RETIREE OPEN ENROLLMENT

2018

WSSC

Where Water Matters

WSSC
Where Water Matters

14501 Sweitzer Lane • Laurel, Maryland 20707-5901

Dear Retiree,

We are pleased to provide you with your 2018 Open Enrollment Booklet which contains important information about your benefits for 2018.

Open Enrollment begins Monday, October 16th and closes Monday, November 13th. This is your annual opportunity to:

- Modify your benefit plan elections
- Change your dependent coverage

This booklet contains important information about your benefits, including:

- Important information about your benefits for 2018 and beyond
- Highlights of Plan Changes for 2018
- Key Contact Information

Please complete and return the enclosed WSSC Retiree Benefit Request Form to change your benefit enrollments and/or contact information.
If you are not making any changes, you do not need to send us the form. Your 2018 benefits will remain the same as those in 2017.
We will send you a confirmation letter listing your 2018 benefits in December.

The best way to get additional information or to have your questions answered is to attend one of our Open Enrollment Information Sessions at a WSSC site closest to you; the schedule of which is contained in this booklet. If you are not able to attend one of the sessions and have questions, please email us at openenrollment@wsscwater.com or call us at 301-206-7034.

Respectfully,

L. Todd Allen, SPHR, CEBS, SHRM-SCP
Director of Human Resources

Table of Contents

Highlights of Plan Changes for 2018

UnitedHealthcare EPO & POS:	Medical Necessity is a new program that conducts a pre-service review using evidence-based guidelines to determine benefit coverage for services, tests or procedures that are medically appropriate for an individual member. When seeking services from a UnitedHealthcare in-network provider, your provider will facilitate the Prior Authorization process for you. However, it is your responsibility to ensure that the provider received Prior Authorization before a service is rendered. When seeking services from an out-of-network provider, you are responsible for obtaining prior authorization by contacting UnitedHealthcare
UnitedHealthcare EPO	Artificial Insemination and InVitro Fertilization coverage will now be the same as the POS In-Network coverage.
CVS/caremark (Non-Medicare Members)	Diabetes Care™—Diabetes continues to be one of our top 5 complex chronic conditions throughout our WSSC population. As such, we are adding a new program, Transform Diabetes Care™, that will improve members' health outcomes, lower pharmacy costs and improve medication adherence, A1c control and lifestyle management.
CVS/SilverScript (Medicare Members)	The Center for Medicare and Medicaid Services (CMS) is planning to remove Social Security Numbers from Medicare identification numbers to reduce the risk of identity theft. CMS will begin an initiative to transition all Medicare beneficiaries to a randomly generated Medicare Beneficiary Identifier (MBI) which will replace the Social Security number based Medicare Claim Number that currently appears on Medicare ID cards. Medicare expects it will take up to 12 months to complete the transition to new MBIs, and will begin issuing new ID cards with the MBI beginning April of 2018. As a result, not every Medicare participant will be changed in April. When you get your new Medicare ID card, you should provide a copy to your health care providers to ensure they have the correct current information to process any claims with Medicare. There will be no need to provide a copy of the new Medicare ID card to WSSC if you are already enrolled in Medicare. That information will be provided to WSSC from the medical and prescription drug plan(s). **NOTE: If you are newly enrolled in Medicare, WSSC will need a copy of your Medicare ID card to ensure that our plans are able to coordinate benefits.**
Delta Dental PPO	General Anesthesia and IV Sedation will now be covered as a standard benefit.
NVA Vision	This will be the last year that new enrollments will be allowed in the vision plan. After 2018, if you are not enrolled, you cannot enroll in the future.

Important Things To Remember

- Open Enrollment Period is October 16–November 13, 2017.
- During Open Enrollment, you have the following options:
  - Elect vision coverage (if currently enrolled in medical). This is the last year that we will allow new enrollments into the Vision plan. After 2018 if you are not enrolled, you cannot enroll in the future.
  - Change to a different health and/or dental plan.
  - Change coverage levels by adding or removing dependents.**
  - Waive health, dental and/or vision coverage for the 2018 Plan Year.
  - Update beneficiary information for Basic and Supplemental Life Insurance (if applicable).
  - Continue, decrease or waive Supplemental Life Insurance (if applicable).
- All changes become effective January 1, 2018.
- If you are enrolling a dependent age 19–26 for the first time, you are required to complete an affidavit. Please see page 6 for information on dependent coverage.
- Medical, Dental and Vision selections will be done on the Benefits Request Form that is enclosed with your open enrollment book. **IF YOU ARE NOT MAKING ANY CHANGES, YOU DO NOT NEED TO SEND YOUR FORM BACK.**
- If you are changing plans, you should receive your new ID cards no later than January 1, 2018. Otherwise, you will not receive a new card.
- Once Open Enrollment closes, your selections are binding and cannot be changed, modified or canceled unless you have a qualified change of life event. See Change of Life Event section on page 7 for further details.

****PLEASE NOTE: Any benefits change to add or remove dependents requires legal documentation before benefits will be available. See Insurance Coverage for Dependents section on page 6.**

Benefits Open Enrollment Schedule

October 16, 2017
Open Enrollment Starts

October 17, 2017
Info Session and Wellbeing Fair – **RGH** – 8:00AM–1:00PM

October 18, 2017
Info Session – **Anacostia** – 7:30–9:00AM

October 19, 2017
Info Session – **Consolidated Lab** – 11:30AM–12:30PM

October 25, 2017
Info Session – **Gaithersburg** – 7:00–8:30AM

October 26, 2017
Info Session – **Seneca** – 7:00AM–8:00AM

October 31, 2017
Info Session – **Potomac** – 7:00–8:00AM

November 1, 2017
Info Session – **Lyttonsville** – 7:00–8:30AM
Info Session – **Western Branch** – 7:00–8:30AM
Info Session – **Piscataway** – 11:30AM–12:30PM

November 7, 2017
Info Session – **RGH** – 11:00AM–1:30PM

November 8, 2017
Info Session – **Temple Hills** – 7:00–8:30AM

November 13, 2017
Open Enrollment Ends

HR & Outside Vendors

Anacostia Depot
Multi-Purpose Room
301-206-4295
3500 Kenilworth Ave.
Hyattsville, MD 20781

Gaithersburg Depot
Multi-Purpose Room
301-206-7350
111 West Diamond Ave.
Gaithersburg, MD 20877

Lyttonsville Depot
Multi-Purpose Room
301-206-4086
2501 Lyttonsville Rd.
Silver Spring, MD 20910

Richard G. Hocevar Building
LK 120 & 121
301-206-8696
14501 Sweitzer Lane
Laurel, MD 20707

Temple Hills Depot
Multi-Purpose Room
301-206-7300
8444 Temple Hill Rd.
Temple Hills, MD 20748

HR Representatives Only

Consolidated Laboratory
Conference Room
(behind Lobby)
301-206-7575/7580
12245 Tech Road
Silver Spring, MD 20904

Potomac Water Filtatrion Plant
Multi-Purpose Room
301-206-7390
12200 River Road
Potomac, MD 20854

Seneca Water Filtatrion Plant
Multi-Purpose Room
301-206-7900
12600 Great Seneca Hwy.
Germantown, MD 20874

Piscataway Wastewater Treatement Plant
Conference Room
301-206-7420
11 Farmington Road West
Accokeek, MD 20708

Richard G. Hocevar Building
LK 120 & 121
301-206-8696
14501 Sweitzer Lane
Laurel, MD 20707

Western Branch Wastewater Treatement Plant
Conference Room
301-206-7550
6600 Crain Hwy.
Upper Marlboro, MD 20772

2018 Medical, Dental & Vision Plan Rates for Retirees

Plan & Coverage Level	Monthly Rate	WSSC Monthly Contribution	Retiree Monthly* Deduction
United Healthcare ChoicePlus POS			
Individual	$ 1,118.00	$ 849.68	**$ 268.32**
2-Person	$ 2,208.00	$ 1,678.08	**$ 529.92**
Family	$ 2,792.00	$ 2,121.92	**$ 670.08**
United Healthcare Select EPO			
Individual	$ 768.00	$ 606.72	**$ 161.28**
2-Person	$ 1,536.00	$ 1,213.44	**$ 322.56**
Family	$ 2,235.00	$ 1,765.65	**$ 469.35**
Kaiser Permanente HMO			
Individual	$ 537.00	$ 424.23	**$ 112.77**
2-Person	$ 1,073.00	$ 847.67	**$ 225.33**
Family	$ 1,626.00	$ 1,284.54	**$ 341.46**
United Healthcare Medicare Supplement			
Individual Medicare**	$ 615.00	$ 485.85	**$ 129.15**
2-Person Medicare**	$ 1,234.00	$ 974.86	**$ 259.14**
Kaiser Permanente Medicare Plus			
Individual Medicare**	$ 249.00	$ 196.71	**$ 52.29**
2-Person Medicare**	$ 497.00	$ 392.63	**$ 104.37**
Delta Dental PPO			
Individual	$ 40.00	$ -	**$ 40.00**
2-Person	$ 67.00	$ -	**$ 67.00**
Family	$ 99.00	$ -	**$ 99.00**
Delta Dental HMO			
Individual	$ 21.00	$ -	**$ 21.00**
2-Person	$ 34.00	$ -	**$ 34.00**
Family	$ 50.00	$ -	**$ 50.00**
National Vision Administrators			
Individual	$ 3.49	$ -	**$ 3.49**
Family	$ 12.23	$ -	**$ 12.23**
NOTE: Must be enrolled in Retiree medical to participate in the vision plan.			

- *For the 2018 plan year, WSSC contributes 76% of the monthly premium towards the United Healthcare Choice Plus POS plan and 79% of the monthly premium for all other health plans.*
- *There is no WSSC contribution to the Dental or Vision plans.*

** Rates may vary based on years of service and/or retirement status. If you were hired after April 1, 1994 and have less than 20 years of service, or you are a deferred retiree with less than 20 years of service, you are subject to a higher perceptage of cost sharing than what is shown in this chart. Please contact HR for more details.*

*** Once you become eligible for Medicare Part B, you must enroll. Your plan with WSSC will coordinate with Medicare to pay your medical bills. Please see pages 19–23 in this booklet for more information.*

Open Enrollment Timeline

Open Enrollment Activity	Dates
Open Enrollment begins	October 16, 2017
Open Enrollment information sessions	See page 3
Open Enrollment ends	November 13, 2017
Benefit plan elections take effect	January 1, 2018
New benefit deductions begin	January 1, 2018

Important Information about your Benefits for 2018 & Beyond

We are very pleased to report again that we experienced an excellent renewal for our medical, pharmacy and dental insurance plans for 2018. We have taken steps over the past several years to ensure we are implementing plan design changes and services to support healthy lifestyles and help manage expenses.

We are continuing our commitment to a strategic view of our benefit plans and appropriately managing related costs. It is our goal to demonstrate the value of the benefits plans and how they contribute to talent acquisition, talent retention, talent attraction, productivity and ultimately, organizational performance. Cost management of our health benefit program continues to be a top priority. Efforts have included encouraging members to use preferred providers that emphasize better outcomes and cost savings in high-priority clinical conditions such as diabetes, musculoskeletal health and mental health. Over the next few years, we will continue to seek to improve member engagement, expand the use of analytics and efficiently manage pharmacy costs and utilization.

Specialty pharmacy costs continue to remain a top concern as new high-priced drugs come on the market. (Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion).) To help control these surging costs, we are implementing proven utilization management protocols in 2018.

WSSC is steadfast in its goal to improve health outcomes of our members by encouraging them to practice a healthy lifestyle. When we think about the health of our population, people will fall along a specific risk spectrum. Those at the low end of the spectrum may be totally healthy now but at risk for future health concerns and we want to support prevention and early detection of diseases. At the other end of the spectrum are persons managing existing chronic conditions and actively engaged in current and often more expensive health care services.

We encourage you to take advantage of screenings and regular examinations to stay on top of current or looming health issues. Establish a strong relationship with your primary care physician. Understand what is communicated to you and ask questions when clarification is needed. Take advantage of the education opportunities and services your health plan offers to learn how to modify your behavior such as exercise, weight, nutrition and tobacco use.

In order to ensure we can continue to offer a comprehensive benefit package in the future, we will continue to regularly monitor the usage of our benefit plans and plan for federal and state requirements that affect our care and costs.

We encourage you to read this booklet to learn more about your benefits, attend one of our Open Enrollment Information Sessions, the Wellbeing Fair and take a proactive role in managing your personal health and wellbeing!

Insurance Coverage for Dependents

Eligible Dependents are:

a. A spouse — husband or wife, of the opposite or same sex, with whom you are legally married;

b. An unmarried/married dependent child regardless of student status until the end of the birth month in which he or she reaches age 26;

c. An unmarried/married dependent child who is incapable of self-support because of a mental and/or physical disability and who depends on you for support.

* Ineligible dependents are: domestic partners and civil union partners, both same sex or opposite sex.

The term "**Dependent child**" means any of the following:

a. Biological children;

b. Legally adopted children or children placed in the retiree's home pending final adoption;

c. Stepchildren;

d. Foster children;

e. Children who are under the legal guardianship of the retiree;

f. Children for whom the retiree is required to provide health care coverage under a recognized Qualified Medical Child Support Order.

Coverage Effective Date for Newly Enrolled Dependents

Coverage is effective on January 1, 2018 for eligible, newly enrolled dependents.

Dependent Eligibility Verification

In order to provide coverage for your newly enrolled dependents, you must submit proper legal documentation to Human Resources no later than November 13, 2017.

Spouse: marriage certificate

Dependent child: birth certificate

Stepchild: birth certificate AND marriage certificate.

Foster child, adopted child or child whom you have legal guardianship: birth certificate AND legal documents from the court.

Any NEWLY ENROLLED dependent child between the ages of 19-26:

Documents listed above AND a completed AND notarized affidavit. See below.

Age Limits

Dependent children may be covered through the end of the birth month in which they turn 26. Prior to January 1, 2015, WSSC required a completed and notarized affidavit to cover any dependent children between the ages of 19-26. Now, we only require submission of an affidavit for newly enrolled dependents between the ages of 19-26. You will not need to submit an affidavit if your overage dependent child is already enrolled on our plan(s).

Please Note: Dependents must be enrolled in the same health insurance carrier as the subscriber.

WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL INFO?
Contact the Benefits Team in Human Resources at hr_benefits@wsscwater.com or call (301) 206-7034.

Change of Life Events

According to the Internal Revenue Service (IRS) regulations that govern flexible benefit plans, the optional Benefits you elect during enrollment must remain in effect throughout the calendar year, unless you experience a *qualified change of life event*.

If you decide to change your elections as the result of one of the events listed below, **you must do so within 30 days after the qualifying event**. If you do NOT notify the Human Resources Office within 30 days after the event, **you cannot change your elections until the next annual open enrollment**. You must provide the Human Resources Office with verification of all change of life events.

Event	Qualified Status Change	How to begin
If you experience a life change – such as marriage, legal separation, divorce, birth or adoption of a child, or death.	Yes – you have 30 days to notify Human Resources.	• Contact the Benefits Team in Human Resources and make a request to add or drop dependents. • Provide HR with certified documentation such as a marriage license, birth certificate, divorce decree or other legal document.
If you, your spouse or dependent child become covered by another plan or lose coverage in another plan.	Yes – you have 30 days to notify Human Resources.	• Contact the Benefits Team in Human Resources and make a request to enroll (or disenroll) in our benefits or to add (or remove) dependents to your existing plan. • Provide HR with proof of previous (or new) coverage from the family members insurance carrier and/or former employer.
If you experience a loss of coverage due to relocation out of the Plan's coverage area.	Yes – you have 30 days to notify Human Resources.	• Contact the Benefits Team in Human Resources and make a request to enroll in another health and/or dental plan. • Provide HR with proof of your new residence.
If your physician or facility discontinues participation in plan.	No – you must wait until the next open enrollment to change plans.	• You must wait until the next open enrollment to change plans.

NOTE: This chart applies only if you currently have coverage.

Summary of Services Disclaimer

The purpose of this Open Enrollment Guide is to give you basic information about your benefit options and how to enroll for coverage or make changes to existing coverage. This guide is only a summary of your choices and does not fully describe each benefit option. For a more detailed description of benefits, please refer to the plan's benefit booklet, brochure, summary plan description (SPD), summary of benefits and coverage (SBC) or evidence of coverage (EOC). You may also call the plan using the customer service phone number on the last page of this booklet.

Please note that plans will not cover a service if it is not considered medically necessary. Additionally, if your physician or facility discontinues 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.

Every effort has been made to make the information contained in this booklet accurate; however, if there are discrepancies between this document and the contract with the carrier, the contract will govern.

2018 Non-Medicare Medical Summary of Services

This chart does not apply to Medicare Eligible members. Please see pages 19–23 for Medicare Supplement Plan details.

Plan Benefits	UnitedHealthcare Select EPO In-Network Only	UnitedHealthcare Choice Plus POS In-Network	UnitedHealthcare Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Copays: PCP Specialists	$20 $25 No PCP or referrals required.	$25 $30 No PCP or referrals required.	N/A No PCP or referrals required.	$20 $25 Requires PCP & referrals.
Deductibles	N/A	N/A	$300 Individual $600 Family	N/A
Out-of-Pocket Maximum	$2,000 Individual $4,500 Family	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family	$3,500 Individual $9,400 Family
Child Preventive Visits	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance through age 18. Not subject to deductible.	$0 Well Child Exams / Immunizations.
Adult Preventive Visits	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	$0 copay for exam / Immunizations.
Physician Office Visit (PCP) Sickness and Injury	Covered at 100% after PCP copay.	Covered at 100% after PCP copay.	Covered at 70% of Plan Allowance after deductible.	PCP copay; waived for children under age 5.
Specialist Office Visit Sickness and Injury	Covered at 100% after Specialist copay (non-routine care).	Covered at 100% after Specialist copay (non-routine care).	Covered at 70% of Plan Allowance after deductible.	Specialist copay.
Routine Gynecological Exam	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Mammogram Screening	Covered at 100% for routine screenings.	Covered at 100% for routine screenings.	Covered at 70% of Plan Allowance. Not Subject to deductible.	Covered at 100%.
Cancer Screenings, Prostate, PAP, Colorectal	Covered at 100% for routine screenings. Diagnostic Lab covered at 100%.	Covered at 100% for routine screenings. Diagnostic Lab covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Allergy – Office Visit	Covered at 100% after applicable PCP or Specialist copay.	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	$20 copay PCP/ $25 copay Specialist.
Allergy Testing	Covered at 100% after applicable PCP or Specialist copay.	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	$20 copay PCP/ $25 copay Specialist.
Allergy Injections	Covered at 100% after applicable PCP or Specialist copay.	Covered at 100% after applicable PCP or Specialist copay.	Covered at 70% of Plan Allowance after deductible.	$20 copay.
Inpatient Hospital/ Facility Hospital Services	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Skilled Nursing Facility	Covered at 100%; (Limited to 60 days per benefit year).	Covered at 100%; (Limited to 60 combined days per benefit year).	Covered at 70% of Plan Allowance after deductible; (Limited to 60 combined days per benefit year).	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 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Surgery, Anesthesia	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Diagnostic Radiology & Pathology	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Physical Therapist Services	Please see Outpatient Rehabilitation Services.	Please see Outpatient Rehabilitation Services.	Please see Outpatient Rehabilitation Services.	Covered at 100%.

SUMMARY OF SERVICES DISCLAIMER

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2018 Non-Medicare Medical Summary of Services

This chart does not apply to Medicare Eligible members. Please see pages 19–23 for Medicare Supplement Plan details.

Plan Benefits	UnitedHealthcare Select EPO In-Network Only	UnitedHealthcare Choice Plus POS In-Network	UnitedHealthcare Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Outpatient Hospital/ Facility–Diagnostic Services, Pre-admission testing	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Outpatient Professional Services Labs and X-Ray	Diagnostic Lab and X-Ray covered at 100%. Professional services covered at 100%.	Diagnostic Lab and X-Ray covered at 100%. Professional services covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%. (Outpatient Specialty Imaging $50 copay)
Surgery	Outpatient hospital covered at 100%. Professional services covered at 100%.	Outpatient hospital covered at 100%. Professional services covered at 100%.	Covered at 70% of Plan Allowance after deductible.	$25 copay.
Maternity Benefits Hospitalization	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Birthing Center	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100% if Kaiser authorized.
Professional— Pre & Postnatal Care	Covered at 100% after the first visit to applicable PCP.	Covered at 100% after the first visit to applicable PCP.	Covered at 70% of Plan Allowance after deductible.	$25 copay for initial visit, then covered at 100%.
Newborn Pediatric Inpatient Care	Nursery care covered at 100%.	Nursery care covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Infertility Services Infertility Counseling and Testing				
Artificial Insemination	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	50% of allowable charges.
In Vitro Fertilization	Covered at 100% after applicable PCP or specialist copay; limit of 3 attempts per live birth; not to exceed lifetime limit $100,000.	Covered at 100% after applicable PCP or specialist copay; limit of 3 attempts per live birth; not to exceed lifetime combined limit $100,000.	Covered at 70% of Plan Allowance after deductible; Limit of 3 attempts per live birth; not to exceed lifetime combined limit $100,000.	50% of allowable charges for up to 3 attempts per live birth. Not to exceed lifetime limit of $100,000.
Mental Health & Substance Abuse Benefits-Inpatient Professional	Covered at 100%.	Covered at 100%.	Covered at 70% of Plan Allowance after deductible.	Covered at 100%.
Mental Health & Substance Abuse Benefits-Outpatient Professional	Covered at 100% after $20 copay.	Covered at 100% after $20 copay.	Covered at 70% of Plan Allowance after deductible.	Copays: $20 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 $25 copay.	Covered at 100% after $25 copay.	$25 copay.
Emergency Room	$150 copay for ER; waived if admitted.	$150 copay for ER; waived if admitted.	Covered at the network level.	$150 copay for emergency room; waived if admitted.
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.	$50 copay.

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2018 Non-Medicare Medical Summary of Services

This chart does not apply to Medicare Eligible members. Please see pages 19–23 for Medicare Supplement Plan details.

Plan Benefits	UnitedHealthcare Select EPO In-Network Only	UnitedHealthcare Choice Plus POS In-Network	UnitedHealthcare Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Emergency & Urgent Care—In Area In Office *(Continued)*				
Emergency & Urgent Care—Out of Area/ Out of Network Emergency Room or Urgent Care Center	Covered at 100% after $150 copay, waived if admitted. Non-emergency use – no coverage. $20 copay for Urgent Care if participating facility.	Covered at 100% after $150 copay, waived if admitted. Non-emergency use – no coverage. $25 copay for Urgent Care if participating facility.	Covered at the network level.	$150 copay for emergency room, waived if admitted; $25 for urgent care.
Outpatient Rehabilitative Services Physical, Occupational and Speech Therapy	Covered at 100% after $25 copay; Short term non chronic conditions; 60 visits per benefit year.	Covered at 100% after $30 copay; short term non chronic conditions; 60 visits per therapy per benefit year, combined with non-network benefits.	Covered at 70% of Plan Allowance after deductible; 60 visits per therapy per benefit year combined with network benefits.	$25 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 100% after $30 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.	$25 copay; 20 visits per calendar year.
Acupuncture	Covered at 100% after $25 copay; up to 12 visits per benefit year.	Covered at 100% after $30 copay; up to 12 combined visits per benefit year.	Covered at 70% of Plan Allowance after deductible; up to 12 combined visits per benefit year.	$25 copay; 20 visits per calendar year.
Home Health Care	Covered at 100%.	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%.
Hospice Care	Covered at 100%.	Covered at 100%; 180 day combined lifetime maximum.	Covered at 70% of Plan Allowance after deductible; 180 day combined lifetime maximum.	Covered at 100%.
Durable Medical Equipment **Orthotics**	Covered at 100%. Shoe Orthotics limited to two pair every benefit year.	Covered at 100%. Shoe Orthotics limited to two pair every benefit year, combined with non-network benefits.	Covered at 70% of Plan Allowance after deductible. Shoe Orthotics limited to two pair every benefit year, combined with network benefits.	Covered at 100% when deemed medically necessary.
Hearing Aids **Audiometric Exam, Evaluation Test, Purchase and Fitting**	Covered at 80%; limited to $1,200 every 3 benefit years. No dollar limit applies to children under the age of 26.	Covered at 80%; limited to $1,200 combined maximum every 3 benefit years. No dollar limit applies to children under the age of 26.	Covered at 70% of Plan Allowance after deductible; limited to $1,200 combined maximum every 3 benefit years. No dollar limit applies to children under the age of 26.	Covered at 100% per each hearing impaired ear every 36 months for children up to age 26.
Vision Services	Specialist copay for eye refractive exam every benefit year.	Specialist copay for eye refractive exam every benefit year.	Covered at 70% after deductible; one eye exam every benefit year.	$25 copay.
Glasses & Contacts	Discounts on lenses and frames at participating providers.	Discounts on lenses and frames at participating providers.	N/A	25% discount on eyeglasses and 15% initial fitting and purchase discount on contact lenses, when purchased from plan providers.
Prescription Benefit	See full description of the CVS/caremark Prescription Benefit on page 11.	See full description of the CVS/caremark Prescription Benefit on page 11.	See full description of the CVS/caremark Prescription Benefit on page 11.	See Kaiser Pharmacy description on page 13.

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CVS/caremark™

Your Personal Prescription Benefit Program

Your Prescription Benefit Plan Copay Overview

	CVS/caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	CVS Caremark Mail Service Pharmacy For long-term medications (Up to a 90-day supply)
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$10** for a generic prescription	**$20** 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.	**$20** for a preferred brand-name prescription	**$40** 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.	**$45** for a non-preferred brand-name prescription	**$90** for a non-preferred brand-name prescription
Refill Limit	One initial fill plus 1 refill for maintenance medications	None
Maximum Allowable Benefit	$1,200 per individual (applies to Smoking Cessation Medications)	
Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the brand copayment.		

Where to fill your prescription

Choosing where to fill your prescription depends on whether you are ordering a short-term or long-term medication:

Short-term medications are generally taken for a limited amount of time and have a limited amount of refills, such as an antibiotic. You can fill prescriptions for these medications at any pharmacy in the CVS/caremark retail network.

- Choose from more than 67,000 network pharmacies nationwide, including independent pharmacies, chain pharmacies and 7,400 CVS/pharmacy locations.
- Find a participating pharmacy at www.caremark.com

Tip: To avoid filling out claims paperwork, bring your Prescription Card with you when you pick up your prescription, and use a pharmacy in the CVS/caremark retail network.

Long-term medications are taken regularly for chronic conditions, such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions.

Choose **one** of three easy ways to start using the CVS Caremark Mail Service Pharmacy:

1. Fill out and send in a mail service order form – use the one included in this welcome kit or print one at www.caremark.com
2. Use the FastStart® tool found on www.caremark.com
3. Call FastStart toll-free at 1-800-875-0867

Customer Care

If you have questions about your prescriptions or benefits, you can contact Customer Care 24 hours a day, seven days a week. You can either e-mail customerservice@caremark.com or call toll-free at 1-888-790-4271 after your benefits begin. For TDD assistance, please call toll-free 1-800-863-5488.

Copayment, copay or coinsurance means the amount a plan member 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 feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-790-4271.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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CVS/caremark™

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: • 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.** • 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.

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Prescription Benefits At-A-Glance

(For Non-Medicare prescription drug coverage)

	Kaiser Permanente Medical Center (Preferred)	Community Based/ Network Pharmacy	Mail Order Program (Preferred)
When to Use Your Benefit:	For immediate or short term prescriptions:	For immediate or short term prescriptions:	For short term, maintenance and long term prescriptions:
Where:	Prescriptions can be filled at a Kaiser Permanente Medical Center. ***Please Note:*** *Copays are lower when filled at a Kaiser Permanente Medical Center vs. a community network pharmacy.*	Prescriptions can also be filled at community pharmacies such as: Giant®, Safeway®, Rite Aid®, Target®, Wal-Mart®, and K-Mart®. ***Please Note: Copays are higher*** *when filled at a community network pharmacy.*	You can have prescriptions mailed right to your home through the Kaiser Permanente Mail order program.
Cost to You:	**Up to a 30-day supply:** • $10 for generic. • $20 for brand name drugs. • $45 for non-preferred drugs. **Up to a 90-day supply:** • $20 for generic. • $40 for brand name drugs. • $90 for non-preferred drugs.	**Up to a 30-day supply:** • $20 for generic. • $35 for brand name drugs. • $55 for non-preferred drugs. **Up to a 90-day supply:** • $40 for generic. • $70 for brand name drugs. • $110 for non-preferred drugs.	**Up to a 90 day supply:** • $20 for generic. • $40 for brand name drugs. • $90 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 though the members only section of the Kaiser Permanente web site, **www.kp.org**.		

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Washington Suburban Sanitary Commission
Group Number# 8735000001

www.e-nva.com

Schedule of Vision Benefits

Benefit Frequency	*Participating Provider*	*Non-Participating Provider*
Examination Once Every Calendar Year	▪ Covered 100%	Reimbursed Amount ▪ Up to $64 (OD) ▪ Up to $84 (MD)
Lenses Once Every Calendar Year ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	Standard Glass or Plastic ▪ Covered 100%	 ▪ Up to $50 ▪ Up to $90 ▪ Up to $110 ▪ Up to $310
Frame Once Every Two Calendar Years	Wholesale Allowance ▪ Up to $50①	▪ Up to $50
Contact Lenses Once Every Calendar Year	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	▪ Up to $100 Retail① (25% discount off balance)*	▪ Up to $100
Medically Necessary**	▪ Up to $600	▪ Up to $600

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every calendar year and a frame once every two calendar years or contact lenses once every calendar year. (If you choose a frame, you will not be eligible for contact lenses for two calendar years)

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 8735000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Contact Fill (NVA Mail Order) and may be prohibited by some manufacturers.
**Pre-approval from NVA required.

①Provider will charge the difference between the wholesale cost and the plan allowance plus 20%.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $10 Solid Tint
- $12 Fashion / Gradient Tint
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $75 Polarized
- $50 Progressive Lenses Standard*
- $65 Transitions Single Vision Standard
- $70 Transitions Multi-Focal Standard
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $30 Blended Bifocal (Segment)
- $55 High Index
- $100 Progressive Lenses Premium*

***Fixed Pricing not available on certain brands**
Options not listed will be priced by NVA providers at their R&C retail price less 20%. In Maryland, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

www.e-nva.com

DELTA DENTAL®

Delta Dental PPO

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 $50 annual deductible for selected dental services
(not to exceed $150 for family level coverage)

Basic Restorative ("Silver" & "white" fillings)	90%
Oral Surgery (Extractions)	80%
IV Sedation and General Anesthesia	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%

Refer to the plan brochure for complete list

DELTA DENTAL®

Deltacare USA DHMO

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.

NOTE: The DeltaCare plan is available in all states. However; some states do not have enough DHMO dentists and we consider those states to be Open Access states. In these states a member may see a PPO provider.

Open Access states are:

Alaska
Connecticut
Louisiana
Maine
Mississippi
Montana
New Hampshire
North Dakota
North Carolina
Oklahoma
South Dakota
Vermont
Wyoming

Right care. Right place. Right savings.

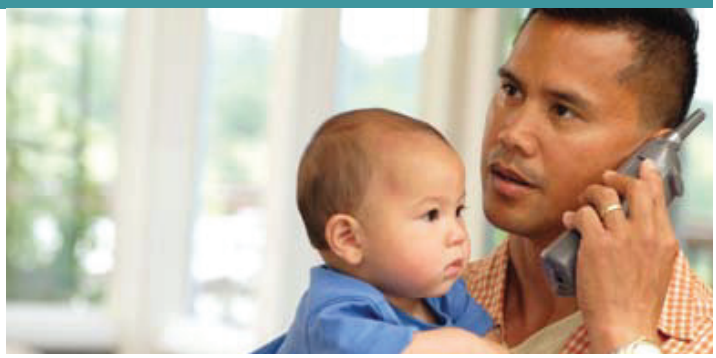
With many options for getting care, how do you choose? This chart can help you understand where to go for what – and how you can save money.

Where to get care	What it is	Type of Care	Cost
NurseLine℠ 	NurseLine℠ connects you with registered nurses 24/7: **1-877-440-0547**.	• Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions	**No additional cost**
Virtual Visit 	A virtual visit lets you see a doctor via your smartphone, tablet or computer.	• Allergies • Bladder infections • Bronchitis • Cough/colds • Diarrhea • Fever • Pink eye • Rashes • Seasonal flu • Sinus problems • Sore throats • Stomach aches	**$**
Convenience Care Clinics 	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Common infections (e.g. strep throat) • Minor skin conditions (e.g. poison ivy) • Vaccinations • Pregnancy tests • Minor injuries • Ear aches	**$$**
Primary Care Physician 	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management	**$$**
Urgent Care 	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Small cuts that may need a few stitches • Minor burns • Minor infections • Minor broken bones	**$$$**
Emergency Room 	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Breathing difficulty • Major broken bones	**$$$$**

UnitedHealthcare®

WHEN TO SEEK URGENT CARE AT KAISER PERMANENTE

Sometimes you're not sure whether your medical condition requires urgent or emergency care. You may also be spending more money visiting the emergency room when urgent care is where you should go. You can get better service if you understand what type of care you need when you are sick or injured.



ADVICE IS JUST A PHONE CALL AWAY

If you need help determining what type of care you need, you can call an advice nurse at any time. Advice nurses are registered nurses who are specially trained to help assess medical problems and provide advice over the phone, when medically appropriate. They can often resolve a minor concern or advise you about what to do next, including making a same-day or next-day immediate appointment (numbers below).

A representative will schedule a same-day appointment with your doctor or a doctor at a Kaiser Permanente urgent care center. If an immediate appointment is not available, or you are not near a Kaiser Permanente urgent care center, you may be directed to an affiliated network urgent care center.

Washington metro area
703-359-7878 703-359-7616 (TTY)
Outside Washington metro area
800-777-7904 (toll free) 800-700-4901 (TTY)

Please remember to call the appointment/advice line for a check-in time before coming to any of the medical centers or urgent care centers.

WHAT IS THE DIFFERENCE BETWEEN URGENT CARE AND EMERGENCY SERVICES?

Urgent care services are those required because of a sudden illness or injury, which requires prompt attention but is not of an emergent nature. Examples of conditions that might require urgent care include, but are not limited to:

- sprains
- minor burns
- frequent/burning urination
- upper respiratory symptoms
- high fevers
- ear infections
- cuts and lacerations

Emergency services are those provided for the sudden onset of a medical condition 1) that manifests itself by symptoms of sufficient severity (including severe pain) and 2) that the absence of immediate medical attention could reasonably be expected by a prudent layperson (one who possesses an average knowledge of health and medicine) to result in:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- serious jeopardy to the health of the mother and/or fetus, in the case of a pregnant woman

If you think you may be experiencing a medical emergency, call 911.

Este documento contiene información importante sobre nuestros servicios de atención urgente y lo que hay que hacer en caso de una emergencia. Para más información, por favor llame a Servicios para Miembros de Kaiser Permanente al 301-468-6000.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, MD 20852 **10321**_UrgentCare_M_fl 5/14/10–5/14/11

kp.org

KAISER PERMANENTE®

Medicare-Eligible Retirees and Dependents

WSSC requires that its retirees enroll for Medicare part B when eligible. Most people become eligible at age 65 but you could become eligible sooner if disabled. You should receive information from the Social Security Administration when you become eligible for Medicare Part B, however, if you do not, it is your responsibility to contact them. Failure to enroll in Medicare Part B could compromise your eligibility for WSSC medical and prescription benefits and/or subject you to permanent premium penalties.

Once you are enrolled in Medicare Parts A & B, you must send a copy of your Medicare ID card to the WSSC HR Department so that we can ensure that you are enrolled in the proper medical and prescription plans. UnitedHealthcare members are then moved into the UnitedHealthcare Medicare Supplement Plan and the SilverScript Prescription Drug Plan (PDP). Please refer to pages 22–23 to learn more about SilverScript. Kaiser members transition into the Kaiser Medicare Plus plan, but they must also complete the Kaiser Medicare Plus application and return it directly to Kaiser.

You should not enroll in an individual Medicare Part D program if you are enrolled in one of the WSSC health insurance plans, because Medicare does not allow you to enroll in two Part D plans. Enrolling in an individual plan could compromise your eligibility for WSSC sponsored medical and prescription coverage.

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.

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, your coverage will be changed to the Medicare Supplement Plan. The Medicare Supplement Plan is 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.

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 Frequently Asked Questions

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

You must enroll in Medicare Parts A & B when eligible. WSSC's insurance carriers will coordinate your benefits with Medicare once HR receives a copy of your Medicare ID card. If you are enrolled in Kaiser, you will transition to the Kaiser Medicare Plus Plan. If you are enrolled in UnitedHealthcare, you will transition from the UnitedHealthcare EPO or POS plan to the UnitedHealthcare Medicare Supplement plan. Medicare will cover approximately 80% of your medical expenses and your WSSC plan will cover the remaining 20%. You may still have a copay depending on which plan you select.

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

You must submit a copy of your Medicare ID card to the WSSC HR department so that WSSC's insurance carriers can coordinate your benefits with Medicare. Medicare will cover approximately 80% of your medical expenses and your WSSC plan will cover the remaining 20%. You may still have a copay depending on which plan you select.

WHAT HAPPENS TO MY PRESCRIPTION COVERAGE WHEN I AM ELIGIBLE FOR MEDICARE PARTS A & B?

If you are enrolled in Kaiser, you will transition to the Kaiser Medicare Plus Plan and your prescription benefit will continue to be administered by Kaiser. You may refer to the chart on page 21 for the copays for Kaiser Medicare Plus members.

If you are enrolled in UnitedHealthcare, you will transition from the UnitedHealthcare EPO or POS plan to the UnitedHealthcare Medicare Supplement plan. Currently, CVS/caremark administers the prescription benefits for all non-Medicare-eligible UnitedHealthcare members. Members who are enrolled in United-Healthcare and become Medicare-eligible will transition from CVS/caremark to SilverScript. Please refer to pages 22–23 for more information about the SilverScript PDP and page 11 for the copays.

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 plan 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 member is enrolling in Medicare, your WSSC insurance enrollment is modified from a "two-person" or "family" plan to a "split plan." The Medicare-eligible enrollee will have the Medicare Supplement Plan, while the other member who is not eligible for Medicare will continue with their current plan. You will see separate deductions for these plans on your pension check.

WHAT HAPPENS TO MY MONTHLY BENEFIT DEDUCTION?

Once the Benefits Team has a copy of your Medicare ID card to verify you have successfully enrolled in Medicare Parts A & B, your monthly deductions will be updated. Each carrier has different premiums for their Medicare Supplement plan. Please refer to the rates on page 5 of 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.

Medicare-eligible Summary of Services

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

Plan Benefits	UnitedHealthcare PPO Medicare Supplement	Kaiser Permanente 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 at 100%
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	$50 copay (copay waived if admitted)
Prescriptions	See Caremark on page 11. Copays for SilverScript are the same as the CVS/ caremark commercial plan	$10 copay for up to a 90 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% (after $25 copay) for a refractive eye examination every calendar year at participating providers; discounts on frames and lenses at participating providers	$15 copay for eye exam; discounts on frames, lenses and contact lenses
Primary Insurance	Medicare: Parts A & B	Kaiser Permanente
Secondary Insurance	UnitedHealthcare	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.

SilverScript Prescription Drug Coverage for Medicare-eligible UnitedHealthcare Members

Effective January 1, 2018, Medicare-eligible Washington Suburban Sanitary Commission (WSSC) retirees, and/or their Medicare-eligible dependents who are enrolled in UnitedHealthcare, will have their prescription drug coverage provided under the SilverScript Prescription Drug Plan (PDP) sponsored by WSSC and administered by SilverScript® Insurance Company (SilverScript), a CVS/caremark™ company. Medicare-eligible Kaiser Permanente Health Plan members receive their prescription coverage through Kaiser Permanente.

About SilverScript

Q. *How does SilverScript work?*

A. There are two plan components working together as a single plan administered by SilverScript:

1. A component that provides Federal government-approved standard Medicare Part D prescription benefits (known as an "Employer Group Waiver Plan" or "EGWP"), and
2. A second component (often referred to as a "Wrap" or "Wraparound") that will help maintain pre-Medicare current coverage levels.

Eligibility

Q. *Who is eligible for Silverscript?*

A. Individuals that:

- Have prescription drug coverage through the CVS/caremark Commercial plan, *and*
  - become Medicare-eligible (retirees, dependents of retirees, or eligible survivors), *and*
  - are enrolled in Medicare Parts A and/or B.

Note: The current CVS/caremark Commercial plan will continue to be offered to non-Medicare eligible plan participants.

Q. *Who is not eligible to enroll in SilverScript?*

A. Individuals who are:

- Active WSSC employees and their enrolled dependents;
- WSSC retirees, dependents or survivors who are not yet eligible for Medicare;
- Medicare-eligible WSSC retirees, dependents, or survivors who are not enrolled in Medicare Parts A and/or B;
- Retirees, dependents or survivors who do not have prescription coverage provided by WSSC, or who are covered under an active WSSC employee's plan;
- Enrolled in the Kaiser Permanente Health Plan, regardless of Medicare eligibility; and
- Retirees and dependents residing outside the United States (i.e., those not residing in the fifty federated states, District Of Columbia, American Samoa, Guam, the Northern Mariana Islands, or Puerto Rico), or who are incarcerated.

Q. *Must I be age 65 and over to enroll in SilverScript?*

A. No. Enrollment is based on Medicare eligibility, not age. This means that retirees and their covered dependents under age 65 who are eligible for Medicare (and are enrolled in Medicare Parts A and/or B) will be enrolled in SilverScript.

Q. *My family has "split coverage," meaning that one or more of my covered family members are Medicare-eligible and one or more is not eligible for Medicare. Will the SilverScript plan apply to all of us, or just to those who are Medicare-eligible?*

A. SilverScript will apply only to those individuals who are eligible for Medicare and enrolled in Medicare Parts A and/or B. Individuals who are not eligible for Medicare will continue to have their benefits administered by CVS/caremark under the current Commercial plan.

Q. *I will be turning age 65 in 2018 and will become eligible for Medicare; what will happen to my prescription plan coverage?*

A. Prior to becoming eligible for Medicare, you will receive information from WSSC about your benefits and how they will coordinate with Medicare. You must enroll in Medicare Parts A and B when eligible, and you must provide WSSC with your Medicare ID card as soon as you receive it. At that point, WSSC will begin the process of enrolling you in SilverScript.

What You Need to Do (or Not Do)

If you are eligible for Medicare, but not currently enrolled in Medicare Parts A and Part B, **you must** enroll in both parts (call 1-800-MEDICARE) immediately. You must be enrolled in Medicare Parts A and/or B before becoming eligible for coverage under SilverScript. Failure to enroll in Medicare could result in the loss of both WSSC sponsored Medical and Prescription Drug coverage.

SilverScript Prescription Drug Coverage *(cont'd)*

Q. *Can I cancel my WSSC coverage before 2018 and enroll in a standard Medicare Part D Prescription Drug Plan that is not offered by WSSC?*

A. You should not enroll in an individual Medicare Part D plan on your own if you wish to be covered by the WSSC plan. If you enroll in a Medicare Part D plan on your own, your coverage through WSSC will automatically be cancelled because the Federal government does not allow coverage under two Medicare Part D plans. **T**he WSSC plan includes a second component that will provide benefits above and beyond the standard government-approved Medicare Part D prescription benefits to help maintain current coverage levels (i.e., the "Wrap"). The benefits of this second component will not be available to you if you enroll in a plan not offered through WSSC. In addition, since the prescription drug coverage is linked to your health insurance election, a decision to cancel your prescription drug coverage will also cancel your medical coverage. WSSC will take the necessary steps to enroll new Medicare-eligible members in the SilverScript plan. The change will be automatic if you are eligible for Medicare, are enrolled in Medicare Parts A and/or B, and have prescription coverage through WSSC (excluding Kaiser).

Premiums and Subsidies

Q. *Is there a subsidy available for low income retirees?*

A. Yes, under certain circumstances, covered members may be eligible for a Low Income Subsidy. Low income status is determined by either the Social Security Administration (SSA) or the State Medicaid office. Generally, those eligible include individuals with income less than 150% of Federal Poverty Level ($18,090 for single persons in 2017) and with total resources less than $13,820 (for single persons in 2017). For more details, visit the SSA website at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Q. *Can you explain the extra amount high income retirees are required to pay?*

A. Medicare Part D requires that Part D plan participants who are determined to be high income retirees be charged an Income Related Monthly Adjustment Amount or "IRMAA." This IRMAA charge will apply because SilverScript is a Medicare Part D plan. The SSA determines who is considered a high income retiree based on tax status and yearly income as reported on IRS tax returns from two years ago. The IRMAA charge will be deducted directly from the member's Social Security check. In some instances, the SSA will bill affected retirees directly. To keep their coverage, high income retirees in the SilverScript plan must pay this amount to SSA. In 2018 monthly IRMAA charges range from $13.00 to $74.80 per person and are based on modified adjusted gross income (MAGI).

If your filing status and yearly income in 2016 was:			
File individual tax return	**File joint tax return**	**File married & separate tax return**	**You pay monthly (in 2018)**
$85,000 or less	$170,000 or less	$85,000 or less	your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$13.00 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	not applicable	$33.60 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$54.20 + your plan premium
above $214,000	above $428,000	above $129,000	$74.80 + your plan premium

Plan Benefits

Q. *Can I use a retail pharmacy other than a CVS pharmacy?*

A. Yes, you may use one of the over 68,000 participating pharmacies currently available to you such as Giant, Walgreens and Walmart.

Q. *Will I still be able to save money by using Maintenance Choice for my maintenance medications?*

A. For maintenance medications (long-term medications taken regularly for chronic conditions, such as high blood pressure, high cholesterol or diabetes, or long-term therapy), you may fill up to a 90-day prescription at either a CVS pharmacy retail location or through CVS/caremark Mail Service Pharmacy and pay the mail order copay for up to a 90-day supply. In addition, you may fill a 90-day prescription at a retail pharmacy other than a CVS pharmacy, however, your total copay will equal three 30-day copays.

Q. *Is there a different formulary for SilverScript?*

A. No. Like today, you will use the CVS/caremark Preferred Drug List (PDL). However, the Medicare Part D part of SilverScript also uses a CMS formulary; you may receive CMS required mailings regarding this formulary stating that certain drugs are not covered. In most cases you may **disregard these CMS letters** because the wrap feature of the WSSC plan will pick up coverage of those medications because it uses the same, more comprehensive formulary.

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 UnitedHealthcare 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 UnitedHealthcare 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 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.

Certificate of Creditable Coverage for Medicare Part D

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

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

Contact our office for further information at 301-206-8696 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 16, 2017
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:	301-206-8696

CMS Form 10182-CC Updated September 14, 2012.

Legislative Information

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. Coverage for these items may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. 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). These rights include:

- Coverage for a hospital stay of up to 48 hours for a vaginal birth and 96 hours for a cesarean section delivery without previous authorization.
- A plan cannot provide incentives to a mother or Provider to encourage a shorter stay.
- A plan cannot penalize a mother or Provider to encourage a shorter stay.
- A plan must provide notice of these rights with respect to the hospital lengths of stay in connection with child birth.

Our Medical Plans comply with these requirements.

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.

UnitedHealthcare, Kaiser Permanente, CVS/caremark, Delta Dental, National Vision Administrators and SilverScript

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 September 23, 2013, and is an amendment of WSSC's prior notice of 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.

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.

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. In addition, we will not use your genetic information for underwriting purposes.

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.

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

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 incompliance 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 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. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a 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.

BREACH OF UNSECURED PROTECTED HEALTH INFORMATION: You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use, or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

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, including your protected health information maintained in an electronic format. 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. For example, if your protected health information is available in an electronic format, you may request access electronically and that this be transmitted directly to someone you designate. 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. But any fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record. 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 licensed health care professional chosen by us will review your request and

HIPAA

Individual Rights *(cont'd)*

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, including a disclosure involving an electronic health record, for purposes other than treatment, payment, health care operations and certain other activities (Note: this exemption does not apply to electronic health records). 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 (three years in the case of a disclosure involving an electronic health record).

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 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 (premiums 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: Carole.Silberhorn@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 there 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.

EVIDENCE OF COVERAGE (EOC): A comprehensive resource guide to your health care coverage. It explains your benefits, premiums, and cost-sharing; conditions and limitations of coverage; and plan rules.

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 individuals 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.

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.

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 (PPACA): 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.

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.

Glossary of Insurance Terms

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).

SUMMARY OF BENEFITS AND COVERAGE (SBC): The Summary of Benefits and Coverage document is intended to provide consumers with a concise document explaining, in plain language, simple and consistent information about health plan benefits and coverage. It will summarize the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

SUMMARY PLAN DESCRIPTION (SPD): A document which describes your Benefits, as well as your rights and responsibilities, under the Plan.

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.

URGENT CARE: Walk-in center that should be considered for problems that are urgent but not severe enough to warrant a trip to the ER, such as a fracture or deep cut that may need stitches.

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.

WSSC Where Water Matters

MetLife®

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 ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Name of Employer: Washington Suburban 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

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

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: 109925

Signature of WSSC HR Representative: _____ Date: _____

PERFORATE

Customer Service Contacts

WSSC Contacts

Open Enrollment Hotline
openenrollment@wsscwater.com
301-206-7034

HR Benefits
hr_benefits@wsscwater.com

Angela Costalas
Angela.Costalas@wsscwater.com
301-206-8695

Lee McDonough
Lee.McDonough@wsscwater.com
301-206-8995

Miriam McMillan
Miriam.McMillan@wsscwater.com
301-206-8692

Susan Menefee
Susan.Menefee@wsscwater.com
301-206-8702

Regina Rodriguez
Regina.Rodriguez@wsscwater.com
301-206-8696

Carole Silberhorn
Carole.Silberhorn@wsscwater.com
301-206-8691

Other Contacts

CVS/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

Deltacare USA (HMO)
Delta Dental PPO
Group # 5804
www.deltadentalins.com
1-800-932-0783

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

Medical Advice Line
1-800-777-7904

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

National Vision Administrators
Group # 8735000001
www.e-nva.com
1-800-672-7723

SilverScript Prescription Drug Plan
wssc.silverscript.com
844-819-3073

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

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

UnitedHealth Wellness
www.myuhc.com

UnitedHealth Cancer Resource Services
1-866-936-6002

UnitedHealth Healthy Pregnancy
www.healthy-pregnancy.com
1-800-411-7984

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

My Nurse Line
1-800-401-7396