



Children's National[®]

2019 Benefits Guide





Dear Children's National employee,

Our core values - Compassion, Commitment, and Connection – define what Children's National Medical Center believes in, and extend beyond the exceptional care we provide for patients and their families. Our values also guide the experience of our employees at work, and Children's National is dedicated to taking care of our employees.

We are committed to providing quality health care for our employees that is affordable and accessible. As part of that commitment, and as a leader in pediatric health care, we are excited to offer an attractive and comprehensive health care package. We also offer additional benefits that are designed to support many aspects of your life—from health and wellness services to income protection and retirement.

At Children's National Medical Center, our goal is to make your benefits enrollment experience as easy as possible for you and your family. This guide offers detailed information that will help you make informed decisions.

Please know that we are here to support you throughout the year and help you make the most of your benefits. If you have question about how the Children's National benefits program works, please contact a member of our benefits team at 301-830-7640 or Benefits@ChildrensNational.org.

Sincerely,

Darryl Varnado
EVP & Chief People Officer

This benefits guide provides highlights of some of your Children's National benefit plans. This guide is not intended to provide detailed descriptions of plans. Details are contained in the official Plan documents and contracts. If there is any discrepancy between those documents and contracts and this guide, the official Plan documents and contracts will govern. Children's National reserves the right to change or terminate its benefit plans at any time and for any reason. Participation in these plans is not a guarantee of continued employment.

Your benefit choices are important. This guide will help you understand your benefit choices as a Children’s National employee. Understanding your options helps you maximize the value of your Children’s National benefits package. Please take time to review this guide carefully. The more you know about your benefits, the better equipped you are to make the benefit decisions that are right for you and your family.

TABLE OF CONTENTS

YOUR BENEFITS OPTIONS AT A GLANCE.....	2
ELIGIBILITY AND ENROLLMENT.....	3 – 6
– Eligibility	
– Dependent Documentation	
– Coverage Levels	
– When To Enroll or Make Changes	
– What Happens If I Don’t Enroll	
– How to Enroll or Make Changes	
– Making Changes During the Year	
– When Benefits Begin – New Hires	
FOR YOUR HEALTH.....	7 – 28
– Making Your Enrollment Decisions	
– Medical Plan Options	
– Dental Plan Options	
– Vision Service Plan	
– Health Care Flexible Spending Account (FSA)	
– Dependent Care FSA	
FOR YOUR INCOME PROTECTION.....	29 – 32
– Life Insurance	
– Long-Term Disability	
– Short-Term Disability	
– Whole Life Insurance	
– Critical Illness	
– Accident Insurance	
– Hospital Protection	
FOR YOUR RETIREMENT.....	33 – 34
– Retirement Plan Options	
FOR YOUR LIVING RESOURCES.....	35 – 39
– Legal Insurance	
– Homeowners and Automotive Coverage	
– Pet Insurance	
– Identity Theft Protection	
– Retail Benefits Marketplace	
– Employee Assistance Program (EAP)	
– Back-up Child and Elder Care	
– Children’s National Discount on Hospital Services	
– Commuter Benefits	
– Gym Memberships	
– Educational/Tuition Assistance	
– Credit Union Membership	
FREQUENTLY ASKED QUESTIONS.....	40 – 43
LEGAL NOTICES.....	44 – 50
BENEFITS RESOURCES.....	51 – 52

Your Benefits Options at a Glance

COVERAGE	PLAN OPTIONS
Medical	Bear Advantage PPO (Aetna Choice POS II network) Bear High Deductible Health Plan with Health Savings Account (Aetna Choice POS II network) Bear Select HMO (Aetna Select) Kaiser Permanente HMO
Dental	Delta Dental Plus Premier Standard Delta Dental Plus Premier Enhanced
Vision	Vision Service Plan (VSP) Standard Vision Service Plan (VSP) Signature
Flexible Spending Accounts (FSA)	Medical FSA: \$2,650 pre-tax limit Dependent Care FSA: \$5,000 pre-tax limit
Basic Life Insurance and Accidental Death & Dismemberment (AD&D)	Coverage based on your staff level. See page 29 for details.
Supplemental Life & Dependent Life Insurance	Employees – purchase in \$10,000 increments Spouse/Same-sex Spouse – purchase in \$5,000 increments Children – Purchase \$5,000 or \$10,000 Certain maximums apply. See page 29 for details.
Long Term Disability	Coverage based on your staff level. See page 31 for details.
Retirement	401(k)
Optional Income Protection Benefits	Hospital Protection Whole Life Insurance Accident Insurance Critical Illness Plan Short Term Disability (STD)
Optional Benefits	Legal Insurance Homeowners and automotive insurance Pet Insurance Identity Theft Protection Retail Benefits Marketplace
Employee Assistance Program (EAP)	Confidential Counseling 24 hour telephone access and web resources Free educational materials
Backup Child and Elder Care	24 hour access to emergency home-based and center-based care
Children's Discount	Discount for children of employees who receive hospital services at Children's
Commuter Benefits	SmartBenefits for Metrorail and Metrobus
Fitness Centers	Global Fit discounted memberships Trinity University Fitness Center Washington Sports Clubs
Educational Assistance	Available for benefit eligible employees
Credit Union	Free checking, online banking, bill payment, and other services

Eligibility and Enrollment Information

ELIGIBILITY

You are eligible for the benefits described in this guide if you are a benefits-eligible employee regularly scheduled to work 20 or more hours per week.

You also may enroll your eligible dependents, which include your:

- Spouse (including same-sex spouse);
- Dependent children under age 26;
- Unmarried children age 26 or older who are mentally or physically disabled and rely on you for support and care

DEPENDENT DOCUMENTATION

Dependent documentation is required for newly added dependents of current employees and new hires. Documentation for dependents that are added during open enrollment must be submitted no later than October 31, 2018. The following is a list of acceptable documentation: birth certificate, adoption agreement, marriage certificate, and/or court order documents. Proof of disability is required to enroll a disabled child age 26 or older. New hires who enroll dependents must submit acceptable documentation to the Benefits Department within 30 days of hire date.

Documentation can be faxed to 301-830-7695, or emailed to Benefits@ChildrensNational.org.

COVERAGE LEVELS

When you enroll for medical, dental, and vision coverage, you must choose a coverage level. Coverage level choices may differ from benefit to benefit. For example, you can choose "Family" coverage for medical and "Employee Only" coverage for dental.

Children's National provides the following coverage levels to accommodate you and your family:

- Employee Only
- Employee + Spouse (including same-sex spouse)
- Employee + Child(ren)
- Family (employee, spouse, and children)

SPECIAL ENROLLMENT RIGHTS UNDER CHIPRA

Employees who lose eligibility for Medicaid or CHIP or become eligible for a state premium assistance subsidy have a HIPAA special enrollment period of 60 days to enroll in a Children's National medical plan.

- Enrollment must occur within 60 days of loss of coverage or becoming eligible for the premium assistance subsidy.
- Additional information is available in the Legal Notices section of this guide.

During Open Enrollment – Enroll by October 30, 2018:

- You must re-enroll in the flexible spending account (FSA) by October 31, 2018, if you want to participate in the FSA for 2019. 2018 FSA coverage does not roll-over to the next year.
- If you are enrolled in the High Deductible Health plan you must re-elect your Health Savings Account (HSA) payroll contribution by October 31, 2018. If you do not re-elect an HSA payroll contribution, you will not be able to fund your 2019 HSA account through payroll contributions.
- Minimum annual HSA payroll contribution amount of \$50 required for HSA payroll contributions.
- If you were not enrolled in a Children's National medical, dental, vision, flexible spending accounts, supplemental or dependent life or Hartford short-term disability for 2018, and want to enroll for 2019, you must enroll by October 31, 2018.

WHEN TO ENROLL OR MAKE CHANGES

As a New Hire

You must enroll in benefits within 30 days of your hire date. The benefits you elect will become effective the first day of the month following your hire date. For example: if your hire date is March 14 and you enroll within 30 days (by April 12), your benefits will be effective April 1. Your premiums will be based on the April 1 effective date of your benefits. If you choose to enroll on the 30th day, your check will reflect an increased deduction until all premiums have been satisfied.

During Open Enrollment (October)

You have one opportunity each year to make changes to your medical, dental, vision benefits and to re-enroll in the flexible spending account benefits for the next calendar year. This is the annual Open Enrollment period in October. Any medical, dental, vision and flexible spending account changes made by October 31, 2018, will be effective on January 1, 2019.

WHAT HAPPENS IF I DON'T ENROLL

- **New Hire:** You must enroll within 30 days of your hire date if you want medical, dental, vision, flexible spending accounts, short-term disability or supplemental life coverage. If you do not enroll within 30 days of your hire date you will only be enrolled in Basic Life and AD&D, and Long-Term-Disability Insurance.

Default Coverage If You Don't Enroll as a New Hire

Benefit	If you don't enroll
Medical	No coverage
Dental	No coverage
Vision	No coverage
Flexible Spending Accounts	No coverage
Basic Life and AD&D	Children's National provides coverage
Supplemental Life or Dependent Life	No coverage
Long-Term Disability	Children's National provides coverage

Default Coverage for 2019 If You Don't Make Changes During Open Enrollment

If you are currently enrolled in	If you don't make changes by 10/31/18
Medical	2018 coverage continues for 2019, Premium change
Dental	2018 coverage continues for 2019, Premium change
Vision	2018 coverage continues for 2019, Premium change
Flexible Spending Accounts	You will not have Flexible Spending Account (FSA) coverage for 2019. You must re-enroll in the FSA each year during open enrollment to continue coverage for the next year.
Supplemental Life or Dependent Life	2018 coverage continues for 2019

HOW TO ENROLL OR MAKE CHANGES

The best way to enroll or make changes is online. You can access the online enrollment system from any computer with Internet access. Here are the easy steps for enrolling online.

1. From any computer with Internet access go to Bear Resources: <https://bearhr.cnmc.org/psp/cnmhrprd>
2. Enter your username and password.
 - Your User ID is your Network ID.
 - Your password is the same password you use to log on to the network.
If you need to reset your password or you have problems logging in, please contact the HelpDesk at 202-476-4357.
3. After you have completed your enrollment or made changes, be sure to confirm your elections before exiting.

If you don't have Internet access and want to enroll

- Call the HR Call Center at 301-830-7640, Monday – Friday, from 7 am until 5 pm (EST).

MAKING CHANGES DURING THE YEAR

Outside of annual open enrollment, you may change your medical, dental, vision, flexible spending account benefits, and optional benefits **within 30 days** of experiencing one of the following qualifying life events during the year:

- Birth, legal adoption or placement for adoption
- Marriage, divorce or legal separation
- Dependent child reaches age 26
- Spouse gains or loses employment or eligibility with current employer
- Death of spouse or dependent child
- Spouse or dependent becomes Medicare/Medicaid or SCHIP eligible or ineligible
- Change in residence that changes eligibility for coverage
- Court-ordered change

To make changes during the year, call the HR Call Center at 301-830-7640 within 30 days of the event.

The following is a list of acceptable documentation: birth certificate, adoption agreement, marriage certificate, COBRA, divorce decree, death certificate, and/or court order documents. **If you fail to make changes within 30 days of the event, you will have to wait until the next open enrollment period to make changes.**

WHEN BENEFITS BEGIN – NEW HIRES

For these benefits...	Enroll	When Coverage Begins
Health Benefits <ul style="list-style-type: none"> • Medical • Dental • Vision • Flexible Spending Accounts • Health Spending Account 	<ul style="list-style-type: none"> • Within your first 30 days of hire Note: If you do not enroll within your first 30 days, your next opportunity to enroll will be during annual open enrollment, unless you have a qualifying life event such as a birth, adoption, marriage, death or divorce • Log into BearResources HR: https://bearhr.cnmc.org/psp/cnmhrprd • Call 301-830-7640 (M-F, 7:30am – 5pm) 	<ul style="list-style-type: none"> • On the first of the month following your date of hire (if you enroll within the first 30 days of your employment) • For example, if your hire date is January 15, coverage begins on February 1 • If your hire date is February 1, your coverage starts on February 1
Basic Life Insurance	<ul style="list-style-type: none"> • You are automatically enrolled • You must designate a beneficiary • To designate a beneficiary log into BearResources HR: https://bearhr.cnmc.org/psp/cnmhrprd/ or call 301-830-7640 (M-F, 7:30am – 5pm) 	<ul style="list-style-type: none"> • There is a 30-day waiting period • Your coverage will begin 30 days after your date of hire
Supplemental Life & Dependent Life Insurance	<ul style="list-style-type: none"> • Within your first 30 days of hire • Log into https://bearhr.cnmc.org/psp/cnmhrprd or • Call 301-830-7640 (M-F, 7:30am – 5pm) 	<ul style="list-style-type: none"> • There is a 30-day waiting period • Your coverage will begin 30 days after your date of hire
Long-Term Disability	<ul style="list-style-type: none"> • You are automatically enrolled 	<ul style="list-style-type: none"> • Six months after your hire date
UNUM Short-Term Disability (STD) The Hartford Short-Term Disability	<ul style="list-style-type: none"> • Apply within the first 30 days of hire. Application must be reviewed by UNUM Underwriting. If denied, you cannot enroll during the semi-annual Optional Benefits enrollment period • Call 1-877-454-3001 to enroll • Log on to https://bearhr.cnmc.org/psp/cnmhrprd 	<ul style="list-style-type: none"> • Approval is not automatic • Coverage begins based on approval by UNUM, the STD vendor • First of the month following your date of hire
Retirement <ul style="list-style-type: none"> • 401(k) 	<ul style="list-style-type: none"> • At any time • Start contributions by logging into Fidelity Net Benefits at www.netbenefits.com/atwork or • Calling 1-866-461-2662 (M-F, 7:30am – 9pm) • Complete enrollment/beneficiary designation online at www.netbenefits.com/atwork 	<ul style="list-style-type: none"> • Contributions start on the next available pay period after you enroll • 401(k) matching employer contributions begin after one year of employment if you are contributing to the 401(k)
Optional Income Protection Benefits <ul style="list-style-type: none"> • Identity Theft • Homeowners/automobile insurance • Legal Insurance • Pet Insurance 	<ul style="list-style-type: none"> • Any time by logging into https://enrollvb.com/cnmc • Use the group login and password to access the site • Login: your employee ID • Type in your date of birth • Begin the self-enrollment experience 	<ul style="list-style-type: none"> • Contributions start based on your enrollment in these plans
Optional Benefits <ul style="list-style-type: none"> • Whole Life Insurance • Accident Insurance • Critical Illness Plan • UNUM Short Term Disability (STD) • Hospital Protection 	<ul style="list-style-type: none"> • During the semi-annual Optional Benefits enrollment period with guaranteed issue (coverage approved even if you have a pre-existing condition) • May enroll in Short-Term Disability during the semi-annual Optional Benefits enrollment period if you did not apply for STD during the first 30 days of hire • You may enroll during the semi-annual Optional Benefits enrollment period 	<ul style="list-style-type: none"> • Coverage begins on the effective date established for the semi-annual enrollment period

For Your Health

MAKING YOUR ENROLLMENT DECISIONS

Everyone has different needs when it comes to benefits coverage, so Children's National offers you many choices. Ultimately, the decision is up to you. To help you make your choices, the enrollment decisions of three sample Children's National employees are shown in this guide. Each employee has a different size family, health concerns, and annual income. If you are unsure as to what is the best health benefit option for you, use ALEX. ALEX is an interactive benefits tool that can be used to compare Children's National benefit plan options, and help you select the best benefit plan option for you. Please visit the Benefits Open Enrollment page on the CNMC Intranet for more information.

MEDICAL PLAN OPTIONS

You have four medical options to select from:

- One Preferred Provider Organization (PPO) Plan administered by Aetna
 - **Bear Advantage PPO** (Aetna Choice POS II)
- One High Deductible Plan administered by Aetna
 - **Bear High Deductible Health Plan with Health Savings Account** (HSA) (Aetna Choice POS II)
- Two Health Maintenance Organization (HMO) Plans
 - **Bear Select HMO** (Aetna Select)
 - **Kaiser Permanente HMO**

TERMS YOU NEED TO KNOW

Co-pay: a fixed dollar amount that covered employees and dependents pay for medical services.

Co-insurance: a percentage of medical plan costs that covered employees and dependents pay after the deductible is met.

Deductible: a fixed dollar amount that covered employees and dependents pay out-of-pocket before the plan will begin paying benefits.

- Under the PPO plans, examples of expenses that do not count toward the deductible include preventive care, office visits, and prescription drugs.

In-network: doctors, hospitals, and other providers with whom the medical plan has an agreement to care for its members. Covered employees and dependents have lower out-of-pocket costs when using in-network providers.

Out-of-network: care received from a doctor, hospital, or other provider with whom the medical plan does not have an agreement. Covered employees and dependents pay more to use out-of-network providers.

Pre-certification: when you need authorization from your insurance provider before specific services can be covered. Often times, this includes hospital admissions (inpatient or outpatient) or surgery. Failure to obtain precertification could result in a financial penalty.

ALEX BENEFITS COUNSELOR

One-on-One Conversation

ALEX Benefits Counselor is a one-on-one conversation that teaches you how to select and use your benefits.

- ALEX uses simple, humorous language, animations, and behavioral science to engage you, the employee.
- ALEX's personalized recommendations helps you make smarter benefits decisions.
- ALEX gives you printable reference pages so you don't have to memorize everything.

Make the Best Decisions for you and your Family

ALEX helps you choose the best benefits for your unique situation.

- ALEX makes personalized benefits recommendations by learning about employee households, health care needs, and spending style.
- ALEX helps employees make better, smarter benefits decisions.
- ALEX increase employees' understanding of benefits, making it easier for you to stay healthy and productive.



HOW THE OPTIONS COMPARE

Your medical options are different in some important ways, such as how you access care, your cost when you seek care, and your bi-weekly premiums. Over the next few pages, we'll explain the differences in each type of plan.

• PREFERRED PROVIDER ORGANIZATION (PPO)

A PPO gives you the freedom to choose any provider when you need care. You pay less and there are no claim forms to file when you use a provider in the PPO's network of doctors, hospitals, and other facilities. Aetna's large network of over 22,000 PCPs and 59,000 specialists in the DC, MD, and VA area (including PA and DE) offers you many choices when it comes to finding a network provider. If you decide to go out-of-network, you are still covered but you pay more. There are limits on the amount you have to pay out of your pocket each year (out-of-pocket maximum) for all covered services. If you meet your out-of-pocket maximum during a calendar year, the plan pays 100% of your remaining eligible expenses.

NOTE: This is a summary. Please see the Schedule of Benefits and Plan Booklet for detailed information.

PPO Comparison Chart

	Bear Advantage PPO (Aetna Choice POS II)	
BENEFIT SUMMARY	In-Network	Out-of-Network*
Annual Deductible (Individual/Family)	\$300/\$600	\$600/\$1,200
Annual Out of Pocket Maximum (Individual/ Family)	\$3,500/\$7,000	\$7,000/\$14,000
Lifetime Maximum Benefit (per covered person)	None	None
PREVENTIVE CARE	In-Network	Out-of-Network*
Well Child Exams	Covered at 100%	40% after deductible
Well Adult Routine and Physical Exams @ PCP	Covered at 100%	40% after deductible
Routine Gynecological Exam	Covered at 100%	40% after deductible
Routine Cancer Screenings (Routine Mammogram and PAP smears, PSA, Colonoscopy)**	Covered at 100% Deductible waived	40% after deductible
** see Aetna Schedule of Benefits for restrictions and limits.		
PHYSICIAN SERVICES	In-Network	Out-of-Network*
Primary Care Physician Office Visit	\$25 co-pay	40% after deductible
Specialist Office Visit	\$40 co-pay	40% after deductible
Teladoc	\$15 co-pay	

* Out of network services subject to allowable benefit.

KEEPING YOU HEALTHY

Children's National and Aetna, our health plan administrator, have partnered to offer you a wealth of resources you can use to get and stay healthy, monitor your health and address health issues as they arise. Make sure to check out the specific health tools that Aetna provides to its participants.

AETNA NAVIGATOR

Manage your health via a simple, secure website. Aetna Navigator offers health and personal benefits information, self-service features, interactive tools, and much more. Visit www.Aetnanavigator.com to enroll.

PPO Comparison Chart

Bear Advantage PPO (Aetna Choice POS II)

MATERNITY CARE SERVICES	In-Network	Out-of-Network*
Initial Office Visit	Covered at 100%	40% after deductible
Prenatal Maternity	Covered at 100%	40% after deductible
Diagnostic, X-ray, and Lab, (DXLR, ultrasound, amniocentesis)	20% after deductible	40% after deductible
Outpatient Facility / Outpatient Hospital: Diagnostic, X-ray, and Lab, (DXLR, ultrasound, amniocentesis)***	20% after deductible	40% after deductible
Delivery Hospital	20% after deductible	40% after deductible
Physician Delivery Charges, (Global Maternity Package - subject to deductible & coinsurance - Includes ante partum care, urinalysis and delivery)	20% after deductible	40% after deductible

PRESCRIPTION DRUG (Administered by CVS/caremark)	In-Network	Out-of-Network*
At Pharmacy (30 day supply)		
Generic	\$15 co-pay	\$15 co-pay
Preferred Brand	\$35 co-pay	\$35 co-pay
Non-Preferred Brand	\$60 co-pay	\$60 co-pay
Specialty (4th Tier)	20% with max of \$150	NA Co-pay applies after deductible
Mail Order (90 day supply)		
Generic	\$30 co-pay	NA
Preferred Brand	\$70 co-pay	NA
Non-Preferred Brand	\$120 co-pay	NA
Mail Order covered In-Network only		

HOSPITAL/FACILITIES SERVICES	In-Network	Out-of-Network*
Emergency Room (Co-pay waived if admitted)**	\$200 co-pay plus deductible then 20%	\$200 co-pay plus deductible then 20%
Urgent Care Center (no coverage for non-urgent use in or out of network)	\$40 co-pay	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery (includes facility and provider)	20% after deductible	40% after deductible
Outpatient Hospital Expenses (hospitals and other facilities such as ambulatory surgery center, hospital outpatient dept., free-standing birthing center). Includes STR in an outpatient setting.	20% after deductible	40% after deductible
Advanced Imaging (X-rays, MRI, PET Scan, CAT Scan) at free-standing facilities and outpatient hospital facilities	20% after deductible	40% after deductible
Outpatient Lab Free-standing Facility Services provided by Quest/LabOne covered at 100% through LabCard Program	20% after deductible	40% after deductible
Outpatient Lab in outpatient hospital facility	20% after deductible	40% after deductible
Outpatient X-ray at free-standing facility or	20% after deductible	40% after deductible
Outpatient X-ray at hospital facility	20% after deductible	40% after deductible

* Out of network services subject to allowable benefit
 ** 40% Coinsurance after deductible for non-emergency use
 *** Lab is administered through Quest

PPO Comparison Chart

Bear Advantage PPO (Aetna Choice POS II)

OTHER	In-Network	Out-of-Network*
Allergy Testing and Treatment	\$25 co-pay PCP performs \$40 co-pay Specialist performs	40% after deductible
Allergy Injections**	\$25 co-pay PCP performs \$40 co-pay Specialist performs	40% after deductible
Infertility Testing (Diagnosis and treatment of underlying medical condition only)	\$25 co-pay PCP performs \$40 co-pay Specialist performs	40% after deductible
Chiropractic Care (50 visit maximum)	\$40 co-pay Deductible waived	40% after deductible
MENTAL HEALTH/ SUBSTANCE ABUSE	In-Network	Out-of-Network*
Inpatient	20% after deductible	40% after deductible
Detoxification	20% after deductible	40% after deductible
Inpatient Rehabilitation	20% after deductible	40% after deductible
Outpatient Rehabilitation	\$40 co-pay office visit/therapy 20% after deductible for all other Outpatient Settings (i.e. Partial Hospitalization, Outpatient Hospital)	40% after deductible
HOME HEALTH CARE	In-Network	Out-of-Network*
Home Health Services (120 visits maximum annually)	20% after deductible	40% after deductible
Hospice Care (Inpatient 60 day maximum)	20% after deductible	40% after deductible
DURABLE MEDICAL EQUIPMENT	In-Network	Out-of-Network*
Durable Medical Equipment	20% after deductible	40% after deductible
Vision	In-Network	Out-of-Network*
Vision Exam 1 routine exam every 12 months	\$40 Specialist co-pay deductible waived for office visit	NA
Lenses/Frames * at participating optical centers	Aetna Vision sm Discounts Program discounted eyewear	NA

* Out of network services subject to allowable benefit

** Allergy injections are covered with no co-pay if no office visit is charged.

• HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)

The Bear High Deductible Health Plan with Health Savings Account (HSA) uses a network of providers, just like the PPO plan, but the way you pay for your care and prescription drugs is different. **You must meet a deductible before the Plan pays for all other services other than preventive care.** In addition, the cost of participating in this plan (“your payroll contribution”) is significantly lower than the cost for other health coverage offered by Children’s National.

The Bear High Deductible Health Plan includes four components:

- 100% coverage for preventive care in-network
- Deductible for all other services
- Plan coverage (in- and out-of-network)
- Health Savings Account (HSA)

Let’s look at the features of the plan more closely:

Preventive Care – When you use an in-network provider, your preventive care services, such as annual physicals, well childcare, annual gynecological visits, and wellness screenings are covered in full – and no deductible applies.

Deductible – You must meet a deductible before the plan pays for all other services other than preventive care. This includes office visits, hospital stays, and prescription drugs. The deductible is significantly higher than the deductible for the PPO Option.

You can pay your deductible from your own pocket, or you can decide to use funds from your Health Savings Account (HSA).

Plan Coverage – Once you meet the deductible, the plan pays for covered services. Most services received in-network are covered at 90% and out-of-network services are covered at 70% of reasonable and customary amounts.

Health Savings Account (HSA) – If you elect the High Deductible Health Plan, you have the option of opening an HSA with your own pre-tax contributions. You can use your HSA to pay your qualified out-of-pocket health care expenses. It is a good idea to save at least an amount equal to your deductible. You must re-elect your payroll contribution for the HSA each year during open enrollment to fund your account for the upcoming year.

BENEFITS OF AN HSA

- It’s a type of savings account permitted under current tax law.
- Money you contribute to this account will be automatically deducted from your pay on a pre-tax basis each pay period.
- The money in your account can grow with investment earnings on a tax-free basis.
- Unlike the flexible spending accounts, any money you have left in the account at the end of the year can be rolled over to the next year and there is no deadline to receive reimbursement for health care expenses.
- You can roll the money over to a new health savings account or take the money with you if you leave Children’s National.
- You can use the money you have saved over time to help pay for any health care expenses whenever you need it. You won’t have to pay taxes on any of the money you withdraw if you use it for qualified health care expenses.

IS THE HIGH DEDUCTIBLE HEALTH PLAN RIGHT FOR YOU?

If you don't use health care services frequently and are looking for a plan with the lowest paycheck contribution, the High Deductible Health Plan may be the right choice for you. A high deductible health plan might result in you spending more time identifying services that are the best for you, at the most reasonable cost. Since there is a tax savings element to this plan, you will need to be sure to save all bills, explanation of benefits (EOB) forms or other documentation to support your use of your HSA funds.

If you have an ongoing medical condition or are anticipating a major medical event (such as the birth of a baby), the High Deductible Health Plan may not be your best option. The decision is yours. Log on to www.aetna.com/hsa/videopre for useful information in determining if an HSA is right for you.



LIMITED FLEXIBLE SPENDING ACCOUNT (FSA)

You may not elect the Medical FSA if you select the High Deductible Health Plan with HSA option. As an HSA participant, you are eligible to participate in a special Medical FSA known as a "Limited FSA." This is a pre-tax account that can be used in addition to your HSA to pay for eligible out-of-pocket dental and vision expenses.

HSA ENROLLMENT

You may only contribute to an HSA if you are enrolled in the High Deductible Health Plan. When you enroll, you can elect the HSA and the amount you want to contribute. Your contributions will be deducted from your pay in equal installments over the course of the year, tax-free. For 2019, the IRS maximum annual HSA contribution for an individual with Employee Only coverage is \$3,500. For Family coverage, the maximum contribution is \$7,000. In addition, catch-up contributions for participants who are age 55 or older are \$1,000.

Note: This is a summary. Please see the High Deductible Health Plan Schedule of Benefits and Plan Booklet for detailed information.

HSA DEPENDENT TREATMENT

Health Care Reform has made it possible for parents to keep dependents up to age 26 on their health plan. The IRS tax law did not change the definition of a dependent. You may have adult dependent children covered under your health plan who are not dependents for tax purposes. HSA funds can only be spent on family members who qualify as true tax dependents.

HSA AND ENROLLMENT IN MEDICARE PART A

According to IRS rules, you will not be eligible to contribute to your HSA if you or your spouse are enrolled in a regular Health Care Spending Account (HCSA) and are covered by your HSA medical plan. In addition, you will not be eligible to contribute to the HSA if you and/or your spouse are enrolled in Part A and/or Part B of Medicare.

Bear High Deductible Health Plan w/ Health Savings Account (Aetna Choice POS II)

BENEFIT SUMMARY	In-Network	Out-of-Network**
Deductible (Individual/Individual Plus One/Family)	\$1,500/\$2,700/\$3,000	\$3,000/\$5,200/\$6,000
Out of Pocket Maximum (Individual/Individual Plus One, Family)	\$3,000/\$5,200/\$6,000	\$6,000/\$10,400/\$12,000
Lifetime Maximum Benefit (per covered person)	None	
Health Savings Account (HSA) Funding 2018 Annual Contribution Maximums	Employee Funded Individual \$3,500 Family \$7,000 Catch-up (age 55 or older) \$1,000	
PREVENTIVE CARE	In-Network	Out-of-Network**
Well Child Exams	Covered at 100%	30% after deductible
Well Adult Routine and Physical Exams at PCP (1 per 12 months)	Covered at 100%	30% after deductible
Routine Gynecological Exam (1 per calendar year)	Covered at 100%	30% after deductible
Routine Cancer Screenings (Routine Mammogram and PAP smears, PSA, Colonoscopy) ** see Aetna Schedule of Benefits for restrictions and limits.	Covered at 100% Deductible waived	30% after deductible
PHYSICIAN SERVICES	In-Network	Out-of-Network**
Primary Care Physician Office Visit	10% after deductible	30% after deductible
Specialist Office Visit	10% after deductible	30% after deductible
MATERNITY CARE SERVICES	In-Network	Out-of-Network**
Initial Office Visit	10% after deductible	30% after deductible
Prenatal Maternity	Covered at 100%	30% after deductible
In office Diagnostic, X-ray, and Lab, (DXLR, ultrasound, amniocentesis)	10% after deductible	30% after deductible
Outpatient Facility / Outpatient Hospital: Diagnostic, X-ray, and Lab, (DXLR, ultrasound, amniocentesis)	10% after deductible	30% after deductible
Delivery Hospital	10% after deductible	30% after deductible
Physician Delivery Charges (Global Maternity Package – subject to deductible & coinsurance – Includes routine prenatal office visit, antepartum care, urinalysis and delivery)	10% after deductible	30% after deductible
PRESCRIPTION DRUG (Administered by CVS/Caremark)	In-Network	Out-of-Network**
At Pharmacy (30 day supply)	— Satisfy Deductible First before Copay Applies —	
Generic	\$15 co-pay	\$15 co-pay
Preferred Brand	\$35 co-pay	\$35 co-pay
Non-Preferred Brand	\$60 co-pay	\$60 co-pay
Specialty (4th Tier)	20% with max of \$150	NA
MAIL ORDER (90 day supply)	— Satisfy Deductible First before Copay Applies —	
Generic	\$30 co-pay	NA
Preferred Brand	\$70 co-pay	NA
Non-Preferred Brand	\$120 co-pay	NA
Mail Order covered In-Network only		

** Out of network services subject to allowable benefit

Bear High Deductible Health Plan w/ Health Savings Account (Aetna Choice POS II)

HOSPITAL/FACILITIES SERVICES	In-Network	Out-of-Network**
Inpatient	10% after deductible	30% after deductible
Outpatient Surgery (includes facility and provider)	10% after deductible	30% after deductible
Outpatient Hospital Expenses (hospitals and other facilities such as ambulatory surgery center, hospital outpatient dept., free-standing birthing center). Includes STR in an outpatient setting.	10% after deductible	30% after deductible
Emergency Room*	10% after deductible	10% after deductible
Urgent Care Center (no coverage for non-urgent use)	10% after deductible	30% after deductible
Advanced Imaging (X-rays, MRI, PET Scan, CAT Scan)	10% after deductible	30% after deductible
Advanced Imaging at Free-standing Facility (X-rays, MRI, PET Scan, CAT Scan)	10% after deductible	30% after deductible
Advanced Imaging at Outpatient Hospital Facility (X-rays, MRI, PET Scan, CAT Scan)	10% after deductible	30% after deductible
Outpatient Lab Free-standing Facility Services provided by Quest/LabOne covered at 100% through LabCard Program	10% after deductible	30% after deductible
Outpatient Lab in Outpatient Hospital Facility	10% after deductible	30% after deductible
Outpatient X-ray at Free-standing Facility or Outpatient Hospital Facility	10% after deductible	30% after deductible
OTHER	In-Network	Out-of-Network**
Allergy Testing and Treatment	10% after deductible	30% after deductible
Allergy Injections	Covered at 100% after deductible	Covered at 100% after deductible
Infertility Testing (Diagnosis and treatment of underlying medical condition only)	10% after deductible	30% after deductible
Chiropractic Care (50 visit maximum)	10% after deductible	30% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE	In-Network	Out-of-Network**
Inpatient	10% after deductible	30% after deductible
Detoxification	10% after deductible	30% after deductible
Inpatient Rehabilitation	10% after deductible	30% after deductible
Outpatient Rehabilitation	10% after deductible	30% after deductible
HOME HEALTH CARE	In-Network	Out-of-Network**
Home Health Services (120 visits maximum annually)	10% after deductible	30% after deductible
Hospice Care (Inpatient 60 day maximum)	10% after deductible	30% after deductible
DURABLE MEDICAL EQUIPMENT	In-Network	Out-of-Network**
Durable Medical Equipment	10% after deductible	30% after deductible
VISION	In-Network	Out-of-Network**
Vision Exam 1 routine exam every 12 months	Covered at 100%	N/A
Lenses/Frames	Aetna Vision Discounts Program discounted eyewear services at participating optical centers nationwide	N/A

* 30% coinsurance after deductible for non-emergency use (in or out-of-network)

** Out of network services subject to allowable benefit

• HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

With an HMO, all care must be received from doctors and hospitals who participate in that HMO network. If you receive care from a provider who does not belong to the HMO, it's not covered. There is one exception – emergency care. Coverage for the use of non-HMO providers is limited to a medical emergency. In addition, you must select a primary care physician within the HMO who is responsible for managing all of your care. You may select a separate primary care physician for yourself and each of your covered dependents. With an HMO, there are no claim forms to complete.

HMO coverage includes:

- No deductible
- Hospital services covered in full
- Most other services, including office visits and prescription drugs covered in full after a co-payment
- An annual out-of-pocket maximum limit on the amount you have to pay for covered services for the calendar year

HMO Benefits Comparison

	Bear Select HMO (Aetna Select)	Kaiser Permanente HMO
BENEFIT SUMMARY		
Deductible (Individual/Individual Plus One/Family)	None	None
Out of Pocket Maximum) (Individual/Individual Plus One, Family)	\$2,750/\$6,500	\$2,250/\$4,500
Lifetime Maximum Benefit (per covered person)	None	None
Coinsurance, Deductible and out-of-pocket	None	None
PREVENTIVE CARE		
Well Baby and childcare	0-36 months – No charge 3-19 years – No charge	0-60 months - No charge 5-19 years – No charge
WELL ADULT CARE at PCP		
Annual Gynecological Visit	Covered at 100%	Covered at 100%
Mammogram	Covered at 100%	Covered at 100%
Cancer Screenings	Covered at 100%	Covered at 100%
PHYSICIAN SERVICES		
Primary Care Doctor	\$20 co-pay	\$20 co-pay (co-pay waived for children under age 5)
Specialist**	\$20 co-pay	\$20 co-pay
Teladoc	\$15 co-pay	
MATERNITY CARE SERVICES		
Initial Office Visit	\$20 co-pay	\$20 co-pay
All Other Office Visits	Covered at 100%	Covered at 100%
Delivery at Hospital	\$500 per admission copay, thereafter covered at 100%	\$500 per admission copay

*This is a summary. See the HMO Schedule of Benefits and Plan Booklet for detailed information.

** Referrals/approvals are needed. Contact your Primary Care Doctor for referrals and approvals (in or out-of-network).

HMO Benefits Comparison

	Bear Select HMO (Aetna Select)	Kaiser Permanente HMO
OTHER		
Allergy Care Testing	\$20 co-pay	\$20 co-pay
Injections	Covered at 100%	\$20 co-pay
HOSPITAL/FACILITIES SERVICES		
Inpatient	\$500 co-pay	\$500 co-pay
Outpatient Surgery	\$250 co-pay	\$250 co-pay
Emergency Room (Co-pay waived if admitted)*	\$200 co-pay plus 10% coinsurance	\$200 co-pay
Urgent Care Center	\$50 co-pay	\$20 co-pay
Outpatient Lab & Lab X-ray	Covered at 100%	No charge
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment	Covered at 100%	No charge
MENTAL HEALTH (MH)/SUBSTANCE ABUSE (SA)		
Inpatient Facility Services (MH)	Covered at 100%	\$500 co-pay
Inpatient Physician Services (MH)	Covered at 100%	No charge
Outpatient Services (MH)	\$20 copay per visit; No limit	\$20 individual/\$10 group co-pay
Inpatient (SA)	No charge; No limit	\$500 co-pay
Outpatient Services (SA)	covered at 100%; No limit	\$20 individual/\$10 group co-pay
Outpatient Detoxification (SA)	\$20 co-pay per visit; No limit	\$20 individual/\$10 group co-pay to comply with MHPA
Inpatient Rehabilitation (SA)	Covered at 100%; No limit	\$500 co-pay
Outpatient Rehabilitation (SA)	\$20 co-pay per visit; No limit	\$20 individual/\$10 group co-pay to comply with MHPA
PRESCRIPTION DRUG (Administered by CVS/caremark)		
Pharmacy		
Generic	\$15 co-pay	\$15 co-pay
Preferred Brand	\$35 co-pay	\$25 co-pay
Non-Preferred Brand	\$60 co-pay	\$40 co-pay
Specialty (4th Tier)	20% with max of \$150	\$50% with max of \$100
MAIL ORDER (90 day supply)		
Generic	\$30 co-pay	\$30 co-pay
Preferred Brand	\$70 co-pay	\$50 co-pay
Non-Preferred Brand Covered In-Network Only	\$120 co-pay	\$80 co-pay
Specialty (4th Tier)		50% with max of \$200
VISION DISCOUNTS		
Lenses/Frames	Participants may access Aetna VisionSM Discounts Program, to receive discounts on eye-care products, including eyeglasses contact lenses and solution, non-prescription sunglasses, other eye-care accessories and LASIK (laser correction) surgery. Optical Centers include LensCrafters®, Target Optical®, and select Sears® Optical and Pearle Vision® locations.	15% discount for initial fitting and purchase of contact lenses at Kaiser optical center only 25% discount for frames and lenses
OUT-OF-NETWORK		
Care received by a non-participating provider (Individual/Family)	No out-of-network coverage	No out-of-network coverage

* Bear Select HMO no coverage for non-emergency use

PAYING FOR BENEFITS

The rate sheet, posted on the Benefits Open Enrollment Intranet page, shows your costs for enrolling in medical, dental and vision plans for 2019. For medical and dental, you and Children's National share the cost of coverage. Your benefits costs are deducted from your paycheck throughout the year on a pre-tax or after-tax basis, as follows:

- **Pre-tax contributions** are deducted from your paycheck for medical, dental, vision, flexible spending accounts, and the 401(k) plan before federal or Social Security taxes are deducted.
- **Federal tax law** does not permit pre-tax deductions for same-sex domestic partner medical coverage, so these are taken out after tax – after income and Social Security taxes have been deducted. For more information about pre-tax contributions, consult a tax adviser.
- **After-tax contributions** will be taken from your paycheck for supplemental life insurance and optional benefits.

DOCFIND – AETNA'S ONLINE PROVIDER DIRECTORY

Find Aetna health care professionals that accept your plan:

- You could end up paying a lot more if you use a health care professional that does not accept your plan or does not provide the highest level of coverage under your plan.
- The most current information on doctors and facilities that participate in the Aetna PPO and Aetna Select network can be found on Aetna's DocFind online directory. DocFind also shows medical schools attended, board certification status, and languages spoken by each network doctor.
- To find a network doctor: Go to www.aetna.com and click on "Find a Doctor," and then search by zip code, city, state or country.

For This Plan:

Bear Advantage PPO

Bear HDHP with HSA

Bear Select HMO

On DocFind Select:

"Aetna Open Access® Plans" –
Aetna Choice® POS II (Open Access)

"Aetna Open Access® Plans" –
Aetna Choice® POS II (Open Access)

"Aetna Standard Plans" – Aetna Select

BENEFITS OF USING AN IN-NETWORK PROVIDER

As a PPO or High Deductible Health Plan participant, the best way to manage your health care costs is to use in-network providers. With in-network providers, you pay less and there are no claim forms to file. Aetna's in-network providers can be located online using DocFind. Kaiser providers can be located on the Kaiser Permanente website.



What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving members 24/7/365 access to quality medical care through phone and video consults.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, Emergency Medicine, or Pediatrics. They average 15 years of practice experience, and are licensed in the state where the patient is physically located at the time of consult.

Do Teladoc physicians treat both adults and children?

Yes. Teladoc provides quality care for members of any age.

How do I set up my Teladoc account?

Setting up your account is a quick and easy process online. Visit the Teladoc website and click "Set Up Account". Follow the online instructions. You can also call Teladoc directly at 1-855-TELADOC to set up your account.

PRE-CERTIFICATION REQUIREMENTS

All Aetna medical options (PPO, High Deductible Health Plan, and HMO) require that all planned hospital admissions and certain procedures be approved before they are performed. This is called precertification. If you have questions about precertification, you can contact Aetna directly at 1-888-632-3862 (for PPO-based plans). If pre-certification is not obtained, there is a \$200 penalty for out-of-network inpatient confinement.

PRESCRIPTION DRUGS

Prescription drug coverage is provided automatically with all medical options. Under all Aetna medical options, prescription benefits will be managed by CVS/Caremark and must be filled at a network pharmacy or through CVS/Caremark's mail order program. For High Deductible Health Plan participants, the co-pay applies after the deductible is met. Under Kaiser Permanente, prescription drugs must be filled at a Kaiser Community pharmacy or through the Kaiser mail order program. Co-payments for prescription drugs under all medical options are based on a formulary (an approved list of drugs). There are four levels of drugs – generic, specialty, preferred brand, and non-preferred brand. Your lowest co-payment is for generic drugs and applies to a 30-day supply.

Maintenance Choice - Delivery or Pick-up

Do you take maintenance medicines regularly? These are drugs that treat conditions like arthritis, asthma, diabetes or high cholesterol. If you need this type of drug, you can get a 90-day supply. The Maintenance Choice® program lets you choose how to get 90-day supplies of your maintenance medications through mail service or at a CVS pharmacy store. Either way, you pay mail service prices.

Mail Service Pharmacy

Use the CVS/Caremark Mail Service pharmacy to fill your long-term prescriptions. Mail order is a cost-effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail.

ExtraCare Health Card

Provides you and your family with a 20 percent discount on CVS Brand health-related products, from cough and cold medication to pain and allergy relief. Your card and additional information will be mailed to your home.

MAINTENANCE MEDICINE

Once you fill a 30-day supply at any network pharmacy, you may only receive up to two refills.

See page 20 for details.

SAVE MONEY WHEN YOU BUY GENERIC

When your doctor recommends a prescription, be sure to ask if a generic is available. If your prescription is for an ongoing medical condition, use the mail order program. This way, your costs will be lower.

PRESCRIPTION DRUG TERMS TO KNOW

Formulary	An extensive list of safe and effective brand name and generic prescription drugs.
Generic	A drug that meets the same quality of standards as its brand name equivalent. Generic drugs generally have a lower co-pay.
Preferred Brand	Any drug that has been approved and/or recommended on the basis of a clinical review by the CVS/Caremark National P&T Committee. Preferred brands are usually at a lower copay than non-preferred.
Non-preferred Brand	Any brand drug that has a preferred alternative (within the same therapeutic category) listed on the CVS/Caremark standard drug list.
Specialty*	A drug that helps patients with complex conditions. Specialty drugs have the highest co-pay.

*For more information on Aetna specialty drugs, visit www.caremark.com or call 1-877-232-8129.

*For more information on Kaiser specialty drugs, visit www.kp.org/formulary.

GENERIC SUBSTITUTION

If your physician prescribes, or you request your physician to prescribe, a brand name drug when a generic is available you will pay a higher cost. In this situation, your physician generally writes the prescription using a "dispense as written" (DAW) statement. In this case, the pharmacist can't substitute a generic drug. Because the physician's note doesn't allow for a generic substitution, your costs are higher. In addition to your regular co-pay for the brand name drug, you will pay the difference between the cost of the generic and the brand name drug. Here's an example:

Brand Name Drug	Brand Name Drug Cost	Generic Name Drug	Generic Name Drug Cost	Your non-preferred brand co-pay	Difference in cost between Brand Name and Generic Drugs	Your Total Cost for selecting the brand drug
Lipitor	\$166.24	Atorvastatin	\$65.84	\$60	\$100.40*	\$160.40

*You would save \$100.40 by choosing the generic drug.

GENERIC CO-PAY INCENTIVE

If you are taking a brand medication that has a generic option available, you can get up to 6 free refills when you make the change to the generic prescription medication. You can talk to your doctor or pharmacist to see if any generic options would work for you. Here's an example:

You currently take:	Therapeutic Equivalent:	Current Non-preferred	Generic Co-pay: Brand Co-pay:	Your annual savings by switching to the preferred generic
Prevachol	Pravastatin	\$60	\$15	\$630

*When you switch from Prevachol to Pravastatin you will have \$0 co-pay for 6 months which is a savings of (Prevachol co-pay \$60 x 6 months) \$360. For the remaining 6 months your savings is the difference between the Prevachol and Pravastatin co-pays (\$60-\$15) = \$45 x 6 months = \$270. Total annual savings (\$360 + \$270) = \$630.

STEP THERAPY

Step Therapy is a process of finding the best drug treatment for your situation balancing both cost and effectiveness. Genetic Step Therapy Plans (GSTP) requires the use of cost-effective generic alternatives, within the same therapeutic class, as first line therapy before targeted brands are covered. If there are problems with this first treatment, the next step is to try an alternative or back-up drug. The medications available for treatment are updated frequently as new products and generic drugs become available. Here's an example:

Drug Class	Your prescription is written for one of the back-up drugs	In Step Therapy, you will be asked to take one of the front-line drugs
Ulcers/Acid Reflux	Dexilant and Nexium*	A documented trial of one month of each of two preferred drugs: Pantoprazole OR Lansoprazole OR Omeprazole

You can determine which category or tier your prescription drugs fall under by checking the formulary lists of the health plan websites or calling the health plans.

Example of Mail Order Savings Bear Advantage PPO

Prescription Level	Retail co-pay (30-day supply)	Retail co-pay (if purchasing 60-day supply)	Mail order co-pay (90-day supply)	Savings by using mail order or maintenance choice
Generic	\$15	\$30 (\$15 x 2 months)	\$30	\$15
Preferred Brand	\$35	\$70 (\$35 x 2 months)	\$70	\$35
Non-preferred Brand	\$60		\$120	\$60
Specialty	20% of co-pay up to \$150		Not available	Not available

RESOURCES FOR LIVING WELL

Aetna Navigator

Aetna Navigator is Aetna's online tool to help you manage your health care online, anytime and from anywhere that you have computer access. This site allows you to check for participating doctors and facilities, check claim status, order a new ID card, research hospital outcomes, price medical procedures, and more!

Aetna Mobile

Life takes you on the go. Now your health information can follow. Use your cellphone with web access to view your health plan information. The Aetna Mobile app works with iPhone® mobile digital devices and Android™ powered phones. Use a different Smartphone or mobile device? Instead of loading an app, just visit www.aetna.com and use the mobile web version of the site.

* Target drugs could change in the future

RESOURCES FOR LIVING WELL (continued)

24-Hour Nurseline

Did you know you have access to a nurse 24 hours a day and seven days a week? Nurses are available to help you with your medical needs anytime, day or night. Just call the Aetna Nurseline, 1-800-556-1555.

Disease Management Programs

If you have a chronic disease, chances are the Aetna Health Connections disease management program can help you better manage your condition. Aetna Health Connections offers support for 35 common medical conditions, such as congestive heart failure, diabetes, hypertension, asthma, COPD, and cancer. You can request program enrollment by calling 1-866-269-4500 or through the Aetna Navigator website at www.aetna.com. In certain cases, a caseworker may contact you based on your medical and pharmacy claims data. The program offers information on your condition, a review of your treatment plan, and access to a 24-hour toll-free disease management phone number.

Newtopia

Aetna offers Newtopia, a free health/weight management program, as part of your health benefit plan.

Through Newtopia you can:

1. Get a personalized plan custom-tailored to help you achieve your health goals
2. Understand how your genes play a role in nutrition and exercise by taking a simple saliva test
3. Get personality-matched with a certified personal coach who will support, motivate and inspire you throughout the program
4. Access devices and online tools to help you track your progress throughout the program including a mobile app, social platform, cellular-enabled weight scale, and fitness tracking device.

To determine if you are a candidate for the Newtopia program, please take a quick, 2-minute online risk survey at www.newtopia.com/cnhs. (Please use Internet Explorer to access the survey). Based on your results you may be invited to join the Newtopia program.

SPECIFIC RESOURCES FOR LIVING WELL

As an Aetna member, you have access to the following resources designed to help you live well:

- Aetna Navigator
- 24 Hour Nurseline
- Aetna Health Connections Disease Management
- Newtopia Weight Management
- Livongo Diabetes Management
- Discounts for healthy living programs and services
- Aetna Mobile
- And much more!

RESOURCES FOR LIVING WELL (continued)

Livongo

The Livongo Diabetes Management Program is designed to help you in your diabetes management. This free program is part of your health benefit plan.

Who can join:

You and your family members with diabetes can join at no cost if you have CNMC medical coverage.

What you get:

- **Connected Meter:** Automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.
- **Support from Coaches When You Need It:** Communicate with a coach anytime about diabetes questions on nutrition or lifestyle changes.
- **Unlimited Strips at No Cost:** When you are about to run out, we ship more supplies, right to your door.

Enroll today: welcome.livongo.com/CNMC

For more information please visit the Lifestyle Benefits page on the CNMC intranet

Discount Programs

As an Aetna member, you have access to discounts on fitness club memberships, treadmills, elliptical trainers, LASIK surgery, massage therapy, colored contact lenses, and more. Participating vision discount providers include Sears Optical, Target Optical, JC Penney Optical, LensCrafters, and Pearle Vision. Through the Aetna Natural Products and Services Program, you can save on services not typically covered by insurance, such as acupuncture, chiropractic care, dietetic counseling, and natural products such as vitamins and health supplements. You also receive a discount for participation in the Jenny Craig weight loss program. For additional information, go to www.aetna.com.

To download your free Aetna mobile app, text Apps to 44040 to download. Standard text messaging rates may apply.

RESOURCES FOR LIVING WELL (continued)

Teladoc*

Teladoc gives you 24/7/365 access to U.S. board-certified doctors who can treat many of your medical issues by phone or video. It is an added medical benefit that gives you an affordable alternative to more costly urgent care or ER visits. It does not replace your primary care physician but it gives you a convenient and less expensive option for quality urgent care. Telephone and online visits are covered under the Aetna health plans. Some conditions Teladoc can treat:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems

Teladoc copay is \$15 for both the PPO and HMO.

A \$40 consultation fee is required for the HDHP, until deductible is met, then subject to coinsurance.

You **MUST** pre-register at www.teladoc.com/MyTeladoc or call 1-855-Teladoc (835-2362), before using Teladoc.

Teladoc.com/MyTeladoc or 1-855-Teladoc (835-2362)

*Plan co-pays, deductibles, and coinsurance may apply.

Dental

DENTAL PLAN OPTIONS

You have two dental options:

- Delta Dental PPO plus Premier Standard Plan
- Delta Dental PPO plus Premier Enhanced Plan

Dental options cover:

- Preventive Care – such as exams, routine x-rays, and cleanings
- Basic Care – such as fillings, simple extractions, endodontics, and periodontics
- Major care – such as crowns, bridges, dentures, inlays, and onlays

DENTAL PROVIDERS

Access to dental providers is outlined below:

Delta Dental Plans

With both the Delta Dental PPO plus Premier Standard and Delta Dental PPO plus Premier Enhanced plans, you may see any dentist, and you save time and money when you see a Delta Dental PPO network dentist because there are no claim forms to file and your dentist accepts the negotiated rate. If you see a non-network dentist, your out-of-pocket costs will be higher. Remember, when you use in-network providers, your benefits are higher, which saves you money.

Delta Dental Online

Delta Dental offers a convenient website that you can access for your dental health care needs. Log in to www.deltadentalins.com and you can print your ID card or a claim form, find a dentist, read dental health tips, and visit the kid's dental health website.

NEED ORTHODONTIA CARE?

The Delta Dental PPO plus Premier Enhanced Plan provides a \$3,000 orthodontia benefit for adults and children.

How are Dental claims paid?

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the calendar year deductible and maximum benefit based on the date of service. After you have satisfied your deductible requirement, Delta Dental will provide payment for covered services at a percentage indicated in the Benefit Summary Chart, up to a maximum for each enrollee in a calendar year.

Orthodontic Payments

Delta Dental will pay half of its orthodontic payment up front, at the time of banding. The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment began prior to the enrollee becoming eligible with Delta Dental, any payments made by a previous dental carrier will be applied to the enrollee's lifetime orthodontic maximum.

Delta Dental on the go: www.deltadentalins.com

Go mobile for convenient services and fast easy access to your information. Find a dentist, view ID card, manage your account, check benefits, eligibility, check claims status, and claims history.

Delta Dental PPO Plan Summary

	Delta Dental PPO plus Premier Enhanced Plan	Delta Dental PPO plus Premier Standard Plan
DENTAL SUMMARY		
Deductible calendar year per individual Deductible is not applied to diagnostic and preventive services	\$25	\$50
Benefit maximum per calendar year per individual	\$2,000	\$1,500
PREVENTIVE/DIAGNOSTIC		
Oral exams, prophylaxis/cleaning, fluoride treatments, space maintainers, X-rays	Plan pays 100%	Plan pays 100%
BASIC RESTORATIVE		
Fillings, simple extractions, surgical extractions	Plan pays 80%	Plan pays 60%
Oral Surgery	Plan pays 80%	Plan pays 60%
Endodontics	Plan pays 80%	Plan pays 60%
Periodontics	Plan pays 80%	Plan pays 60%
MAJOR RESTORATIVE & PROSTHODONTICS		
Dentures, bridges, implants, inlays/onlays, and crowns	Plan pays 80%	Plan pays 60%
Implants	Plan pays 80%	Plan pays 60%
ORTHODONTICS – LIFETIME MAXIMUM BENEFIT		
Dependent Children up to age 26	Plan pays up to 50% \$3,000 maximum per person	N/A
Adults	Plan pays up to 50% \$3,000 maximum per person	N/A

* Out-of-network providers are covered at the same percentage level. However, your costs may be higher since benefits for non-network dentists are subject to usual and customary rates. You are responsible for any amount that exceeds the usual and customary amount. Adult fluoride treatments not covered.

Vision

VISION SERVICE PLAN (VSP)

With VSP, you have coverage for eye exams, prescription glasses, and contact lenses. You also are eligible for discounts on laser vision corrective surgery. The plan is built around a network of vision care providers, with higher benefits when you use providers who belong to the VSP network. If you see an out-of-network provider, you must pay out-of-pocket and file a claim for reimbursement. To locate a VSP provider, go to www.vsp.com, go to "Find a VSP Doctor," then if prompted to select doctor network, select VSP Signature or call 1-800-877-7195.

The chart below shows coverage amounts for both VSP plans. Note that benefits for eye exams and prescription lenses are covered once a year.

	VSP Standard	VSP Signature	Non-VSP Provider
Exam	\$10 co-pay (exam every 12 months)	\$10 co-pay (exam every 12 months)	\$52 allowance
Prescription Glasses			Lenses:
Single Vision	100% coverage after co-pay	100% coverage after co-pay	\$55 allowance
Lined Bifocal	100% coverage after co-pay	100% coverage after co-pay	\$75 allowance
Lined Trifocal	100% coverage after co-pay • Lenses covered in full every 12 months. • Polycarbonate lenses for dependent children Photochromic lenses/tints covered in full	100% coverage after co-pay • Lenses covered in full every 12 months. • Polycarbonate lenses for dependent children Photochromic lenses/tints covered in full	\$100 allowance
Frames	• \$150 frame allowance • 20% discount on amount over allowance	• \$150 frame allowance • 20% discount on amount over allowance	Frames: \$70 allowance
Contact Lenses	• Covered every 12 months when you choose contacts instead of glasses. • \$130 allowance applies for contacts. Contact lens exam (fitting and evaluation) no more than up to \$60	• Covered every 12 months • \$130 allowance for contacts. Contact lens exam (fitting and evaluation) no more than up to \$60	\$105 allowance
Second Pair of Prescription Glasses or Contact Lenses	Discount Only	You obtain a second pair of glasses or contact lenses for a \$10 co-pay. \$150 frame allowance and \$130 allowance for contacts	Discount Only

WHICH PLAN TO CHOOSE?

Maria's Choice

VSP Signature Premium

Maria's entire family will use her vision coverage and she knows at least one of her children will lose their eyeglasses during the year. She can obtain a second pair for only a \$10 co-pay.

Chris' Choice

VSP Standard

As a contact lens wearer, Chris needs a plan that covers his regular eye exams and keeps his lenses up to date. He doesn't mind paying the small premium for the plan.

Sarah's Choice

No vision plan

Neither Sarah nor her children have vision problems, so she does not want to pay for vision coverage when she doesn't plan to seek vision care for herself or her children.

Flexible Spending Accounts (FSA)

HOW FSAs WORK

You can use pre-tax dollars to pay for your eligible out-of-pocket costs for health and dependent care.

You have two FSA plan options:

- Medical FSA for eligible out-of-pocket health care costs.
- Dependent Care FSA for eligible dependent care expenses you have while you work.

HOW FSAs WORK

You choose whether you want to contribute to one or both FSAs.

It works like this:

1. You decide how much you want to contribute for the calendar year.
2. Your contributions are taken out of your paychecks in equal amounts before taxes each payday.
3. When you incur health care or dependent care expenses, you are reimbursed from your account.

FSAs SAVE YOU MONEY

When you use an FSA to pay for eligible expenses, it's like buying these items "on sale." With savings of up to 35% or more (depending on your tax bracket), the amount you save can really add up. Log on to www.PayFlexDirect.com to view a list of common eligible expenses and other helpful FSA tools. These tools will help you determine if you should participate in an FSA, and how much you should contribute to cover your eligible out-of-pocket medical and dependent care expenses.

FSA RULES

It is important to remember certain IRS rules apply to FSA accounts. FSA accounts are designed as "use it or lose" plans so you want to make sure to carefully estimate what your health care and dependent care expenses will be for the year.

The IRS has established rules for FSA administration:

1. For the calendar year 2019, all claims should be incurred between January 1, 2019 and March 16, 2020, (a full 14 1/2 months) to be reimbursed from your 2019 FSA account.
2. You must file all claims by May 15, 2019.
3. You forfeit any money that remains in your FSA after the deadline.
4. The two FSAs are separate – you cannot transfer money from the Medical FSA to the Dependent Care FSA or vice versa.

PayFlex CARD:

If you elect to enroll in the medical FSA account, you will automatically receive a PayFlex debit card. If you do not wish to utilize it, you do not have to activate it.

ESTIMATE YOUR COSTS CAREFULLY

How can you avoid "losing" money that remains in your FSA? The answer is simple. Just take the time to carefully estimate what you think your expenses will be for the year.

IMPORTANT REMINDER:

You must re-enroll for your FSA annually during open enrollment. You are not automatically re-enrolled for next year, even if you participated this year.

FSAs

Plan Feature	Medical FSA	Dependent Care FSA
You can contribute...	<ul style="list-style-type: none"> • Up to \$2,650 in 2018 (if you enroll in the high deductible health plan, you are not eligible for the medical FSA), but may enroll in the Limited Scope FSA. 	<ul style="list-style-type: none"> • Up to \$5,000 \$2,500 limit if married and you and your spouse file separate returns
To pay for...	<p>Health related expenses, such as:</p> <ul style="list-style-type: none"> • Out-of-pocket medical, prescription, dental or vision expenses not reimbursed by health care plans • Co-pays, deductibles, and co-insurance • Alternative medical care, such as acupuncture and holistic treatments • Smoking cessation programs • Weight loss programs for individuals diagnosed as obese • Over-the-counter medications, if prescribed by a doctor. <p>For eligible expenses see www.PayFlexDirect.com</p>	<p>Out-of-pocket expenses for dependent children under age 13 or disabled dependents of any age, such as:</p> <ul style="list-style-type: none"> • Day Care centers or in-home care provided by someone who is not your child and who you do not claim as a tax dependent • Pre-school expenses for children not yet in kindergarten or a higher grade • After school programs or summer camps for children under age 13 • Day camp expenses (not overnight)
Qualifying expenses must be...	<ul style="list-style-type: none"> • Medically necessary • Not reimbursable under the plan • Incurred by you or anyone you claim as a dependent on your tax return 	<ul style="list-style-type: none"> • Necessary so you can work and, if you are married: <ul style="list-style-type: none"> – Necessary so your spouse can work or attend school full-time, or – Necessary to care for your disabled dependent of any age • Incurred by you
Reimbursement Options	<ul style="list-style-type: none"> • Direct Deposit: you can have your reimbursements deposited into your bank account. • Debit Card: use the debit card to pay co-pays. 	<ul style="list-style-type: none"> • Submit your claim and upload receipts online. • You can receive a paper check or direct deposit to your bank account. • You can only receive reimbursement based on the balance in your account.

PAY WITH EASE

We'll show you how simple it is to pay for your eligible expenses:

- Use the PayFlex Card®, your account debit card: When you use the PayFlex debit card (if offered), your expense is automatically paid from your FSA.
- Pay yourself back: Pay for eligible expenses with cash, a check or your personal credit card. Then submit a claim to pay yourself back. For speed, have your claims payment deposited directly into your checking or savings account.
- Pay your provider: Use PayFlex's online feature (if offered) to pay your provider directly from your account.

Here are a few FSA reminders:

- Save your itemized statements and detailed receipts.
- View the IRS contribution limits and a list of common eligible expense items on the PayFlex member website.
- FSAs have a use-it-or-lose-it rule. This means you'll lose any unused funds at the end of the plan year. Check your plan details to confirm how it works.
 - The run-out period gives you extra time to submit claims to pay yourself back.
 - If your plan has a grace period,* you'll have additional days to use your funds.
 - If offered, you may be able to carry over up to \$500 in unused health care FSA dollars to the next plan year.

For Your Income Protection

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

As a Children’s National employee, you automatically receive basic life and accidental death and dismemberment insurance (AD&D) at no cost to you.

Life insurance provides benefits upon your death for any reason. AD&D insurance provides benefits if you die or suffer a covered loss as the result of an accident.

Basic life and AD&D insurance is based on your staff level, as shown in the chart to the right.

Basic Life and AD&D

Staff Level	Coverage	Maximum
Non-exempt staff Exempt management Exempt non-management staff CP&A (Not included in any other staff level) Fellows/Residents	2 x annual base salary	\$200,000*
Faculty, Directors and above	3 x annual base salary	\$600,000

* Maximum does not apply to DCNA members

EMPLOYEE PAID LIFE INSURANCE

You must enroll in these benefits within 30 days of your hire date, or during the semi-annual optional benefits open enrollment period.

Supplemental Employee Life Insurance

You can add to your basic life insurance by purchasing supplemental employee life insurance. Supplemental employee life insurance is available in \$10,000 increments up to a maximum benefit of five times your annual earnings or \$500,000, whichever is less.

Spousal Life Insurance

If you elect supplemental employee life insurance for yourself, you also may elect life insurance for your spouse/same-sex spouse. Coverage for your spouse/same-sex spouse is available in \$5,000 increments, up to a maximum benefit of \$250,000.

Dependent Life Insurance

If you elect supplemental employee life insurance for yourself, you also may elect life insurance for your dependent children under the age of 26. Coverage for your dependent children is available in amounts of \$5,000 or \$10,000.

Life Insurance Costs

The cost of supplemental life insurance for you and your spouse depends on your age. Your premiums change as your age increases.

WHAT IS EVIDENCE OF INSURABILITY?

Evidence of insurability (EOI) requirements (proof showing you/your dependents are in good health) apply to your supplemental life insurance elections. Additionally, beginning in 2018, if you are not a new hire you must complete an EOI, regardless of the amount of coverage you elect. Please note for children, coverage is guaranteed up to the elected amount with no EOI required.

THE HARTFORD, OUR BASIC LIFE AND AD&D INSURANCE VENDOR, PROVIDES THE FOLLOWING BENEFITS:

Free Will – EstateGuidance Program

This service helps you create a simple legal will quickly and conveniently online, with the support of licensed attorneys if needed. It can save you the time and expense it would take to create a will with a private attorney. Creating your will online is just a few simple steps away:

1. Access The Hartford's EstateGuidance service online at www.EstateGuidance.com/wills.
2. Sign in to the secure site by entering the access code HFD3543.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

When creating your will, EstateGuidance gives you the option to save a draft of your will for up to 6 months. Revisions to the will can be made during this period at no cost to you, provided you have not already printed or downloaded your will.

Everest Funeral Planning and Concierge Service

Your basic life insurance policy through The Hartford provides a 24/7 funeral planning assistance from Everest, the first nationwide funeral planning and concierge service. You and your family (spouse/partner and children under age 25) are entitled to:

- 24/7 Advisor Planning Assistance: assistance with funeral planning issues and help creating a personal funeral plan. A Sr. Advisor is assigned to the family to provide 24 hour assistance throughout the funeral process including communicating the Personal Funeral Plan to the funeral home, gathering pricing information and presenting it in an easy-to-read format, negotiating funeral service pricing with local funeral homes and helping the family compare prices of caskets and other products.
- Everest PriceFinder: detailed, local funeral home price comparisons available on demand via the website www.everestfuneral.com.
- Online Funeral Planning Tools that are stored in a secure data warehouse for you.

Call an Everest Advisor at 1-800-913-8318 if you have questions or log into the website www.everestfuneral.com, select **Client Log In** and select **Create Your Profile** in the **New to Everest?** box to view services available to you.

ESTATE PLANNING

Planning an estate is one of the most important steps anyone can take to help their families. Whether you have some assets to pass on or you have a modest estate, planning lets you gain greater control over your finances and personal affairs.

Estate planning is all about passing on assets, goals and dreams to the people you care about most. Make sure they know what your intentions are and where they can find the documents necessary to carry them out.

Funeral Planning

While you can't predict life's certain outcome, you can now prepare for it - and give your family the most precious gift you can possibly leave behind.

Your life insurance policy entitles you to expert advice, assistance and services from the first nationwide funeral planning and concierge service – Everest. With Everest, you plan your funeral well ahead of time, making your wishes known electronically and on paper - from the type of service you prefer to funeral home selection and various other choices.



TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

The Hartford's travel assistance and ID theft protection services provides four kinds of services for your business or vacation travels: emergency medical assistance, pre-trip information, emergency personal services, and identity theft protection while traveling. Contact Europ Assistance USA at 1-800-243-6108, and provide Travel Assistance Identification Number GLD-09012.

DISABILITY INSURANCE

Long-Term Disability Insurance

As a Children's National employee, you automatically receive long-term disability insurance at no cost to you. Long-term disability insurance may cover you if your illness or injury continues beyond three months. You are eligible to participate in long-term disability insurance after you have been continuously employed by Children's National for six months.

Benefits are based on your staff level, as shown below:

Long-Term Disability

Staff Level	% of Monthly Pay	Maximum
Non-exempt	60%	\$5,000/month
Exempt/Managers	60%	\$5,000/month
Faculty/Directors/ Fellows/Residents/ Physicians	70%	\$10,000/month

OPTIONAL INCOME PROTECTION BENEFITS

You must enroll in these benefits within 30 days of your hire date, or during the annual optional benefits open enrollment period.

UNUM Short-Term Disability Income (STD) Plan

This option replaces up to 60 percent of your income in the event of a qualified sickness or injury that keeps you from working. The maximum monthly benefit is \$5,000; you decide the amount of coverage needed. Your income benefit is payable for three months, less the 14 day waiting period. All monthly benefits are received income tax free to you. You pick the plan that best fits your needs and your budget.

As a new employee, you have two options for enrolling in STD:

- **Apply within your first 30 days of employment**
 - If you apply now and have pre-existing medical conditions, you could be denied for coverage. If your application is denied, you will not be able to apply during the annual optional enrollment period.
 - If you don't have pre-existing medical conditions and want to apply now, call 1-877-454-3001. UNUM will review the application and make a decision.
- **Enroll later**
 - If you enroll later, during the semi-annual enrollment period, your coverage will be approved whether or not you have a pre-existing medical condition.

If you have questions about the STD coverage, please call 1-877-454-3001.

FINANCIAL SECURITY WHEN YOU NEED IT MOST

Three out of every 10 employees between the ages of 25 and 65 will be out of work for three months or longer due to an accident or illness. Long-term disability insurance can help by continuing a portion of your income during the time you are disabled.

The Hartford Short-Term Disability Income (STD) Plan

Short-term disability has two options: 60% (weekly benefit amount of \$2,310) and 50% (weekly benefit amount of \$1,950). New hires can elect the 50% STD plan with no EOI; however, the 60% option would require EOI. Late entrants require EOI for any option. Increases from 50% to 60% require EOI. You must enroll within your first 30 days of employment or during annual open enrollment. Please note there is a 30-day waiting period before your benefit becomes effective.

OTHER OPTIONAL INCOME PROTECTION BENEFITS - AVAILABLE DURING OPTIONAL BENEFIT ENROLLMENT PERIOD

You may only enroll in the following Optional Income Protection Benefits during annual Optional Benefits Enrollment period. The Optional Benefits Enrollment period will be held in September. You will receive additional enrollment information prior to the annual Optional Benefits Enrollment period.

Whole Life Insurance with Long-Term Care Insurance Rider

This option provides a fixed premium and level death benefit for life, as well as cash value accumulation within the policy as long as premiums are paid by the due date. Coverage starts as low as \$10,000 of death benefit. Coverage also is available for your spouse and children under the age of 25. Benefits are paid as a lump sum and are received income tax free to you. With the long-term care insurance rider, your long-term care insurance will cover you when you are chronically ill. Being chronically ill means you are unable to perform at least two Activities of Daily Living (ADLs) – such as bathing, dressing, toileting, transferring, continence and eating – without assistance, or you suffer from severe cognitive impairment, requiring substantial supervision to protect you from threats to your health and safety. In addition, optional benefits available to your long-term coverage include:

- **Restoration Benefit** – restores 100 percent of the policy's specified amount, death benefit, and cash value.
- **Continuation Benefit** – continues benefits after all monthly amounts under that rider have been exhausted. No death benefit is payable during continuation.
- **Combination Restoration/Continuation** – combines both of the above riders' features, triples the long-term care benefit available.

Critical Illness Plan

This option pays a one-time lump sum amount, determined by the employee, if the employee is diagnosed with any of the following critical illnesses: heart attack, stroke, major organ transplant, permanent paralysis, end stage renal failure, coronary artery bypass, or cancer. A policy is not guaranteed for this coverage; you will be asked limited medical health questions to qualify.

Accident Insurance

This option provides flat dollar payments that are not offset by health insurance benefits, when an accidental injury occurs on and off the job. The base plan covers a wide range of injuries and accident-related expenses such as hospitalization, physical therapy, transportation and lodging, plus coverage for accidental death and catastrophic accidents that involve the loss of sight, hearing, speech, arms, or legs. An optional Sickness Confinement Rider can be added to the base accident plan that pays a daily hospital confinement sickness benefit (\$100 per day for employee and spouse and \$75 per day for children) for covered sicknesses if confined as an inpatient to a hospital for at least 20 hours or more. Login to the Enrollvb web link, a special self-service enrollment website. The Enrollvb global link and initial login and passwords are:

1. Go to Link: <https://enrollvb.com/cnmc>
2. Click on the 'Enroll Now'
3. Type in the last four digits of your social security number
4. Type in your date of birth
5. Begin the self-enrollment experience

If you have questions on how to navigate the self-service enrollment

Hospital Protection

AFLAC will pay the amount of \$400 per day for sickness or \$500 per day for injury for the first five (5) days of hospitalization when a covered person requires hospital confinement for a covered sickness or injury and a charge is incurred. Benefits are limited to a total benefit payment of five (5) days per calendar year, per policy.

For Your Retirement

RETIREMENT PLAN OPTIONS

Planning for retirement is important. That's why Children's National offers a retirement plan to help you save for the future and contributes to your retirement account. You may enroll in a Children's National retirement plan or change your retirement plan contributions at any time during the year by calling Fidelity at 1-888-461-2662, or logging on to Fidelity Net Benefits at www.netbenefits.com/atwork.

401(k) Retirement Plan (all staff)

Your contributions to the 401(k) retirement plan are deducted before taxes and you are immediately 100% vested. After one year of employment, Children's will begin making a 100% matching contribution (based on your contribution) up to 5% of your gross bi-weekly salary*. The money that you and Children's contributes invests over time in selected funds with Fidelity Investments. You choose your own investments. Your contributions are limited to \$18,500 in 2019 per IRS regulations. To find out more about the services Fidelity offers to plan participants, log on to www.netbenefits.com/atwork or call Fidelity at 1-888-461-2662.

RETIREMENT SPECIAL CATCH-UP RULES

If you are age 50, or turning 50 in 2019, the IRS allows you to make additional contributions (called "catch-up contributions") over and above the annual limit. For 2019, you may contribute an additional \$6,000, if eligible, after you have reached the \$18,500 annual limit.

**Must work at least 1,000 hours during the first year of employment to be eligible for the match.*

IMPORTANT NOTE

You can change your retirement plan contributions at any time during the year. Retirement plan contribution changes will take affect the next available pay period after you elect changes.

The table below shows you the key features of each retirement plan offered at Children’s National.

Retirement Benefits at a Glance

401(k) Plan

When may I enroll?	Immediately following hire date
When am I vested?	100% immediate vesting
How much may I contribute?	\$18,500 per year under 2018 IRS limit. If you are age 50 or over, the catch-up contribution limit is \$6,000
Is there a matching contribution by Children’s?	After one year of service, Children’s National matches your contributions at 100% up to 5% of your gross bi-weekly salary
Can I rollover money from another qualified retirement plan?	Yes
Can I take a loan against my retirement account?	A loan or a hardship withdrawal can be taken if you meet certain criteria

WHICH PLAN TO CHOOSE?

Maria’s Choice

401(k) Plan

Maria knows she needs to prepare for retirement, so she contributes 10% on a pre-tax basis and receives a 5% match from Children’s National because she contributes at least 5%.

Sarah’s Choice

401(k) Plan

Sarah knows she needs to be ready for retirement, so she contributes 5% on a pre-tax basis. She receives a 5% match from Children’s National because she contributes at least 5%.

For Your Living Resources

We realize you work hard at Children’s National, so you deserve benefits that help you balance work and life. The chart below summarizes the work/life benefits available to you. You are automatically eligible for these benefits. Benefits marked with a “check” are paid by Children’s National.

SUMMARY OF LIVING RESOURCES BENEFIT PROGRAMS

- Legal Insurance
- Homeowners and Automotive Coverage
- Pet Insurance
- Identity Theft Protection
- ✓ Employee Assistance Program (EAP)
- Back-up Child Care Program
- Children’s Discount on Hospital Services
- Commuter Benefits—SmartBenefits
- Global Fit Gym Membership
- Trinity Fitness Center
- Washington Sports Club
- ✓ Educational Assistance
- Credit Union Membership

OPTIONAL INSURANCE PROTECTION AND SERVICES

You may enroll in the following benefits at any time during the year.

Legal Insurance

The LegalEASE LegalGuard Family Legal Protection Plan provides you access to professional legal consultation and representation at affordable group rates. If you need legal assistance, simply call the Member Service Center and a Specialist will help you get in touch with the right Plan Attorney for your legal matter.

Homeowners and Automotive Insurance

Travelers Insurance offers special discounted rates and quality coverage for auto, home, condo and other personal insurance coverage. This option offers you a group discount with the added convenience of payroll deduction for all your auto, home/condo and renter insurance needs.

Pet Insurance

PetFirst insurance provides comprehensive coverage for accidents, illnesses and routine care. Save up to 90% on your pet's veterinary bills after a \$50 per incident deductible. Reimbursement issued within two weeks. Important features include: use any veterinarian nationwide, easy online policy management to track claims processing, quick and easy administration. You pay for this benefit via credit card or electronic debit from your bank account. For questions or to enroll call PetFirst at 866-937-7387.

Identity Theft Protection

AllClear ID provides advanced and effective identity theft protection to help safeguard your personal information. AllClear ID Protection gives you the ability to respond to threats to your identity faster by delivering secure phone alerts that enables you to take immediate action if you suspect your identity is at risk. You pay for this benefit via credit card.

Retail Benefits Marketplace

As an employee at Children's National, you are automatically a member in Retail Benefits, which provides you with access to hundreds of brand name retailers, all from one website! Find great deals and enjoy unique discounts up to 40 percent on all your purchases.

HOW TO ENROLL IN OPTIONAL INSURANCE PROTECTION AND SERVICES

To enroll or find out more about the optional income protection and services benefits listed above, including premiums and services, login to the Enrollvb web link, a special self-service enrollment website.

The Enrollvb global link and initial login and passwords are:

1. Go to Link: <https://enrollvb.com/cnmc>
2. Click on the 'Enroll Now'
3. Type in your employee ID
4. Type in your date of birth
5. Begin the self enrollment experience

If you have questions on how to navigate the self-service enrollment, please dial the customer service toll-free number 1-877-454-3001.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Aetna's EAP/Work Life Program can help you and your family members with personal or work-related issues that affect your work, health or general well-being. Through the EAP, you may take advantage of the following benefits and services:

- **24-Hour Telephone Access** — call 1-855-213-2933 24 hours a day, seven days per week.
- **Confidential Counseling** — receive up to six free counseling sessions to help with stress, depression, relationship issues, addictions, eating disorders, etc.
- **Interactive Web Resources** — use a full range of web-based tools and resources on a variety of behavioral health, work/life and other relevant topics.
- **Expert Guidance** — get guidance on childcare, adoption, elder care, health and wellness, relocation.
- **Personalized Referrals** — access a wide range of work/life services and referrals to local providers to assist you with any of your related issues.
- **Free Educational Materials** — get informational materials on child care, parenting, pregnancy, and adoption.

For more information, go to www.mylifevalues.com and enter **company user ID**: children and **password**: EAP or call **1-855-213-2933**.

BACKUP CHILD AND ELDER CARE

When regular child or elder care is not available due to an emergency, use the backup care services provided through Aetna's Backup Care Connection. When you enroll in Backup Care Connection, you receive the following benefits at a cost of \$5.00 for half-day of coverage and \$10.00 for a full day of coverage:

- Placement at local and credentialed childcare centers or qualified in-home professionals when your child is well.
- Placement at qualified in-home care when your child is mildly ill.
- Care for children of all ages.
- Backup care for older loved ones.

Aetna's Backup Care Connection offers:

- The largest network of backup care providers, including child development centers and in-home caregivers.
- National coverage so you can use the benefit no matter where you are located.
- Licensed and credentialed providers that meet the highest quality standards, such as NAEYC and other industry certifications.
- Solutions for both child and elder care.

To enroll in Aetna's Backup Care Connection, call the Aetna EAP number at **1-855-213-2933**.

CHILDREN'S NATIONAL DISCOUNT ON HOSPITAL SERVICES

Receive the very best in medical advice and care for your children and come to Children's National when your child needs medical attention. Employees receive a discount on their share of the cost of hospital services for their child(ren) at Children's National.

- **If you have insurance and services are billed to insurance** - You are eligible for a 50% discount on any remaining balance for hospital services billed to insurance for your children at Children's National (after applicable copays and deductibles have been paid). Only co-insurance, non-covered, or self-pay services are eligible for the discount. **For example:** If a bill for your child's services at the hospital is a total of \$1,000 and your insurance covers \$800, the balance you owe (as an employee) could be reduced from \$200 to \$100.

If you bring your children to Children's National, here's what you need to do:

- Identify yourself as a Children's National employee when your child receives care
 - Pay your co-pay to the physician's office
 - File the claim with your insurance company
 - After receiving your bill, call Children's National Billing Customer Service (301-572-3542 or 1-800-787-0021) to receive your discount.
 - If at the main campus, take your bill to the Billing Office, 1st floor, room 1845.
- **If you do not have insurance or services are not covered by insurance** – You are eligible for a 65% discount on services for your children at Children's National, that are not covered by insurance and will not be billed to insurance. Identify yourself as an employee at the time of service, indicate that you are uninsured or are seeking services not covered by your insurance. After receiving your bill, call 301-572-3542, Children's Billing Customer Service to receive your discount.

COMMUTER BENEFITS - SmartBenefits®

If you take public transportation to commute to and from work, the SmartBenefits® and SmarTrip® program may be for you. This commuter benefit program allows you to use pre-tax dollars to pay for your commute to work. You can elect up to \$260 a month to ride Metrorail and Metrobus and/or up to \$260 for parking at a metro station.

Additional information about the SmartTrip® card can be found at Washington Metropolitan Area Transit Authority, (WMATA's) website at www.wmata.com (click on the SmarTrip® link). To enroll, complete and submit (to the Benefits Office) the SmartBenefits enrollment form available on the intranet on the Benefits page under Forms, Policies, and Procedures.

GLOBAL FIT MEMBERSHIPS

Enroll with Global Fit and your membership includes a host of discounts and resources on living a healthier lifestyle through diet and exercise. The Global Fit membership provides discounts on local gym memberships, information on getting fit, tips on eating healthy, and much more. To enroll, contact GlobalFit at 1-800-294-1500 or www.globalfit.com.

TRINITY UNIVERSITY FITNESS CENTER

Trinity University offers discounted memberships to Children's National employees. The discounted membership fee is \$150 for a quarterly membership. The membership includes full use of all of the facilities including the basketball court, tennis courts, pool, spa, walking track, and fitness area, and majority of classes. For more information or to enroll, go to the fitness center or call 202-884-9092. For club hours and address visit <http://www.trinitydc.edu/trinity-center/contact-information/>

WASHINGTON SPORTS CLUBS (TOWN SPORTS INTERNATIONAL)

Children's National employees and their spouses, domestic partners and children age 16 or older are eligible for a discount on the one-year Passport Membership. The Passport Membership provides full membership privileges to all club locations at all times, all group exercise classes and club amenities. There are 19 locations in the D.C., Maryland and Virginia area. Payroll deduction is available. **To enroll, contact James Kameen. Call 202-332-0100 or email james.kameen@tsiclubs.com.** For club locations and hours go to www.mysportsclubs.com. There is a \$49 new enrollment fee to activate swipe card.

EDUCATIONAL ASSISTANCE

At Children's National, we encourage our employees to further their education and their careers. After six months of employment, employees are eligible to receive educational assistance. Full-time, non-union employees are eligible to receive up to \$1,200 per fiscal year (July 1 – June 30). Part-time, non-union, benefit eligible employees are eligible to receive up to \$600 per fiscal year (July –June 30). Educational assistance benefits may be used to obtain a Certification, Associates, Bachelor's, and Master's degrees. There is no benefit for PhD degrees.

To apply for educational assistance, you must submit a completed Educational Assistance application, course description(s) and tuition/fee schedule to Human Resources three weeks prior to class start date. Educational Assistance applications are on the intranet on the Benefits page under Forms, Policies, and Procedures.

SEIU members should consult the collective bargaining agreement for details on available tuition benefits.

NURSING TUITION ASSISTANCE

If you are a regular, full-time or part-time benefits-eligible RN, Children's National provides you with an additional tuition assistance program. Nursing pays for the costs of formal education courses at accredited colleges or universities. The courses must be related to your job or related to a health care career or a requirement of a health care career program. You are eligible for this tuition assistance after successfully completing six months of employment. You must submit tuition assistance applications to the Nursing Staff Development Department. Benefit is subject to availability of funds.

After you have completed your courses, you are required to remain employed by Children's National in at least a part-time capacity for a minimum of six months following completion of the course(s). Otherwise, you will be required to repay any assistance received. Also, if you fail to successfully complete a course (with a grade of "C" or better) or end employment prior to completing a course(s), you are required to repay any assistance received. You are not required to repay assistance received if you are involuntarily terminated from employment with Children's National.

CREDIT UNION MEMBERSHIP

Employees may join the SECU Credit Union (www.secumd.org) to receive free checking, online banking, bill payment and other services. Employees may obtain a SECU Credit Union application from the main Human Resources office.

TUITION ASSISTANCE BENEFITS

Full-Time RNs

Nursing will reimburse tuition in an amount not to exceed the cost of two courses per semester, or six courses per year, at the out-of-state tuition rate charged by the University of Maryland.

Part-Time RNs

Nursing will reimburse tuition not to exceed the cost of one course per semester, or three courses per year, at the out-of-state tuition rate charged by the University of Maryland.

Frequently Asked Questions

NEW HIRE ENROLLMENT

When do I need to enroll if I am a new hire?

You must enroll in medical, dental, vision, flexible spending accounts, short-term disability and supplemental life insurance within 30 days of your hire date.

How do I enroll?

Go to <https://bearresourceshr.cnmcc.org> or call the HR Call Center at 301-830-7640, Monday through Friday, from 7 am until 5 pm (EST). If you enroll online, you will need your username and password. See page 4 (How to Enroll) for detailed instructions.

When will my benefits start?

Enrollment is effective on the first day of the month, if you enroll within 30 days of your hire date. If your hire date is the first of the month, coverage begins on the same day, if you enroll within 30 days of your hire date. STD Benefits are effective based on UNUM's approval date.

What if I don't enroll in medical, dental, vision or flexible spending plans?

You will not have coverage in these plans. You will be enrolled in Children's National paid basic life, AD&D and long-term disability insurance.

When do I receive my insurance cards?

You should receive medical and dental cards within three weeks of enrolling. You can print temporary ID cards from the Aetna and Delta Dental websites. ID card is available for vision coverage but not required. You may obtain a vision ID card by calling 800-877-7195.

OPEN ENROLLMENT

Do I need to re-enroll for 2019?

No, if you want medical, dental, or vision benefits to remain the same for 2019, you do not have to re-enroll. You must re-enroll in the flexible spending accounts (FSA) each year if you wish to participate during the upcoming year. You must re-elect your HSA payroll contribution if you are in the High Deductible Health plan by October 31, 2018.

What if I don't re-enroll in the dependent care or medical flexible spending account (FSA) plans?

You will not have coverage in the FSA for 2019.

When will my open enrollment changes be effective?

If enrolling or re-enrolling during open enrollment, coverage is effective on January 1, 2019.

Up to what age can I cover my child?

You may cover dependent children on the medical, dental, and vision plans up to their 26th birthday.

When do I receive my insurance cards?

- If enrolling for the first time during open enrollment, you should receive your medical and dental cards by the end of December.
- If you did not make any changes, your current medical and dental cards are still effective.

CHANGES DURING THE YEAR

What if I want to change coverage?

The IRS permits changes to coverage only during open enrollment or within 30 days of certain qualifying events (ex. marriage, birth, adoption of a child, etc.).

I am getting married in August. Can I add my future spouse now?

- You must add your spouse to medical, dental, and vision plans within 30 days of your marriage. Call the HR Call Center, at 301-830-7640, to make this change.
- If you do not enroll your spouse within 30 days, you must wait until the next Open Enrollment.

I am having a baby. Is my newborn covered automatically?

No. You must add your newborn to your Children's National coverage within 30 days of birth. Call the HR Call Center, at 301-830-7640, to make this change.

My spouse will start a new job in June. Should we enroll now?

- If you are covered by your spouse’s plan and coverage ends when your spouse terminates employment or loses eligibility, you are eligible to enroll in Children’s National medical, dental, and vision plans within 30 days of the event.
- Coverage under the medical, dental, and vision plans is effective on the date the other coverage ends. You must provide proof of your loss of coverage.

What if I have changes during the year?

Call the HR Call Center, at 301-830-7640, Monday through Friday, from 7 am until 5 pm (EST) within 30 days of the qualified life event for assistance with your enrollment and eligibility questions or changes.

MEDICAL

How do I find an Aetna doctor?

The most current information on doctors that participate in the health plans administered by Aetna is available at www.aetna.com. Click on “Find a Doctor” and choose Aetna Choice POS II or Aetna Standard Plan under select a plan, then “OPEN ACCESS” or “HMO” under Type of Plan.

Does my family have to choose the same primary care provider (PCP)?

No, each covered family member may select his or her own PCP.

How much will I have to pay for labs if I select one of the PPO plans?

Any preventive lab work sent via LabOne to a Quest Lab will be considered in network and paid at 100% under the Aetna PPO health plans.

Who do I contact for medical claims information or problems?

Aetna Customer Service at 1-800-570-6874 or log on to www.aetna.com. Create a login and password for Aetna Navigator.

How do I find medical network providers?

You have two options:

- Go online to www.aetna.com. Click on “Find a Provider,” and select “Plan type: Aetna Choice POS II (Open Access).”
- Call Aetna Customer Service at 1-800-570-6874.

How can I access Teladoc?

Print your Teladoc ID card and set up your account at Teladoc.com/Aetna (you will need your Aetna ID card to register).

To request a consult with a Teladoc doctor, visit Teladoc.com/Aetna or call 1-855-Teladoc (835-2362).

DENTAL

Do any of the dental plans provide orthodontia benefits for adults?

The Delta Dental Plus Premier Enhanced option offers adult orthodontia benefits.

Who do I contact for dental claims information or problems?

Delta Dental Customer Service at 800-932-0783.

How do I find dental network providers?

Contact Delta Dental Customer Service or log on to www.deltadentalins.com.

VISION

Who do I contact for vision claims information or problems?

Vision Service Plan (VSP) Customer Service at 1-800-877-7195.

How do I find vision network providers?

Contact VSP Customer Service or log on to www.vsp.com.

PRESCRIPTIONS

What is the difference between a generic medication and a brand name or formulary drug?

Both generics and brand-name drugs have the same active ingredients. A generic is a less expensive duplicate version of the brand-name. It can be less expensive because the pharmaceutical company that led the research and development of the original brand-name drug charged more for that drug during the period of time it was protected from competition. This higher charge resulted in a profit for them and offset the development costs. The company producing the generic drug is charging for the cost of the ingredients and their production expenses.

How do I know the generic is effective and safe?

The Food and Drug Administration (FDA) oversees the manufacturing of the generic drug to make sure it's the same strength and purity as the brand-name drug. The FDA requires that the generic drug be exactly the same in all aspects including having the same active ingredient, same dose and strength, absorbed the same by the person taking it, as well as being safe and effective.

How can I find out how much a drug will cost?

If you are enrolled in an Aetna plan and have Internet access, you can use the "Check Drug Cost Tool" on your secure member website to find out your estimated medication costs. Log in to www.caremark.com and click on "Check Drug Costs".

From there, enter the name of your prescription and your dose. The tool will also show you how much you could save by using Aetna's mail order pharmacy. If you do not have access to the Internet, you can always call member Services at 1-877-232-8129.

How do I use the CVS/Caremark mail order pharmacy?

You can place orders or obtain mail order forms through the CVS/Caremark website at www.caremark.com.

STEP THERAPY/GENERIC CO-PAY INCENTIVE

What if I can't take the generic drug? What if I can't take the preferred drug in this new step therapy?

If your physician confirms that you are not able to take either the generic or the preferred drug, your doctor can complete a waiver form. This form will be sent to CVS/Caremark for review and approval. If your request is approved, you will pay only the co-pay for the prescription.

Will Step Therapy apply to all medications or apply only to targeted conditions or diseases?

Step Therapy only applies to targeted medications for certain conditions and diseases.

What if I already have a prescription for a maintenance medication and I'm not scheduled to go back to my physician for several months for a refill? How and when can I take advantage of Step Therapy or the Generic Co-pay Incentive?

You would have to contact your physician to obtain a new prescription for your maintenance medication prior to your refill date to take advantage of Step Therapy. You can take advantage of the Generic Co-pay Incentive if you are taking a generic maintenance medication or you are able to make the switch to a generic maintenance medication.

Can I go to any pharmacy to get my prescription filled?

Yes, even with the generic choice option and step therapy, you can go to any in-network pharmacy to get your prescription filled. As a reminder, the mandatory mail order program requires maintenance medications to be filled through mail order or picked up at a CVS pharmacy. Be sure to check the list of pharmacies in the CVS/Caremark network so that you are choosing a pharmacy where you, and Children's National, pay the least cost.

Can I use mail order with Step Therapy and the Generic Co-pay Incentive?

Yes, CVS/Caremark mail order service is a great way to fill your prescription for maintenance medications. Maintenance medications are those you take on a frequent basis to help you control a medical condition such as high blood pressure, migraine headaches or asthma.

FLEXIBLE SPENDING ACCOUNTS (FSA)

When can I use the pre-tax money I put in my Medical Spending FSA Account?

You will have access to your total annual election on the first of the month after you enroll. This means that you can spend up to your annual election at any time during the year, regardless of whether the money has yet been deducted from your paycheck.

When can I use the pre-tax money I put in my Dependent Care FSA Account?

You will have access to your dependent care account funds as they accrue throughout the year.

HEALTH SAVINGS ACCOUNT (HSA)

Can I enroll in the Health Savings Account if I am not in a Children's medical plan?

You must be in a High Deductible Health Plan (HDHP) to take advantage of HSAs.

How much can I contribute to a Health Savings Account in 2019?

- \$3,500 for employee only coverage
- \$7,000 for family coverage (or employee + spouse or employee + child(ren))
- You can elect an additional \$1,000 in catch-up contributions each year if you are 55 or older and enrolled in a High Deductible Health Plan.

What happens if I don't use all of the money in the HSA by the end of the calendar year?

- The unused balance in an HSA automatically rolls over year after year.
- You won't lose your money if you don't spend it within the year.
- You must re-elect your HSA payroll contribution each year during open enrollment to participate for the next year.

Can I use my HSA for other expenses?

Any amounts used for purposes other than to pay for "qualified medical expenses" are considered as additional income and are subject to an additional 20% tax penalty.

Examples:

- Medical expenses that are not considered "qualified medical expenses" under federal tax law (e.g., cosmetic surgery).
- Other types of health insurance unless specifically described above.
- Medicare insurance premiums.
- Expenses that are not medical or health-related.

Once you turn age 65, you can use your account to pay for non-medical expenses without the 20% tax penalty, but the amount withdrawn will be taxable as income. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a 20% penalty on the amount withdrawn.

OTHER BENEFITS

Can I change my retirement contributions at any time?

Yes, you can change your 401(k) contributions at any time during the year by calling Fidelity Net Benefits at 1-888-461-2662 or logging on to www.netbenefits.com/atwork. It may take up to two paychecks for the changes to be reflected.

When do my benefits end if my employment ends?

Benefits end on your last day of employment. You will have the opportunity to continue health benefits through COBRA.

Legal Notices

Federal law requires that you receive the information provided below each year.

IMPORTANT NOTICE TO EMPLOYEES FROM CHILDREN'S NATIONAL HEALTH SYSTEM ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Children's National Health System medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2019. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2018 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Children's National Health System and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Children's National Health System prescription drug plans you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2019. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active

employee, you may also continue your employer coverage. In this case, the Children's National Health System plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Children's National Health System coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Children's National Health System plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Children's National Health System and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Children's National Health System coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit HYPERLINK "<http://www.medicare.gov>" www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at HYPERLINK "<http://www.socialsecurity.gov>" www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Human Resources Call Center
12200 Plum Orchard Drive
301-830-7640

For More Information About Your Current Children’s National Prescription Drug Coverage, Call

- CVS/caremark at 1-877-232-8129 for the Bear Advantage PPO, Bear High Deductible Health Plan and Bear Select HMO.

NOTE: You will receive this notice each year before the next period you can join a Medicare drug plan. You also may request a copy of this notice at any time.

For Information About Your Medicare Prescription Drug Coverage Option

- Access the “Medicare & You” handbook at www.medicare.gov. This handbook contains information on Medicare plans that offer prescription drug coverage. You can also order this book by calling Medicare.
 - Visit www.medicare.gov
 - Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
 - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 10/01/2018

Name of Entity/Sender:
Children’s National Medical Center
Contact: Benefits Service Center

Address: 111 Michigan Avenue, NW,
Washington, DC 20010-2970

Phone Number: 301-830-7640

WOMEN’S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

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

(WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Plan	Deductible (in-network)	Coinsurance (in-network)
Bear PPO	\$300	20%
Bear HDHP	\$1,500	10%
Bear HMO	\$0	100%
Kaiser HMO	\$0	100%

If you would like more information on WHCRA benefits, contact the HR Call Center at 301-830-7640.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT (NMHPA OR “NEWBORNS’ ACT”) NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact the HR Call Center at 301-830-7640.

HIPAA PRIVACY NOTICE REMINDER

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Children's National Health System Employee Health and Welfare Benefit Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact the HR Call center at 301-830-7640.

Provider-Choice Rights Notice

1. The Kaiser HMO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact member services at 1-800-464-4000 or kp.org/searchdoctors.
2. For children, you may designate a pediatrician as the primary care provider.

Notice of Special Enrollment Rights for Medical/Health Plan Coverage

As you know, if you have declined enrollment in Children's National Health System's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Children's National Health System will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Children's National Health System group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

CONTINUATION OF GROUP MEDICAL, DENTAL AND VISION COVERAGE (COBRA)

If you are covered by a Children's National sponsored medical or dental plan, you have a right to choose this continuation coverage if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced such that you are no longer eligible for employee health insurance, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced such that he or she is no longer eligible for employee health insurance;
- 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 any of the following qualifying events happens:

- The parent (Children's National employee) dies;
- The parent's hours of employment are reduced such that he or she is no longer qualified for employee health insurance;
- The parent's employment ends for any reason other than his or her gross misconduct;
- The parent becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents divorce; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Under the law, the employee or family member is responsible for informing the Children's Benefits Department of a divorce or a child losing dependent status under the group health plan within 60 days of the date that coverage would be lost because of the event. Failure to notify Children's National within

60 days waives the right for continuation of coverage for all qualified beneficiaries with respect to the event.

Upon notification, Aetna will send notification of eligibility to the employee and family members.

If you do not choose continuation of coverage, your group health insurance coverage will end.

If you choose continuation of coverage, Children's National will be required to provide coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. You will be charged the full premium plus 2% administrative cost for coverage. The average required continuation coverage period is 18 months. Your continuation of coverage may be cut short for any of the following reasons:

1. Children's National no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid;
3. You become an employee covered under another group health plan;
4. You become eligible for Medicare;
5. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

You do not have to show that you are insurable to choose continuation of coverage. At the end of the 18 months; you may enroll in an individual conversion health plan.

If You Have Questions

This is only a summary. Contact Aetna at 1-800-570-6874 for COBRA premiums and payment information.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members

of your family) is more than 9.56% (for 2018) of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the HR Call Center at 301-830-7640.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Effective date: January 1, 2018

EEOC Notice (for Wellness Plans that include Disability-Related Inquiries or Medical Examinations)

NOTICE REGARDING WELLNESS PROGRAM

The Children's National wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of \$150 for completion. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the \$150.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, but Children's National does not use that information to offer you services through the wellness program. You are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Children's National Health System may use aggregate information it collects to design a program based on identified health risks in the workplace, Children's National Health System will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to

a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the Occupational Health Department in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please call the HR Call center at 301-830-7640.

2018 SAFE HARBOR NOTICE TO PARTICIPANTS IN THE CHILDREN'S NATIONAL MEDICAL CENTER AFFILIATES' 401(K) RETIREMENT PLAN

You are receiving this notice because you are a participant in the Children's National Medical Center Affiliates' 401(k) Retirement Plan (the "Plan"). This notice will describe the employer matching contributions that Children's National Medical Center makes to the Plan. To meet certain "safe harbor" nondiscrimination requirements in the Internal Revenue Code, the Plan is required to provide you with this notice. It is also required to include specific language in the notice so that you are notified of the plan options and your rights.

Your Contributions to the Plan

You are permitted to defer a portion of your compensation to the Plan. The maximum amount that you may defer in 2018 is \$18,500. If you are age 50 or older or turn age 50 during 2018, you are permitted to make an additional "catch-up" contribution of up to \$6,000. Your contributions to the Plan are taken out of your pay and are not subject to federal income tax at the time it is deducted from your pay. Instead, these pre-tax amounts are contributed to your Plan account and can grow over time with earnings. Your account will be subject to federal income tax only when you or your beneficiary receives benefits from the Plan. This helpful tax rule is a reason to save for retirement through Plan contributions. Plus, your contributions are matched by Children's National!

For the purposes of the Plan, "Compensation" for deferrals means your base salary, overtime, and shift differentials but excludes any bonuses and incentive payments. Your compensation, or W-2 income, also includes amounts that you contribute to the 401(k) Plan, maintained by Children's National and any amounts that you contribute to a Section 125 cafeteria plan, a pre-tax commuter program or a 457(b) plan maintained by Children's National.

To begin contributing to the Plan or change the amount of your contributions, contact Fidelity Investments at 1-888-461-2662, or log on to www.netbenefits.com/atwork. Your election or change will generally be effective on the first available payroll date after you submit the election.

How the Employer Match Works

Besides depositing the amounts you have taken out of your pay, Children's National makes matching contributions to your Plan account. Children's National matching contribution will depend on the amount you contribute out of your pay each pay period.

Children's National will match your biweekly contribution to the Plan in an amount equal to one dollar for each dollar (\$1.00 for \$1.00) you contribute up to the first 5% of your Compensation. In the matching plan, Compensation does not include bonuses. Thus, you get the full Employer matching contribution by contributing at least 5% of your base salary, overtime and shift differentials each biweekly pay period. Your matching contribution is 100% vested, meaning that you do not lose your matching contributions no matter when you leave employment with Children's National.

Other Contributions

Children's National may, if it chooses to, make an additional contribution to the Plan, but it is not required to do so. To receive any additional contribution, you must be employed by Children's National on the last day of the plan year (December 31, 2018) or

have terminated employment during the year because of death, disability, or retirement at the normal retirement age (age 65). If Children's National makes a discretionary contribution, it will be allocated among participants based on Compensation (not including bonuses). Discretionary contributions, if any, are 100% vested. Eligible employees may also make rollover contributions to the Plan. For more information about other contributions, please see the Summary Plan Description.

When You Can Access Your Plan Funds

In general, amounts accumulated and vested in the Plan are available if you terminate employment with Children's National. Amounts will also be available to your beneficiaries if you die while employed at Children's National. There are some exceptions when you may receive distributions from the Plan while you are actively employed:

- You may receive all or a portion of the monies you contributed if you have a financial hardship. Hardship distributions may not be taken from earnings on your elective contributions or from any employer contributions. Hardship distributions must be for a specified reason – for qualifying medical expenses, costs of purchasing your principal residence (or preventing eviction from or foreclosure on your principal residence, or repairing qualifying damages to your principal residence), qualifying post-secondary education expenses, or qualifying burial or funeral expenses. Before you can take a hardship distribution, you must have taken other permitted withdrawals and loans from qualifying Employer plans. If you take a hardship distribution, you may not contribute to the Plan for 6 months.
- You may be able to take a loan from your account in the Plan. You may have only one loan outstanding from this Plan and the Children's National Medical Center Affiliates' 403(b) Retirement Plan at any time. You may not take out more than one loan in any 12 month period from both Plans.
- You may be able to take a withdrawal at age 59 1/2, if you become disabled or if you are called to active duty for a period greater than 179 days ("qualified reservist distribution").

Note that there is an extra 10% tax on certain distributions you receive before age 59 1/2 (including hardship distributions). For more information about withdrawals and loans, see the Plan's Summary Plan Description. You can also learn more about the extra 10% tax and the distributions to which it applies in IRS Publication 575, Pension and Annuity Income.

How to Request More Information or Make Election Changes

To change your contributions and investments under the Plan: Call Fidelity Investments at 1-888-461-2662 or visit www.netbenefits.com/atwork.

You may also write to the Plan Administrator, Children's National Medical Center Affiliates' 401(k) Retirement Plan, 111 Michigan Ave, NW, Washington, DC 20010, if you would like to request a copy of the Summary Plan Description.

BENEFITS RESOURCES

WHO TO CONTACT	PURPOSE
HR Call Center 301-830-7640, 7:30am - 5pm, Monday - Friday https://bearresourceshr.cnmc.org Benefits@ChildrensNational.org	<ul style="list-style-type: none"> • To enroll in benefits or add/drop dependents from coverage • To report a life event (marriage/divorce, birth/adoption, spouse gains/losses coverage or court-ordered) • To reset your password or login call the HELPDESK at 202-476-4357
Bear Advantage PPO Bear High Deductible Health Plan with HSA Bear Select HMO 1-800-570-6874 www.aetna.com	<ul style="list-style-type: none"> • For ID cards, plan benefits/services, claims payments, and prescription questions • To find an in-network provider • For Pre-certification 1-888-632-3862 • Health Savings Account: 1-800-594-9371, option 2
Kaiser Permanente HMO 301-468-6000 or 1-800-777-7902 www.kp.org	<ul style="list-style-type: none"> • For ID cards, plan benefits/services, claims payments, and prescription questions
CVS/caremark 1-877-232-8129 www.caremark.com	<ul style="list-style-type: none"> • Prescription benefit questions • Retail network pharmacy questions • Mail Service pharmacy • Maintenance Choice
Flexible Spending Accounts 1-888-879-9925 www.payflexdirect.com	<ul style="list-style-type: none"> • For Dependent care and Medical FSA reimbursements and services • For eligible expenses and other plan questions
Delta Dental PPO 1-800-932-0783 www.deltadentalins.com	<ul style="list-style-type: none"> • For ID cards, plan benefits/services, claims and provider questions • To find a Delta Dental provider
Vision Service Plan (VSP) 1-800-877-7195 www.vsp.com	<ul style="list-style-type: none"> • For Vision benefit plan questions • To find a VSP provider • To file out-of-network reimbursements
Employee Assistance Plan Living Resources Back-Up Care 1-888-238-6232 1-800-873-1322 TDD/TTY www.mylifevalues.com (user ID: children, password: EAP)	<ul style="list-style-type: none"> • For employee assistance benefits, work-life benefits or to make back up care arrangements
Fidelity Investments 1-888-461-2662 www.netbenefits.com/atwork	<ul style="list-style-type: none"> • 401(k) retirement information • Rollovers • Loans and withdrawals

>> *continued on next page*

BENEFITS RESOURCES

WHO TO CONTACT	PURPOSE
The Hartford 1-800-752-9713 www.thehartford.com	<ul style="list-style-type: none">• For Group Life, AD&D, Supplemental Life claims• For Group Long-Term Disability claims
The Hartford/Leave Management 1-888-899-1915 www.thehartford.com	<ul style="list-style-type: none">• For FMLA leave• For Short-Term disability claims.• ADA
UNUM/Willard-Block 1-877-454-3001 www.enrollvb.com	<ul style="list-style-type: none">• To enroll or make changes to Computer Purchase, Pet Insurance, Homeowners & Automotive insurance, Legal Insurance and Identity Theft• For deduction and benefit questions
Aflac Customer Service 877-384-5939 www.aflac.com/childrensnational	<ul style="list-style-type: none">• Individual Hospital Confinement Indemnity Insurance
Global Fit 1-800-294-1500 www.globalfit.com/cnmc	<ul style="list-style-type: none">• To receive fitness center discount information• To join a fitness center
Trinity Fitness Center 202-884-9092 www.trinitydc.edu/trinity-center/facilities.html	<ul style="list-style-type: none">• To join the fitness center
Washington Sports Clubs 202-332-0100 james.kameen@tsiclubs.com www.mysportsclubs.com	<ul style="list-style-type: none">• To receive fitness center membership information• To join a fitness center



Children's National.

111 Michigan Ave NW
Washington, DC 20010-2970

www.ChildrensNational.org

This Guide offers details of your benefit options with Children's – details you can use to make informed benefit decisions. We hope you value and appreciate these benefits and use them when you need to. For more complete information on any one of these benefit plans, please refer to the Summary Plan Descriptions (SPD) located on the Children's National Intranet.

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Children's National does not discriminate on any grounds prohibited by applicable law, including race, color, religion, age, sex, national origin or ancestry, sexual orientation, marital status, status as a disabled or Vietnam veteran or as a qualified disabled individual.