



Washington Suburban
Sanitary Commission

Eat Well, Be Well, Stay Well



Retiree Open Enrollment

Benefits & Wellness Programs

2012 Plan Year

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Washington Suburban Sanitary Commission

14501 Sweitzer Lane • Laurel, Maryland 20707-5901

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September 23, 2011

Dear Retiree:

The time to make elections for 2012 benefits is quickly approaching. Open enrollment is October 3 – 28, 2011 and this is your annual opportunity to modify your benefit choices and to sign up for any new benefits that are effective January 1, 2012.

We continue to experience challenging economic times. Our benefit costs have continued to rise but we continue to seek opportunities to provide excellent offerings at the lowest possible prices. Despite our best efforts, we have experienced some increases. After much consideration, we have chosen to maintain our cost sharing arrangements at the current level, but a few co-pays have increased.

The most significant change for 2012 is that we are ending our relationship with CareFirst as of December 31, 2011. We will still maintain two medical carriers, United Healthcare and Kaiser Permanente.

While we do everything we can to negotiate with the carriers to keep costs down, we also need your help so we can continue to offer these excellent benefits. One way you can help is to focus on prevention and taking care of yourself. Take advantage of health screenings available through your insurance carrier. They are covered at 100% (copay may apply) and are a great way to stay healthy and to learn about or continue preventive healthcare. You can also save money by using an urgent care center or seeing your doctor instead of the emergency room, unless of course you have a life threatening emergency. Always follow your physician's instructions and take your medications as prescribed.

This is a special reminder to all retirees who select coverage for dependent children age 19-26. We must have documentation to verify eligibility. We audit these submissions to ensure we are in compliance with all regulatory and plan requirements. As we continue to audit last year's submissions, we will give a critical eye to this year's submissions as well. Eligibility must be verified before 2012 coverage will be authorized.

This Open Enrollment booklet contains specific details of all changes. Give special attention to the *Highlights of Plan Changes for 2012* section. It outlines summary details of the various insurance plans being offered for calendar year 2012.

SPECIAL ATTENTION:

WSSC's insurance carriers coordinate benefits with Medicare. This means that you should have Medicare Part A and Part B, when eligible. WSSC will not pay for the services that Medicare Part B normally covers, if you do not elect Medicare Part B.

You must complete and return the Benefit Request Form for the 2012 Plan Year (2-sided form) and return in the self-addressed, stamped envelope to:

- **change or keep your current benefits** for 2012; and
- to list the names and Social Security Numbers of your dependents to be in compliance with the law which requires this information.

If you have Carefirst, you must choose another medical plan or you will not have medical coverage for 2012.

The best way to get additional information or have your questions answered is to stop by one of the open enrollment sessions at a WSSC site closest to you. A schedule of these sessions is contained in this booklet. For assistance please email openenrollment@wsscwater.com or call 301-206-7034.

Respectfully,

A handwritten signature in black ink that reads "Yvonne D. McKinney".

Yvonne D. McKinney
Director, Human Resources Office

2012 Health & Dental Plan Rates for Retirees

Plan & Coverage Level	2012 Monthly Rate	WSSC Monthly Contribution	Retiree Monthly Deduction
United Healthcare ChoicePlus POS			
Individual	\$ 840.00	\$ 655.20	\$ 184.80
2-Person	\$ 1,659.00	\$ 1,294.02	\$ 364.98
Family	\$ 2,099.00	\$ 1,637.22	\$ 461.78
United Healthcare Medicare Supplement			
Individual Medicare	\$ 463.00	\$ 370.40	\$ 92.60
2-Person Medicare	\$ 927.00	\$ 741.60	\$ 185.40
United Healthcare Select EPO			
Individual	\$ 577.00	\$ 461.60	\$ 115.40
2-Person	\$ 1,155.00	\$ 924.00	\$ 231.00
Family	\$ 1,680.00	\$ 1,344.00	\$ 336.00
Kaiser Permanente HMO			
Individual	\$ 465.00	\$ 372.00	\$ 93.00
2-Person	\$ 930.00	\$ 744.00	\$ 186.00
Family	\$ 1,408.00	\$ 1,126.40	\$ 281.60
Medicare	\$ 211.00	\$ 168.80	\$ 42.20
2-Person Medicare	\$ 422.00	\$ 337.60	\$ 84.40
Delta Dental PPO			
Individual	\$ 38.00	\$ 0.00	\$ 38.00
2-Person	\$ 65.00	\$ 0.00	\$ 65.00
Family	\$ 97.00	\$ 0.00	\$ 97.00
Delta Dental HMO			
Individual	\$ 20.00	\$ 0.00	\$ 20.00
2-Person	\$ 32.00	\$ 0.00	\$ 32.00
Family	\$ 48.00	\$ 0.00	\$ 48.00

Note: For the 2012 plan year, WSSC contributes 78% of the monthly premium towards the United Healthcare Choice Plus POS plan and 80% of the monthly premium for all other health plans. There is no contribution to the dental plans.

Benefits Open Enrollment Schedule

October 2011

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
2	3 OPEN ENROLLMENT BEGINS	4 INFO SESSION RGH Building 9:00 a.m.-1:00 p.m.	5 INFO SESSIONS Temple Hills 7:30 a.m.-9:30 a.m. Western Branch 11:00 a.m.-12:30 p.m.	6	7	8
9	10 BENELOGIC OPENS Columbus Day Offices Closed	11	12 INFO SESSIONS Gaithersburg 7:30 a.m.-9:30 a.m. Potomac 11:00 a.m.-12:30 p.m.	13	14	15
16	17	18	19 INFO SESSIONS Lyttonsville 7:30 a.m.-9:30 a.m. Consolidated Lab 11:00 a.m.-12:30 p.m.	20 INFO SESSION RGH Building 12:00 p.m.-3:00 p.m.	21	22
23	24	25	26 INFO SESSION Anacostia 7:30 a.m.-9:30 a.m.	27	28 OPEN ENROLLMENT ENDS BENELOGIC CLOSES	29

Richard G. Hocevar Building
LK 120 & 121
301-206-8696
14501 Sweitzer Lane, Laurel, MD 20707
October 4, 2011, 9:00 a.m.-1:00 p.m.
October 20, 2011, 12:00 p.m.-3:00 p.m.

Temple Hills Depot
Multi-Purpose Room
301-206-7300
8444 Temple Hill Rd., Temple Hills, MD 20748
October 5, 2011, 7:30 a.m.-9:30 a.m.

Western Branch WWTP
Conference Room
301-206-7550
6600 Crain Hwy., Upper Marlboro, MD 20772
October 5, 2011, 11:00 a.m.-12:30 p.m.

Gaithersburg Depot
Multi-Purpose Room
301-206-7350
111 West Diamond Ave., Gaithersburg, MD 20877
October 12, 2011, 7:30 a.m.-9:30 a.m.

Potomac WFP
Multi-Purpose Room
301-206-7390
12200 River Road, Potomac, MD 20854
October 12, 2011, 11:00 a.m.-12:30 p.m.

Lyttonsville Depot
Multi-Purpose Room
301-206-4086
2501 Lyttonsville Rd., Silver Spring, MD 20910
October 19, 2011, 7:30 a.m.-9:30 a.m.

Consolidated Laboratory
Conference Room (behind Lobby)
301-206-7575/7580
12245 Tech Road, Silver Spring, MD 20904
October 19, 2011, 11:00 a.m.-12:30 p.m.

Anacostia Depot
Multi-Purpose Room
301-206-4295
3500 Kenilworth Ave., Hyattsville, MD 20781
October 26, 2011, 7:30 a.m.-9:30 a.m.

Highlights of Plan Changes for 2012

CareFirst

As previously communicated, we are ending our relationship with CareFirst effective December 31, 2011. If you are currently enrolled in CareFirst, you will need to choose Kaiser or United Healthcare during this Open Enrollment period in order to have medical benefits (through WSSC) as of January 1, 2012. If you fail to choose another plan during this Open Enrollment period, you will not have medical benefits in 2012 nor will you be able to re-enroll in the future.

Kaiser Permanente HMO

Added hearing aid coverage for dependent children up to age 26.

United Healthcare Choice Plus POS In-network:

- The copay amount for all physicians will change from \$15 to \$20.
- The copay amount for specialists will change from \$20 to \$25.
- Ambulance transportation from an out-of-network hospital to an in-network hospital for a non-emergency situation will be covered at 100%.
- Coverage for rehabilitative services will change from 60 combined visits for all types of therapy to 60 visits per therapy per year.
- Coverage for the number of visits for chiropractic services will change from 24 to 36 per year.
- The copay amount for outpatient mental professional services will change from \$5 to \$10.

United Healthcare Choice Plus POS Out-of-network:

- Ambulance transportation from an out-of-network hospital to an in-network hospital for a non-emergency situation will be covered at 100%.
- Coverage for rehabilitative services will change from 60 combined visits for all types of therapy to 60 visits per therapy per year.
- Coverage for the number of visits for chiropractic services will change from 24 to 36 per year.

United Healthcare Select EPO:

- The copay amount for all physicians will change from \$15 to \$20.
- The copay amount for specialists will change from \$20 to \$25.
- Ambulance transportation from an out-of-network hospital to an in-network hospital for a non-emergency situation will be covered at 100%.
- Coverage for the number of visits for chiropractic services will change from 24 to 36 per year.
- The coverage for chiropractic services will change from 100% after coinsurance to \$25 per visit.

Delta Dental PPO

- Dental implants will be covered as a standard benefit at 60% of the charge, after you pay the \$25 annual deductible.
- Added a new option to promote dental wellness and awareness. The D & P Maximum Waiver encourages preventive care and stretches employee maximums.
- Diagnostic and Preventive care does not count against calendar year maximum.

Highlights of Plan Changes for 2012

Caremark

- The copay amount for retail brand-name on the federal drug list will change from \$10 to \$15.
- The copay amount for retail brand-name not on the federal drug list will change from \$25 to \$30.
- The copay amount for mail order brand-name on the federal drug list will change from \$20 to \$25.
- The copay amount for mail order brand-name not on the federal drug list will change from \$50 to \$55.
- Added a Generic Step Therapy Plan which encourages the use of lower cost generics and preferred brands. This plan promotes prescription benefit education and helps to reduce our overall prescription costs.

Note: The copay amount for generics will remain the same as 2011.

Wellness/Health Management Programs

We encourage all of our members to be proactive in managing their health by taking advantage of screenings, wellness visits, educational opportunities and other resources available. There is no cost to you for these services. Ultimately, participating in these programs will provide savings for you and the Commission as well as improve the health of all our members.

Summary of Services Disclaimer

The 2012 Medical Summary of Services chart is intended to provide plan highlights. It is a summary of benefits; not an all inclusive listing of services provided by the carriers. For a more detailed description of benefits, please refer to the plan's benefit booklet, brochure, or service agreement. Or, you may call the plan using the customer service phone number on the back page of this booklet. Please note that plans will not cover a service if it is not considered medically necessary.

Should your physician or facility discontinue participation in a plan, you will not be allowed to change plans outside the window of Open Enrollment as this is NOT considered a qualifying life event for you or your dependents.

If there are any discrepancies between this document and the contract with the carrier, the contract will govern.

Open Enrollment Frequently Asked Questions

Enrollment

■ WHEN IS OPEN ENROLLMENT?

- October 3, 2011 through October 28, 2011

■ WHAT OPTIONS DO I HAVE DURING OPEN ENROLLMENT?

- Change to a different health and/or dental plan
- Change coverage levels by adding or deleting dependents**
- Waive health and/or dental coverage for the 2012 Plan Year
- Continue or decrease coverage, or waive Supplemental Life Insurance (if applicable)
- Update beneficiary information for Basic Life Insurance and Supplemental Life Insurance (if applicable)

** PLEASE NOTE: Any benefits change to add or delete dependents requires legal documentation before benefits will be available. See Change of Life Event section below.

■ HOW DO I ENROLL?

ALL ENROLLMENT IS DONE ON THE BENEFITS REQUEST FORM RECEIVED WITH THIS BOOKLET.

- Complete the form, even if you're not making changes, and SIGN-IT.
- Make sure both sides are complete.
- Mail the completed form back to WSSC's HR Department using the enclosed postage-paid envelope.
- If you have CareFirst you need to choose another plan.

■ WHAT IF I AM NOT MAKING ANY CHANGES?

- You are still required to sign the enclosed form and return it to WSSC so we can validate your enrollment for 2012 and make sure all your eligible dependents have coverage.
- Once Open Enrollment is over, you will not be able to make any changes to your plans or coverage levels unless you have a qualifying life event change. See Change of Life Events section for further details.

■ WHAT IF I CHANGE MY MIND AFTER OPEN ENROLLMENT?

- Once Open Enrollment closes, your selections are binding and can not be changed, modified or canceled unless you have a qualifying life event change. See Change of Life Events section for further details.

Health and Dental Benefits

■ WHEN DO THE CHANGES I MAKE BECOME EFFECTIVE?

- All changes become effective January 1, 2012.

■ WHAT HEALTH AND DENTAL PLANS WILL BE OFFERED?

- **Health Plan Options:** United Healthcare Choice Plus POS, United Healthcare Select EPO, and Kaiser Permanente HMO (available to retirees whose zip code is within a 30 mile radius of a Kaiser facility).
- **Dental Plans Options:** Delta Dental PPO and Delta Dental HMO (Delta Care USA).

■ WHAT IS HAPPENING TO CAREFIRST?

- CareFirst coverage will end December 31, 2011. All CareFirst members must choose another plan to continue coverage in 2012.
- If you have CareFirst and do not choose another plan, you will not have any medical coverage in 2012 and will permanently lose medical coverage through WSSC.

Open Enrollment Frequently Asked Questions

■ WHEN WILL I RECEIVE MY HEALTH CARE CARDS?

- If you are changing plans you should receive your health care cards no later than January 1, 2012. Otherwise, you will not receive a new card.

■ WHY AM I REQUIRED TO PROVIDE MY DEPENDENTS SOCIAL SECURITY NUMBERS?

- The federal government coordinates all employers' group health plans with Medicare to insure coverage and proper payment. This is found in Section 111 of "The Medicare, Medicaid and SCHIP Extension Act of 2007" which requires all group health plans to submit Medicare Secondary Payer data to the Centers for Medicare and Medicaid Services (CMS) which include dependent names as well as social security numbers for subscribers and dependents. The provisions of this Act are effective January 1, 2011. This data submission is required for coordination of benefits purposes.

■ ARE THERE ANY FORMS OR DOCUMENTS TO COMPLETE?

- Yes, the Benefits Request Form you received with this booklet.
- If enrolling a dependent child age 19-26, a notarized affidavit and birth certificate is required. See Insurance Coverage for Dependent Children Age 19-26.

■ HOW DO I ELECT LONG TERM CARE INSURANCE?

- The Long Term Care Insurance Plan is administered directly through Prudential. For more information on the Long Term Care Insurance Plan, please contact Prudential at 1-800-732-0416, or visit their website at www.prudential.com/gluc/mca.html. Please see the Long Term Care Insurance summary on page 18 in this booklet for more information.

Life Insurance

■ DO I HAVE BASIC LIFE INSURANCE AS A RETIREE?

- Anyone who retired in 1982 or later has Basic Life Insurance. If you have not updated your beneficiaries we highly recommend you complete a new form. One is included in this booklet. It is important that your benefit go to the person(s) of your choosing.

■ DO I HAVE SUPPLEMENTAL LIFE INSURANCE AS A RETIREE?

- This benefit was offered to retirees in 1988 and is an optional life insurance. If you chose to keep this benefit when you retired, and are paying the premiums, then you have Supplemental Life Insurance. You would have had to select your benefit amount when you retired, as that was the only time you could elect this benefit. The maximum amount available is (and was) \$20,000.00. You can never increase your coverage, but you have the option to decrease or stop coverage. Please make sure your beneficiaries are up-to-date. Contact HR if you would like a new form.

■ WHY AM I BEING ASKED TO PROVIDE MY BENEFICIARIES SOCIAL SECURITY NUMBERS AND ADDRESSES?

- This is the best way for us to locate your beneficiaries in the event something happens to you and to ensure that the right person, as designated by you, receives the benefit.

Change of Life Events

■ WHAT HAPPENS TO MY BENEFITS IF I GET MARRIED, HAVE A BABY, ADOPT A CHILD, GET DIVORCED...?

- You need to inform HR **WITHIN 30 DAYS OF THE EVENT** and provide HR with certified documentation such as a marriage license, birth certificate, divorce decree or legal documents.

■ WHAT IF MY SPOUSE LOSES BENEFITS AT HIS/HER JOB?

- You need to inform HR **WITHIN 30 DAYS OF THE EVENT** and provide HR with proof of previous coverage from the spouse's insurance and/or HR department.

Open Enrollment Frequently Asked Questions

■ WHAT IF I MOVE AND MY INSURANCE DOES NOT OFFER COVERAGE IN MY NEW AREA?

- You need to inform HR **WITHIN 30 DAYS OF THE EVENT** and provide HR with proof of your new residence.
- You will then be able to choose another plan that does offer coverage in your area.

Insurance Coverage for Dependent Children Age 19-26

■ ARE DEPENDENT CHILDREN AGE 19-26, COVERED?

- Yes, per Health Care Reform, plans and insurers that offer dependent coverage must offer coverage to members' dependent children age 19-26. This started in 2011.
- We will not require that the dependent child age 19-26 live with his or her parent, is a dependent on a parent's tax return or is a full-time student.
- The new policy provides coverage to both married and unmarried dependent children age 19-26.

■ WHEN DOES THEIR COVERAGE START?

- Coverage will be effective January 1, 2012 for newly enrolled dependents age 19-26, with a completed Affidavit.

■ HOW DO I ENROLL MY DEPENDENT CHILD(REN) AGE 19-26 IN HEALTH AND DENTAL COVERAGE?

- Each retiree must complete a notarized AFFIDAVIT and submit a copy of the certified birth certificate (even if you believe we already have a copy) to enroll each dependent child age 19-26. Falsifying this document is considered insurance fraud. Please contact HR if you need the form.
- If you sent an Affidavit with required documentation last year, you do not need to complete another one. Your 19-26 year old Dependent Child will retain health and dental insurance unless you remove them from coverage.

■ WHAT IF MY CHILD IS AWAY AT COLLEGE OR LIVING OUT OF THE AREA?

- Make sure your health plan will cover your child(ren) where they live. The Kaiser HMO is only a regional plan and not available outside the Washington, DC metro area. The United Healthcare Plans are nationwide and you can choose either in-network only doctors or opt to use any doctor, in or out-of-network, but pay additional amounts for out-of-network coverage.
- A true emergency, as defined by the insurance company, will always be covered at the in-network level.

■ WHAT IF I HAVE A DISABLED CHILD(REN)?

- An eligible dependent who is incapable of self-support because of a mental and/or physical disability and who depends on you for support may continue to be covered on any of the health and dental plans, with proper documentation, regardless of age. Please contact the Open Enrollment phone line at 301-206-7034 or email openenrollment@wsscwater.com to request the Disabled Dependent Verification form.

WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL INFO?

Contact the Open Enrollment phone line at 301-206-7034 or email openenrollment@wsscwater.com. Please leave your full name, I.D. number, home address and phone number.

**ALL DOCUMENTATION FOR CHANGES EFFECTIVE
JANUARY 1, 2012 MUST BE SENT TO THE BENEFITS OFFICE
NO LATER THAN OCTOBER 28, 2011.**



KAISER PERMANENTE® Prescription Benefits

Prescription Benefits At-A-Glance

(For Non-Medicare prescription drug coverage)

	Kaiser Permanente Medical Center	Community Based/ Network Pharmacy	Mail Order Program
When to Use Your Benefit:	For immediate or short term prescriptions:	For immediate or short term prescriptions:	For maintenance or long term prescriptions:
Where:	Prescriptions can be filled at a Kaiser Permanente Medical Center. <i>Please Note: Copays are lower when filled at a Kaiser Permanente Medical Center vs. a community network pharmacy.</i>	Prescriptions can also be filled at community pharmacies such as: Giant®, Safeway®, Rite Aid®, Target®, Wal-Mart®, and K-Mart®. <i>Please Note: Copays are higher when filled at a community network pharmacy.</i>	You can have prescriptions mailed right to your home through the Kaiser Permanente Mail order program.
Cost to You:	<p>Up to a 60-day supply:</p> <ul style="list-style-type: none"> • \$5 for generic. • \$15 for brand name drugs. • \$30 for non-preferred drugs. <p>Up to a 90-day supply:</p> <ul style="list-style-type: none"> • \$7.50 for generic. • \$22.50 for brand name drugs. • \$45 for non-preferred drugs. 	<p>Up to a 60-day supply:</p> <ul style="list-style-type: none"> • \$20 for generic. • \$35 for brand name drugs. • \$50 for non-preferred drugs. <p>Up to a 90-day supply:</p> <ul style="list-style-type: none"> • \$30 for generic. • \$52.50 for brand name drugs. • \$75 for non-preferred drugs. 	<p>Up to a 90 day supply:</p> <ul style="list-style-type: none"> • \$7.50 for generic. • \$22.50 for brand name drugs. • \$45 for non-preferred drugs.
Web Services:	Members are able to order prescription refills online or check the status of a prescription refill for yourself or another member, and review a list of covered drugs through the members only section of the Kaiser Permanente web site, www.kp.org .		

Your Personal Prescription Benefit Program

Washington Suburban Sanitary Commission

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the back side, you will find details about Maintenance Choice®, which offers two ways for you to save on your long-term medications. CVS Caremark and Washington Suburban Sanitary Commission are confident you will find value with your new prescription benefit program.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS/pharmacy For long-term medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 64,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-888-790-4271.	You have the convenience of getting your long-term medications at one of our 7,100 CVS/pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	\$5 for a generic prescription	\$10 for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	\$15 for a preferred brand-name prescription	\$25 for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	\$30 for a non-preferred brand-name prescription	\$55 for a non-preferred brand-name prescription
Refill Limit	One initial fill plus two refills for long-term medications	None
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.	
Customer Care	Visit www.caremark.com or call toll-free at 1-888-790-4271.	
Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.		

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

NUBAAG

Use Maintenance Choice to Fill Your Long-Term Medications

Maintenance Choice® offers you choice and savings when it comes to filling long-term prescriptions. Now you have **two ways to save:**

CVS Caremark Mail Service Pharmacy:

- Enjoy convenient home delivery
- Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- Talk to a pharmacist by phone

CVS/pharmacy:

- Pick up your medication at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com.

To Get Started

The following chart provides detailed steps to help you start enjoying all the benefits of Maintenance Choice.

IF YOU WOULD LIKE...	THEN...
To continue with mail service	You don't have to do anything. We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	Please let us know. You can do so quickly and easily. Choose the option that works best for you: <ul style="list-style-type: none"> • Register or log into www.caremark.com to select a CVS/pharmacy location for pick up • Visit your local CVS/pharmacy and talk to the pharmacist • Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest
To sign up for mail service for the first time	You can do so easily online or by phone. <ul style="list-style-type: none"> • Register or log into www.caremark.com, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	Give us a call. Use the phone number on the back of your Prescription Card to call us toll-free.

Before you reach your 30-day fill limit and your out-of-pocket cost increases, we will contact you to help you get started with Maintenance Choice. We'll then help you get a 90-day prescription from your doctor so you can choose to fill it through mail service or at a CVS/pharmacy.

Plan Description

- Delta Dental offers fee-for-service dental benefits coupled with the cost management features of managed care. Subscribers have freedom of choice among dentists. Delta Dental has two networks of participating dentists: Delta Dental Premier® and Delta Dental PPOSM. Participating dentists complete and submit claim forms and participating dentists have agreed to accept Delta Dental’s applicable Maximum Plan Allowances, or their actual charge, whichever is less (the “Allowed Amount”), as payment in full for covered services.
- The maximum benefit per person per year for services provided by PPO dentists is \$1,500.
- The maximum benefit per person per year for services provided by Premier or non-participating dentists is \$1,250.
- There is a separate \$1,500 lifetime maximum per person for orthodontic services (covered for enrollees, spouses and dependents to the end of the month of the 26th birthday).
- Subscribers who use non-participating dentists may need to file claim forms for reimbursement. Plan payments will be based on Delta Dental’s applicable Maximum Plan Allowances, or the dentist’s actual charge, whichever is less (the “Allowed Amount”).

Diagnostic & Preventive Services

- These services are covered at 100%, if applicable. Allowed Amount with no deductible includes: up to three oral exams per calendar year, up to three bitewing x-rays in a calendar year, one set of full mouth x-rays in a three-year period, up to three prophylaxes (teeth cleanings) in a calendar year, up to three fluoride treatments (to age 19) in a calendar year, sealants (to age 14, once in any 36-month period on unfilled permanent first and second molars), and space maintainers (to age 14).
- Diagnostic & Preventive Maximum Waiver: Diagnostic and Preventive care will not count against your plan year maximum.
- Enhanced Benefits for Pregnancy: Includes additional oral exam and choice of: additional cleaning, additional periodontal scaling/root planning, or additional periodontal maintenance procedure.

Percentage Paid by Delta Dental, following \$25 annual deductible for selected dental services (refer to the plan brochure for complete list)

Basic Restorative (“Silver” & “white” fillings)	90%
Oral Surgery (Extractions)	80%
Endodontics (Root canal therapy)	80%
Crown & Bridge Recementation	80%
Denture Repair	80%
Night Guards	80%
Injectable antibiotics	80%
Periodontics (Treatment of gum disorders)	60%
Major Restorative (Crowns, inlays, onlays)	60%
Prosthodontics (Dentures, bridges, implants)	60%
Orthodontics (No Deductible)	50%

Plan Description

- DeltaCare USA promotes great dental health for you and your family with quality dental benefits at an affordable cost. DeltaCare USA plans are designed to encourage you and your family to visit the dentist regularly to maintain your dental health. Today, over 1.2 million enrollees are covered by DeltaCare USA plans.
- When you enroll, you select a primary contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

DeltaCare USA DHMO Enrollment Option:

- Your chosen primary contract dentist will take care of the dental needs for each enrolled family member. If you require treatment from a specialist, your primary dentist will handle the referral for you.
- A family may elect up to 3 dentists.
- After you have enrolled, you will receive a membership packet that includes an identification card and an Evidence of Coverage that fully describes the benefits of your plan. Also included in this packet is the name, address and phone number of your primary dentist.
- Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your primary dentist) for certain benefits.

Please note: Dental services that are not performed by your chosen primary dentist, or are not covered under provisions for emergency care, must be preauthorized by the Administrator to be covered by your DeltaCare USA program.

PATIENT PAY

Periodic oral exam (D0120)	No Charge
Bitewing x-ray, single film (D0270)	No Charge
Prophylaxis cleaning, adult (D1110)	\$5.00
Amalgam restoration, single surface (D2140)	\$8.00
Crown, porcelain fused to metal (D2750)	\$395.00
Root canal, anterior	\$125.00
Complete denture, maxillary (D5110)	\$365.00

Please see complete fee schedule available at open enrollment meetings or by visiting Human Resources.

2012 Medical Summary of Services

Plan Benefits	United Healthcare Choice Plus POS In-Network	United Healthcare Choice Plus POS Out-of-Network	United Healthcare Select EPO In-Network Only	Kaiser Permanente HMO In-Network Only
Copays: PCP Specialists	\$20 \$25	\$20 \$25	\$20 \$25	\$15 \$20 Requires PCP & referrals.
	No PCP or referrals required.			
Well Child Office Visits, Annual Exam & Immunizations	Covered at 100% after \$20 copay through age 18.	Covered at 70% of Plan Allowance through age 18. Not subject to deductible.	Covered at 100% after \$20 copay.	\$0 Well Child Exams / Immunizations \$0.
Adult Office Visits, Annual Exam & Immunizations	Covered at 100% after \$20 copay.	Covered at 70% of Plan Allowance after deductible. No immunizations over age 18.	Covered at 100% after \$20 copay.	\$0 copay for exam / Immunizations \$0.
Physician Office Visit (PCP)	Covered at 100% after \$20 copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after \$20 copay.	\$15 Copay; waived for children under age 5.
Specialist Office Visit	Covered at 100% after \$25 copay (non-routine care).	Covered at 70% of Plan Allowance after deductible.	\$25 copay (non-routine care).	\$20 copay.
Routine Gynecological Exam	Covered at 100% after applicable PCP copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after applicable PCP copay.	Covered at 100%.
Mammogram Screening	Covered at 100% for routine screenings; see plan summary for age and frequency schedule.	Covered at 70% of Plan. Not Subject to deductible.	Covered at 100%.	Covered at 100%.
Cancer Screenings, Prostate, PAP, Colorectal	Covered at 100% for routine screenings after applicable PCP copay. Diagnostic Lab covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% for routine screenings after applicable PCP copay. Diagnostic Lab covered at 100%.	Covered at 100%.
Allergy – Office Visit	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after applicable PCP or Specialist copay.	\$15 copay PCP / \$20 copay Specialist.
Allergy Testing	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after applicable PCP or Specialist copay.	\$15 copay PCP / \$20 copay Specialist.
Allergy Injections	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after applicable PCP or Specialist copay.	\$15 copay.
Inpatient Hospital/ Facility Hospital Services	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Skilled Nursing Facility	Covered at 100%; (Limited to 60 combined days per benefit period).	Covered at 70% of Plan Allowance after deductible; (Limited to 60 combined days per benefit period).	Covered at 100%; (Limited to 60 days per benefit period).	Covered at 100% when deemed medically necessary; (Limited to 100 days per contract year).
Inpatient Professional Services–Medical Physician Services	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Surgery, Anesthesia	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Diagnostic Radiology & Pathology	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Physical Therapist Services	Please see Outpatient Rehabilitation Services.	Please see Outpatient Rehabilitation Services.	Please see Outpatient Rehabilitation Services.	Covered at 100% for up to 30 days per condition.

This is a summary of health care benefits. In the event of a difference between this summary and the plan brochure, the plan brochure will govern.

PLEASE NOTE: Copay (copayment) charges are PER VISIT unless specified otherwise.

2012 Medical Summary of Services

Plan Benefits	United Healthcare Choice Plus POS In-Network	United Healthcare Choice Plus POS Out-of-Network	United Healthcare Select EPO In-Network Only	Kaiser Permanente HMO In-Network Only
Outpatient Hospital/Facility–Diagnostic Services, Pre-admission testing	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Outpatient Professional Services Labs and X-Ray	Diagnostic Lab and X-Ray covered at 100%. Professional services covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Diagnostic Lab and X-Ray covered at 100%. Professional services covered at 100%.	Covered at 100%.
Surgery	Outpatient hospital covered at 100%. Professional services covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Professional services covered at 100%.	\$20 copay.
Maternity Benefits Hospitalization	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Birth Center	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100% if Kaiser authorized.
Professional—Pre & Postnatal Care	Covered at 100% after the first visit to applicable PCP.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after the first visit to applicable PCP.	\$20 copay for initial visit, then covered at 100%.
Newborn Pediatric Inpatient Care	Nursery care covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Nursery care covered at 100%.	Covered at 100%.
Infertility Services Infertility Counseling and Testing				
Artificial Insemination	Covered at 100%; \$3,000 combined maximum per lifetime.	Covered at 70% of Plan Allowance after deductible; \$3,000 combined maximum per lifetime.	Covered at 100% after 50% coinsurance, limited to \$3,000 lifetime.	50% of allowable charges.
In Vitro Fertilization	Covered at 100% after \$20 copay; limit of 3 attempts per live birth; not to exceed lifetime limit \$100,000.	Covered at 70% of Plan Allowance after deductible; Limit of 3 attempts per live birth; not to exceed lifetime limit \$100,000.	50% coinsurance, limit 3 attempts per live birth; not to exceed lifetime limit \$100,000.	50% of allowable charges for up to 3 attempts per live birth. Kaiser pays a maximum lifetime benefit amount of \$100,000.
Mental Health & Substance Abuse Benefits	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Inpatient Professional	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.	Covered at 100%.
Outpatient Professional	Covered at 100% after \$10 copay.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% after Specialist copay.	Copays: \$15 Individual and \$10 group therapy.
Emergency & Urgent Care—In Area In Office				
Urgent Care Center Plan Affiliated	Covered at 100% after \$20 copay.	Covered at 100% after \$20 copay.	Covered at 100% after \$20 copay.	\$20 copay.
Emergency Room	\$75 copay for ER; waived if admitted.	Covered at the network level.	\$75 copay for ER; waived if admitted.	\$75 copay for emergency room.
Ambulance – Ground and Air	Covered at 100% for emergencies and some non-emergency situations.	Covered at 100% for emergencies and some non-emergency situations.	Covered at 100% for emergencies and some non-emergency situations.	Covered at 100% if approved by Kaiser.

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2012 Medical Summary of Services

Plan Benefits	United Healthcare Choice Plus POS In-Network	United Healthcare Choice Plus POS Out-of-Network	United Healthcare Select EPO In-Network Only	Kaiser Permanente HMO In-Network Only
Emergency & Urgent Care—In Area In Office <i>(Continued)</i>				
Emergency & Urgent Care—Out of Area/ Out of Network Emergency Room or Urgent Care Center	ER: non-emergency use—no coverage; emergency use—covered at 100% after \$75 copay, waived if admitted; \$20 copay for Urgent Care if Participating facility.	Covered at the network level.	\$75 ER copay; \$20 copay for Urgent Care if Participating facility.	\$75 copay for emergency room and \$20 for urgent care.
Outpatient Rehabilitative Services Physical, Occupational and Speech Therapy	Covered at 100%; 60 visits per therapy per benefit year.	Covered at 70% of Plan Allowance after deductible; 60 visits per therapy per benefit year.	Short term non chronic conditions, Specialist copay; 60 combined visits.	\$20 copay; limit 30 visits. 90 day limit for speech and occupational therapy.
Chiropractic Services	Covered at 100% after \$25 copay; up to 36 combined visits per benefit year.	Covered at 70% of Plan Allowance after deductible; up to 36 combined visits per benefit year.	Covered at 100% after \$25 copay; up to 36 combined visits per benefit year.	\$20 copay; 20 visits per calendar year.
Home Health Care	Covered at 100%; 120 combined visits per benefit year.	Covered at 70% of Plan Allowance after deductible; 120 combined visits per benefit year.	Covered at 100%.	Covered at 100%.
Hospice Care	Covered at 100%; 180 day combined lifetime maximum.	Covered at 70% of Plan Allowance after deductible; 180 day combined lifetime maximum.	Covered at 100%.	Covered at 100%.
Durable Medical Equipment Orthopedics Shoe Orthotics limited to two pair every benefit year.	Covered at 100%; \$2,500 combined maximum per benefit year.	Covered at 70% of Plan Allowance after deductible; \$2,500 combined maximum per benefit year.	Covered at 100%.	Covered at 100% when deemed medically necessary.
Hearing Aids (Dependents up to age 26 only) Audiometric Exam, Evaluation Test, Purchase and Fitting	Covered at 80%; limited to \$1,200 combined maximum every 3 benefit years.	Covered at 70% of Plan Allowance after deductible; limited to \$1,200 combined maximum every 3 benefit years.	Covered at 80% coinsurance; limited to \$1,200 every 3 benefit years.	Covered up to \$1,400 maximum per each hearing impaired ear every 36 months for children up to age 26.
Vision Services	Specialist copay for eye refractive exam every 12 months.	Covered at 70% after deductible; One eye exam every 12 months.	Specialist copayment for eye refraction exam every 12 months.	\$15 copay PCP/ \$20 copay Specialist.
Glasses & Contacts	Discounts on lenses and frames at participating providers.		Discounts available on lenses and frames, at participating providers.	Contacts & Frames: 25% discount on lenses and frames.
Prescription Benefit	See full description of the Caremark Prescription Benefit on pages 10-11.	See full description of the Caremark Prescription Benefit on pages 10-11.	See full description of the Caremark Prescription Benefit on pages 10-11.	See Kaiser Pharmacy description on page 9.
Deductibles	N/A.	\$250 Individual \$500 Family.	N/A.	N/A.
Out-of-Pocket Maximum	N/A.	\$2,250 Individual \$4,500 Family.	\$1,100 Individual \$3,600 Family.	N/A.

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Wellness Fair

WSSC Wellness Event During Open Enrollment

Last year's Wellness Fair at RGH was a huge success so we will offer a similar event at this year's Open Enrollment on **Tuesday, October 4, 2011**. Once again this event is sponsored by the Employee Development Group of Human Resources.

In addition to the normal benefit selections that occur with open enrollment, employees and retirees will have the opportunity to learn about Wellness opportunities, partake in some demonstrations, and find more tools to improve their health and well-being.

WELLNESS PROGRAM MISSION

The Wellness Program is a component of the Employee Development Program. The wellness program's mission is to improve the health and well-being of our employees through physical, emotional and financial education and programs that will support positive lifestyle changes resulting in improved health, productivity, retention and healthcare cost savings.

- This mission will be achieved through Lunch N' Learns at RGH, Morning Wellness Sessions at the Depots, distribution of health information, increased employee fitness opportunities and special services and health exhibitors during Open Enrollment.
- Partnerships with the Employee Development Group and WSSC's Healthcare Providers, Employee Fitness Center, Safety Office, WSSC Federal Credit Union, PNC Bank and other community organizations will help to ensure that we are "Keeping People and Fish Healthy and Happy" by strategically working together to serve the WSSC employees.
- Employee wellness champions (representatives from the Depots) will help provide feedback, coordinate sessions at the Depots and provide suggestions for the wellness program development and implementation.

Sample Wellness sessions to be considered for FY'12:

Exercise & Fitness	Heart Health	Men's Health
Women's Health	Stress Management	Oral Health
Protecting Yourself Against Identity Theft	Care for the Caregivers	Stroke Prevention
Alzheimer's, Dementia & Senior Health Awareness	Diabetes & Hypertension	Smoking Cessation
Nutrition & Healthy Eating	Preventing Back Injuries	Cancer Awareness
Understanding Your Credit Report & Credit Rights	Credit & Borrowing	Saving & Budgeting
Financial Investments, Wills & Trusts	Emotional Health in a Chaotic World	

WHAT ARE THE BENEFITS OF WELLNESS?

Employees of companies that offer wellness programs are "significantly" more satisfied with their jobs, more likely to remain with the company long term, and more likely to recommend it to a friend or family member as a place to work. Not only do wellness programs boost employee health, but participants in such programs are more engaged employees. Research also shows that a wellness program that contributes to a healthier workforce will reduce health care costs.

For more information about the Wellness Fair,
e-mail Cynthia Parker-Bolden at EmpDev@wsscwater.com.

Long-Term Care Insurance

WSSC will continue to offer a Long Term Care Insurance plan. The plan is administered through Prudential. To request an enrollment kit, call **1-800-732-0416**. To view plan information, rates, exclusions, or to enroll online, please visit the Prudential Long Term Care website at www.prudential.com/glrc/mca.html. The group name login is wssc, and the password is wsscltc.

Once you have received an enrollment kit, mail the completed application directly to Prudential, not WSSC. Payment arrangements are between you and Prudential, not WSSC.

What is Long Term Care?

Long Term Care is the care you may need to go about everyday activities such as bathing, eating and getting dressed. It is care you may need as a result of an accident, debilitating disease or ailment due to aging. Long Term Care may be provided in your home, at an adult day care facility or nursing home or in an assisted living facility. With the Prudential Long Term Care plan, you select the amount you would like to be reimbursed for daily nursing home or home and community based care.

Long Term Care is portable. If you sign up for this benefit while working at WSSC, you can take it with you when you leave since the plan is managed by Prudential and not WSSC.

Base Plan Features

Coverage Amounts

You have your choice of Daily Maximums for Home and Community Based Care and Nursing Home Care. Prudential will pay for your covered expenses up to the applicable Daily Maximum you select.

	Nursing Home Care Daily Maximum	Home & Community Based Care Daily Maximum	Lifetime Maximum*
Option \$100	\$100	\$50	\$182,500
Option \$150	\$150	\$75	\$273,750
Option \$200	\$200	\$100	\$365,000

**All benefits paid will draw down the lifetime maximum*

Eligibility Criteria

You are eligible to apply for this coverage if you are:

- an active employee of WSSC; or
 - a spouse of an eligible WSSC employee; or
 - a parent, parent-in-law, grandparent, or grandparent-in-law of an eligible WSSC employee;
- or
- a WSSC retiree or retiree's spouse.

Please Note: Qualified family members may apply for coverage under this plan even if the eligible WSSC employee or retiree does not.

Legislative Information

HEALTH CARE REFORM

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (the Affordable Care Act), to extend insurance to the 32 million Americans who are currently without it and protect those that already have insurance. WSSC has made some changes to comply with the provisions of the Patient Protection and Affordable Care Act, such as extending coverage to dependent children between the ages of 19-26. Other provisions of the Act did not and will not require any plan changes at this time because WSSC is already in compliance.

WSSC's health plans are a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Office at 301-206-7034. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

ANNUAL DISCLOSURE NOTICE

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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.
- Treatment of physical complications of the mastectomy, including lymphedema.

Our medical plans comply with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Our plan neither imposes penalties (for example, reducing or limiting reimbursement) nor provides incentives to induce providers to provide care inconsistent with these requirements.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

You have specific rights under the Act which protect you and your newborn(s).

The Description of Rights includes:

- General 48/96 Hour Stay Rule.
- Provider Authorization.
- Incentives/Penalties to Mothers or Providers.
- Disclosure with Respect to Hospital Lengths of Stay in Connection with Childbirth.

Our Medical Plans comply with these requirements.

Legislative Information

CHIP – CHILD HEALTH INSURANCE PROGRAM

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a covered State, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit www.insurekidsnow.gov to find out how to apply. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.**

SPECIAL ENROLLMENT RIGHTS UNDER CHIPRA

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) creates two new special enrollment rights for employees and their dependents. All group health plans must permit eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

1. **Loss of coverage under Medicaid or a state child health plan:**
2. **Gaining eligibility for coverage under Medicaid or a state child health plan: The Eligible Person previously declined coverage under the Plan.**
3. **Event Takes Place (for example, a birth, marriage or determination of eligibility for state subsidy).**
4. **Missed Initial Enrollment Period or Open Enrollment Period.**

Please note: Once you terminate your enrollment in our group health plan, your children's enrollment will also be terminated. Failure to notify us of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days, will prevent you from enrolling in our plans and/or making any changes to your coverage elections until our next open enrollment period.

To request special enrollment or if you have questions regarding these disclosures please contact the Benefits Team at hr_benefits@wsscwater.com. You may also find more information by visiting http://www.dol.gov/ebsa/consumer_info_health.html.

Medicare Rules

When you become Medicare eligible at age 65, you automatically receive coverage under Medicare Part A once you start receiving Social Security Benefits. However, coverage under Medicare Part B is not automatic; you are responsible for enrolling in Medicare Part B. You will receive information from the Social Security Administration (SSA) and if you do not, it is your responsibility to contact them.

- ▶ WSSC's insurance carriers will coordinate your benefits with Medicare.
- ▶ This means your coverage with WSSC's plans will not pay for services that would normally be covered by Medicare Part B – whether or not you elect Part B.

If you do not elect Medicare Part B, when eligible, you will pay for up to 80% of your medical expenses.

You are strongly encouraged to enroll in Medicare Part B when you become eligible. It is very important for you to contact the Social Security Administration regarding Medicare Part B since there are certain timeframes established for enrollment. Failure to enroll within these timeframes can result in premium penalties.

After you are enrolled in Medicare Parts A & B, send a copy of your Medicare card to WSSC – HR Department to ensure you have the correct insurance coverage.

If you become eligible for Medicare prior to age 65, coordination of benefits with WSSC's insurance carriers will occur as soon as the WSSC Benefits Office receives a copy of your Medicare card to verify that you are eligible for both Medicare Parts A and B.

You do not need to enroll in a Medicare Part D program if you are enrolled in one of the WSSC's health insurance plans, which include prescription benefits.

SEE SEPARATE FLYER

Medicare Frequently Asked Questions

■ I'M TURNING 65 THIS YEAR, HOW DOES MEDICARE WORK WITH MY INSURANCE?

WSSC's insurance carriers will coordinate your benefits with Medicare once HR receives a copy of your Medicare card. This means that if you have Medicare Part B, then Medicare will pay 80% of your bills and your WSSC insurance will pay 20%. You may still have a co-pay depending on which WSSC plan you select.

- If you are a United Healthcare participant, Medicare coverage becomes your primary insurance carrier and your WSSC coverage becomes your secondary insurance carrier.
- If you are a Kaiser participant, Kaiser will be your primary carrier and Medicare is secondary.

■ WHAT IF I'M NOT 65, BUT HAVE MEDICARE PART A & PART B DUE TO A DISABILITY?

Medicare will pay up to 80% of eligible expenses and your WSSC Medicare Supplement Plan will pay up to 20%. You may still have a co-pay depending on which WSSC plan you select.

■ IF MEDICARE DOES NOT PAY A MEDICAL BILL, BECAUSE A SERVICE IS NOT COVERED, WILL MY SUPPLEMENTAL PLAN PAY THE BILL?

No. Your doctor must accept Medicare in order for your WSSC coverage to pay up to the 20%. This is the same for medical services, they must be Medicare approved for your WSSC coverage to pay their portion of the bill. Make sure to check with your physician, or visit www.medicare.gov or call 1-800-MEDICARE before you have any tests, surgeries, etc. to make sure it is covered by Medicare.

■ WHAT IF MY SPOUSE TURNS 65 BEFORE ME or I TURN 65 BEFORE MY SPOUSE?

When one spouse is enrolling in Medicare, your WSSC insurance enrollment is modified so that you have two separate policies instead of one "two-person" or "family" policy. The Medicare eligible enrollee will have the Medicare Supplement Plan, while the other dependent(s) who are not eligible for Medicare will continue their current coverage.

■ WHAT HAPPENS TO MY MONTHLY BENEFIT DEDUCTION?

Once the Benefits Team has a copy of your Medicare card to verify Medicare Part A & Part B enrollment, your deduction will be updated. Each WSSC carrier has different premiums for Medicare Supplement plans. Please see the rates in this booklet.

■ WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL FORMS?

You may contact the Open Enrollment phone line at 301-206-7034 or email openenrollment@wsscwater.com. Please leave your full name, I.D. number, home address and phone number.

**Please send us a copy of your Medicare card
so we can make the change to your benefit deductions.**

Medicare Summary

Medicare is a national health insurance program covering individuals age 65 and older, younger people with disabilities and people with end stage renal disease (kidney failure). **Medicare Part A** (Hospital Insurance) helps cover inpatient care in hospitals (including critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals), inpatient care in a skilled nursing facility (not custodial or long-term care), hospice care services, home health care services, and inpatient care in a Religious Nonmedical Health Care Institution. Certain conditions must be met to get these benefits. **Medicare Part B** (Medical Insurance) helps cover medically necessary services like physician services, outpatient care, home health care services, and other medical services. Medicare Part B also covers some preventive services. **Medicare Part D** offers coverage for prescription drugs (not necessary when you have a WSSC Medicare Supplement Plan). Your Medicare card shows the Medicare coverage(s) you have and the effective date of your coverage.

Medicare doesn't cover everything. If you need services that Medicare doesn't cover, you will have to pay out of pocket unless you have other insurance (such as a Medicare Supplement Plan) to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments. To find out if Medicare covers a service you need, visit www.medicare.gov and select "Find Out What Medicare Covers," or call **1-800-MEDICARE (1-800-633-4227)**.

Once you're enrolled in Medicare Parts A & B, you will need to change your WSSC sponsored health plan to a Medicare Supplement plan. The Medicare Supplement plans are designed to work in conjunction with your Medicare plan to supplement benefits that Medicare does not offer. When you change to a Medicare Supplement plan offered through WSSC, you are still considered a member of that health plan and may still be governed by the health plans rules on physician and hospital selection, referrals to a specialist, and places where you can receive diagnostic testing or have prescriptions filled.

The Patient Protection and Affordable Care Act (PPACA) passed by Congress and signed by President Obama will provide important new benefits that include free preventive care services like colorectal cancer screening and mammograms. You can also get a free annual physical to develop and update your personal prevention plan based on current health needs.

Listed below are some services that are **not** covered or paid in full by Medicare Part A and/or Part B but would be covered or paid in full by your Medicare Supplement plan.

Medicare Parts A & B	Medicare Supplement Plan
Deductible on your first hospital admission for each benefit period	Pays for the hospital deductible
Daily copayment on hospital days 61-90	Pays for the hospital copayment
Daily coinsurance for days 21-100 in each benefit period for skilled nursing care	Pays the daily coinsurance for skilled nursing care
Deductible for medical services covered under Part B	Pays the deductible
Routine eye exams or eyeglasses	Covers routine eye exams and offer discounts on eyeglass frames & lenses
Hearing aids or routine hearing loss exams	Most of the Medicare Supplement plans offer a hearing exam as part of the annual physical. Hearing aids are not covered

Medicare Eligible Supplement Plan Highlights

All WSSC sponsored health plans provide supplemental coverage for retirees with Medicare Part A and Part B. Benefits under the United Healthcare and Kaiser Medicare Supplements differ from non-Medicare benefit plans and are described below.

Plan Benefits	United Healthcare PPO Medicare Supplement	Kaiser Medicare Plus
Doctor and Hospital Choice	You may choose any doctor or hospital that accepts Medicare	You may choose any Kaiser Permanente network doctor, specialist, and participating hospital. Specialty care may require a referral from your Primary Care Physician.
Annual Physical	Covered at 100%	Covered in full after \$15 copay
Inpatient Hospital Care	Plan pays 100% of covered charges remaining after Medicare	Unlimited days for a Medicare covered stay in a network hospital are covered in full after \$100 copay
Doctor's Office Visits	Plan pays 100% of covered charges remaining after Medicare	\$15 copay
Diagnostic Tests, X-rays & Lab Services	Plan pays 100% of covered charges remaining after Medicare	\$15 copay for radiation therapy; no charge for XRays, lab services, or diagnostic tests
Emergency Room Services	Plan pays 100% of covered charges remaining after Medicare	\$75 copay (copay waived if admitted)
Prescriptions	See Caremark on pages 10–11	\$10 copay for up to a 60 day supply of mail order medicine (brand or generic), \$15 copay for up to a 60 day supply (brand or generic) at Kaiser Permanente center pharmacy, \$25 copay for up to a 60 day supply (brand or generic) at participating network pharmacy
Durable Medical Equipment	Plan pays 100% of covered charges remaining after Medicare. Prior notification required	Covered in full through participating providers
Vision Services	Plan pays 100% for a refractive eye examination every other calendar year; hardware (frames, lenses, etc) are excluded	\$15 copay for eye exam; discounts on frames, lenses and contact lenses
Primary Insurance	Medicare: Parts A & B	Kaiser Permanente
Secondary Insurance	United Healthcare	Medicare: Parts A, B & D

This is a summary of health care benefits. In the event of a difference between this summary and the plan brochure, the plan brochure will govern.

Certificate of Creditable Coverage for Medicare Part D

Important Notice from WSSC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Washington Suburban Sanitary Commission (WSSC) 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. WSSC has determined that the prescription drug coverage offered by WSSC's United Healthcare Medical Plans through CVS Caremark RX Services and WSSC's Kaiser Medical Plan, is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

■ When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current WSSC coverage will be affected. If you are enrolled in the United Healthcare Medicare Supplement, your prescription coverage is provided to you through CVS Caremark. If you elect a Medicare drug plan and you have CVS Caremark prescription coverage then you will no longer be eligible for prescription coverage under CVS Caremark. If you are enrolled in the Kaiser Medicare Plus Supplement, then you do not have to elect Medicare Part D as it is automatic when enrolled in that plan.

If you do decide to join a Medicare drug plan and drop your current WSSC medical coverage, be aware that you and your dependents will not be able to get this coverage back.

■ 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 your WSSC's Medical Plan and don't 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

Certificate of Creditable Coverage for Medicare Part D

Important Notice from WSSC About Your Prescription Drug Coverage and Medicare *(cont'd)*

least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact our office for further information at 301-206-7034 or email openenrollment@wsscwater.com.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through WSSC changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'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 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).

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

Date:	October 3, 2011
Name of Entity / Sender:	Washington Suburban Sanitary Commission
Contact—Position / Office:	Human Resources Department—Benefits
Address:	14501 Sweitzer Lane, Laurel, MD 20707-5902
Phone Number:	301-206-7034

HIPAA

Washington Suburban Sanitary Commission and its affiliated entities NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

**The following entities, owned by or affiliated with WSSC
are covered by this notice:**

This notice applies to the privacy practices of the health plans listed below. As affiliated (related) entities, we might share your protected health information and the protected health information of others on your insurance policy as needed for payment or health care operations.

CareFirst, United Healthcare, Kaiser Permanente, CVS Caremark Rx Services, Delta Dental, SHPS, a Carewise Solution, United Behavioral Health

Our Legal Duty

This Notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and is not intended to amend any prior notice of WSSC's privacy practices. We reserve the right to change our privacy practices and the terms of this

notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within sixty days of the effective date of the change. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

HIPAA

Uses and Disclosures of Medical Information

Primary Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for payment and health care operations. The federal health care Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We might use and disclose your protected health information for all activities that are included within the definition of “payment” as written in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We might use and disclose your protected health information for all activities that are included within the definition of “health care operations” as defined in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our

behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, our business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities: In addition, we might use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we might disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information: The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To You or with Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed on this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we might not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.

HIPAA

Uses and Disclosures of Medical Information (*cont'd*)

To Plan Sponsors: Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We may also disclose summary health information (this type of information is defined in the Federal Privacy Regulations) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

To Family and Friends: If you agree (or, if you are unavailable to agree), such as in a medical emergency situation we might disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Underwriting: We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health Oversight Activities: We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect: We might disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety: Consistent with certain federal and state laws, we might disclose your protected health information if we believe that the disclosure is necessary to prevent

or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We might disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research: We might disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we might disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: We might disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety: We might disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by Law: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We might disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a

HIPAA

Uses and Disclosures of Medical Information (*cont'd*)

court order, warrant, or grand jury subpoena, we might disclose your protected health information to law enforcement officials.

Law Enforcement: We might disclose to law enforcement officials limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We might disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials

protected health information required for lawful intelligence, counterintelligence, and other national security activities.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION: Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

Individual Rights

Access: You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so. We might deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed by a licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests. You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for

HIPAA

Individual Rights (*cont'd*)

uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing. You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premi-

ums and claims) will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice. Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: This notice is also posted on our web site.

Questions and Complaints

Information WSSC's Privacy Practices: If you want more information about our privacy practices or have questions or concerns, please contact the member services number on the back of your card.

Filing a Complaint: If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services (DHHS). We will provide you with the contact information for DHHS upon request. We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIPAA website:

<http://www.hhs.gov/ocr/privacy/>

WSSC Privacy Official:

Carole C. Silberhorn

Human Resources Manager – Benefits

14501 Sweitzer Lane

Laurel, MD 20707-5902

Phone: 301-206-8691

Fax: 301-206-8713

Email: csilber@wsscwater.com

Alternate Email: hr_benefits@wsscwater.com

Glossary of Insurance Terms

BENEFITS: A benefit is a form of indirect compensation designed to provide employees added protection, promote goodwill and reward employment. It usually takes a form other than money and are typically extended to employees as well as their immediate family members.

BRAND-NAME DRUG: A prescription drug that has been patented and is only available through one manufacturer.

CERTIFICATE OF CREDITABLE COVERAGE: A written certificate issued by a group health plan or health insurance company that states the period of time you were covered by your health plan.

CLAIM: A request to the insurance company to pay for benefits or services rendered (either by an individual or his or her health care provider).

CO-INSURANCE: The percentage or amount that the individual is required to pay after a deductible has been met and before the insurance company will pay.

CO-PAYMENT: Amount of money, usually a set amount that a policyholder is required to pay for each visit to a hospital or doctor's office for services.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA): Gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COORDINATION OF BENEFITS: If the insured has more than one health insurance provider, such as being under a spouse's insurance plan along with their own, the insurance company would not pay double benefits. In this case, the health insurance company would coordinate benefits with the other health insurance plan.

DEDUCTIBLE: Refers to the amount of money that the insured would need to pay (per benefit period) before any claims from the health insurance company would be paid.

DEFERRED COMPENSATION: Payment for services under any employer-sponsored plan or arrangement that allows an employee (for tax related purposes) to defer income to the future.

DEPENDENT CARE FSA: A benefit plan designed to allow employees to set aside pre-tax dollars to pay for eligible dependent care expenses, such as daycare, day camp, or elder care. FSAs are strictly regulated by IRS guidelines and it is the employee's responsibility to ensure that their expenses will be eligible for reimbursement prior to enrollment.

DISABLED DEPENDENT: If a child who is physically or mentally incapable of self-support is covered under the benefit plan, the child may continue coverage beyond the normal age limit if the disability continues, the child does not have any other insurance coverage and the child remains unmarried. Medical certification of disability must accompany the carriers required documentation.

DISPENSE AS WRITTEN (DAW): An order on a prescription commanding the pharmacist to provide the recipient with the prescription exactly as it was written.

EXPLANATION OF BENEFITS (EOB): An EOB is not a bill; it is an itemized statement that shows what action was taken on your claims. The EOB explains the services or benefits you received, the doctor(s) visited, the date of service, the amount paid by the insurance company, and any amount you may owe.

EMERGENCY CARE: Care for severe pain, injury, sudden illness, or suddenly worsening illness that you believe can cause serious danger to your health if you do not get immediate medical care.

EMPLOYEE ASSISTANCE PROGRAM (EAP): An EAP is a free confidential program designed to help employees and their family members deal with personal problems that might adversely impact their work performance, relationships, health, and well-being. Examples of EAP services include confidential expert counseling, legal assistance, stress management, alcohol or drug dependency, and financial services.

EMPLOYEE SELF-SERVICE: A trend in human resource management that allows employees to handle many job-related tasks normally conducted by HR (such as benefits enrollment, updating personal information and accessing company information) through the use of a company's intranet, specialized kiosks or other Web based applications.

EXCLUSIONS: Specific conditions or circumstances for which the insurance policy will not provide benefits. These will be phased out over the next few years with the implementation of health care reform law.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN: A plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; a more restrictive type of preferred provider organization. There is no coverage for care received from a non-network provider except in an emergency situation under an EPO plan.

FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993: The Family and Medical Leave Act (FMLA) allows employees who have met minimum service requirements (12 months employed by the company with 1,250 hours of service in the preceding 12 months) to take up to 12 weeks of unpaid leave per year for: (1) a serious health condition; (2) to care for a family member with a serious health condition; (3) the birth of a child; or (4) the placement of a child for adoption or foster care.

FAMILY STATUS/LIFE EVENT CHANGE: Used to define changes to an individual's existing family standing. Typically found in health care benefit plans covered by section 125 of the Internal Revenue Code. IRC 125 does not allow individuals enrolled in a covered benefit plan to make election changes to their existing benefits coverage outside of the plans annual open enrollment period, unless a qualifying change in family or employment status, defined by the IRS as a "Qualified Family Status Change" has occurred (i.e. marriage, divorce, legal separation, death, birth/adoption, changes in employment status, cessation of dependent status, or a significant change in cost or reduction of benefits.) You have 30 days to make enrollment changes following a qualifying family status change (life event). Contact the Benefits Office for more information.

FORMULARY: A list of brand name and generic prescription medications that are preferred or recommended for use under a prescription or health plan.

Glossary of Insurance Terms

FULLY INSURED PLAN: A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

GENERIC DRUG: A "twin" to a "brand name drug" once the brand name company's patent has run out and other drug companies are allowed to sell a duplicate of the original. Generic drugs are less expensive, and most prescription and health plans reward clients for choosing generics.

GENERIC STEP THERAPY: Plans used by pharmacies to encourage the use of lower cost generics and preferred brands. These highly effective solutions promote prescription benefit education and help to reduce our overall prescription costs.

GINA: Title I of the Genetic Information Nondiscrimination Act (2008) prohibits the use of genetic information in employment or health insurance decision-making

HOME HEALTH CARE: In home health care services for an injury or illness that may include skilled nursing care and physical, occupational, and speech therapy.

HOSPICE CARE: Program or facility that provides medical care and support services for terminally ill patients and their families. Its focus is to help make people as comfortable as possible at the end of their life, rather than trying to cure their illness or injury. Hospice care includes physical care, pain control, and counseling.

HEALTH MAINTENANCE ORGANIZATION (HMO): A health benefits program that requires that the member receives care from the doctors and hospitals that are part of the plan's network. HMO's also require that the member select a primary care physician (PCP); generally a family practitioner, internist or pediatrician, who is part of the plan's network. A referral is required from the primary care physician to see specialists in the network.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA): A benefit plan designed to allow employees to set aside pre-tax dollars to pay for eligible medically related expenses, such as medical, vision or dental exams, copays and deductibles, as well as other out-of-pocket expenses.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Federal law designed to allow people to change jobs without fear of losing insurance because of a pre-existing condition. HIPAA also requires additional protections for the privacy of health information.

INPATIENT CARE: Care that you receive in the hospital that requires an overnight stay.

LONG-TERM CARE INSURANCE: An insurance plan that provides coverage for individuals with long-term illnesses or disabilities by paying in whole or in part for long-term medical and non-medical care services. This is often an employee paid benefit without an employer contribution. Health care reform created the Community Living Assistance Services and Supports (CLASS) Act, which creates a voluntary national social insurance program providing limited long-term-care (LTC) coverage through the workplace for employees. The government-run LTC option is intended to provide a baseline for extended care.

MANAGED CARE: A general term for organizing doctors and hospitals into health care delivery networks with the intent of lowering costs and managing the medical care. There are many different kinds of managed care plans including Preferred Provider Organization (PPO) plans, and Health Maintenance Organizations (HMO) plans.

MEDICARE: A health insurance program administered by the Social Security Administration which is broken into two distinct categories: 1) Medicare Part A helps with hospital costs; and 2) Medicare Part B requires a monthly fee and is used to pay medical costs for people 65 years of age and older, some disabled people under 65 years of age and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant). WSSC active employees 65+ can maintain their regular benefits plans. Contact HR for further details.

MEDICARE APPROVED AMOUNT: The amount in which Medicare decides is a reasonable payment for a medical service. Medicare generally pays 80 percent of the approved amount and your supplemental WSSC insurance generally pays 20 percent. (This rule is different for active 65+ employees. Contact HR for further details.)

MEDICARE SECONDARY PAYER: Is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "Coordination of Benefits" when assigning responsibility for first and second payment.)

MENTAL HEALTH PARITY ACT: Health plans that provide coverage for mental health and/or substance abuse treatment must provide benefits that are on par with medical and surgical benefits. This means that health plans may no longer apply, to mental health and substance abuse treatment, limits or financial terms that don't also apply to medical and surgical benefits.

NETWORK: A group of doctors or health care providers that work with specific health insurance companies. Generally, you get your medical care from the health care providers within your insurance company's network.

OPEN ENROLLMENT PERIOD: The period of time designated by the employer's health or other benefit plan when employees may enroll in new benefit plans or make changes to existing benefit plans for a new plan year.

OUT-OF-PLAN (OUT-OF-NETWORK): This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plans network. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) plan's may go out-of-network, but will pay higher out-of-pocket costs. Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-network health professionals may not be covered, or covered only in part by an individual's insurance company.

Glossary of Insurance Terms

OUT-OF-POCKET MAXIMUM: The maximum dollar amount one would pay out of their own pocket for co-pays, coinsurance, or deductible for the year, excluding premiums. Once the out-of-pocket limit is met, the plan pays 100% of the allowed amount for covered services for the rest of the benefit period.

OUTPATIENT CARE: Medical or surgical care that does not include an overnight stay in a hospital.

PATIENT PROTECTION AND AFFORDABILITY CARE ACT (HEALTH CARE REFORM): enacted in March 2010. The Patient Protection and Affordable Care Act will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. Systemic insurance market reform will eliminate discriminatory practices such as pre-existing condition exclusions, eliminate lifetime and unreasonable annual limits on benefits and provide assistance for those who are uninsured because of a pre-existing condition. Beginning in 2014, more significant insurance reforms will be implemented.

POINT OF SERVICE (POS): A plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The insured may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

PRE-EXISTING CONDITION: A pre-existing condition is a health problem that existed before you apply for a health insurance policy or enroll in a new health plan.

PREMIUM: A payment made by or on your behalf for ongoing health insurance coverage. You might pay a premium to Medicare, an insurance company, or a health care plan. It does not include any deductibles or co-payments the plan may require.

PRE-TAX CONTRIBUTIONS: Contributions made to a benefit plan that are exempt from all applicable state or federal tax withholding requirements.

PRESCRIPTION DRUG BENEFITS: Typically a provision included in a group health plan designed to provide covered employees and their dependents with payment assistance for medically prescribed drugs.

PREVENTIVE CARE: Care that keeps you healthy or prevents illness. Examples are routine physical exams, colorectal cancer screenings, mammograms, and immunizations.

PRIMARY CARE PHYSICIAN (PCP): A physician who serves as a group member's primary contact within the health plan. In a HMO or managed care plan, the primary care physician provides basic medical services, coordinates, and if required by the plan, authorizes referrals to specialists and hospitals.

QUALIFIED DEPENDENT CHILD(REN) AGE 19–26: Dependent child(ren) that you may add to your health insurance plans upon completion of WSSC's affidavit form and birth certificate. WSSC will not require that the dependent child(ren) live with his or her parent(s), is a dependent on a parents tax return, or is a full time student. Both married and unmarried dependent children may have access to coverage.

REFERRAL: Authorization from your primary care physician or health insurer to see a specialist or receive a special test or procedure. HMO's often require that you obtain a referral for most specialty care. It is important to know what your health insurer's rules and procedures are for referrals.

REHABILITATIVE SERVICES: Health care ordered by your doctor to help you recover from an illness or injury. These services are given by skilled nurses, and physical, occupational, and speech therapists. Examples are working with a physical therapist to help you walk and/or with an occupational therapist to help you take a shower or get dressed.

SELF-FUNDED/SELF-INSURED: A benefit plan whereby the employer assumes all the risk, paying for claims while saving the cost of any associated premiums.

SKILLED NURSING CARE: Care ordered by your doctor that must be given or supervised by a licensed registered nurse. Examples are giving shots, providing oxygen to help you breathe, and changing the dressing on a wound. Help from family members or care you give yourself is not considered skilled nursing care.

SKILLED NURSING HOME OR (SKILLED NURSING FACILITY): A place with the staff and equipment to give skilled nursing and/or rehabilitative care.

SPECIALIST: A specialist is a physician who provides non-routine care. Examples include: Cardiologists (heart), Psychiatrists (Mental Health), Oncologists (cancer), and Rheumatologists (arthritis).

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA): The Act provides for the continuation of health benefits for persons who are absent from work to serve in the military services. The three employee regulatory requirements include (1) the right to continue health benefit coverage, (2) a right to reinstate and, (3) the maximum payable in premiums.

USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES: Conventional indemnity plans (80/20) operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

WELLNESS PROGRAM: Programs, such as on-site or subsidized fitness centers, health screenings, smoking cessation, weight reduction/management, health awareness and education, that target keeping employees healthy, thereby lowering employer's costs associated with absenteeism, lost productivity and increased health insurance claims.

WORKERS' COMPENSATION: State laws enacted to provide workers with protection and income replacement benefits due to an illness or injury suffered on the job. Employers must carry appropriate workers' compensation insurance, as required by state law, or have a sufficient source of funding for claims incurred.



RETIREE GROUP LIFE INSURANCE BENEFICIARY CHANGE FORM

(If you have Supplemental Life Insurance, contact the Benefits Office to request a Beneficiary Change Form)

Name (first name, middle initial, last name)		Social Security Number	Date of Birth
Employee/Retiree ID #	Occupation	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

Name of Employer: WashingtonSuburban Sanitary Commission **Group Policy No.** 109925

In accordance with the conditions of the Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and designate as primary beneficiary(ies) and contingent beneficiary(ies), if any, in the event of the insured's death, the following:

Primary Beneficiary Designation				
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip
<i>In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)</i>				
Contingent Beneficiary Designation				
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address		City	State	Zip

Employee/Retiree Signature: _____ Date: _____

WSSC Use Only

Current Amount of Coverage:	Policy Effective Date:
Employee/Retiree ID #	Policy Number: <u>109925</u>

Signature of WSSC HR Representative: _____ Date: _____

Customer Service Contacts

WHY SHOULD YOU CONTACT YOUR INSURANCE CARRIER?

- Lost your insurance card and need to order another one.
- Need to confirm that your doctor is part of the insurance network.
- Want to ask if a procedure is covered by insurance before you have it done.
- Would like to speak to someone about your health issues, many insurance plans have nurse hotlines you can call.

Caremark Prescription Services

Group # WSSCX
www.caremark.com
1-888-790-4271
Email: customerservice@caremark.com

Centers for Medicare and Medicaid Services

www.cms.hhs.gov
1-800-633-4227
TTY: 877-486-2048

Delta Dental

Group # 5804
www.deltadentalins.com
1-800-932-0783

Kaiser Permanente HMO

Group # 4418
www.kp.org
1-800-777-7902

MetLife Life Insurance

Group # 109925
www.metlife.com
1-800-638-6420

Prudential Long Term Care Insurance

Group Name: wssc; Password: wsscltc
www.prudential.com/gltc/mca.html
1-800-732-0416

Social Security Administration

www.ssa.gov
1-800-772-1213
TTY 1-800-325-0778

United Healthcare Choice Plus POS and United Healthcare Select EPO

Group # 712974
www.myuhc.com
1-800-697-3481

United Health Wellness

www.myuhc.com

United Health Cancer Resource Services

1-866-936-6002

United Health Healthy Pregnancy

www.healthy-pregnancy.com
1-800-411-7984

United Health Vision

www.myuhcvision.com
1-877-426-9300

My Nurse Line

1-800-401-7396

