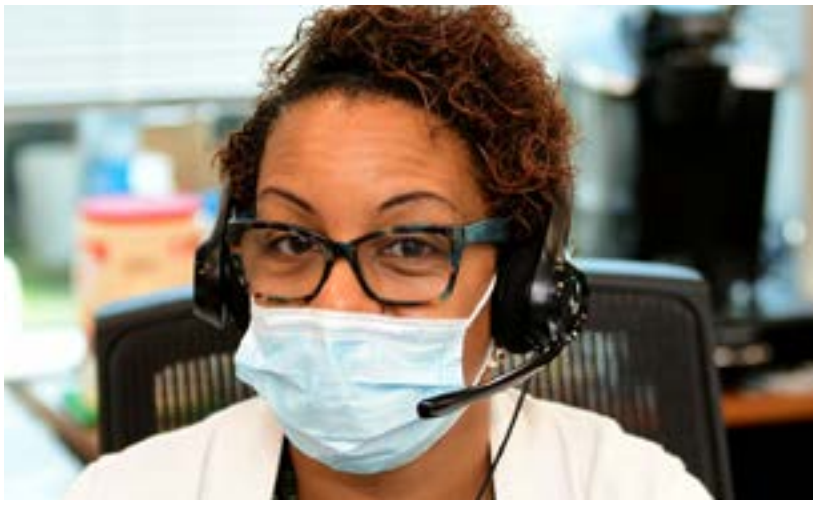
2021

Employee Benefits Guide

October 5-23, 2020

H_2O HEROES WORK HERE

WSSCWATER
DELIVERING THE ESSENTIAL



Enrolling in Your Benefits Using Oracle Self Service

Benefits Enrollment must be completed in One-Source.
There are six main parts to this process and each is outlined in this step-by-step guide.

1. Access the link for One-Source through the WSSC Water Internet or Intranet. (**https://onesource.wsscwater.com**)
2. Click on EMPLOYEE SELF SERVICE then click on BENEFITS.

Page 1: Dependents and Beneficiaries

This is where you will enter anyone you want to list as a dependent and/or beneficiary.

NOTE: *If the person you wish to add/update is also a WSSC Water employee or a dependent of another WSSC Water employee, you must contact Human Resources (hr_benefits@wsscwater.com or 301-206-8696) to update their records.*

3. Click ADD ANOTHER PERSON.
4. Enter the person's Name, Relationship and Relationship start date (which can be the current date).
5. Enter Address Information, or if they share the same residence as you, check the shared residence box.
6. Enter all other Required Information. (Gender, Social Security, Date of Birth)
   a. Social Security Numbers must be entered in the following format (include dashes) : 123-45-6789
   b. Date of Birth must be entered in the following format : DD-MON-YYYY (01-JAN-2019)
7. When finished, click APPLY.
8. Repeat steps 4-7 as many times as necessary to add dependents and beneficiaries.
9. When you are ready to continue, click NEXT.

Page 2: Benefits Enrollments

This page will show an overview of available benefits and your current status.

10. Click UPDATE BENEFITS
11. Scroll to review/update your Medical, Dental, Vision, FSA Health Care, FSA Dependent Care, Supplemental Life, Spouse Life, Child Life, Legal Services and Sick Leave Bank elections by checking the boxes.
12. When you have made your selections and are ready to continue, click NEXT.

Page 3: Update Benefits – Cover Dependents

This is where you will choose which dependents will be covered for your selected benefits.

13. Click on the box next to their name if you want them to be covered under this corresponding benefit.
14. When you have made your selections and are ready to continue, click NEXT.

Page 4: Update Beneficiaries: Add Beneficiaries *New options available*

This is where you can specify what percentage of life insurance, Retirement Plan and Final Salary - Unused Earned Vacation Leave you want each of your beneficiaries to receive.

15. Choose which beneficiaries would receive anything as a primary recipient (for example, will your spouse receive 100% of the benefit if something happens to you)?
16. Choose which beneficiaries would receive anything as a contingent recipient (for example, what will your children receive if something happens to you and your primary recipient)?
17. If you want to designate a Trust, click on the SEARCH icon in the field "Trust Name", click "GO" in the new search page, and then select "TRUST"– and then enter the corresponding Percentage.

    You must contact Human Resources to provide details about your trust (official name of Trust) to be entered into the system. Email : hr_benefits@wsscwater.com or 301-206-8696.
18. Repeat for Supplemental Life if applicable, and Retirement Plan and Final Salary - Unused Earned Vacation Leave.
19. When you are ready to continue, click NEXT.

Page 5: Add Primary Care Providers

20. If you enrolled in Kaiser Permanente HMO or Deltacare USA HMO, you will be asked to enter your primary care provider's ID, name and specialty. If you do not enter any information, a primary provider will be assigned to you.
21. When you are ready to continue, click NEXT.

Page 6: Confirmation Page

This page allows you to review everything you have selected.

22. Click CONFIRMATION STATEMENT to generate a summary of all of your elections and ***print or save a copy for your records***.
23. When finished, click FINISH.

Dear H2O People,

2020 has been a year full of uncertainty and change, and our 2021 Open Enrollment season is no exception. The good news is that, although we are not able to deliver the same in-person sessions or robust Wellbeing Fair as in the past, we are committed to providing the same level of exceptional service and information.

Our goal was to keep changes to a minimum, and we have some enhancements that should make things easier for you. Please refer to the Highlights section in this Benefits Guide for more information.

This Open Enrollment season, we're providing a series of virtual information sessions where our benefit vendors deliver brief presentations and Q&A sessions. The Benefits team and the Retirement Office also will be available for live, one-on-one meetings. The MyLife team will be delivering sessions as well. Look for some educational and fun sessions surrounding nutrition, social connection and physical movement. Please refer to the detailed schedule in the Benefits Guide or go to the WSSC Water Intranet homepage to access the most up-to-date information.

To support our core value of environmental stewardship, the annual Benefits Guide will not be printed. Instead, it is available on the Intranet homepage and WSSC Water Internet Employee Portal. This year's guide includes updates regarding Covid-19 and benefits, instructions for updating plans and beneficiaries in One-Source, information about all the vendors, dependent and change-of-life event information, legislative information, and more.

If you are not able to attend one of the virtual vendor sessions or schedule a one-on-one meeting with a Benefits team member, please email us at open.enrollment@wsscwater.com or call us at 301-206-7034 for all of your Open Enrollment questions.

New Employees
Welcome to WSSC Water! This guide contains important information about your benefits. We will be happy to assist you with any questions you may have. You may email us at hr_benefits@wsscwater.com or call us at 301-206-8692.

Respectfully,

DeAnna Thomas
DeAnna G. Thomas
Acting Director, Human Resources

Carole C. Silberhorn
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Division Manager, Benefits

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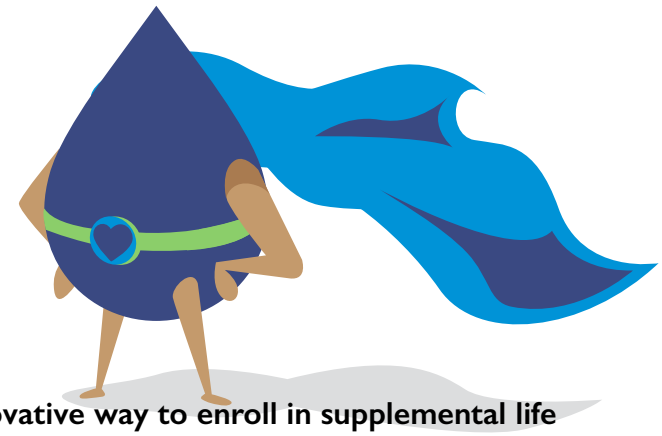
WHAT'S NEW FOR 2021



MetLife

- **In 2019, we partnered with MetLife to offer a new innovative way to enroll in supplemental life insurance (utilizing limited medical underwriting). This program will be offered again for 2021. More information is forthcoming to you about this program called EnrollSmart.**

Legal Services

- **We are pleased to announce that we will be transitioning our voluntary legal services plan from US Legal Services to Legal Resources. To make things easier for employees, we will be defaulting currently enrolled participants into the new plan. Therefore, if you are currently enrolled but would NOT like to participate in 2021, you will have to log in to One-Source and OPT OUT of the new plan.**

Beneficiaries in One-Source

- **In the past, employees have only been able to update their life insurance beneficiaries in One-Source. Beneficiaries for the "Retirement Plan" and "Final Salary - Unused Earned Vacation Leave" have been updated on paper forms. This year during Open Enrollment you will be able to designate your beneficiaries for all three plans in One-Source. We encourage each employee to update their beneficiaries online, as the need for paper forms in the past has resulted in failure to make updates when life events have occurred.**

FSA

- **The annual maximum for Medical FSA will increase from $2,700 to $2,750.**

Summary of Services Disclaimer

The purpose of this Benefits 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 guide.

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 to make the information contained in this guide accurate; however, if there are discrepancies between this guide and the contract with the carrier, the contract will govern.

2020 OCTOBER

Virtual vendor presentations will be held on Tuesdays (see details below) and virtual one-on-one appointments will be available with the Benefits team.

Educational and fun sessions will be offered throughout Open Enrollment as well:
Let's Connect, Let's Eat, Let's Learn, Let's Move and MyLife Ask The Expert!

You can sign up for any of these activities by visiting the Virtual Open Enrollment Portal:
https://www.employeewellnesshub.com/wsscwater/

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4	5 **Open Enrollment Begins**	6 Vendor Presentations see details below Organic/Plant-Based Webinar 12:00 pm	7 Healthy Cooking Made Easy 10:00 am	8 Low-Impact Cardio 8:30 am Animal Therapy 4:00 pm	9	10
11	12 Columbus Day Indigenous Peoples' Day	13 Vendor Presentations see details below Dental Wellness Webinar-1:00 pm	14 SleepCharge Portal Demo Sleep Charge-10:00 am Time Saving Favorites 4:00pm	15 Yoga Class 9:00 am Bingo 4:30pm	16	17
18	19	20 Vendor Presentations see details below Ergonomics/Posture Webinar-8:30 am	21 Smoothie Demo HFP-10:00 am Pathways to Smoking Freedom Chat-11:00 am	22 Zumba Class 4:30 pm Healthy Happy Hour Mocktail Demo 5:00 pm	23 Is Coaching Right For Me?-12:00 pm **Open Enrollment Ends**	24

VENDOR	6-Oct	13-Oct	20-Oct
UnitedHealthcare	12-12:45	8-8:45	10-10:45
Kaiser	10-10:45	7-7:45	1-1:45
Delta Dental	11-11:30	11-11:30	11-11:30
CVS Health	1-1:45	9-9:45	3-3:45
MetLife	7-7:45	10-10:45	2-2:45
Legal Resources	2-2:45	12-12:45	7-7:45
EyeMed	8-8:45	1-1:45	N/A
EAP-ComPsych GuidanceResources®	3-3:45	3-3:45	9-9:45
Benefit Strategies	9-9:45	2-2:45	12-12:45

2021 Medical, Dental & Vision Plan Rates for Employees

Plan & Coverage Level	Monthy Rate	WSSC Monthly Contribution	Employee Monthly Deduction	WSSC Semi-monthly Contribution	Employee Semi-monthly Deduction
United Healthcare Plus POS					
Individual	$1,130.00	$847.50	$282.50	$423.75	$141.25
2-Person	$2,230.00	$1,672.50	$557.50	$836.25	$278.75
Family	$2,820.00	$2,115.00	$705.00	$1,057.50	$352.50
United Healthcare Select EPO					
Individual	$799.00	$631.21	$167.79	$315.61	$83.90
2-Person	$1,599.00	$1,263.21	$335.79	$631.61	$167.90
Family	$2,326.00	$1,837.54	$488.46	$918.77	$244.23
Kaiser Permanente					
Individual	$589.00	$465.31	$123.69	$232.66	$61.85
2-Person	$1,178.00	$930.62	$247.38	$465.31	$123.69
Family	$1,785.00	$1,410.15	$374.85	$705.08	$187.43
Delta Dental PPO					
Individual	$40.00	$32.00	$8.00	$16.00	$4.00
2-Person	$67.00	$53.60	$13.40	$26.80	$6.70
Family	$99.00	$79.20	$19.80	$39.60	$9.90
Delta Dental HMO					
Individual	$21.00	$16.80	$4.20	$8.40	$2.10
2-Person	$34.00	$27.20	$6.80	$13.60	$3.40
Family	$50.00	$40.00	$10.00	$20.00	$5.00
EyeMed					
Individual	$5.40	$-	$5.40	$-	$2.70
2-Person	$14.10	$-	$14.10	$-	$7.05
Family	$20.70	$-	$20.70	$-	$10.35

Note: For the 2021 plan year, WSSC Water will contribute 75% towards the monthly premium for United-Healthcare Choice Plus POS , 79% for the UnitedHealthcare EPO and Kaiser HMO plans, 80% for the Delta Dental PPO and Delta Dental HMO, and 0% to the Vision Plan.

Important Things To Remember

- The Open Enrollment period is is October 5-October 23, 2020
- During Open Enrollment, you have the following options:
  - Enroll in the health, dental and/or vision plan.
  - 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 2021 Plan Year.
  - Enroll, continue, increase or decrease coverage, or waive Supplemental Life Insurance.
  - Enroll, continue, increase or decrease coverage, or waive Dependent Child or Spouse Life Insurance.
  - Enroll or waive Flexible Spending Accounts (both medical and dependent care).
  - Flexible Spending enrollments do not rollover from the previous year. If you want to participate in flex spending in 2020, you must reenroll.
  - Enroll, continue, or waive coverage in the Sick Leave Bank Program.
  - Enroll or waive coverage in the legal plan. NOTE: legal vendor will be changing from US Legal Services to Legal Resources effective January 1, 2021. Anyone currently enrolled in the Legal Plan will automatically be enrolled into the new plan. If you do not wish to participate, you must login to waive.
- You can now designate beneficiaries for the Retirement Plan and Final Salary/Unused Earned Vacation in One-Source (in addition to Life Insurance). Even if you are not making changes to benefits, please login to One-Source to add/update your beneficiary designations.
- All changes become effective January 1, 2021
- If you are enrolling a dependent age 19–26 for the first time, you are required to complete an affidavit. Please see page 9 for information on dependent coverage.
- If you are changing plans, you should receive your health care cards no later than January 1, 2021.
- 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 10 for further details.

****PLEASE NOTE: Any benefits change to add or delete dependents requires legal documentation before benefits will be available. See Insurance Coverage for Dependents section on page 9.**

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 employee's home pending final adoption;

c. Stepchildren;

d. Foster children;

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

f. Children for whom the employee 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, 2021 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 October 23, 2020.

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. Newly enrolled dependents between the ages of 19-26 require submission of an affidavit. You will not need to submit an affidavit if your overage dependent is already enrolled on our plan(s). The affidavit is in Human Resources, on the Intranet and One-Source.

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, divorce, birth or adoption of a child, or death.	Yes – you have 30 days to notify Human Resources.	• Log into One-Source and make a request to add or drop/delete 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.	• Log into One-Source and make a request to enroll (or disenroll) in our benefits or to add 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.	• Log into One-Source 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.

MyLife Wellbeing

MyLife is designed to help you find and maintain personal balance, and as your world changes, so will the offerings of the MyLife program. All services are offered through third party partners and are free, voluntary and confidential.

TAKE ADVANTAGE OF THESE SPECIAL SERVICES & PROGRAMS

MyLife Coaching

Personal, confidential support when you're feeling stuck or overwhelmed and want to find an easier way to work through issues with your health, stress, relationships, family or work. Register online, or call/text: 970-946-1586
Email: progress_health_coach1@bresnan.net

Diabetes Infoline and Diabetes Community Webinars

Call, text or email Claudine to discuss your personal diabetes experience and get expert advice to make your life around diabetes better. The Diabetes Community meets every month via webinar. Claudine can be reached at WSSC ext. 7784, text 301-246-0361 or email claudinecoach@gmail.com

Pathways to Smoking Freedom

Call, text or email Monica to get answers to your questions, and the guidance and support you need to quit smoking. Monica can be reached at WSSC ext. 7785, text 443-366-3163, or email monica@sp8strategies.com

MyLife Advocates

The MyLife Advocates visit all our sites on a rotating basis to provide opportunities to participate in MyLife programs wherever you are. Check the MyLife Calendar and Splash to see when they will be at your location, or email advocate@welladvantage.com.

Nutrition Infoline

Call, text or email Coach Ashley to talk about any issue related to your personal nutrition. Ashley can be reached at WSSC ext. 7783, text 301-337-8446, or email nutritioninfoline@gmail.com

SleepCharge by Nox Health

Everyone deserves good quality sleep for the best chance at optimal health. SleepCharge will help you with the best therapies, medical resources, sleep education and care managers. Take the assessment today at sleepcharge.com/wsscmylife or call 1-877-615-7257 to learn more.

Your wellbeing is our priority – physical, mental, emotional, financial, social, spiritual, personal and professional. Explore these resources and reach out any time, so we can help you be your best self every day.

WSSCWATER
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Need help sorting it out?

Your Employee Assistance Program can show you how. Our counseling, self-improvement tools and solutions for everyday issues can help you be your best, at home and at work. The services are free, confidential and available all day, every day to you and your household members. We can help you get it together.

Here when you need us.

Call: 855-737-8665
TTY: 800.697.0353
App: GuidanceNow℠
Online: guidanceresources.com
Web ID: WSSC

GuidanceNow℠

WSSC Water

Protect Yourself and Your Family For Only $18.00 Per Month!

Few employee benefits offer so much for so little. As a Legal Resources Member,you'll have immediate and ongoing access to **comprehensive legal coverage, services, and expertise** that will easily save you money — and could save you a whole lot more.

Don't let this opportunity get away!

FULLY COVERED SERVICES

LEGAL RESOURCES COVERS 100% OF THE ATTORNEY FEES FOR FULLY COVERED LEGAL SERVICES[1]

General Advice and Consultation
- Unlimited in-person or telephone advice and consultation for fully covered services

Family Law
- Uncontested domestic adoption
- Uncontested divorce
- Uncontested name change

Elder Law
- Estate advice
- Powers of attorney for members' parents

Criminal Matters[2]
- Defense of misdemeanor
- Misdemeanor defense of juveniles

Fully covered for first offense involving alcohol or illegal drugs

Wills and Estate Planning
- Will preparation and periodic updates
- Advance medical directive
- Financial powers of attorney
- Contingent trust for minor children

Traffic Violations
- Traffic infractions and misdemeanors
- Speeding
- Reckless driving
- Driving under the influence

1st Offense

Civil Actions
- Representation as defendant
- Representation as plaintiff
- Insurance matters
- Initial administrative hearing
- Small Claims Court advice

Preparation and Review of Routine Legal Documents
- Unlimited pages and occurrences

Real Estate
- Purchase, sale, or refinance of primary residence
- Deed preparation
- Tenant-Landlord matters
- Landlord-Tenant consultation

Consumer Relations and Credit Protection
- Warranty disputes
- Billing disputes
- Collection agency harassment

Identity Theft
- Prevention assistance
- Education services
- Identity recovery assistance

This **SUMMARY OF COVERAGE** is intended to provide a broad general overview of plan coverage and is not a contract. Coverage may vary by organization. For specific coverage questions, please call Member Services at 800.728.5768. Member is responsible for all non-attorney costs such asfiling fees, court costs, fines, etc.

YOUR LEGAL NEEDS WILL BE COVERED!

Don't see your legal need listed?

The Legal Resources Plan covers pre-existing legal matters as well as ANY less commonly needed legal service at a **25% discount.**[3]

Please visit LegalResources.com for more information or call Member Services at 800.728.5768.

1 Member is responsible for all non-attorney costs such as filing fees, fines, court costs etc. The Plan covers the individual, spouse and qualifying dependents. 12 month commitment required.Courtroom representation, when necessary, is fully covered through General District Court for claims in excess of $400. The definition of General District Court may vary by state.

2 Offenses involving illegal drugs, alcohol (except 1st offense DUI) and firearms are covered at a 25% discount.

3 Since your employer is the participating sponsor, you may not use the Plan in a dispute withyour employer.

2021 Medical Summary of Services

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.	$30 $35 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	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 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

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

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

2021 Medical Summary of Services

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 $10 copay.	Covered at 100% after $10 copay.	Covered at 70% of Plan Allowance after deductible.	Copays: $10 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	$200 copay for ER; waived if admitted.	$200 copay for ER; waived if admitted.	Covered at the network level.	$200 copay for ER; 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.

SUMMARY OF SERVICES DISCLAIMER

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.

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2021 Medical Summary of Services

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 $200 copay, waived if admitted. Non-emergency use – no coverage. $20 copay for Urgent Care if participating facility.	Covered at 100% after $200 copay, waived if admitted. Non-emergency use – no coverage. $25 copay for Urgent Care if participating facility.	Covered at the network level.	$200 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 $35 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	N/A	N/A	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 14.	See full description of the CVS/caremark Prescription Benefit on page 14.	See full description of the CVS/caremark Prescription Benefit on page 14.	See Kaiser Pharmacy description on page 13.

SUMMARY OF SERVICES DISCLAIMER

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KAISER PERMANENTE®

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. • $25 for brand name drugs. • $75 for non-preferred drugs. **Up to a 90-day supply:** • $20 for generic. • $50 for brand name drugs. • $150 for non-preferred drugs.	**Up to a 30-day supply:** • $20 for generic. • $50 for brand name drugs. • $150 for non-preferred drugs. **Up to a 90-day supply:** • $40 for generic. • $100 for brand name drugs. • $300 for non-preferred drugs.	**Up to a 90 day supply:** • $20 for generic. • $50 for brand name drugs. • $150 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**.		

Here's an overview of your CVS Caremark benefits.

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

The information below is a brief summary of your prescription benefits as well as some frequently asked questions about the CVS Caremark prescription benefit program. CVS Caremark and Washington Suburban Sanitary Commission are confident you will find value with your new prescription benefit program.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service Pharmacy (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10** for a generic medicine	**$20** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$25** for a preferred brand-name medicine	**$50** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$75** for a non-preferred brand-name medicine	**$150** for a non-preferred brand-name medicine
Refill Limit	**One initial fill plus one refill for maintenance medications. Specialty prescriptions are limited to a 30-day supply. $45 for a preferred specialty brand medication. $75 for a non-preferred specialty brand medication.**	**None**

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.

Smoking cessation medications are subject to a $1200 maximum allowable benefit per individual.

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

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

NUBAAG

CVS caremark®

Frequently Asked Questions

ABOUT THE CVS CAREMARK RETAIL NETWORK

Can I receive additional Prescription Cards?
Yes, for additional Prescription Cards, please call a Customer Care representative toll-free at 1-888-790-4271.

May I fill my medication at a non-participating pharmacy?
There are more than 68,000 participating pharmacies in the CVS Caremark retail network. When you choose to go to a non-participating pharmacy, you will pay the full prescription price. If you use a non-participating pharmacy, you should submit a paper claim form along with the original prescription receipt(s) to CVS Caremark for reimbursement of covered expenses. You can download and print a claim form when you log in to www.caremark.com.

How do I change my prescription from a non-participating retail pharmacy to a CVS Caremark participating retail pharmacy?
Go to a CVS Caremark participating retail pharmacy and tell the pharmacist where your prescription is currently on file. The pharmacist will contact the pharmacy and make the transfer for you. To find a CVS Caremark participating retail pharmacy, click on "Find a Pharmacy" at www.caremark.com.

When should I use a retail pharmacy instead of the CVS Caremark Mail Service Pharmacy?
You should use the retail pharmacy for your immediate and short-term medication needs. Use mail service for your long-term maintenance medication needs.

ABOUT THE CVS CAREMARK MAIL SERVICE PHARMACY

Why should I use the CVS Caremark Mail Service Pharmacy for my prescriptions?
The CVS Caremark Mail Service Pharmacy is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication. You can have your long-term medication delivered to your home, office or a location of your choice with free standard shipping. By using mail service, you minimize trips to the pharmacy while saving money on your prescriptions.

How long does it take for my prescriptions to arrive by mail?
Please allow 7-10 days for delivery from the time the order is placed.

How do I check the status of my order?
You can check your refill order status at www.caremark.com or by calling toll-free at 1-888-790-4271.

How should I ask my doctor or other prescriber to write my prescription in order to receive the maximum benefit from the CVS Caremark Mail Service Pharmacy?
Remind your doctor or other prescriber to write a "90-day supply plus refills," when clinically appropriate, for maintenance medications that are purchased through the CVS Caremark Mail Service Pharmacy. CVS Caremark must fill your prescription for the exact quantity of medication that your doctor or healthcare provider prescribes, up to your plan design limit. When you need to take your maintenance medication right away, ask your doctor or other prescriber for two prescriptions:

- The **first** for up to a 30-day supply
- The **second** for up to a 90-day supply, with refills when clinically appropriate

Have the short-term supply filled immediately at a CVS Caremark participating retail pharmacy and send the 90-day supply prescription to the CVS Caremark Mail Service Pharmacy.

ABOUT THE CVS CAREMARK DRUG LIST

What is a drug list?
It is a list of preferred prescription medications that have been chosen because of their clinical effectiveness and safety. This list is typically updated every three months. The drug list promotes the use of preferred brand-name medications and generic medications whenever possible. Generic medications are therapeutically equivalent to brand-name medications and must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness. Generally, generic medications cost less than brand-name medications. You can get a drug list by either visiting www.caremark.com or by calling Customer Care toll-free at 1-888-790-4271.

How do I change to a generic or preferred drug?
To save money, have your doctor or other prescriber choose a generic or preferred brand-name medication from the CVS Caremark Drug List, if appropriate. You may want to take the list with you when you visit your doctor or other prescriber.

WSSC - 1018169

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on www.eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Co-pay	Up to $84
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay, $150 Allowance, 20% off balance over $150	Up to $58
Standard Plastic Lenses		
Single Vision	$0 Co-pay	Up to $50
Bifocal	$0 Co-pay	Up to $90
Trifocal	$0 Co-pay	Up to $110
Lenticular	$0 Co-pay	Up to $310
Standard Progressive Lens	$50 Co-pay	Up to $90
Premium Progressive Lens[Δ]	$70 Co-pay - $95 Co-pay	
Tier 1	$70 Co-pay	Up to $90
Tier 2	$80 Co-pay	Up to $90
Tier 3	$95 Co-pay	Up to $90
Tier 4	$50 Co-pay, 20% off retail less $120 Allowance	Up to $90
Lens Options		
UV Treatment	$12 Co-pay	Up to $3
Tint (Solid and Gradient)	$10 Co-pay	Up to $4
Standard Plastic Scratch Coating	$10 Co-pay	Up to $4
Standard Polycarbonate–Adults	$25 Co-pay	Up to $12
Standard Polycarbonate–Kids under 19	$25 Co-pay	Up to $12
Standard Anti-Reflective Coating	$40 Co-pay	Up to $4
Premium Anti-Reflective Coating[Δ]	$52 Co-pay - $63 Co-pay	Up to $4
Tier 1	$52 Co-pay	Up to $4
Tier 2	$63 Co-pay	Up to $4
Tier 3	20% off retail	Up to $4
Photochromic/Transitions	$65 Co-pay	Up to $8
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay, $150 Allowance, 15% off balance over $150	Up to $100
Disposable	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $100
Medically Necessary	$0 Co-pay, paid-in-full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids, call 1-844-526-5432.	N/A
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contact Lenses (in lieu of lenses)	Once every 12 months	
Frame	Once every 12 months	

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. [Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	$0 Co-pay	Up to $84
Frames (once every 12 months)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $58
Single Vision Lenses (once every 12 months)	$0 Co-pay	Up to $50
or Contacts (once every 12 months)	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $100

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

91% SAVINGS with us*

With EyeMed		Without Insurance**	
Exam	$0 Co-pay	Exam	$106
Frame	$163 -$150 Allowance $13 -$2.60 (20% discount off balance) $10.40	Frame	$163
Lens	$0 Co-pay $12 UV treatment add-on +$10 scratch coating add-on $22	Lens	$78 $23 UV treatment add-on +$25 scratch coating add-on $126
Total	$32.40	Total	$395

Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Target Optical | Sears Optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.

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

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 PPO℠. 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 $1,750.
- The maximum benefit per person per year for services provided by Premier or non-participating dentists is $1,500.
- 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%

MetLife Life Insurance:
Basic, Supplemental & Dependent

Life Insurance for WSSC Water employees is provided through the Metropolitan Life Insurance Company www.metlife.com, (800) 638-6420

ENROLLSMART is back! This Open Enrollment season METLIFE is offering its ENROLLSMART program making it easier for WSSC Water employees to enroll in or increase supplemental life insurance.

■ BASIC LIFE INSURANCE

- Basic Life Insurance is a term insurance policy WSSC Water provides for every permanent employee at no cost to the employee. Enrollment is automatic.
- Basic Life Insurance is valued at 2 times your Basic Annual Earnings (including longevity pay if applicable), rounded to the next higher $1,000. The maximum Basic Life Benefit is $400,000. Coverage is pro-rated for part-time employees.

■ ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

- WSSC Water also provides AD&D for every permanent employee, at no cost to the employee. AD&D is the value of your Basic Life Insurance. The maximum AD&D Benefit is $400,000. Enrollment is automatic.

■ SUPPLEMENTAL LIFE INSURANCE

- Supplemental Life Insurance is an optional term life insurance policy that permanent employees may purchase to provide extra coverage beyond the amount provided through the WSSC Water's Basic Life and AD&D insurance package.
- Supplemental Life Insurance coverage is an amount, elected by you, with a maximum of $500,000. Coverage is available in $10,000 increments between $10,000 and $200,000 or you may elect one of the three higher options of $300k, $400k or $500k. The cost of this coverage is based on your age and coverage amount.
- Current participants already enrolled in Supplemental Life who wish to increase their benefit amount by up to $20,000 (2 levels) up to a maximum of $200,000 are NOT required to answer any medical questions.
- Employees who wish to increase by more than $20,000, or those NOT currently enrolled who wish to enroll for the first time, may do so by electing the amount in One-Source and answering only five medical questions. MetLife will send an email after the Open Enrollment period ends with instructions.
    - Only if a "yes" is answered to any of the medical questions a full Statement of Health will be required.
- Enrollment in Supplemental Life is not automatic. You must elect Supplemental Life and the coverage amount in One-Source and be approved by MetLife.

Age	Semi-monthly rate per $10,000 in coverage	Age	Semi-monthly rate per $10,000 in coverage
under 30	$0.21	55-59	$1.57
30-34	$0.27	60-64	$2.59
35-39	$0.31	65-69	$4.52
40-44	$0.34	70-74	$7.48
45-49	$0.55	75+	$8.76
50-54	$0.82		

MetLife Life Insurance:
Basic, Supplemental & Dependent

SPOUSAL LIFE INSURANCE

- Spousal Life Insurance is an optional term insurance policy that permanent employees may purchase for coverage of their spouse:
- You, as the employee, are the beneficiary.
- You cannot purchase life insurance for a spouse who is also a WSSC Water employee.
- Spousal Life Insurance coverage is an amount, elected by you, which is a multiple of $10,000 with a maximum life benefit of $100,000. The cost of this coverage is based on your age and coverage amount.

Age	Semi-monthly rate per $10,000 in coverage	Age	Semi-monthly rate per $10,000 in coverage
under 30	$0.15	50-54	$0.76
30-34	$0.17	55-59	$1.20
35-39	$0.22	60-64	$1.91
40-44	$0.31	65-69	$3.28
45-49	$0.46	70-74	$6.28

- Current participants who wish to increase their benefit amount or new participants may enroll by electing their amount in One-Source and answering only five medical questions. MetLife will send an email with instructions after the Open Enrollment period ends.
    - Only if a "yes" is answered to any of the medical questions a full Statement of Health will be required.

DEPENDENT CHILD LIFE INSURANCE

- Child Life Insurance on your eligible children up to 26 years of age is offered in the amount of $15,000. The semi-monthly rate for $15,000 in coverage will be $1.08.
- You can not purchase Child Life Insurance for a child who is already covered by another WSSC Water employee.
- You will not be required to answer any medical questions or complete a statement of health form to enroll in Child Life Insurance.
- Enrollment in Child Life Insurance is not automatic. You must elect it in One-Source.

Please Note: If you are requesting a new life insurance policy or an increase in your life insurance coverage that is subject to answering medical questions and/or completion of a Statement of Health form, your request will be pending until we are notified by MetLife that the request has been approved. A letter will also be mailed to your home address.

PLEASE ENTER THE ADDRESS, DATE OF BIRTH AND SOCIAL SECURITY NUMBERS OF ALL YOUR BENEFICIARIES INTO ONE-SOURCE. THIS ENSURES THAT THE RIGHT PERSON RECEIVES YOUR BENEFIT.

Flexible Spending Accounts

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows employees to pay for eligible medical and/or dependent (i.e. daycare) care expenses (up to age 13) on a pre-tax basis, saving you money on your income taxes.

HOW MUCH MONEY CAN I PUT IN MY FSA ACCOUNT?

The maximum annual contribution for the Medical FSA account in 2021 is $2,750; the minimum annual contribution is $260.

The maximum annual contribution for the Dependent Care FSA account in 2021 is $5,000 (per household); the minimum annual contribution is $260.

HOW DO I ENROLL?

Enrollment is done in One-Source during the Open Enrollment Period. If you have FSA in 2020 and want it to continue in 2021, YOU MUST re-enroll online to participate in 2021. **Your current enrollment will not carry over to 2021.**

HOW DO I GET REIMBURSED FOR ELIGIBLE EXPENSES?

Eligible expenses through the Medical FSA can be paid with the debit card provided by Benefit Strategies, or by submitting your receipt(s) with a signed Healthcare Reimbursement Form. Auto-validation is also available (participation in WSSC Water insurance program required and not applicable to Kaiser Participants).

Eligible expenses through the Dependent Care FSA are reimbursed through a Dependent Care Reimbursement Form. You can mail, fax, or submit your signed Dependent Care claim form online along with your receipt(s) to Benefit Strategies. Payments are issued three times per week and you can elect to have a check mailed to your home or directly deposited into your personal bank account.

All reimbursement forms can be found on the WSSC Water Intranet and the Benefit Strategies web sites.

WHAT IS AUTO-VALIDATION?

Your insurance carrier will send Benefit Strategies your visit or service information to validate your FSA debit card transactions. This will reduce the number of times Benefit Strategies requests receipts from you to prove you used your card correctly. Please remember that the auto-validation process applies only to services that are first sent to your insurance carrier.

CAN I CHANGE THE AMOUNT I CHOOSE TO CONTRIBUTE TO MY FSA?

Your annual goal amount can only be changed within 30 days of a change of life event. See page ? to learn more about change of life events.

WHAT HAPPENS IF I HAVE EXCESS MONEY LEFT IN MY ACCOUNT FOR 2020 AT THE END OF THE YEAR?

You have until April 15, 2021 to submit claims for reimbursement with dates of service from January 1, 2020 through December 31, 2020. ***If you have a balance remaining in your FSA account on December 31, 2020, you may submit qualified receipts for dates of service from January 1, 2021 to March 15, 2021 which would be applied to your balance of 2020 (this helps you in reducing any remaining funds).*** IRS regulations require that any funds left in your account after that date be forfeited. **NOTE:** These grace period provisions were extended for the 2019 plan year due to COVID-19 and it is possible that they will be extended for the 2020 plan year as well.

IF I ENROLL IN FSA FOR 2021, CAN I GET REIMBURSED FOR EXPENSES THAT I INCURRED IN 2020?

No, this is referred to as a split payment and would be denied. You cannot get reimbursed for expenses that you incurred in a previous plan year, with the exception of the grace period provisions outlined above.

For more information on FSAs, view the plan brochure or contact Benefit Strategies and speak with a FSA specialist.

FSA Eligible Expense List

Health FSA Eligible Expenses

NEW: Over-The-Counter Medicines and Drugs no longer require a prescription!

Ace bandages
Acne treatments
Acupuncture
Allergy and sinus medicine
Antacids and digestive aids
Antibiotic ointments
Antifungal and anti-itch
Aspirin and other pain relievers
Asthma medicine
Athletic treatments
Band-aids
Blood pressure monitors
Canker and cold sore remedies
Chest rubs
Chiropractic care
Cholesterol meter test kit and supplies
Cold and flu medicines
Contact lenses
Contact lens cleaning solution
Co-insurance
Copays
Corn and callus removers
Cough medicine
CPAP machine
Crutches, canes and walkers
Deductibles
Dental care (routine and corrective)
Dentures
Diabetic monitors and supplies
Diaper rash ointments
Eye exams
Eye glasses
Eye related equipment
Fertility monitors
First aid kits
Gastrointestinal medication
Genetic testing*
Glucosamine
Group therapy
Hearing aids and batteries
Hearing care
Herbal medicine*
Hospitalization costs
Hypnosis – treatment of illness
Immunizations
Imaging scans
Incontinence supplies
Individual therapy
Laboratory fees
Lasik eye surgery
Laxatives
Lice treatments
Massage therapy*
Medical equipment
Medical monitoring and testing
New! Menstrual care products (tampons, pads, etc.)
Mileage to receive medical care
Motion and nausea medicine
Nutritional supplements*
Orthodontia
Orthopedic and surgical supports
Orthotics
Physical exams
Physical therapy
Physician services
Pregnancy tests
Prescription drugs
Psychoanalysis and mental health therapy
Reading glasses
Sleep aids
Smoking deterrents
Sunscreen (SPF 30 and higher)
Thermometers
Toothache gels
Urological products
Vision care
Vitamins*
Wart removal treatment
Weight loss drugs and programs*
Wheelchairs and repairs

If you have questions on what constitutes an FSA eligible expense, please contact our Customer Relations Team through online chat, 1-888-401-FLEX(3539) or email info@benstrat.com.

Ineligible Expenses Examples

- Cosmetic Surgery & Procedures
- Health Club Dues
- Insurance Premiums
- Dental Hygiene Products

*Dual Use items and services are those that can be used for general health as well as to treat an illness or physical defect. If the item/service is prescribed to treat an illness or physical defect, a Physician Statement form needs to be submitted to Benefit Strategies for it to be FSA eligible. This form can be found on benstrat.com, or by contacting our Consumer Relations team. Dual Use items/services will not work with the Benefit Strategies Debit card. You will need to pay with another means and submit for reimbursement through one of our reimbursement methods. Remember to submit the Physician Statement, along with the purchase documentation.

Sick Leave Bank Program

The purpose of the Voluntary Sick Leave Bank (SLB) is to provide Sick Leave to participants in the Sick Leave Bank after they have been out of work for at least 30 consecutive days and have exhausted all of their accrued sick and annual leave hours due to a serious health condition. Sick Leave Bank is for extended personal illness or disability (i.e., pregnancy, surgery, or injury) suffered by the Sick Leave Bank member only.

SLB MEMBERSHIP REQUIREMENTS ARE AS FOLLOWS:

- All active permanent full-time and part-time employees may enroll in the SLB upon their employment or during the Open Enrollment period without regard to preexisting conditions.
- An employee may continue or cancel participation in the SLB during the Open Enrollment period by selecting the appropriate election through the online benefit enrollment system.
- To join the SLB, you must start with a donation to the Sick Leave Bank of eight hours of your own accumulated sick leave (or a proportional number of hours for part-time employees).
- To continue enrollment, a donation of four hours of your accumulated sick leave is required each year. These hours are deducted in the beginning of the plan year. If the sick leave balance is insufficient, annual leave may be contributed.
- If you don't have enough accumulated leave (sick/annual) at time donation is pulled, you will not be a member of thE SLB for that Plan Year.

HOW DO I ENROLL IN OR CONTINUE MEMBERSHIP IN THE SICK LEAVE BANK?

- Make your selection in One-Source.

TO APPLY FOR SICK LEAVE BANK (SLB) BENEFITS, THE FOLLOWING CONDITIONS MUST BE MET:

- You are a current SLB member who contributed hours to the SLB during the most recent contribution period.
- You have a serious health condition (non-work related), and you are unable to work for 30 or more consecutive calendar days.

  The first thirty (30) consecutive calendar days of illness or non-work related injury shall not be covered by the SLB, but must be covered by the employee's own accumulated leave balances (sick and annual). During these thirty (30) days, the employee must be completely incapacitated from performing work duties, as documented by the employee's treating physician.

- You have exhausted all of your accumulated sick and annual leave.
- You have obtained a physician's statement that clearly defines and specifically describes the serious health condition and provides an estimated length of time and reason for the related disability. Also required is a claim form required by our Third Party Administrator (TPA), which needs to be completed by both you and your physician.

IMPORTANT REMINDERS:

- SLB leave is only granted to employees who have a serious health condition and are unable to work for 30 or more consecutive calendar days and is not granted to care for a family member.
- The first 30 days of absence are not covered under the Sick Leave Bank.
- Participants may not use SLB leave until they have used all accumulated annual and sick leave. Sick leave hours earned during the period a participant is using SLB hours shall be used each pay period before SLB hours are used.
- To prevent a leave without pay situation, please allow 3 weeks for the processing of your SLB Request.
- SLB leave may be granted to part-time employees on the same pro-rated basis they used for their donations.
- The approval process begins with the medical documentation being evaluated by our TPA. If the claim is approved, the request for hours will be forwarded to the Sick Leave Bank Board for review. If the request is approved through the Sick Leave Bank Board, notification will be sent to both the member and their supervisor.
- If approved, SLB hours will be granted in increments of up to 10 days (80 hours) to a maximum of 30 days (240 hours) at a time. Within a 12 month period, SLB hours granted cannot exceed 60 days (480 hours) or more than 150 days (1,200 hours) during their length of employment with WSSC Water. (Prorated for part-time employees.)

Sick Leave Bank Program

- The SLB Board may not return leave back to a participant once it has been contributed; however if a participant has been awarded hours from the SLB, the Board may, for one time only at the request of the participant, also credit hours over the 8 hour minimum that the participant has contributed to the SLB to the participant to be used to shorten the 30-day waiting period.
- Participants needing additional hours should reapply at least 7 calendar days prior to the exhaustion of granted leave time.
- SLB leave does not take the place of other leave programs such as the Short Term Disability Program. SLB was created to bridge the gap from the 31st day to the 90th day of consecutive calendar days of absence which is when an employee may be eligible for Short Term Disability. If a SLB member is receiving SLB leave and is approved for Short Term Disability, SLB leave will end and any balance of leave will be returned to the SLB Bank.
- SSLB leave will not be granted for serious injuries or illnesses directly or indirectly related to Workers' Compensation.

Additional questions may be directed to Susan Menefee in the WSSC Human Resources Office – Benefits Division at 301-206-8702 or email at Susan.Menefee@wsscwater.com.

WSSC Water reserves the right to change or eliminate its benefit programs at any time and without notice.

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.

CHILD HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must **request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

Legislative Information

CHIP *(continued)*

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

NEW JERSEY – Medicaid

Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Toll-free Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

VIRGINIA – Medicaid and CHIP

Medicaid Website: www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924

CHIP Website: www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) SPECIAL ENROLLMENT RIGHTS

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) creates two new special enrollment rights for employees and their dependents. All group health plans must permit

eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

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

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

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

Legislative Information

Certificate of Creditable Coverage for Medicare Part D

Important Notice from WSSC Water 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 Water) 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 Water has determined that the prescription drug coverage offered by WSSC Water's UnitedHealthcare Medical Plans through CVS Health Services and WSSC Water'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 Water coverage will be affected. If you are enrolled in the UnitedHealthcare Medicare Supplement, your prescription coverage is provided to you through CVS Health. If you elect a Medicare drug plan and you have CVS Health prescription coverage then you will no longer be eligible for prescription coverage under CVS Health. 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 Water 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 Water'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.

Legislative Information

Certificate of Creditable Coverage for Medicare Part D

Important Notice from WSSC Water 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 Water 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 1, 2020
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.

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 Water 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 Health, Delta Dental, Benefit Strategies, ComPsych GuidanceResources®, Progress Health, Well Advantage, EyeMed, Fusion Health and Legal Resources

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 Water'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.

HIPAA

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 the denial.

HIPAA

Individual Rights *(cont'd)*

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 Water'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 Water Privacy Official:

Human Resources Division Manager – Benefits

14501 Sweitzer Lane

Laurel, MD 20707-5902

Phone: 301-206-8696

Fax: 301-206-8713

Alternate Email: hr_benefits@wsscwater.com

Customer Service Contacts

WSSC Water Contacts

Open Enrollment Hotline (through 10/23)
open.enrollment@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

Other Contacts

Benefit Strategies (Flexible Spending Accounts)
online chat is www.benstrat.com
1-888-401-3539
Email: info@benstrat.com

CVS Health
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

EAP – ComPsych GuidanceResources
www.GuidanceResources.com
1-855-737-8665

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

EyeMed
Group #1018169
www.eyemed.com

1-866-0982

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

Medical Advice Line
1-800-777-7904

Legal Resources
www.LegalResources.com

800-728-5768

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

Progress Health Coaching
Gail Johnston
Progress_health_coach1@bresnan.net wssc
970-946-1586
To register for coaching:
progresshealthcoaching.com/registration/wsscreg.asp

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