do not apply to grandfathered health plans. For Plans that are not governed by ERISA, you may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**. You may also contact our Member Services Department at **1-888-333-4742** with any questions about which protections apply to your grandfathered health plan.

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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MASSACHUSETTS HMO
General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim HMO Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion	Description
Alternative Treatments	
	1. Acupuncture care, except when specifically listed as a Covered Benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for these benefits. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs and wellness clinics; and wilderness programs (therapeutic outdoor programs). 6. Massage therapy. 7. Myotherapy.
Dental Services	
	1. Dental Care, except when specifically listed as a Covered Benefit. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. 4. Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Planned home births. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
Mental Health and Substance Use Disorder Treatment	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. 3. Methadone maintenance, except when specifically listed as a Covered Benefit. 4. Sensory integrative praxis tests. 5. Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 6. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 7. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 8. Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

Exclusion	Description
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins.
Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. 4. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. 5. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. 6. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. 3. Charges for missed appointments. 4. Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook*. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Exclusion	Description
Telemedicine Services	
	1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.
Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except when specifically listed as a Covered Benefit. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. 2. Hearing aids, except when specifically listed as a Covered Benefit. 3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions	
	1. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage. 2. Any service or supply furnished in connection with a non-Covered Benefit. 3. Any service or supply (with the exception of contact lenses) purchased from the internet. 4. Beauty or barber service. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law.

Exclusion	Description
All Other Exclusions (Continued)	
	7. Guest services. 8. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 9. Services for non-Members. 10. Services for which no charge would be made in the absence of insurance. 11. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable). 12. Services that are not Medically Necessary. 13. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. 14. Taxes or governmental assessments on services or supplies. 15. Transportation other than by ambulance. 16. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

Prescription Drug Coverage

PREMIUM 3 TIER

Covered prescription medications are available at participating pharmacies.

	Retail	Mail (up to a 90-day supply)
Tier 1	**Up to a 30-day supply:** $10 Copayment **Up to a 90-day supply:** $30 Copayment	$10 Copayment
Tier 2	**Up to a 30-day supply:** $25 Copayment **Up to a 90-day supply:** $75 Copayment	$25 Copayment
Tier 3	**Up to a 30-day supply:** $45 Copayment **Up to a 90-day supply:** $135 Copayment	$45 Copayment

Visit **www.harvardpilgrim.org/2022Premium3T** for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.

Harvard Pilgrim Health Care

General Notice About Nondiscrimination and Accessibility Requirements

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HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CITY OF WALTHAM
MASSACHUSETTS
119 SCHOOL ST., WALTHAM, MASSACHUSETTS 02451
781-314-3355 FAX 781-314-3358
E-MAIL - KMURPHY@CITY.WALTHAM.MA.US

KRISTIN MURPHY
HUMAN RESOURCES DIRECTOR
WORKERS' COMPENSATION AGENT

RECEIPT OF EMPLOYER INFORMATION

I _____ employed by the _____ department
(First & Last Name) (Department)

Hereby acknowledge and confirm receipt of the following policies:

- ☐ Network Use Policy
- ☐ Employee Orientation Booklet
- ☐ Sexual Harassment Policy
- ☐ Drug & Alcohol Policy
- ☐ COBRA notice
- ☐ Pregnant Workers Fairness Act, FMLA & Parental Leave Notices
- ☐ Equal Employment Opportunities (EEO) Notice

Employee Signature:

_____

Date:

_____

All city employees are provided with this Summary of the Conflict of Interest Law for Municipal Employees within 30 days of hire or election, and then annually. All city employees are then required to acknowledge in writing that they received the summary.

All employees must log in and complete the on-line Conflict of Interest/Ethics exam at the following website:

https://massethicstraining.skillburst.com/User/index.php

You will receive a certificate once you have completed the training that must be printed or scanned and returned to Human Resources.

Summary of the Conflict of Interest Law for Municipal Employees

This summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation. Municipal employees can obtain free confidential advice about the conflict of interest law from the Commission's Legal Division at our website, phone number, and address above. Municipal counsel may also provide advice.

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public's trust and confidence in that service by placing restrictions on what municipal employees may do on the job, after hours, and after leaving public service, as described below. The sections referenced below are sections of G.L. c. 268A.

When the Commission determines that the conflict of interest law has been violated, it can impose a civil penalty of up to $10,000 ($25,000 for bribery cases) for each violation. In addition, the Commission can order the violator to repay any economic advantage he gained by the violation, and to make restitution to injured third parties. Violations of the conflict of interest law can also be prosecuted criminally.

I. Are you a municipal employee for conflict of interest law purposes?

You do not have to be a full-time, paid municipal employee to be considered a municipal employee for conflict of interest purposes. Anyone performing services for a city or town or holding a municipal position, whether paid or unpaid, including full- and part-time municipal employees, elected officials, volunteers, and consultants, is a municipal employee under the conflict of interest law. An employee of a private firm can also be a municipal employee, if the private firm has a contract with the city or town and the employee is a "key employee" under the contract, meaning the town has specifically contracted for her services. The law also covers

private parties who engage in impermissible dealings with municipal employees, such as offering bribes or illegal gifts. Town meeting members and charter commission members are not municipal employees under the conflict of interest law.

II. On-the-job restrictions.

(a) Bribes. Asking for and taking bribes is prohibited. (See Section 2)

A bribe is anything of value corruptly received by a municipal employee in exchange for the employee being influenced in his official actions. Giving, offering, receiving, or asking for a bribe is illegal.

Bribes are more serious than illegal gifts because they involve corrupt intent. In other words, the municipal employee intends to sell his office by agreeing to do or not do some official act, and the giver intends to influence him to do so. Bribes of any value are illegal.

(b) Gifts and gratuities. Asking for or accepting a gift because of your official position, or because of something you can do or have done in your official position, is prohibited. (See Sections 3, 23(b)(2), and 26)

Municipal employees may not accept gifts and gratuities valued at $50 or more given to influence their official actions or because of their official position. Accepting a gift intended to reward past official action or to bring about future official action is illegal, as is giving such gifts. Accepting a gift given to you because of the municipal position you hold is also illegal. Meals, entertainment event tickets, golf, gift baskets, and payment of travel expenses can all be illegal gifts if given in connection with official action or position, as can anything worth $50 or more. A number of smaller gifts together worth $50 or more may also violate these sections.

Example of violation: A town administrator accepts reduced rental payments from developers.

Example of violation: A developer offers a ski trip to a school district employee who oversees the developer's work for the school district.

Regulatory exemptions. There are situations in which a municipal employee's receipt of a gift does not present a genuine risk of a conflict of interest, and may in fact advance the public interest. The Commission has created exemptions permitting giving and receiving gifts in these situations. One commonly used exemption permits municipal employees to accept payment of travel-related expenses when doing so advances a public purpose. Another commonly used exemption permits municipal employees to accept payment of costs involved in attendance at educational and training programs. Other exemptions are listed on the Commission's website.

Example where there is no violation: A fire truck manufacturer offers to pay the travel expenses of a fire chief to a trade show where the chief can examine various kinds of fire-fighting equipment that the town may purchase. The chief fills out a disclosure form and obtains prior approval from his appointing authority.

Example where there is no violation: A town treasurer attends a two-day annual school featuring multiple substantive seminars on issues relevant to treasurers. The annual school is paid for in part by banks that do business with town treasurers. The treasurer is only required to make a disclosure if one of the sponsoring banks has official business before her in the six months before or after the annual school.

(c) Misuse of position. Using your official position to get something you are not entitled to, or to get someone else something they are not entitled to, is prohibited. Causing someone else to do these things is also prohibited. (See Sections 23(b)(2) and 26)

A municipal employee may not use her official position to get something worth $50 or more that would not be properly available to other similarly situated individuals. Similarly, a municipal employee may not use her official position to get something worth $50 or more for someone else that would not be properly available to other similarly situated individuals. Causing someone else to do these things is also prohibited.

Example of violation: A full-time town employee writes a novel on work time, using her office computer, and directing her secretary to proofread the draft.

Example of violation: A city councilor directs subordinates to drive the councilor's wife to and from the grocery store.

Example of violation: A mayor avoids a speeding ticket by asking the police officer who stops him, "Do you know who I am?" and showing his municipal I.D.

(d) Self-dealing and nepotism. Participating as a municipal employee in a matter in which you, your immediate family, your business organization, or your future employer has a financial interest is prohibited. (See Section 19)

A municipal employee may not participate in any particular matter in which he or a member of his immediate family (parents, children, siblings, spouse, and spouse's parents, children, and siblings) has a financial interest. He also may not participate in any particular matter in which a prospective employer, or a business organization of which he is a director, officer, trustee, or employee has a financial interest. Participation includes discussing as well as voting on a matter, and delegating a matter to someone else.

A financial interest may create a conflict of interest whether it is large or small, and positive or negative. In other words, it does not matter if a lot of money is involved or only a little. It also does not matter if you are putting money into your pocket or taking it out. If you, your immediate family, your business, or your employer have or has a financial interest in a matter, you may not participate. The financial interest must be direct and immediate or reasonably foreseeable to create a conflict. Financial interests which are remote, speculative or not sufficiently identifiable do not create conflicts.

Example of violation: A school committee member's wife is a teacher in the town's public schools. The school committee member votes on the budget line item for teachers' salaries.

Example of violation: A member of a town affordable housing committee is also the director of a non-profit housing development corporation. The non-profit makes an application to the committee, and the member/director participates in the discussion.

Example*:* A planning board member lives next door to property where a developer plans to construct a new building. Because the planning board member owns abutting property, he is presumed to have a financial interest in the matter. He cannot participate unless he provides the State Ethics Commission with an opinion from a qualified independent appraiser that the new construction will not affect his financial interest.

In many cases, where not otherwise required to participate, a municipal employee may comply with the law by simply not participating in the particular matter in which she has a financial interest. She need not give a reason for not participating.

There are several exemptions to this section of the law. An appointed municipal employee may file a written disclosure about the financial interest with his appointing authority, and seek permission to participate notwithstanding the conflict. The appointing authority may grant written permission if she determines that the financial interest in question is not so substantial that it is likely to affect the integrity of his services to the municipality. Participating without disclosing the financial interest is a violation. Elected employees cannot use the disclosure procedure because they have no appointing authority.

Example where there is no violation: An appointed member of the town zoning advisory committee, which will review and recommend changes to the town's by-laws with regard to a commercial district, is a partner at a company that owns commercial property in the district. Prior to participating in any committee discussions, the member files a disclosure with the zoning board of appeals that appointed him to his position, and that board gives him a written determination authorizing his participation, despite his company's financial interest. There is no violation.

There is also an exemption for both appointed and elected employees where the employee's task is to address a matter of general policy and the employee's financial interest is shared with a substantial portion (generally 10% or more) of the town's population, such as, for instance, a financial interest in real estate tax rates or municipal utility rates.

Regulatory exemptions. In addition to the statutory exemptions just mentioned, the Commission has created several regulatory exemptions permitting municipal employees to participate in particular matters notwithstanding the presence of a financial interest in certain very specific situations when permitting them to do so advances a public purpose. There is an exemption permitting school committee members to participate in setting school fees that will affect their own children if they make a prior written disclosure. There is an exemption permitting town clerks to perform election-related functions even when they, or their immediate family members, are on the ballot, because clerks' election-related functions are extensively regulated by other laws. There is also an exemption permitting a person serving as a member of a municipal board pursuant to a legal requirement that the board have members with a specified affiliation to participate fully in determinations of general policy by the board, even if the entity

with which he is affiliated has a financial interest in the matter. Other exemptions are listed in the Commission's regulations, available on the Commission's website.

Example where there is no violation: A municipal Shellfish Advisory Board has been created to provide advice to the Board of Selectmen on policy issues related to shellfishing. The Advisory Board is required to have members who are currently commercial fishermen. A board member who is a commercial fisherman may participate in determinations of general policy in which he has a financial interest common to all commercial fishermen, but may not participate in determinations in which he alone has a financial interest, such as the extension of his own individual permits or leases.

(e) False claims. Presenting a false claim to your employer for a payment or benefit is prohibited, and causing someone else to do so is also prohibited. (See Sections 23(b)(4) and 26)

A municipal employee may not present a false or fraudulent claim to his employer for any payment or benefit worth $50 or more, or cause another person to do so.

Example of violation: A public works director directs his secretary to fill out time sheets to show him as present at work on days when he was skiing.

(f) Appearance of conflict. Acting in a manner that would make a reasonable person think you can be improperly influenced is prohibited. (See Section 23(b)(3))

A municipal employee may not act in a manner that would cause a reasonable person to think that she would show favor toward someone or that she can be improperly influenced. Section 23(b)(3) requires a municipal employee to consider whether her relationships and affiliations could prevent her from acting fairly and objectively when she performs her duties for a city or town. If she cannot be fair and objective because of a relationship or affiliation, she should not perform her duties. However, a municipal employee, whether elected or appointed, can avoid violating this provision by making a public disclosure of the facts. An appointed employee must make the disclosure in writing to his appointing official.

Example where there is no violation: A developer who is the cousin of the chair of the conservation commission has filed an application with the commission. A reasonable person could conclude that the chair might favor her cousin. The chair files a written disclosure with her appointing authority explaining her relationship with her cousin prior to the meeting at which the application will be considered. There is no violation of Sec. 23(b)(3).

(g) Confidential information. Improperly disclosing or personally using confidential information obtained through your job is prohibited. (See Section 23(c))

Municipal employees may not improperly disclose confidential information, or make personal use of non-public information they acquired in the course of their official duties to further their personal interests.

III. After-hours restrictions.

(a) Taking a second paid job that conflicts with the duties of your municipal job is prohibited. (See Section 23(b)(1))

A municipal employee may not accept other paid employment if the responsibilities of the second job are incompatible with his or her municipal job.

Example: A police officer may not work as a paid private security guard in the town where he serves because the demands of his private employment would conflict with his duties as a police officer.

(b) Divided loyalties. Receiving pay from anyone other than the city or town to work on a matter involving the city or town is prohibited. Acting as agent or attorney for anyone other than the city or town in a matter involving the city or town is also prohibited whether or not you are paid. (See Sec. 17)

Because cities and towns are entitled to the undivided loyalty of their employees, a municipal employee may not be paid by other people and organizations in relation to a matter if the city or town has an interest in the matter. In addition, a municipal employee may not act on behalf of other people and organizations or act as an attorney for other people and organizations in which the town has an interest. Acting as agent includes contacting the municipality in person, by phone, or in writing; acting as a liaison; providing documents to the city or town; and serving as spokesman.

A municipal employee may always represent his own personal interests, even before his own municipal agency or board, on the same terms and conditions that other similarly situated members of the public would be allowed to do so. A municipal employee may also apply for building and related permits on behalf of someone else and be paid for doing so, unless he works for the permitting agency, or an agency which regulates the permitting agency.

Example of violation: A full-time health agent submits a septic system plan that she has prepared for a private client to the town's board of health.

Example of violation: A planning board member represents a private client before the board of selectmen on a request that town meeting consider rezoning the client's property.

While many municipal employees earn their livelihood in municipal jobs, some municipal employees volunteer their time to provide services to the town or receive small stipends. Others, such as a private attorney who provides legal services to a town as needed, may serve in a position in which they may have other personal or private employment during normal working hours. In recognition of the need not to unduly restrict the ability of town volunteers and part-time employees to earn a living, the law is less restrictive for "special" municipal employees than for other municipal employees.

The status of "special" municipal employee has to be assigned to a municipal position by vote of the board of selectmen, city council, or similar body. A position is eligible to be designated as "special" if it is unpaid, or if it is part-time and the employee is allowed to have another job during normal working hours, or if the employee was not paid for working more than 800 hours

during the preceding 365 days. It is the position that is designated as "special" and not the person or persons holding the position. Selectmen in towns of 10,000 or fewer are automatically "special"; selectman in larger towns cannot be "specials."

If a municipal position has been designated as "special," an employee holding that position may be paid by others, act on behalf of others, and act as attorney for others with respect to matters before municipal boards other than his own, provided that he has not officially participated in the matter, and the matter is not now, and has not within the past year been, under his official responsibility.

Example: A school committee member who has been designated as a special municipal employee appears before the board of health on behalf of a client of his private law practice, on a matter that he has not participated in or had responsibility for as a school committee member. There is no conflict. However, he may not appear before the school committee, or the school department, on behalf of a client because he has official responsibility for any matter that comes before the school committee. This is still the case even if he has recused himself from participating in the matter in his official capacity.

Example: A member who sits as an alternate on the conservation commission is a special municipal employee. Under town by-laws, he only has official responsibility for matters assigned to him. He may represent a resident who wants to file an application with the conservation commission as long as the matter is not assigned to him and he will not participate in it.

(c) Inside track. Being paid by your city or town, directly or indirectly, under some second arrangement in addition to your job is prohibited, unless an exemption applies. (See Section 20)

A municipal employee generally may not have a financial interest in a municipal contract, including a second municipal job. A municipal employee is also generally prohibited from having an indirect financial interest in a contract that the city or town has with someone else. This provision is intended to prevent municipal employees from having an "inside track" to further financial opportunities.

Example of violation: Legal counsel to the town housing authority becomes the acting executive director of the authority, and is paid in both positions.

Example of violation: A selectman buys a surplus truck from the town DPW.

Example of violation: A full-time secretary for the board of health wants to have a second paid job working part-time for the town library. She will violate Section 20 unless she can meet the requirements of an exemption.

Example of violation: A city councilor wants to work for a non-profit that receives funding under a contract with her city. Unless she can satisfy the requirements of an exemption under Section 20, she cannot take the job.

There are numerous exemptions. A municipal employee may hold multiple unpaid or elected positions. Some exemptions apply only to special municipal employees. Specific exemptions may cover serving as an unpaid volunteer in a second town position, housing-related benefits, public safety positions, certain elected positions, small towns, and other specific situations. Please call the Ethics Commission's Legal Division for advice about a specific situation.

IV. After you leave municipal employment. (See Section 18)

(a) Forever ban. After you leave your municipal job, you may never work for anyone other than the municipality on a matter that you worked on as a municipal employee.

If you participated in a matter as a municipal employee, you cannot ever be paid to work on that same matter for anyone other than the municipality, nor may you act for someone else, whether paid or not. The purpose of this restriction is to bar former employees from selling to private interests their familiarity with the facts of particular matters that are of continuing concern to their former municipal employer. The restriction does not prohibit former municipal employees from using the expertise acquired in government service in their subsequent private activities.

Example of violation: A former school department employee works for a contractor under a contract that she helped to draft and oversee for the school department.

(b) One year cooling-off period. For one year after you leave your municipal job you may not participate in any matter over which you had official responsibility during your last two years of public service.

Former municipal employees are barred for one year after they leave municipal employment from personally appearing before any agency of the municipality in connection with matters that were under their authority in their prior municipal positions during the two years before they left.

Example: An assistant town manager negotiates a three-year contract with a company. The town manager who supervised the assistant, and had official responsibility for the contract but did not participate in negotiating it, leaves her job to work for the company to which the contract was awarded. The former manager may not call or write the town in connection with the company's work on the contract for one year after leaving the town.

A former municipal employee who participated as such in general legislation on expanded gaming and related matters may not become an officer or employee of, or acquire a financial interest in, an applicant for a gaming license, or a gaming licensee, for one year after his public employment ceases.

(c) Partners. Your partners will be subject to restrictions while you serve as a municipal employee and after your municipal service ends.

Partners of municipal employees and former municipal employees are also subject to restrictions under the conflict of interest law. If a municipal employee participated in a matter, or if he has official responsibility for a matter, then his partner may not act on behalf of anyone other than

the municipality or provide services as an attorney to anyone but the city or town in relation to the matter.

***Example**:* While serving on a city's historic district commission, an architect reviewed an application to get landmark status for a building. His partners at his architecture firm may not prepare and sign plans for the owner of the building or otherwise act on the owner's behalf in relation to the application for landmark status. In addition, because the architect has official responsibility as a commissioner for every matter that comes before the commission, his partners may not communicate with the commission or otherwise act on behalf of any client on any matter that comes before the commission during the time that the architect serves on the commission.

Example: A former town counsel joins a law firm as a partner. Because she litigated a lawsuit for the town, her new partners cannot represent any private clients in the lawsuit for one year after her job with the town ended.

* * * * *

This summary is not intended to be legal advice and, because it is a summary, it does not mention every provision of the conflict law that may apply in a particular situation. Our website, www.mass.gov/state-ethics-commission, contains further information about how the law applies in many situations. You can also contact the Commission's Legal Division via our website, by telephone, or by letter. Our contact information is at the top of this document.

Version 7: Revised November 14, 2016

Acknowledgement of Receipt of Summary of the Conflict of Interest Law for Municipal Employees

I, _____
, *(first and last name)*

an employee at ___City of Waltham_____ ,
(name of municipal dept.)

hereby acknowledge that I received a copy of the summary of the conflict of interest law

for municipal employees on _____ .
(date)

Municipal employees should complete the acknowledgment of receipt and return it to the individual who provided them with a copy of the summary. Alternatively, municipal employees may send an email acknowledging receipt of the summary to the individual who provided them with a copy of it.

Join MVCU and enjoy
The Benefits of Membership

As an employee of the City of Waltham, you and your family members are eligible to join Merrimack Valley Credit Union (MVCU)!

MVCU is a full-service financial cooperative, owned by and operated for our members. With an MVCU membership, you have access to:

- **Free checking** accounts
- **High Yield savings** accounts
- **Car loans, consumer and personal loans** and **Visa® credit cards**
- **Mortgages and home equity** loans and lines of credit
- Access to **investment and retirement** planning*
- **Insurance** products*

Take Control of Your Financial Life

Our complimentary financial education seminars give you the tools you need to take charge of your financial life. All seminars are held virtually so you can join us from work or home using your desktop, laptop or mobile device. **For a list of seminars and to register, visit rtn.org/financial-education.**

Let us know how we can help you reach your financial goals! For more information, visit **mvcu.com/rtn** or contact our Business Development team at **781-736-9995** or BizDevelopment@rtn.org**.**

RTN Federal Credit Union is now

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*Investment and Insurance products are not insured by NCUA, Not Credit Union Guaranteed, Not Credit Union Deposits or Obligations, May Lose Value.

NCUA EQUAL HOUSING LENDER MSIC NMLS #447563

It's Easy to Bank at Merrimack Valley Credit Union

Visit our **Waltham branch at 600 Main Street** and use our **24-hour ATM.**

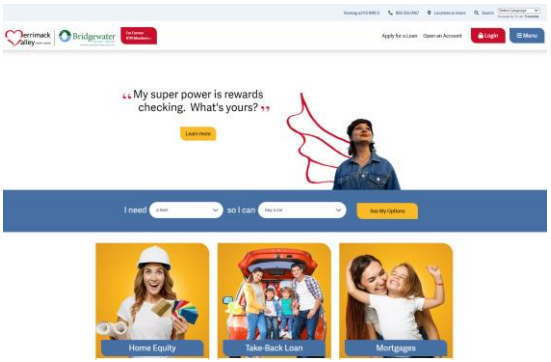
- Monday-Wednesday: 8 am to 4 pm
- Thursday: 8 am to 5 pm
- Friday: 8 am to 4 pm
- Saturday: 8:30 am to 12 pm

Branch phone number: 781-736-9965

Save time and avoid the teller line by using our **Live Video Teller** (available for members who have ATM or Debit cards issued by RTN Federal Credit Union).

A list of all MVCU branch locations and hours is available at mvcu.com.

Go to **mvcu.com** for rates, to open an account, apply for a loan or for information about the Credit Union.



Take advantage of our **high yield savings** accounts and **rewards checking** accounts.

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MSIC Equal Opportunity Lender

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MASSACHUSETTS COMMISSION AGAINST DISCRIMINATION

MCAD Guidance
PREGNANT WORKERS FAIRNESS ACT
Issued 1/23/2018

The Pregnant Workers Fairness Act ("the Act") amends the current statute prohibiting discrimination in employment, G.L. c. 151B, §4, enforced by the Massachusetts Commission Against Discrimination (MCAD). The Act, effective on April 1, 2018, expressly prohibits employment discrimination on the basis of pregnancy and pregnancy-related conditions, such as lactation or the need to express breast milk for a nursing child. It also describes employers' obligations to employees that are pregnant or lactating and the protections these employees are entitled to receive. Generally, employers may not treat employees or job applicants less favorably than other employees based on pregnancy or pregnancy-related conditions and have an obligation to accommodate pregnant workers.

Under the Act:

- Upon request for an accommodation, the employer has an obligation to communicate with the employee in order to determine a reasonable accommodation for the pregnancy or pregnancy-related condition. This is called an "interactive process," and it must be done in good faith. A reasonable accommodation is a modification or adjustment that allows the employee or job applicant to perform the essential functions of the job while pregnant or experiencing a pregnancy-related condition, without undue hardship to the employer.
- An employer must accommodate conditions related to pregnancy, including post-pregnancy conditions such as the need to express breast milk for a nursing child, unless doing so would pose an undue hardship on the employer. "Undue hardship" means that providing the accommodation would cause the employer significant difficulty or expense.
- An employer cannot require a pregnant employee to accept a particular accommodation, or to begin disability or parental leave if another reasonable accommodation would enable the employee to perform the essential functions of the job without undue hardship to the employer.
- An employer cannot refuse to hire a pregnant job applicant or applicant with a pregnancy-related condition, because of the pregnancy or the pregnancy-related condition, if an applicant is capable of performing the essential functions of the position with a reasonable accommodation.
- An employer cannot deny an employment opportunity or take adverse action against an employee because of the employee's request for or use of a reasonable accommodation for a pregnancy or pregnancy-related condition.
- An employer cannot require medical documentation about the need for an accommodation if the accommodation requested is for: (i) more frequent restroom, food or water breaks; (ii) seating; (iii) limits on lifting no more than 20 pounds; and (iv) private, non-bathroom space for expressing breast milk. An employer, may, however, request medical documentation for other accommodations.
- Employers must provide written notice to employees of the right to be free from discrimination due to pregnancy or a condition related to pregnancy, including the right to reasonable accommodations for conditions related to pregnancy, in a handbook, pamphlet, or other means of notice no later than April 1, 2018.

- Employers must also provide written notice of employees' rights under the Act: (1) to new employees at or prior to the start of employment; and (2) to an employee who notifies the employer of a pregnancy or a pregnancy-related condition, no more than 10 days after such notification.

The foregoing is a synopsis of the requirements under the Act, and both employees and employers are encouraged to read the full text of the law available on the General Court's website here:

https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter54.

If you believe you have been discriminated against on the basis of pregnancy or a pregnancy-related condition, you may file a formal complaint with the MCAD. You may also have the right to file a complaint with the Equal Employment Opportunity Commission if the conduct violates the Pregnancy Discrimination Act, which amended Title VII of the Civil Rights Act of 1964. Both agencies require the formal complaint to be filed within 300 days of the discriminatory act.

PREGNANT WORKERS FAIRNESS ACT

I. PURPOSE & SCOPE

In accordance with the Pregnant Workers Fairness Act, the City of Waltham does not discriminate on the basis of pregnancy and/or pregnancy-related conditions.

II. APPLICABILITY

This policy applies to all employees and prospective employees of the City of Waltham.

III. POLICY

The City will:

1. Upon request for an accommodation, engage with the employee in a timely, good faith and interactive process to determine an effective, reasonable accommodation to enable the employee to perform the essential functions of the employee's job or position while pregnant or experiencing a pregnancy-related condition, without undue hardship to the City;

2. Accommodate conditions related to pregnancy, including post-pregnancy conditions such as the need to express breast milk for a nursing child, unless to do so would pose an undue hardship on the employer. "Undue hardship" means that providing the accommodation would cause the City significant difficulty or expense;

3. Not require a pregnant employee to accept a particular accommodation, or begin disability or parental leave if another reasonable accommodation would enable the employee to perform the essential functions of the job without undue hardship to the City;

4. Not refuse to hire a pregnant job applicant or applicant with a pregnancy-related condition because of said pregnancy or pregnancy-related condition, if an applicant is capable of performing the essential functions of the position with a reasonable accommodation;

5. Not deny an employment opportunity or take adverse action against an employee because of the employee's request for or use of a reasonable accommodation for a pregnancy or pregnancy-related condition;

6. Not require medical documentation regarding the need for an accommodation for: - (i) more frequent restroom, food or water breaks; (ii) seating; (iii) limits on lifting no more than 20 pounds; and (iv) private, non-bathroom space for expressing breast milk. However, the City may request medical documentation for other accommodations.

7. Provide written notice to employees of the right to be free from discrimination due to pregnancy or a condition related to pregnancy upon hire and no more than 10 days after notification to the City of a pregnancy or a pregnancy related condition.

IV. COMPLAINTS OF DISCRIMINATION

If you believe you have been subjected to pregnancy and/or pregnancy-related discrimination, you have the right to file a complaint with the City. This may be done in writing or orally.

If you wish to file a complaint, you may do so by contacting the Human Resources Director at 781-314-3355, or visiting the office at 119 School Street, Waltham, MA 02451. The Director is also available to discuss any concerns you may have and to provide information to you about the policy and complaint process.

V. INVESTIGATION

When the City receives the complaint, it will promptly investigate the allegation in a fair and expeditious manner. The investigation will be conducted in such a way as to maintain confidentiality to the extent practicable under the circumstances. The investigation will include a private interview with the person filing the complaint and with witnesses. When the investigation is completed, the City, to the extent appropriate, will inform the person filing the complaint of the results of the investigation.

If it is determined that inappropriate conduct has occurred, the City will act promptly to correct the condition.

VI. RETALIATION

No retaliatory action will be taken against those persons who file complaints of discrimination or against individuals who cooperate in such investigations.

VII. DISCIPLINARY ACTION

If it is determined that inappropriate conduct has been committed by an employee, the City will take such action as is appropriate under the circumstances. Such action may range from counseling to termination from employment and may include such other forms of disciplinary action as it deems appropriate under the circumstances.

VIII. STATE AND FEDERAL REMEDIES

In addition to the above, if you believe you have been subjected to discrimination, you may file a formal complaint with either or both government agencies set forth below. Using our complaint process does not prohibit you from filing a complaint with these agencies. Each of the agencies has a short time period for filing a claim (EEOC - 300 days; MCAD - 300 days).

The United States Equal Employment Opportunity Commission ("EEOC")

(800) 669-4000

The Massachusetts Commission Against Discrimination ("MCAD")

(617) 994-6000

March 30, 2018

Massachusetts Commission Against Discrimination

PARENTAL LEAVE

An Act Relative to Parental Leave expands the current maternity leave law, G.L. c. 149, § 105D, which is enforced by the Massachusetts Commission Against Discrimination (MCAD). Currently, Massachusetts law requires employers with six or more employees to provide eight weeks of unpaid maternity leave for the purpose of giving birth or for the placement of a child under the age of 18, or under the age of 23 if the child is mentally or physically disabled, for adoption. The new law goes into effect on April 7, 2015 and expands the current leave law in the following ways:

The parental leave law is now gender neutral. Both men and women are entitled to parental leave.

If the employer agrees to provide parental leave for longer than 8 weeks, the employer must reinstate the employee at the end of the extended leave unless it clearly informs the employee in writing before the leave and before any extension of that leave, that taking longer than 8 weeks of leave shall result in the denial of reinstatement or the loss of other rights and benefits.

The law clarifies that the right to leave applies to employees who have completed an initial probationary period set by the terms of employment, but which is not greater than 3 months.

The law provides that if two employees of the same employer give birth to or adopt the same child, the two employees are entitled to an aggregate of 8 weeks of leave.

The law clarifies that an employee seeking leave must provide at least 2 weeks' notice of the anticipated date of departure and the employee's intention to return, but also permits the employee to provide notice as soon as practicable if the delay is for reasons beyond the employee's control.

The law clarifies that an employee on parental leave for the adoption of a child shall be entitled to the same benefits offered to an employee on leave for the birth of a child.

The law expands the notice requirements, mandating that employers keep a posting in a conspicuous place describing the law's requirements and the employer's policies as to parental leave.

Boston: One Ashburton Place, Room 601, Boston, MA 02108; 617-994-6000
Springfield: 436 Dwight Street, Room 220, Springfield, MA 01103; 413-739-2145
Worcester: 484 Main Street, Room 320, Worcester, MA 01608; 508-453-9630
New Bedford: 800 Purchase, Room 501, New Bedford, MA 02740; 508-990-2390
Visit our website for more resources and instructions on filing a complaint: www.mass.gov/mcad

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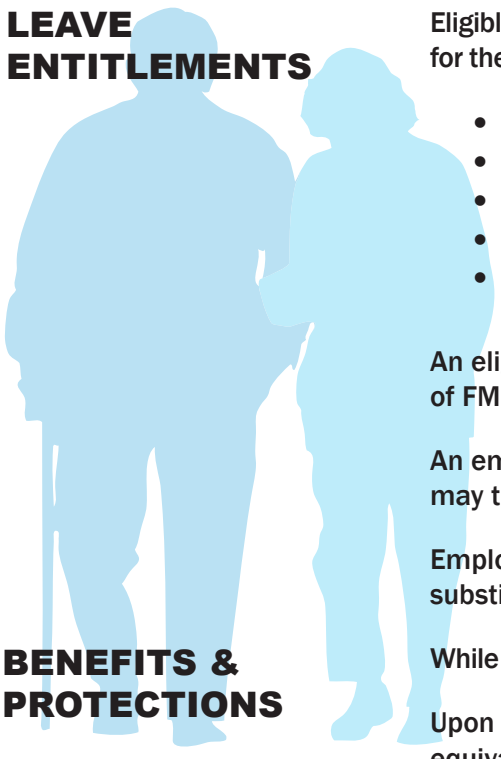
EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

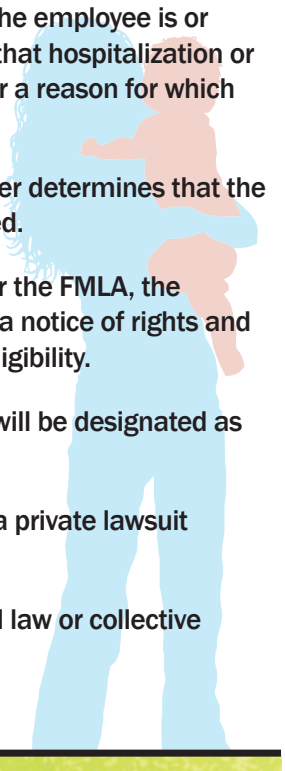
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — May 2022

Equal Employment Opportunity is

THE LAW

Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, protects applicants and employees from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy), or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected:

The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

RETALIATION

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at OFCCP-Public@dol.gov, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.

MIIA Employee Assistance Program
EAP 800-451-1834

Financial worries, aging parents, job stress, health issues - Everyone faces challenges from time to time, with your EAP you don't have to face these things alone.

This includes solutions such as:

ANYTIME, ANYWHERE

24/7/365 Telephone Support

PERSONAL ASSISTANT

Our Personal Assistant helps individuals with their "to do" list. It can be difficult to find extra time in the day to manage everyday tasks. We help lighten the load through researching the best options to benefit you and your loved ones.
SERVICES INCLUDE: Entertainment & Dining, Travel & Tourism, Household Errands, Service Professionals

MENTAL HEALTH COUNSELING

When overwhelmed with personal, work or life stressors, mental health counseling can be a lifesaver. Our licensed master's level counselors support you and your household members through difficult times providing confidential assistance 24/7.
WE HELP WITH: Family Conflict, Couples/Relationships, Substance Abuse, Anxiety, Depression

COACHING

We help employees and their household members meet their personal and professional goals by offering Life Coaching as Well as Wellness Coaching. A coach works actively to help individuals assess their current situation then develop goals to meet their stated expectations. A coach is an accountability partner and helps individuals overcome obstacles to achieve goals. **LIFE COACHES HELP WITH:** Life Transitions, Work/Life Balance, Goal Setting, Improving Relationships **WELLNESS COACHES HELP WITH:** Nutrition, Fitness, Stress Reduction & Tobacco Cessation

WORK/LIFE RESOURCES

Navigating the practical challenges of life, while handling the demands of your job can be stressful. Work/Life resources and referral services are designed to provide knowledgeable consultation and customized guidance to assist with gaining resolution to everyday hurdles.
RESOURCES INCLUDE: Adoption, Elder/Adult Care, Parenting, Child Care, Special Needs Support, Wellness

MEDICAL ADVOCACY

Medical Advocacy is a new approach to maneuvering through the healthcare system. It offers strategies to promote employee health, productivity, and well-being by serving patient populations throughout the entire lifespan and by addressing health problems in every category of disease classification and in all disease stages.
WE HELP WITH: Insurance Navigation, Doctor Referrals, Specialist Referrals, Care Transition, Discharge Planning, Adult Care Coach

LEGAL/FINANCIAL RESOURCES

Legal and Financial resources and referrals are available to connect employees with experienced, vetted professionals in their topical area of legal and financial needs. Benefit includes: Up to three 30 minute telephone consultations.
RESOURCES INCLUDE: Divorce/Custody, Bankruptcy, Budgeting, Estate Planning/Wills, Personal Injury/Malpractice, Major Life Event Planning

PRIVATE, CONFIDENTIAL, & ***FREE***

FOR YOU AND YOUR HOUSEHOLD MEMBERS

Your participation with your EAP is voluntary and strictly confidential. We do not report back to your employer about the things you discuss in private counseling conversations.

An Advisory from the Attorney General's Fair Labor Division
Concerning M.G.L. c. 149, s. 52E
Employment Leave for Victims and Family Members of Abuse

The Office of the Attorney General (AGO) issues the following Advisory regarding M.G.L. c. 149, section 52E, relative to *Employment Leave for Victims and Family Members of Abusive Behavior* (the "Law"), which was enacted as Section 10 of Chapter 260 of the Acts of 2014, entitled "An Act Relative to Domestic Violence" (the "Act"). This Advisory provides guidance with respect to the Attorney General Office's understanding of and enforcement of the Law. This Advisory is not a formal opinion. Opinions of the Attorney General are formal determinations rendered in specific circumstances not present here. See M.G.L. c. 12, §§ 3, 6, and 9. The Advisory is intended to provide guidance only and does not create any rights or remedies. See M.G.L. c. 12, §§ 3, 6, and 9.

I. Introduction

The Act was signed into law on August 8, 2014, and became effective immediately. It provides several criminal justice and service reforms in the area of domestic violence and creates new employment protections for an employee who is, or whose family member is, a victim of abusive behavior, including domestic violence, or have family members that are victims. The Law requires an employer to provide up to 15 days of paid or unpaid leave for a qualifying employee to seek or obtain medical attention, counseling, victim services or legal assistance; secure housing; obtain a protective order from a court; appear in court or before a grand jury; meet with a district attorney or other law enforcement official; or attend child custody proceedings or address other issues directly related to the abusive behavior against the employee or family member of the employee.

The AGO is responsible for enforcement and is authorized to seek injunctive relief or other equitable relief to enforce the Law.

II. Covered Individuals

This Law applies to public and private employers who employ 50 or more employees in Massachusetts. An employee is defined as an individual "who performs services for and under the control and direction of an employer for wages or other remuneration." A "family member" is defined in the statute as: (i) a parent, step-parent, child, step-child, sibling, grandparent or grandchild; (ii) a married spouse; (iii) persons in a substantive dating or engagement relationship and who reside together; (iv) persons having a child in common regardless of whether they have ever married or resided together; or (v) persons in a guardianship relationship.

III. Responsibility of Employers

A. Notification

Employers must notify each employee of his or her rights and responsibilities under the Law. There is no specified manner by which notification must take place, but examples may include: inclusion in a New Employee manual, an addendum to existing employee manuals, memos to employees, or letters or e-mails to employees. Posting notice may also be in a manner consistent with the requirements of G.L. c.151, §16 and in a conspicuous place.

B. Leave

An employer must permit an employee to take up to 15 days of paid or unpaid leave from work in any 12 month period if all the following criteria are met:

(i) the employee, or a family member of the employee, is a victim of abusive behavior as defined in the Law;
(ii) the employee is using the leave from work to: seek or obtain medical attention, counseling, victim services or legal assistance; secure housing; obtain a protective order from a court; appear in court or before a grand jury; meet with a district attorney or other law enforcement official; or attend child custody proceedings or address other issues directly related to the abusive behavior against the employee or family member of the employee; and
(iii) the employee is not the perpetrator of the abusive behavior.

The employer has sole discretion to determine whether any leave taken under the Law is paid or unpaid.

C. Confidentiality of Documents

An employer can request that an employee provide documentation evidencing that the employee or employee's family member has been a victim of abusive behavior, and that the leave is or has been taken consistent with the Law. The types of documents an employee can provide are described in Section IV of this Advisory, below.

An employer is required to keep confidential all information related to the employee's leave under the Law. This information shall not be disclosed by the employer, except to the extent that disclosure is:

(i) requested or consented to, in writing, by the employee;
(ii) ordered to be released by a court;
(iii) otherwise required by applicable federal or state law;
(iv) required in the course of an investigation authorized by law enforcement; or
(v) necessary to protect the safety of anyone employed at the workplace.

Any documentation provided to an employer under the Law may be maintained by the employer in the employee's employment record but only for as long as required for the employer to make a determination as to whether the employee is eligible for leave.

7/6/11

Massachusetts Smoke-Free Workplace Law and Municipal Buildings and Municipal Vehicles

(M.G.L. Chapter 270, section 22)

The Smoke-Free Workplace Law, M.G.L. Ch. 270, §22, mandates that enclosed workplaces with one or more employees must be smoke-free. The state law's intent is to protect workers in enclosed workplaces from secondhand smoke exposure. The full text of the law and additional information is available at www.mass.gov/dph/mtcp.

Are municipal buildings required to be smoke-free?

All city and town buildings and vehicles (such as police department, fire department, and public works) owned, leased, or operated by the Commonwealth, or any political subdivision thereof, must be smoke-free. A *Political Subdivision* in Massachusetts includes counties, cities and towns.

Does the law require a smoker to stand a specific distance away from municipal building entrances?

No, the state law does not required smokers to stand a specific distance away from a public building. However, smoke cannot migrate back into the workplace. Any smoke that migrates back into the building is considered a violation of the law. Contact your local board of health because some municipalities have local regulations, ordinances, or bylaws that require smokers to stand a minimum specific distance from public buildings.

Can someone smoke in his/her private office in a state or municipal workplace?

No, the state law specifically prohibits smoking in private offices in a building or space owned, leased, or otherwise operated by the commonwealth or by a municipal or county government.

Is smoking allowed on public school property and in school buses, even when school is not in session or students are not on the bus?

Public school buildings, facilities, grounds, and buses must be smoke-free at all times, including those times when school is not in session. For more information, a fact sheet on schools and the new smoke-free law is available at *http://www.mass.gov/dph/mtcp*.

Are municipal vehicles required to be smoke-free even if all the occupants consent to smoking?

Yes, the state law specifically prohibits smoking in all owned and leased state and municipal vehicles. However, if the municipal hires a subcontractor to perform a service using a private vehicle owned by the subcontractor, the subcontractor is allowed to smoke, except if the service is performed in municipal buildings or on municipal school property. For example, if the municipality hires a subcontractor to plow snow with his/her own equipment, the contractor cannot smoke while the service is performed on school property owned, or leased by the city or town.

Am I required to post *No Smoking* signs in areas where smoking is prohibited?

Yes, *No Smoking* signs must be posted in locations that are clearly visible to all employees and visitors while in the work place. Signage for both buildings and vehicles are available at your local board of health or at http://www.mass.gov/dph/mtcp.

Who enforces the Smoke-free Workplace Law?

The law requires that the owner, operator, manager or person in charge to ensure that employees and the general public comply with the law. The local health department/board of health can respond to complaints received and may conduct periodic inspections. A local health department/board of health, a local inspection department, a municipal government or its agent, the Massachusetts Department of Public Health and the Alcoholic Beverage Control Commission can enforce the law. The Massachusetts Department of Public Health has established a complaint and information line at 1-800-992-1895.

If you smoke and would like to quit, or know someone who wants to quit, call the Massachusetts Smokers Helpline for free helpful information at 1-800-QUIT-NOW (1-800-784-8669), or visit www.makesmokinghistory.org.

For additional information contact the Massachusetts Department of Public Health 1-800-992-1895
TDD/TTY 617-624-5992 | www.mass.gov/dph/mtcp

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

Information on Employees' Unemployment Insurance Coverage

City of Waltham — Employer name
78303620 — Employer DUA ID #

119 School Street Waltham, MA 02451 — Address

Employees of this business or organization are covered by Unemployment Insurance (UI), a program financed entirely by Massachusetts employers. No deductions are made from your salary to cover the cost of your Unemployment Insurance benefits.

If you lose your job, you may be entitled to collect Unemployment Insurance. Outlined below is the information you need in order to apply for Unemployment Insurance (UI) benefits. Before you file, your employer will give you a copy of the pamphlet: *How to Apply for Unemployment Insurance Benefits*, provided by the Massachusetts Department of Unemployment Assistance (DUA).

You must be in the United States, its territories, or Canada when filing a claim or certifying for weekly UI benefits.

There are two ways to apply for UI Benefits:

Apply by Using UI Online

UI Online is a secure, easy-to-use, self-service system. You can apply for benefits, reopen an existing claim, request weekly benefit payments, check your claim status, sign up for direct deposit, update your address, and even file an appeal online. To apply for benefits using UI Online, go to www.mass.gov/dua, and select *UI Online for Claimants,* and complete the required information to submit your application.

Apply by calling the TeleClaim Center

Unemployment Insurance services are available by telephone. You can apply for Unemployment Insurance benefits, reopen a current claim, obtain up-to-date information on the status of your claim and benefit payment, resolve problems, and sign up for direct deposit — all by telephone. To apply for benefits by telephone, call the TeleClaim Center at 1-877-626-6800 from area codes 351, 413, 508, 774, and 978; or 1-617-626-6800 from any other area code. You will be asked to enter your Social Security Number and the year you were born. You will then be connected to an agent who will take the information necessary to file your claim.

Note: During peak periods from Monday through Thursday, call scheduling may be implemented, providing priority for callers based on the last digit of their Social Security Number. This helps ensure that you and others can get through to the TeleClaim Center in a timely manner. Please check the schedule on the right before calling.

If the last digit of your Social Security Number is:	Assigned day to call Teleclaim is:
0, 1	Monday
2, 3	Tuesday
4, 5, 6	Wednesday
7, 8, 9	Thursday
Any last digit	Friday

This document contains important information. Please have it translated immediately.

В данном документе содержится важная информация. Вам необходимо срочно сделать перевод документа.

Este documento contiene información importante. Por favor, consiga una traducción inmediatamente.

Tài liệu này có chứa thông tin quan trọng. Vui lòng dịch tài liệu này ngay.

Questo documento contiene informazioni importanti. La preghiamo di tradurlo inmediatamente.

Este documento contém informações importantes. Por favor, traduzi-lo imediatamente.

Docikman sa gen enfòmasyon enpòtan. Tanpri fè yon moun tradwi l touswit.

본 문서에는 중요한 정보가 포함되어 있습니다. 본 문서를 즉시 번역하도록 하십시오.

ເອກະສານສະບັບນີ້ ບັນຈຸຂໍ້ມູນອັນສຳຄັນ. ກະລຸນາເອົາເອກະສານສະບັບນີ້ໄປແປອອກຢ່າງບໍ່ລໍຊ້າ.

ឯកសារនេះមានន្ទូវព័ត៌មានដ៏សំខាន់ ។ សូមបកប្រែវាជាបន្ទាន់ ។

Ce document contient des informations importantes. Veuillez le faire traduire au plus tôt.

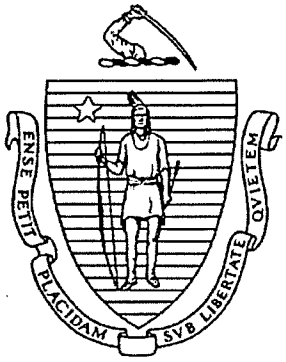
此文件含有重要信息。請立即找人翻譯。

تحتوي هذه الوثيقة على معلومات هامة. يرجى ترجمتها فورًا.

IMPORTANT: Massachusetts General Law, Chapter 151A, Section 62A requires that this notice be displayed at each site operated by an employer, in a conspicuous place, where it is accessible to all employees. It must include the name and mailing address of the employer, and the identification number assigned to the employer by the Department of Unemployment Assistance .

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.
For hearing-impaired relay services, call 711.

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111

(617) 727-4900 – www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

City of Waltham - Self Insured

NAME OF INSURANCE COMPANY

FutureComp

ADDRESS OF INSURANCE COMPANY

N/A	10/1/2019 - present
POLICY NUMBER	EFFECTIVE DATES

NAME OF INSURANCE AGENT	ADDRESS	PHONE #
City of Waltham	119 School Street, Waltham, MA 02451	781-314-3355

EMPLOYER	ADDRESS
Kristin Murphy	119 School Street, Waltham, MA 02451

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

AFC Ugent Care,	1030 Main Street, Waltham MA
NAME OF HOSPITAL	ADDRESS

TO BE POSTED BY EMPLOYER