Welcome

The 2016 Benefits Open Enrollment period for Medical and Voluntary Benefits will take place October 18 through October 28 allowing benefit-eligible employees the opportunity to make changes to their existing healthcare plans. Doctors Community Hospital will host a Benefits Fair on October 19 in the Good Luck Café where many of our vendor partners such as CareFirst, Delta Dental, VSP and Transamerica will be on-site assisting employees with their benefits selections.

Doctors Community Hospital continues to offer comprehensive plans for your family’s medical, dental, vision, insurance (life, disability and pet), legal resources and retirement planning needs. Please carefully review the Benefits guide and select the options that meet your family’s healthcare needs.

As in previous years and in keeping with our Wellness initiatives focusing on our employee’s health and wellness, we will again be implementing a point system allowing you to collect points to help reduce your bi-weekly medical deduction. We are committed to providing you the tools and resources to help you reach your health and fitness goals by offering access to the fitness center, wellness workshops, fitness and nutrition trackers, meal planners and dietitians, exercise plans, salsa and zumba classes, wellness challenges and much more.

Our employees are our greatest asset and we will continue to reinforce our mission of caring for the health of our employee-community by offering flexible benefits to help you achieve and maintain a healthy lifestyle.

In good health,

Paul A. Hagens, Jr.
Vice President, Human Resources

2016 IMPORTANT CHANGES AND REMINDERS

• New Mandatory Generic Program – all medical plan members taking a Brand Tier 2 or Tier 3 drug when a generic equivalent is available will be responsible for paying the difference in cost of the brand drug and the generic drug in addition to the brand copay.
• If you have unused Healthcare FSA funds, you can roll over up to $500 into 2016. Keep this in mind when calculating your 2016 deduction.
• Participation in an FSA is not automatic. You must re-enroll annually during open enrollment.
• CareFirst My Account allows you to access your health information easily. You can get online access to claims information, provider searches, and can order, view or print ID cards. Signing up is simple and safe. Register now by visiting https://member.carefirst.com/wpsm/portal/member/public/memberAccountRegistration
• New 403b Automatic Enrollment – All benefit-eligible employees who are not currently enrolled in the 403(b) tax deferred savings plan will be automatically enrolled at 2%. Also, employees who are contributing at less than 2% will be increased to 2%. Each year, the contribution rate will increase by 1% until you reach 10%.

About This Guide

This guide describes the benefit plans available to you as an employee. The details of these plans are contained in the official plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in summary plan descriptions, as described by the Employee Retirement Income Security Act (ERISA). If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation. All annual required notices, plan document and more can be found at dch.benelogic.com.
Open Enrollment Checklist

☐ Open Enrollment is October 18 through October 28, 2015
☐ Review the 2016 Benefit Guide
☐ Attend the upcoming Benefit Fair on Monday, October 19, 2015
☐ Review your benefits online at dch.benelogic.com
☐ Make changes to your benefits for 2016 by October 28, 2015
☐ Earn 650 points by November 30, 2015 to save $25 per pay period with the Passport to Health Wellness Program

Enrollment Instructions

• Familiarize yourself with your options by reading your Benefit Guide
• Have the following information available on yourself and your dependents:
  » Social Security Numbers
  » Dates of Birth
• To enroll, log on to: dch.benelogic.com
  » Enter you User ID: Your Employee Number
  » If you are a returning user, enter your password
  » If you are a new hire:
    ▪ Your password is the last 4 digits of your Social Security Number
    ▪ Create a new confidential password (Note: you will need this new password when you log into the website again)
  » Follow the instructions and enroll in your benefits
  » Click on the finish button to save your election
  » Print your confirmation statement

NOTE: The Benelogic website may be unavailable periodically during your enrollment period for routine maintenance from the hours of 2:00 am to 6:00 am.
Our Employee Benefit Program

Doctors Community Hospital (DCH) is committed to providing you with a comprehensive variety of benefits. These benefits are a significant and important part of your total compensation package. They provide valuable protection for you and your family. During open enrollment you have the opportunity to meet with a benefit counselor to enroll in both core and voluntary plans. Employees can use the DCH Online Benefits System to enroll in benefits, excluding the voluntary benefits. Voluntary benefits are offered twice a year during Spring and Fall and you must meet with a benefit counselor at that time.

Eligibility

All benefit eligible employees qualify for the following benefits after the required waiting period:

- Medical/Drug - CareFirst BlueCross BlueShield
- Dental - Delta Dental
- Vision - Vision Service Plan (VSP)
- Flexible Spending Account - American Benefits Group (ABG)
- Legal Plan - Legal Resources
- 403(b) Tax Deferred Plan - Transamerica
- Basic Life and AD&D Insurance - UNUM
- Supplemental Term Life Insurance - UNUM
- Dependent Term Life Insurance - UNUM
- Accident with Hospital Coverage - UNUM
- Critical Illness with Optional Cancer Coverage - UNUM
- Disability Coverage (Short-Term) - UNUM
- Universal Life - Transamerica

Elections and Change-in-Life Status

Each year during open enrollment, employees make their benefit selections for the next plan year. The selections you make when you enroll in your benefits remain in effect for the entire plan year (January 1 through December 31). Once the plan year starts, you cannot make changes to your elections unless a Change-in-Life status occurs. Change-in-Life status events are generally defined as the following:

- Marriage
- Birth or adoption of a child
- Significant change in your or your spouse’s employment status
- Divorce
- Death
- Loss of other health coverage

You may change your elections if one of the above events occurs. The change must be requested within 30 days of the event and must be consistent with your change in status. Documentation is required.

Newly Hired Employees

You have 60 days to enroll or waive enrollment in the benefit program. Your benefits are effective on the 1st of the month following 60 days of employment.

New Hires: Collect Points ▶ Save Money ▶ Manage Your Health

You are eligible to participate in the Passport to Health Wellness program to save $25 per pay check on your medical deductions. To earn your Wellness Points and receive the $25 savings per pay check you must complete your biometric screening at Employee Health department. You have 60 days from your hire date to complete your biometric screening. See the Payroll Deductions for the Wellness discount on page 5.

Eligible Dependents

Your dependent must meet one of the following definitions:

1. Spouse: your legally married husband/wife
2. Child(ren): married or unmarried children to age 26 (Life/AD&D to age 19/25 if full-time student)
   - Children include: natural children, stepchildren, legally adopted children, children placed for adoption, and children you are legally appointed as guardian.
3. Disabled Child: unmarried child who is mentally or physically handicapped (handicap sustained before the age of 25) and incapable of engaging in self-sustaining employment due to such incapacity, dependent on your IRS tax return.

Note: enrolling someone who is not qualified as a dependent is considered insurance fraud.

Documentation Required

Documentation will be required for eligible dependents. A dependent will not be added until documentation is provided. Documentation includes:

- Marriage Certificate
- Birth Certificate

Employees must notify Human Resources within 30 days if a dependent becomes eligible or loses eligibility for coverage.
## Payroll Deductions

### 2016 Payroll Deductions (Bi-Weekly Cost)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Standard</th>
<th>Wellness - 650 Points Collected</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
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<td>Legal Resources Legal Plan</td>
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### Part-Time 1 Employees

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<td>Vision Service Plan Vision Only</td>
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</tr>
<tr>
<td>Legal Resources Legal Plan</td>
<td>$8.77</td>
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</tr>
</tbody>
</table>

### Pre-Taxed Payroll Contributions

Some payroll deductions are considered pre-tax, which means you do not pay state, federal, and social security taxes on these premiums. This means more money in your pocket. Your bi-weekly payroll deductions will be pre-tax where applicable. Please see Human Resources if you do not want to pay your premiums with pre-tax income. Your benefit elections will remain in effect for the plan year (January 1—December 31) or until you are no longer eligible for the benefit. You may change your election once a year, during open enrollment for the plan year, unless you experience a Change-in-Life status (see Elections and Change-in-Life status on page 4).
Tobacco User Surcharge

DCH helps employees become tobacco free through the tobacco user surcharge. During open enrollment, all medical plan members are required to complete an online affidavit indicating whether or not they use tobacco products. Employees who use tobacco products will be charged a tobacco user surcharge of $25 per pay period.

Continuing in 2016, a tobacco user surcharge will be charged for all employees who are enrolled in one of the DCH medical plans and are tobacco users. A “tobacco user” is defined as an employee who regularly and routinely uses any form of tobacco products including but not limited to cigarettes, cigars, blunts, chewing tobacco, electronic cigarettes, snuff, loose leaf, pellets, tobacco water, etc.

**IMPORTANT** - Although you do not have to re-enroll in your medical benefits this year, due to the implementation of the Tobacco User Surcharge, ALL employees who are enrolled in one of the DCH medical plans will be designated as a TOBACCO USER. Therefore, if you are not a tobacco user you must go online during the open enrollment period (dch.benelogic.com) and complete the Tobacco User Affidavit certifying that you are not a tobacco user. Failure to complete the affidavit will result in you being charged the smoker user surcharge of $25 per pay period. Falsely certifying the affidavit will be considered a willful act of FRAUD.

Quitting smoking has many short and long-term health benefits. People who quit smoking before age 50 reduce their risk of dying before age 65 by 50 percent compared to others who continue to smoke. Beyond that, the benefits of quitting smoking take effect almost immediately.

To avoid the tobacco surcharge, tobacco users must complete a smoking cessation program.

**Please note:** If employees indicate that they do not use tobacco products, but it is later confirmed that they do, a premium surcharge will be charged for the balance of the year. Additionally, if employees complete a smoking cessation program, yet continue to use tobacco products, they will be required to complete the Well Employee Portal’s program to avoid the premium surcharge.

**Smoking Cessation Program Options:**

To avoid this surcharge, employees must complete a smoking cessation program, some options include:

- **Well Employee Portal** – It is a multi-week and self-paced online program available at welmployeeportal.com with health coaches who are available to provide support and quitting strategies. To make an appointment with a coach, call 855-595-2450.

- **Freedom From Smoking Online** – It is an online program that consists of seven modules. For more information or to register, www.ffsonline.org.

- **Prince George County Health Department** – for information contact, lrconnors@co.p.md.us.

Passport to Health Wellness Program

The Passport to Health Wellness Program is a voluntary program designed to engage employees in opportunities to gain better health, less stress, and healthy energetic lifestyles. Participating in the Program can enhance your overall well-being. The Program is provided for you to explore better ways to become aware, improve, and maintain your health. The Passport to Health Wellness Program is available to all employees. Participation in the Passport to Health program saves you money on your health insurance premiums.

Accessing the Passport to Health Wellness Portal and Coaching

To access the Wellness Portal, start by visiting the Launch Page. The web address for this page is www.wellemployeeportal.com.

To Register for the Wellness Portal (new users):

- At the Launch Page, click the button that says “Register New Account.” You will be redirected to the registration page.
  - For username, use your employee number and password and fill in your personal information.
  - For “Member Number,” use your last name and your six digit birthdate (no space)
  - Those with hyphens or spaces in their last names should remove them for the login (i.e. Susan Smith-King born on November 2, 1972 becomes “SmithKing110272”)
  - Click “Submit.” You will be redirected to the Welcome Screen.

To Access the Wellness Portal (registered users):

- At the Launch Page, enter the username and password that you created during registration. If necessary, click the “Forgot Password” link to request your login information by email.

To Contact a Wellness Coach:

- Call 301-229-7555 ext. 2 between the hours of 8:00 am - 5:00 pm, EST, Monday - Friday. Once you have made contact with a coach, this coach will remain your primary coach contact who you can have unlimited contact with through phone, email or chat.

What is Wellness Coaching?

Wellness Coaches are Registered Dietitians, Fitness Specialists, and Tobacco Educators. They can help you reach your weight loss and fitness goals, assist with meal planning, tobacco cessation, and much more! Call 301-229-7555 ext. 2 to schedule your appointment.

Any questions about the Passport to Health Wellness Program can be directed to Wellness Corporate Solutions at 301-229-7555 x 2 or email: Support@wellnesscorporatesolutions.com.

Doctors Community Hospital Health & Fitness Center

- **Hours**: 24 hours a day, 7 days a week
- **Annual Fee**: $25 for employees and $15 for spouse and each child 16 years or older (payroll deduction in January or at registration)
- **Locations**: West Hospital North Building and East Executive Place COS Office
Prevention is the best medicine, so CareFirst BCBS offers a wide range of services to help you and your family lead healthy, productive lives. Doctors Community Hospital offers 3 plans through CareFirst BCBS for you to select. The 3 plans are BlueChoice HMO, Opt-Out Plus-Open Access POS, and BluePreferred PPO. Primary Care Physician (PCP) information is only required for employees selecting to participate in the HMO or Opt-Out Plus-Open Access POS plan for the first time. **If you wish to change your PCP, please contact CareFirst BCBS directly. Please note, Benelogic does not store current PCP information.**

### Summary of Services

<table>
<thead>
<tr>
<th></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of Network</strong>*</th>
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</thead>
<tbody>
<tr>
<td><strong>Yearly Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$300</td>
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<tr>
<td>Family</td>
<td>None</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$2,000 individual</td>
<td>$2,000 individual</td>
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<td></td>
<td>$5,000 family</td>
<td>$5,000 family</td>
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<tr>
<td><strong>Primary Care Physician (PCP)</strong></td>
<td>$20 copay</td>
<td><strong>Deductible then 20% of eligible expenses</strong></td>
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<tr>
<td>Specialist Office Visit</td>
<td>$20 copay</td>
<td></td>
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<tr>
<td><strong>Well-Child Visits</strong></td>
<td>Covered at 100%</td>
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<tr>
<td><strong>Routine Physicals</strong></td>
<td>Covered at 100%</td>
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</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>Covered at 100% after $200 inpatient copay</td>
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<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>Covered at 100% after $200 copay per admission</td>
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<td><strong>Prescription Drug Retail (30 Day Supply)</strong></td>
<td>$0 copay Preferred Preventive</td>
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<tr>
<td></td>
<td>$10 copay Tier 1</td>
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<td></td>
<td>$25 copay Tier 2</td>
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<tr>
<td></td>
<td>$45 copay Tier 3</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order - CVS/Caremark Only (90 Day Supply)</strong></td>
<td>$0 copay Preferred Preventive</td>
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### New for 2016!

Your prescription drug plan now includes a mandatory generic program. Generic drugs will be covered at the same level for 2016 as 2015. If you choose to take a Tier 2 or 3 brand name drug when a generic equivalent is available, you will be responsible for paying the difference between the cost of the brand drug and the generic drug in addition to the brand drug copay. If there is no generic equivalent available for the Tier 2 or 3 brand drug, you will only be responsible for paying the brand copay. Please be sure to ask your provider about generic equivalents when receiving a prescription. Using a generic equivalent instead of a brand drug is a great way to lower your healthcare spend.

To locate In-Network providers, log on to www.carefirst.com or call 877-691-5856.
Medical and Prescription Drug

Additional Covered Services on Medical Plans

- The Inpatient Hospitalization copay is waived if you go to DCH for inpatient services. You must contact the Business Office at 301-552-8187.
- Employees and Dependents who are covered by DCH’s CareFirst BCBS medical plan are eligible to have basic lab and x-ray services performed at DCH at the in-network benefit level. If you choose to have your labs and x-rays performed at DCH, you must have your physician write the order on a regular PRESCRIPTION PAD. Your physician cannot use any other order form. DCH will not honor any other forms and you will be directed to that medical facility for services. Complex imaging (Mammograms, MRI, CI, PET scans, etc.) must be performed at participating In-Network facilities; otherwise it will be subject to Out-of-Network benefits.
- Payroll deduction DCH ER copay

- **CareFirst BCBS BluePreferred PPO**
  You get access to quality care at the lowest out-of-pocket costs available under your plan by seeing network providers. You also get the freedom to choose the providers you prefer—even if they are not part of the network. Your benefits are the highest when you see “preferred providers”, but you are still covered for visits to other providers. Please remember that certain services such as inpatient hospital care may require pre-certification. It is not necessary for members to choose a PCP when enrolling in the CareFirst BCBS BluePreferred PPO.

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<td></td>
<td>$90 copay Tier 3</td>
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*Reimbursement is based on CareFirst BCBS’s plan allowance. You may be responsible for filing claims and/or paying any charges that exceed the plan allowance.

Members are encouraged to get maintenance prescriptions filled at CVS/Caremark pharmacies or through the Mail Order pharmacy. A 90-day supply of maintenance medications can be obtained at CVS/Caremark or through mail order with two copays only. If maintenance prescriptions are filled at a non-CVS/Caremark retail pharmacy, members will only receive a 30-day supply at a time, with one copay.

To locate In-Network Blue Preferred providers outside the MD/DC/VA area, log on to www.bcbs.com and type your zip code to find the appropriate BCBS network for that area or call 800-810-BLUE.
Dental and Vision

Dental Plan

Dental insurance helps you and your family manage the cost of dental care. DCH offers 2 dental plans offered through Delta Dental. You do not have to elect medical coverage to elect dental coverage.

The Plan name is Delta Dental PPO Plus Premier. There are 3 levels of coverage with this plan. The highest reimbursement tier will be the PPO Network. The second tier is the Premier Network and the lowest tier is Out-of-Network. While there is coverage for Out-of-Network visits, you may be required to pay the provider at the time of service and you may incur higher Out-of-Pocket costs.

To find a Delta Dental dentist, log on to: www.deltadental.com or call 800-932-0783.

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<tr>
<th></th>
<th>Delta Dental Standard Plan</th>
<th>Delta Dental Premier Plan</th>
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<tr>
<td>Family</td>
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<td>$100</td>
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<td>Preventive &amp; Diagnostic Care Services</td>
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<td>Exams, Cleanings, X-Rays</td>
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<tr>
<td>Orthodontia Lifetime Maximum</td>
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<td>$1,000</td>
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*Reimbursement is based on Delta Dental's plan allowance. You may be responsible for filing claims and/or paying any charges that exceed the plan allowance.

Vision Plan

Vision benefits through Vision Service Plan (VSP) are included when you elect medical but can be purchased separately if medical is not elected. The benefits include comprehensive eye exam, eye glasses or contact lenses, and discounts on the cost of professional services from VSP providers for you and your covered dependents.

If you choose to go Out-of-Network, you will be required to pay the provider at the time of service. To request reimbursement from VSP, submit an itemized bill within 12 months from the date of service, along with the employee and patient’s social security numbers and dates of birth to:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997100, Sacramento, CA 95889-7100

<table>
<thead>
<tr>
<th>Fees</th>
<th>In-Network</th>
<th>Out-of-Network (Reimbursement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>No Charge</td>
<td>Up to $52</td>
</tr>
<tr>
<td>Single Lenses</td>
<td>$20 copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Frames</td>
<td>$20 copay</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Bifocals</td>
<td>$20 copay</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Trifocals</td>
<td>$20 copay</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$20 copay</td>
<td>Up to $125</td>
</tr>
<tr>
<td>Elective Contacts</td>
<td>Up to $60 copay</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Medically Necessary Contacts</td>
<td>100%</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>
The Flexible Spending Accounts are designed to help you save on the cost of health care. If you elect to participate in the FSA, you can set aside up to $2,500 annually on a pre-tax basis in the Health Care FSA. Eligible health care expenses include:

- Medical Plan Deductible/Coinsurance
- Dental Plan Deductible/Coinsurance
- Prescription Drug Copays
- Contact Lenses/Eyeglasses/Vision Exams
- Hearing Aids
- Orthodontic (Braces) Fees

If you currently spend money each year on any of the above items, you should consider participating in the Health Care Reimbursement Account. You may elect to deposit up to $2,500 in the Health Care Reimbursement Account each year. DCH has elected to offer the Roll Over (for Health Care FSAs only) with its (2015) FSA plan, meaning that next year (2016) if you are still an active employee and have a balance from the prior year (2015) of up to $500, this balance will roll over to the next plan year (2016) after the run-out claim submission deadline is over for the prior plan year (2015). If you do not enroll in the Health Care FSA plan at open enrollment for the next new plan year (2016), a health care FSA account will be created for you with the roll over balance only (from 2015). The rollover will be done after the run out is complete and not prior. You will only have access to those rollover funds via claim submission because if you do not renew your card usage is terminated on the last day of the prior plan year. If you do enroll, the roll over balance will be in addition to what you elect for the next new plan year (2016).

How the Health Care FSA Works

You can set aside up to $2,500 annually on a pre-tax basis in the Health Care FSA. You can use this money to pay for eligible expenses you incur during the year that are not covered by your basic plans. Eligible health care expenses include:

- Medical Plan Deductible/Coinsurance
- Dental Plan Deductible/Coinsurance
- Prescription Drug Copays
- Contact Lenses/Eyeglasses/Vision Exams
- Hearing Aids
- Orthodontic (Braces) Fees

If you currently spend money each year on any of the above items, you should consider participating in the Health Care Reimbursement Account. You may elect to deposit up to $2,500 in the Health Care Reimbursement Account each year. DCH has elected to offer the Roll Over (for Health Care FSAs only) with its (2015) FSA plan, meaning that next year (2016) if you are still an active employee and have a balance from the prior plan year (2015) of up to $500, this balance will roll over to the next plan year (2016) after the run-out claim submission deadline is over for the prior plan year (2015). If you do not enroll in the Health Care FSA plan at open enrollment for the next new plan year (2016), a health care FSA account will be created for you with the roll over balance only (from 2015). The rollover will be done after the run out is complete and not prior. You will only have access to those rollover funds via claim submission because if you do not renew your card usage is terminated on the last day of the prior plan year. If you do enroll, the roll over balance will be in addition to what you elect for the next new plan year (2016).

How the Dependent Day Care FSA Works

You can set aside up to $5,000 ($2,500 if married filing separately) annually on a pre-tax basis in the Dependent Day Care FSA. Dependent Day Care expenses allows you (or you and your spouse) to work, look for work or attend school full time. Dependent Day Care can be for your dependent children, through age 12, and any dependent who is physically or mentally unable to care for him or herself who spends at least eight hours a day in your home and whom you claim as a dependent on your federal income tax return.

You use money in your account to pay for dependent day care expenses such as preschool or nursery school expenses, babysitter in your home, day care center, summer day camp, after-school care and adult day care center or in-home care for an adult dependent. These services must be performed primarily for the well being and protection of a qualified dependent. In addition, to be considered as an eligible expense, you must be able to provide a tax identification number or Social Security number of the provider and, if married, your spouse must be employed.

General Provisions

Prior to making Health and/or Dependent Day Care account elections, there are several important points that must be considered:

- Elections are made each year during open enrollment.
- Dependent Care eligible expenses must be incurred during the plan year to be eligible for reimbursement.
- You may change your election during the year if you have a qualified family status change such as marriage or divorce, the birth of a child, the death of an eligible dependent or certain changes in employment status.

Use It or Lose It

For Dependent Care accounts, you forfeit any money remaining in your FSA at the end of the year. You need to plan carefully with FSA plans, because you are not able to carry over funds from one year to the next.

For Health Care accounts, you can now roll over up to $500 of unused funds into the following year.

Using your Health Care FSA Debit Card

Per IRS regulations, your debit card is restricted for use at health care providers (merchants that have a merchant category code that indicates they are a health care provider). These merchants include hospitals, doctors, dentists, chiropractors, etc. You may also use your debit card at merchants that have an Inventory Information Approval System such as pharmacies. When using your Health Care FSA Debit Card at an approved merchant, you may need to substantiate your transactions. If any transactions are not auto-approved, you must provide detailed receipts/statements to ABG in order to substantiate the transaction(s). If the transaction is not substantiated, ABG must suspend the card until the required documentation is provided OR you have reimbursed your employer the amount of the transaction. ABG will email you the debit card notifications directly so you are aware of which requirement documentation. You can also review your debit card transaction history online 24-7.
Life, AD&D, and Supplemental Life

Life and AD&D Insurance
In order to provide a full range of protection for you and your family, the DCH benefit program offers a number of life insurance coverage options: Basic Term Life, Accidental Death and Dismemberment (AD&D), and Supplemental Life.

Basic Life and AD&D Insurance
DCH provides Basic Life and AD&D insurance for all full-time employees at 1 times annual base earnings to a maximum of $600,000. The Basic Life insurance provided through this program is term life insurance. It pays a benefit if you should die while an active employee. Term life insurance has no built-in cash value, but allows you to take it with you upon termination based on attained age.

Your base annual earnings are calculated on your base pay and do not include overtime, bonuses, or other pay. If the insurance company deems your death to be a result of an accident, an additional amount equal to your Basic Life will be payable to your beneficiary. Reduced amounts may be payable for certain injuries such as the loss of an arm or a leg.

Supplemental Life Insurance
Supplemental Life Insurance is an optional benefit offered to all benefit eligible employees as a financial resource to protect your families. You can purchase additional life insurance coverage that suits your needs at an affordable group rate through convenient payroll deductions.

You may apply for additional benefits up to 5 times your base annual earnings to a maximum benefit of $1,000,000 (Basic and Supplemental benefit combined). Evidence of Insurability will be required for coverage requested over 3 times your base annual earnings or $600,000 (Basic and Supplemental benefits combined). If you do not elect coverage at initial eligibility, evidence of insurability will be required for any amount elected.

Beneficiary Designation
You must designate a beneficiary for your Basic and Supplemental Life Insurance when you become eligible for coverage. Your “beneficiary” is the person (or people, estate, trust, etc.) who will receive your Life and/or Supplemental Life Insurance benefits if you die. You may change your beneficiary at any time by completing the Beneficiary Designation form. If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.

You are automatically the beneficiary for any dependent life.

Note: The benefits for Basic Life, Accidental Death & Dismemberment, and Supplemental Life Insurance policies are reduced to 65% at age 70 and 50% at age 75. Dependent child(ren) are covered to age 19 (25 if a full time student).

### Benefit Level

<table>
<thead>
<tr>
<th>Basic Life/AD&amp;D</th>
<th>1 times Base Annual Earnings to a Maximum of $600,000 (rounded up to next $1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Employee Life/ AD&amp;D</td>
<td>1, 2, 3, 4, 5 times Base Annual Earnings to a Maximum of $1,000,000 (combined with Basic Life)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent Life</th>
<th>Spouse</th>
<th>Child(ren)</th>
<th>Bi-Weekly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$0.47</td>
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<tr>
<td>Option 2</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$0.69</td>
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<tr>
<td>Option 3</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$1.38</td>
</tr>
<tr>
<td>Option 4</td>
<td>$25,000</td>
<td>$10,000</td>
<td>$1.77</td>
</tr>
<tr>
<td>Option 5*</td>
<td>$50,000</td>
<td>$10,000</td>
<td>$3.54</td>
</tr>
</tbody>
</table>

*Requires an approved Evidence of Insurability form
Voluntary Program Highlights

These products are offered twice a year during Spring and Fall.

UNUM Disability Coverage (Short-Term)
This option provides financial protection if you are out of work due to a pregnancy, illness, surgery or off-the-job injury. The amount of coverage and length of coverage can be customized to meet your personal needs. The maximum amount of coverage that can be purchased is 60% of your salary not to exceed $5,000 per month. Once coverage is active, it can continue to age 72. A variety of plans are available to meet your personal needs. The maximum benefit duration is 5 years for a covered disability.

UNUM Critical Illness Plan with Optional Cancer Coverage
This plan is designed to help you with the out-of-pocket expenses and lost wages associated with serious illnesses. When you enroll, you elect a benefit amount between $5,000 and $50,000. This benefit then pays out a lump-sum benefit, tax-free, if you are diagnosed with one of the covered illnesses. Some of the illnesses covered by this plan include: heart attack, stroke, major organ transplant, permanent paralysis, end stage renal failure, coma, occupational HIV and optional cancer coverage. This coverage is available for you, your spouse and dependent children (newborn through age 24 and unmarried).

UNUM Accident Plan with Hospital Confinement Coverage
This option is designed to financially assist you in the event of an injury, on or off the job. It pays benefits based on the type of injury (or covered incident) you sustain or the type of treatment you need. The benefits are paid directly to you rather than your doctor or hospital. This plan includes an accidental death benefit as well as dismemberment coverage. A hospital confinement rider for sickness is available as well. You can cover yourself, your spouse, and any dependent children ages 14 days through age 24 who are not disabled or married. This plan is portable when you leave your job or retire.

Transamerica Universal Life Insurance with Long Term Care Coverage
This option provides flexible premiums, death benefits for life, and cash value accumulation. Premiums start as low as $4.00 a week and the price does not increase when you get older or if you retire. This policy is individually owned, which means you can take it with you if you retire or leave DCH. Limited underwriting questions, no medical exams, and no blood work are required to apply for coverage. The Long Term Care Coverage allows you to use your life insurance for nursing home, assisted living or home health care.

NOTE: Current enrollees in the UNUM Whole Life Insurance plan may choose to continue this benefit.

Transamerica Tax Deferred Savings Plan 403(b)
The DCH 403(b) Tax Deferred Savings Plan is designed to help you save for your retirement years. With this plan, you have the opportunity to design your own retirement program based on several investment options that offer a wide range of investment choices. Upon hire, all employees are eligible immediately to participate in the 403(b) plan. Benefit eligible employees, upon completing 2 years of service, may receive matching contribution from DCH. The matching contribution is half of the first 4% of your earnings that you contribute each pay period.

Effective January 1, 2014, Doctors Community Hospital has adopted an automatic enrollment provision for the Doctors Community Hospital Tax Deferred Savings Plan. This provision will apply to all benefit eligible employees. Unless elected otherwise, employees will be automatically enrolled at pre-tax contribution rate of 2%. Also, the pre-tax contribution will be automatically increased by 1% each year (on your automatic enrollment anniversary date) until a deferral rate of 10% is reached. This will allow participants to maximize the DCH matching contributions over time. Employees are given a 30 day opt out period before the payroll deduction begins, during which time you may elect not to participate in the program. Employees can contact Transamerica directly to opt out at any time within 30 days following hire. Additionally, participants are also provided the opportunity to request a refund of contributions made to the Plan, without penalty, as long as the refund request is made within 90 days following the first deduction. Employees should contact Transamerica directly to request this refund.

Legal Resources
DCH offers a voluntary benefit, Legal Resources. Now you can hire an attorney and not worry about paying attorney fees.

- All attorney fees for legal services listed in the “Summary of Services” are either covered in full (100%) or discounted (25%) depending on the legal matter.
- You choose a law firm from the Legal Resources network.
- Affordable payroll deducted monthly fee includes unlimited use of covered services for all covered family members.
- You can enroll in this benefit by enrolling online.
- You can enroll in this plan upon hire or during an open enrollment period.
- If you leave your employer you can keep this benefit for up to two years.
- Nationwide coverage is included in the National Protection Rider.
Voluntary and Additional Benefits

Voluntary Benefits continued

Catastrophic Illness/Injury Leave Bank (CILB) Plan
This voluntary benefit allows members to apply for up to a 12-week grant upon diagnosis of a catastrophic illness/injury. You must be employed by Doctors Community Hospital for 6 months before you are eligible to enroll in this plan. Members contribute an annually specified amount of PTO to participate.

PayCheck Direct®
PayCheck Direct is a unique employee benefit program that can help you purchase new products, including computers, appliances, jewelry, furniture, TVs and more, through payroll deduction with no credit check, no down payment, and a 12-month payroll deduction payment plan. This benefit is portable if you leave or retire. You must be 18 years of age, a benefit employee of DCH for at least 6 months, and earn at least $18,000 a year.

PetFirst HealthCare (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. Important features include: use any veterinarian nationwide, easy online policy management to track claims processing, quick and easy administration and payroll deduction.

Additional Benefits

Dell Employee Purchase Program
Employees can take advantage of Dell’s Employee Purchase Program for exclusive savings on technology for personal use, including desktop, notebook PCs, printers and more.

Emergency Child Care Center (ECCC)
This benefit provides emergency child care services ONLY when the Prince George’s County School System closes due to inclement weather or other local or national emergencies are declared by DCH. Employees must register their children in the Human Resources Department to participate in the ECCC. Your children must be ages five (5) to twelve (12) years old to participate in the ECCC. Meals and activities for the children are provided at no cost to the employee. There is a limit of 30 children and space is given on a first come, first serve basis.

Employee Assistance Program (EAP)
The challenges you face each day can lead to stressful feelings. At times, such feelings may overwhelm you. Your home life, your happiness and your performance at work can suffer. We can help. Your Employee Assistance Program (EAP) and WorkLife Benefit is designed to provide confidential support for those everyday challenges or more serious problems, and it is available around the clock—anytime you need it. Your EAP and WorkLife Service Benefit offers assistance and support for all these concerns and more:

- Depression, anxiety and stress
- Substance abuse
- Relationship problems
- Workplace conflicts
- Parenting and family issues
- Living with chronic conditions
- Child and elder care support
- Grief and loss
- Stress management
- Relationship concerns

From short-term counseling services and referrals to more extended care, your benefit offers just what you need. To find out more, call 800-586-6873 or visit www.liveandworkwell.com. Log in with access code DCH.

Family Medical Leave Act (FMLA)
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for Doctors Community Hospital for at least one year and for 1,250 hours over the previous 12 months. For more information please refer to the FMLA policy, or obtain forms from the Human Resources Department.

Medical Copay Payroll Deduction (MCPD)
Employees will be able to use payroll deductions to pay hospital copays only. This option can be initiated during the inpatient, outpatient, or emergency care process. Payroll deductions can range from one to eight payroll periods.

National Preferred Employer Program (NPEP)—Apartment Discount Program
The next time you are ready to rent an apartment, go to www.npep.com to view information on participating apartment communities and the discounts they offer. DCH employees are entitled to enjoy great discounts on a new lease at participating apartment communities. You may obtain a complete apartment listing on www.npep.com.
Paid Time Off (PTO)

Paid Time Off is an employee benefit which combines holiday, vacation and sick leave programs into one plan to provide both employees and DCH with a flexible method of scheduling time off with pay.

NOTE: Part-Time 1 employees accrue pro-rated PTO based on FTE value.

### Full-time Accrual

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>1 to 4</th>
<th>4+ to 8</th>
<th>8+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours Accrued per Pay Period</td>
<td>7.38</td>
<td>8.92</td>
<td>10.46</td>
</tr>
<tr>
<td>Days per Year</td>
<td>24</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Holidays Covered</td>
<td>-6</td>
<td>-6</td>
<td>-6</td>
</tr>
<tr>
<td>Remaining Leave Days (Vacation &amp; Sick)</td>
<td>18</td>
<td>23</td>
<td>28</td>
</tr>
</tbody>
</table>

Parking

The hospital provides free parking for employees. DCH will assign parking as required. Employees are required to park in designated areas only and adhere to all posted parking signs. Each employee is required to obtain a parking permit from Human Resources or the Security Department. The parking permit must be placed on the front windshield in the lower corner of the driver’s side.

QuickCharge

DCH employees will have the ability to use their hospital employee ID badge to make purchases in the Good Luck Café, Gift Shop (maximum $200 per pay period) and during fundraising events sponsored by the Volunteers or DCH Foundation. Look for more details in email and departmental flyers.

Tuition Reimbursement

DCH promotes the development of its staff through education. Tuition reimbursement may be granted to employees who matriculate in a degree program at an accredited institution of higher education or attend an approved course(s). All benefit eligible employees are eligible for the program only after the 90-day introductory period is completed. Participation in Tuition Reimbursement Program must be approved at least 10-days before commencement of the course(s). Tuition costs will be reimbursed up to $1,500 for non-degreed courses, up to $3,000 for degreed courses per calendar year to full-time benefit eligible employees and pro-rated for part-time 1 employees.

United Buying Service (UBS)

UBS offers DCH employees the lowest pre-negotiated price on new and used cars and trucks. The benefits include discounted option pricing and extra savings with rebates and incentives. Employees may review the official UBS price book located in the Human Resources Department.

Working Advantage Discount Program

All employees at DCH are eligible to use the discount savings program which provides up to 60% savings in movie tickets, theme parks, resorts, broadway shows, concerts, events, and more!

Worldwide Emergency Travel Assistance

If you are enrolled in DCH’s Basic Life plan, this plan is offered at no cost to you. The program ensures access to appropriate health care and management of medical emergencies to employees and dependents traveling 100 or more miles from home, or in a foreign country. Should you become ill or have an accident, you can access care anywhere in the world. All it takes is one call to the toll free number of 800-872-1414 (outside US Access code + 609-986-1234) Ref# 01-AA-UN762490 or www.unum.com/travelassistance. Services from Worldwide Emergency Travel:

- Medical consultation and evaluation
- Medical referrals
- Medical monitoring
- Guaranteed hospital admission
- Emergency evacuation
- Medically supervised repatriation
- Emergency medication assistance

And more...

- Bank of America Group Banking Plan
- Greenbelt Federal Credit Union
- SECU
Notice of Health Information Privacy Practices

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

The health plans or options sponsored by DCH (referred to in this Notice as the “Health Plans”) may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by DCH employees who are responsible for overseeing the operation of the Health Plans while other functions may be performed by other companies under contract with the Health Plans (those companies are generally referred to as “service providers”). Regardless of who handles health information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, “Plan” to refer to each Health Plan sponsored by DCH, including any DCH employees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. This Notice applies to each Health Plan maintained by DCH, including plans or programs that provide medical, vision, prescription drug, dental, long term care and health care flexible spending account benefits. However, if any of the Plan’s health benefits are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer’s use of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan’s legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning January 1, 2014 and will remain in effect until it is revised.

If the Plan’s health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information possessed by the Plan that includes identifying information about an individual. Such information, regardless of the form in which it is kept, is referred to in this Notice as Protected Health Information or “PHI”. For example, any health record that includes details such as your name, street address, date of birth or Social Security number would be covered. However, information taken from a document that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow a person who receives or accesses that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and may be used for any purpose that is consistent with applicable law and with the Plan’s policies and requirements.

How the Plan Uses or Discloses Health Information

Protected Health Information may be used or disclosed by the Plan as necessary for the operation of the Plan. For example, PHI may be used or disclosed for the following Plan purposes:

- **Treatment.** If a provider who is treating you requests any part of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

  For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

- **Payment.** The Plan’s agents or representatives may use or disclose PHI about you to determine eligibility for plan benefits, facilitate payment for services you receive from health care providers, to review claims and to coordinate benefits. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan’s payment function.

  For example, if the Plan needs to process a payment to your current physician, but requires additional PHI to process that payment, it may request that PHI from the physician.

- **Other health care operations.** The Plan also may use or disclose PHI as needed for various purposes that are related to the operation of the Plan. These purposes include utilization review programs, quality assurance reviews, contacting providers regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan’s health care operations function.

  For example, if the Plan wishes to undertake a review of utilization patterns under the Plan, it may request necessary PHI from your physician.
In addition to the typical Plan purposes described above, PHI also may be used or disclosed as permitted or required under applicable law for the following purposes:

- **Use or disclosure required by law.** If the Plan is legally required to provide PHI to a government agency or anyone else, it will do so. However, the Plan will not use or disclose more information than it determines is required by applicable law.

- **Disclosure for public health activities.** The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

  The Plan also may disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

  In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

  Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- **Disclosures about victims of abuse, neglect or domestic violence.** (The following does not apply to disclosures regarding child abuse or neglect, which may be made only as provided under Disclosure for public health activities.)

  If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

  If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

- **Health oversight activities.** The Plan may disclose protected health information to a health oversight agency (this includes federal, state or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

- **Disclosures for judicial and administrative proceedings.** The Plan may disclose protected health information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

- **Disclosures for law enforcement purposes.** The Plan may disclose protected health information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

- **Disclosures to medical examiners, coroners and funeral directors following death.** The Plan may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. The Plan also may disclose PHI to a funeral director as needed to carry out the funeral director’s duties. PHI may also be disclosed to a funeral director, if appropriate, in reasonable anticipation of an individual’s death.

- **Disclosures for organ, eye or tissue donation purposes.**

  The Plan may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- **Disclosures for research purposes.** If certain detailed restrictions are met, the Plan may disclose protected health information for research purposes.

- **Disclosures to avert a serious threat to health or safety.**

  The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.
Disclosures for specialized government functions. If certain conditions are met, the Plan may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Also, the Plan may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority under similar conditions.

The Plan may also use or disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by federal law relating to those protective services.

Disclosures for workers’ compensation purposes. The Plan may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs.

Uses and Disclosures That Are Not Permitted Without Your Authorization

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned in this Notice, except as specifically authorized by you. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your authorization.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will not apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

No Use or Disclosure of Genetic Information for Underwriting

Under applicable law, the Plan generally may not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is permitted based on the above rules, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

Your Health Information Rights

Under federal law, you have the following rights:

You may request restrictions with regard to certain types of uses and disclosures. This includes the uses and disclosures described above for treatment, payment and other health care operations purposes. If the Plan agrees to the restrictions you request, it will abide by the terms of those restrictions. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan or is otherwise inappropriate, it may decline the restriction. If you want to request a restriction, you should submit a written request describing the restriction to the Privacy Contact Person listed in this Notice.

You may request that certain information be provided to you in a confidential manner. This right applies only if you inform the Plan in writing (submitted to the Privacy Contact Person listed in this Notice) that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such a request if it is reasonable, but reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.

You may request access to certain medical records possessed by the Plan and you may inspect or copy those records. This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage. However, there are certain limited exceptions. Specifically, the Plan may deny access to psychotherapy notes and to information prepared in anticipation of litigation.

If you want to request access to any medical records, you should contact the Privacy Contact Person listed in this Notice. If you request copies of any records, the Plan may charge reasonable fees to cover the costs of providing those copies to you, including, for example, copying charges and the cost of postage if you request that copies be mailed to you. You will be informed of any fees that apply before you are charged.
You may request that protected health information maintained by the Plan be amended. If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide information to the Plan to establish that the originator of the information is not in a position to amend it. If you want to request that any medical record maintained by the Plan be amended, you should provide your request in writing to the Privacy Contact Person listed in this Notice. Your request should describe the records that you want to be changed, each change you are requesting and your reasons for believing that each requested change should be made.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with your health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

You have the right to receive details about certain non-routine disclosures of health information made by the Plan. You may request an accounting of all disclosures or health information, with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operations, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made more than 6 years before the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12 month period.

You have the right to request and receive a paper copy of this Privacy Notice. If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one. You should contact the Privacy Contact Person identified at the end of this Notice if you want a paper copy.

You have the right to be notified of a breach of unsecured PHI. If unsecured PHI is used or disclosed in a manner that is not permitted under applicable federal law, you will receive a notice about the breach of unsecured PHI, if such a notice is required by applicable law. Unsecured PHI is PHI that is either in paper form or is in an electronic form that is not considered secure.

Privacy Contact Person and Complaint Procedures

After reading this Notice, if you have questions or complaints about the Plan’s health information privacy policies or you believe your health information privacy rights have been violated, you should contact:

Privacy Officer
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706
301-552-8118

To obtain a paper copy of this notice, contact the appropriate business unit contact person listed below:

Privacy Officer
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706
301-552-8118

In addition to your right to file a complaint with the Plan, you may file a complaint with the U.S. Department of Health & Human Services. (Details are available on the Internet at http://www.hhs.gov/ocr/privacy) You will never be retaliated against in any way as a result of any complaint that you file.

Annual Notices

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan...
Annual Required Notices

if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Phone: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740, TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-541-2830

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 - Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability
**Annual Required Notices**

**WISCONSIN** – Medicaid and CHIP  
Website: http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm  
Phone: 1-800-362-3002

**WYOMING** – Medicaid  
Website: http://wyequalitycare.acs-inc.com/  
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**  
Employee Benefits Security Administration  
www.dol.gov/ebsa  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1-877-267-2323, Menu Option 4, Ext. 61565

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**Important Notice from Doctors Community Hospital (DCH) About Your Prescription Drug Coverage and Medicare D**

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

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

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

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**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current CareFirst BCBS coverage will be affected. If you do decide to join a Medicare drug plan and drop your current DCH/CareFirst BCBS coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with DCH/CareFirst BCBS and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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**For More Information About This Notice Or Your Current Prescription Drug Coverage.**

Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period so you can join a Medicare drug plan, and if this coverage through DCH/CareFirst BCBS changes. You may also request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” Handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

**HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage).

However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

If you or your dependents lose eligibility for WHCRA benefits, contact Human Resources. If you would like more information on WHCRA benefits, contact Human Resources.

**Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)**

The Newborns’ Act, and its regulations, provides that health plans and insurance issuers may not restrict a mother’s or newborn’s benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse-midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Newborns’ Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above. A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns’ Act, and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

**USERRA (The Uniformed Services Employment and Reemployment Rights Act)**

Individuals who voluntarily or involuntarily leave their job to perform military services have the right to elect to continue their existing employer-based health plan coverage for themselves and their dependents for up to 24 months while in the military. Even if individuals don’t elect to continue coverage during their military service, they have a right to be reinstated in their employer’s health plan when they are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

**Notice of Patient Protections**

The CareFirst BlueChoice HMO and Opt-Out Plus-Open Access POS plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the 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 CareFirst at 877-691-5856 or go to www.carefirst.com and select “Find a Provider”.

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

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CareFirst at 877-691-5856 or go to www.carefirst.com and select “Find a Provider”.

**Women’s Health and Cancer Rights Act 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. If you have questions, please call the number on your medical plan ID card to speak with a Member Services Representative.
### Enrollment Deductions/Reminders

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<th>Plan</th>
<th>Coverage Level</th>
<th>Your Bi-Weekly Cost</th>
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<tr>
<td>Dental</td>
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<td>Vision Only</td>
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<td>American Benefits Group</td>
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<td>FSA Administrative Fee</td>
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<td>Legal</td>
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<td>Accident Insurance</td>
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<td>Universal Life Insurance</td>
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</tbody>
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**YOUR TOTAL BI-WEEKLY DEDUCTIONS**  

**REMEMBER TO:**

- Enroll, change, or waive CareFirst BCBS Medical (HMO, POS or PPO) / Vision Service Plan
- Enroll, change, or waive Delta Dental (Standard or Premier)
- Enroll, change, or waive Vision Service Plan (if not electing Medical)
- Review and confirm all eligible dependents listed
- Provide Human Resources proof of dependents (marriage certificate for spouse and birth certificate for children)
- Elect 2016 Health Care FSA amount
- Elect 2016 Dependent Care Day Care FSA amount
- Enroll, change, or waive Legal Resources
- Enroll, change, or waive UNUM Supplemental Employee and Dependent Life
- Provide Human Resources with updates to your Beneficiary elections
Human Resources Contact:
Pamela Nicholson-Flora
Benefits & Compensation Manager
Phone: 301-552-8081
Email: pnicholson-flora@DCHweb.org
Avion Joseph-Sutherland
Benefits & Compensation Specialist
Phone: 301-552-8086
Email: ajoseph@DCHweb.org

Medical Benefit Carrier:
CareFirst BlueCross BlueShield
Phone: 877-691-5856
Website: www.carefirst.com
Group #: BC HMO—5800640
BC POS—5800642
BC PPO—5801412
Prescriptions: 800-241-3371

COBRA Administrator:
American Benefits Group (ABG)
Phone: 800-499-3539 ext. 3
Website: www.cobra.mycobraresource.com/PortalLogin.aspx

Dell Employee Purchase Program:
Phone: 877-289-9437
Website: www.dell.com/epp
Member ID: PS22280426

Dental Plan Carrier:
Delta Dental
Phone: 800-932-0783
Website: www.deltadental.com
Group #: 11463

Employee Assistance Program (EAP):
United Behavioral Health
Phone: 800-586-6873
Website: www.liveandworkwell.com
Access Code: DCH

Flexible Spending Accounts (FSA) Administrator:
American Benefits Group (ABG)
Phone: 800-499-3539 ext. 2
Website: www.amben.com/wealthcare

403(b) & Cash Balance Pension Plan:
Transamerica
Phone: 800-755-5801
Website: www.my.trsretire.com

Legal Resources:
Phone: 800-728-5768
Website: www.legalresourcesplan.com

Life/AD&D and Supplemental Life:
UNUM
Phone: 800-421-0344
Website: www.unum.com
Group #: 226205

MEDICARE:
Phone: 1-800-MEDICARE
Website: www.medicare.gov

NPEP Apartment Discount Program:
Phone: 877-629-6082
Website: www.npep.com

PetFirst HealthCare:
Phone: 866-937-7387
Website: www.petfirst.com/dch

PayCheck Direct:
Phone: 866-441-9160
Website: http://dch.mypaycheckdirect.com

United Buying Service:
Phone: 301-657-1920 or 410-792-9070
Website: www.ubs4cars.com

Voluntary Benefits (UNUM Disability, Critical Illness and Accident, and Transamerica Universal Life Insurance):
Administration (Enroll, Changes & Terminations)
Phone: 855-500-2103

UNUM Claims
Phone: 800-635-5597
Website: www.unum.com
Group #: E0301119

Transamerica Universal Life Claims
Phone: 888-763-7474

Vision Carrier (VSP):
Vision Service Plan
Phone: 800-877-7195
Website: www.vsp.com
Group#: 121597810001

Working Advantage:
Phone: 800-565-3712
Website: www.workingadvantage.com
Member ID#: 304083891

UNUM Worldwide Emergency Travel Assistance:
Phone: 800-872-1414
(outside US access code + 609-986-1234)

For more information about benefits and online enrollment visit the DCH online benefits system at dch.benelogic.com.