2021 Retiree Benefits Guide

October 5-23, 2020

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Dear Retiree,

We hope this letter finds you safe and well. While 2020 has been full of uncertainty and change for all of us, we continue to face the challenges of this "new normal" head on.

Due to the pandemic, we are not able to deliver the same in-person sessions or robust Wellbeing Fair as we have in the past, but we are committed to providing the same level of exceptional service and information for this year's Open Enrollment season, October 5-23, 2020.

Our goal was to keep changes to a minimum for 2021 and we were able to do that for you. Please refer to the Highlights section in this Retiree Benefits Guide for more information.

We are happy to announce a new feature for Open Enrollment. We are partnering with Health Fairs Plus to provide a series of virtual information sessions. Beginning in late September, our benefit vendors will be delivering brief presentations and will be available for Q&A sessions. The HR Benefits team will be available for live one-on-one meetings and we will offer some educational and fun sessions surrounding nutrition, social connection and physical movement. While we would love to see you in person, we are pleased to offer this new method of delivering information. Please refer to the detailed schedule in this Retiree Benefits Guide or access the most up-to-date Open Enrollment information on WSSC Water's Internet: wsscwater.com/retirees.

To support WSSC Water's core value of Environmental Stewardship, the annual Retiree Benefits Guide will not be printed this year. Instead, it will be available on the WSSC Water Internet Retiree Portal prior to the start of Open Enrollment. The Retiree Benefits Guide will include updates about benefits related to Covid-19, and information about all the vendors, dependent and change-of-life events, legislative and much 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.

Respectfully,

DeAnna Thomas
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Acting Director, Human Resources

Carole C. Silberhorn
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Division Manager, Benefits

WHAT'S NEW FOR 2021

Vision- EyeMed

- **This Open Enrollment period will be the last opportunity retirees will have to newly elect the Supplemental Vision Plan, which will be effective January 1, 2021. If you are not enrolled in the vision plan when Open Enrollment ends, you will be considered "waived."- Similar to the Medical and Dental plans, once enrollment in Vision is waived, you are unable to enroll in the future.**

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.

Important Things To Remember

- Open Enrollment Period is October 5 to October 23, 2020
- During Open Enrollment, you have the following options:
    - Elect vision coverage (if currently enrolled in medical.) See important information on page 4.
    - 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.
    - Update beneficiary information for Basic and Supplemental Life Insurance (if applicable).
    - Continue, decrease or waive Supplemental Life Insurance (if applicable).
- All changes become effective January 1, 2021.
- If you are enrolling a dependent age 19–26 for the first time, you are required to complete an affidavit. Please see page 7 for information on dependent coverage.
- Medical, Dental and Vision changes should be updated on the Benefits Request Form that is enclosed with your open enrollment guide.
- IF YOU ARE NOT MAKING ANY CHANGES TO YOUR BENEFITS OR PERSONAL INFORMATION; INCLUDING CHANGE OF ADDRESS, PHONE NUMBER, OR EMAIL ADDRESS, YOU DO NOT NEED TO SEND YOUR FORM BACK.
- If you are changing plans, you should receive your healthcare 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 8 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 7.**

2021 Medical, Dental & Vision Plan Rates for Retirees

Plan & Coverage Level	Monthy Rate	WSSC Water Monthly Contribution	Retiree Monthly* Deduction
United Healthcare Choice Plus POS			
Individual	$ 1,130.00	$ 847.50	$ 282.50
2-Person	$ 2,230.00	$ 1,672.50	$ 557.50
Family	$ 2,820.00	$ 2,115.00	$ 705.00
United Healthcare Select EPO			
Individual	$ 799.00	$ 631.21	$ 167.79
2-Person	$ 1,599.00	$ 1,263.21	$ 335.79
Family	$ 2,326.00	$ 1,837.54	$ 488.46
Kaiser Permanente HMO			
Individual	$ 589.00	$ 465.31	$ 123.69
2-Person	$ 1,178.00	$ 930.62	$ 247.38
Family	$ 1,785.00	$ 1,410.15	$ 374.85
United Healthcare Medicare Supplement			
Individual Medicare**	$ 678.00	$ 535.62	$ 142.38
2-Person Medicare**	$ 1,360.00	$ 1,074.40	$ 285.60
Kaiser Permanente Medicare Plus			
Individual Medicare**	$ 255.00	$ 201.45	$ 53.55
2-Person Medicare**	$ 510.00	$ 402.90	$ 107.10
Delta Dental PPO			
Individual	$ 40.00	$ -	$ 40.00
2-Person	$ 67.00	$ -	$ 67.00
Family	$ 99.00	$ -	$ 99.00
Delta Dental HMO			
Individual	$ 21.00	$ -	$ 21.00
2-Person	$ 34.00	$ -	$ 34.00
Family	$ 50.00	$ -	$ 50.00
EyeMed			
Individual	$ 5.40	$ -	$ 5.40
2-Person	$ 14.10	$ -	$ 14.10
Family	$ 20.70	$ -	$ 20.70
NOTE: Must be enrolled in Retiree medical to participate in vision plan			

For the 2021 plan year, WSSC contributes 75% of the monthly premium towards the United Healthcare Choice Plus POS plan and 79% of the monthly premium for all other health plans.

There is no contribution to the dental or vision plans.

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

**Once you become eligible for Medicare Part B, you must enroll. Your plan with WSSC will coordinate with Medicare to pay your medical bills.

Eligibility Requirements for Dependents

Eligible Dependents are:

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

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

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

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

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

a. Biological children;

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

c. Stepchildren;

d. Foster children;

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

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

Coverage Effective Date for Newly Enrolled Dependents

Open enrollment changes become effective on January 1, 2021. Life event change dates may vary based on type of event.

Dependent Eligibility Verification

In order to provide coverage for your newly enrolled dependents, you must submit proper legal documentation to Human Resources no later than November 15, 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).

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 Division in Human Resources at hr_benefits@wsscwater.com or call (301) 206-7034.

NOTE: If you divorce your spouse, they are no longer eligible to be on your health plan. Failure to remove an ineligible spouse within 30 days of divorce may result in you being responsible for any claims incurred.

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

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

2021 Non-Medicare Medical Summary of Services

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

Plan Benefits	UnitedHealthcare Select EPO In-Network Only	UnitedHealthcare Choice Plus POS In-Network	UnitedHealthcare Choice Plus POS Out-of-Network	Kaiser Permanente HMO In-Network Only
Copays: PCP Specialists	$20 $25 No PCP or referrals required.	$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 (including 3D)	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%.

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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.

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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 13	See full description of the CVS/caremark Prescription Benefit on page 13	See full description of the CVS/caremark Prescription Benefit on page 13	See Kaiser Pharmacy description on page 12.

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Prescription Benefits At-A-Glance

(For Non-Medicare prescription drug coverage)

	Kaiser Permanente Medical Center (Preferred)	Community Based/ Network Pharmacy	Mail Order Program (Preferred)
When to Use Your Benefit:	For immediate or short term prescriptions:	For immediate or short term prescriptions:	For short term, maintenance and long term prescriptions:
Where:	Prescriptions can be filled at a Kaiser Permanente Medical Center. ***Please Note: Copays are lower*** *when filled at a Kaiser Permanente Medical Center vs. a community network pharmacy.*	Prescriptions can also be filled at community pharmacies such as: Giant®, Safeway®, Rite Aid®, Target®, Wal-Mart®, and K-Mart®. ***Please Note: Copays are higher*** *when filled at a community network pharmacy.*	You can have prescriptions mailed right to your home through the Kaiser Permanente Mail order program.
Cost to You:	**Up to a 30-day supply:** • $10 for generic. • $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.

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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®

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%

Refer to the plan brochure for complete list

DELTA DENTAL®

Deltacare USA DHMO

Plan Description

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

Deltacare USA DHMO Enrollment Option:

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

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

PATIENT PAY

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

Medicare-Eligible Retirees and Dependents

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

Once you are enrolled in Medicare Parts A & B, you must send a copy of your Medicare ID card to the WSSC Water HR Department so that we can ensure that you are enrolled in the proper medical and prescription plans. UnitedHealthcare members are then moved into the UnitedHealthcare Medicare Supplement Plan and the SilverScript Prescription Drug Plan (PDP). Please refer to pages 20–21 to learn more about SilverScript. Kaiser members transition into the Kaiser Medicare Advantage plan, but they must also complete the Kaiser Medicare Advantage application and return it directly to Kaiser.

During Federal Annual Open Enrollment, you will likely be solicited by individual Medicare Part D programs asking you to enroll in a private Medicare Part D plan. You should NOT enroll in an individual Medicare Part D program if you are enrolled in one of the WSSC Water health insurance plans, because Medicare does not allow you to enroll in two Part D plans. Enrolling in an individual plan could compromise your eligibility for WSSC Water-sponsored medical and prescription coverage.

Medicare Summary

Medicare is a national health insurance program covering individuals age 65 and older, younger people with disabilities and people with end stage renal disease (kidney failure). **Medicare Part A** (Hospital Insurance) helps cover inpatient care in hospitals (including critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals), inpatient care in a skilled nursing facility (not custodial or long-term care), hospice care services, home health care services, and inpatient care in a Religious Nonmedical Health Care Institution. Certain conditions must be met to get these benefits. **Medicare Part B** (Medical Insurance) helps cover medically necessary services like physician services, outpatient care, home health care services, and other medical services. **Medicare Part B** also covers some preventive services. **Medicare Part D** offers coverage for prescription drugs. Please note that the SilverScript plan offered by WSSC Water is a Medicare Part D plan that also provides an enhanced benefit including pharmacy.

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

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

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

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

Medicare Frequently Asked Questions

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

If you are enrolled in Kaiser, you will transition to the Kaiser Medicare Advantage Plan and your prescription benefit will continue to be administered by Kaiser. You may refer to the chart on page 19 for the copays for Kaiser Medicare Advantage members.

If you are enrolled in UnitedHealthcare, you will transition from the UnitedHealthcare EPO or POS plan to the UnitedHealthcare Medicare Supplement plan. Currently, CVS/caremark administers the prescription benefits for all non-Medicare-eligible UnitedHealthcare members. Members who are enrolled in UnitedHealthcare and become Medicare-eligible will transition from CVS/caremark to SilverScript. Please refer to pages 20–21 for more information about the SilverScript PDP and page 11 for the copays.

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

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

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

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

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

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

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

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

■ WHAT HAPPENS TO MY MONTHLY BENEFIT DEDUCTION?

Once the Benefits Division has a copy of your Medicare ID card to verify you have successfully enrolled in Medicare Parts A & B, your monthly deductions will be updated. Each carrier has different premiums for their Medicare Supplement plan. Please refer to the rates on page 4 of this booklet.

■ WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL FORMS?

You may contact the Open Enrollment phone line at 301-206-7034 or email open.enrollment@wsscwater.com. Please leave your full name, I.D. number, home address and phone number. After October 23, 2020, please call 301-206-8696 or email HR_Benefits@wsscwater.com.

Medicare-Eligible Summary of Services

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

Plan Benefits	UnitedHealthcare PPO Medicare Supplement	Kaiser Medicare Advantage
Doctor and Hospital Choice	You may choose any doctor or hospital that accepts Medicare	You may choose any Kaiser Permanente network doctor, specialist, and participating hospital. Specialty care may require a referral from your Primary Care Physician
Annual Physical	Covered at 100%	Covered at 100%
Inpatient Hospital Care	Plan pays 100% of covered charges remaining after Medicare	Unlimited days for a Medicare covered stay in a network hospital are covered in full after $100 copay
Doctor's Office Visits	Plan pays 100% of covered charges remaining after Medicare	$15 copay
Diagnostic Tests, X-rays & Lab Services	Plan pays 100% of covered charges remaining after Medicare	$15 copay for radiation therapy; no charge for XRays, lab services, or diagnostic tests
Emergency Room Services	Plan pays 100% of covered charges remaining after Medicare	$50 copay (copay waived if admitted)
Prescriptions	See Caremark on page 11. Copays for SilverScript are the same as the CVS/ caremark commercial plan	$10 copay for up to a 90 day supply of mail order medicine (brand or generic), $15 copay for up to a 60 day supply (brand or generic) at Kaiser Permanente center pharmacy, $25 copay for up to a 60 day supply (brand or generic) at participating network pharmacy
Durable Medical Equipment	Plan pays 100% of covered charges remaining after Medicare. Prior notification required	Covered in full through participating providers
Vision Services	Plan pays 100% (after $25 copay) for a refractive eye examination every calendar year at participating providers; discounts on frames and lenses at participating providers	$15 copay for eye exam; discounts on frames, lenses and contact lenses (only at Kaiser Vision Centers)
Primary Insurance	Medicare: Parts A & B	Kaiser Permanente
Secondary Insurance	UnitedHealthcare	Medicare: Parts A, B & D

New for Kaiser - Transportation: $0 copay for up to 24 one-way rides to and from KP Medical Centers and contracted facilities.
Brain HQ: Free subscription to brain training application.

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

SilverScript Prescription Drug Coverage for Medicare-eligible UnitedHealthcare Members

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

About SilverScript

Q. *How does SilverScript work?*

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

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

Eligibility

Q. *Who is eligible for Silverscript?*

A. Individuals that:

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

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

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

A. Individuals who are:

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

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

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

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

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

Q. *I will be turning age 65 in 2021 and will become eligible for Medicare; what will happen to my prescription plan coverage?*

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

What You Need to Do (or Not Do)

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

SilverScript Prescription Drug Coverage *(cont'd)*

Q. *Can I cancel my WSSC Water coverage before 2021 and enroll in a standard Medicare Part D Prescription Drug Plan that is not offered by WSSC Water?*

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

- *Enrollment in the SilverScript Plan has to be approved by the Center for Medicare and Medicaid Services (CMS) and usually takes 6 to 8 weeks. Enrollment will start at the beginning of the approved by CMS. Prior to enrollment, you should continue to use your CVS/Caremark card to fill prescriptions.*

Premiums and Subsidies

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

A. Yes, under certain circumstances, covered members may be eligible for a Low Income Subsidy. Low income status is determined by either the Social Security Administration (SSA) or the State Medicaid office. Generally, those eligible include individuals with income less than 150% of Federal Poverty Level ($18,210 for single persons in 2019) and with total resources less than $14,100 (for single persons in 2019). For more details, visit the SSA website at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

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

A. Medicare Part D requires that Part D plan participants who are determined to be high income retirees be charged an Income Related Monthly Adjustment Amount or "IRMAA." This IRMAA charge will apply because SilverScript is a Medicare Part D plan. The SSA determines who is considered a high income retiree based on tax status and yearly income as reported on IRS tax returns from two years ago. The IRMAA charge will be deducted directly from the member's Social Security check. In some instances, the SSA will bill affected retirees directly. To keep their coverage, high income retirees in the SilverScript plan must pay this amount to SSA. In 2019 monthly IRMAA charges range from $12.40 to $77.40 per person and are based on modified adjusted gross income (MAGI).

CMS had not published the monthly IRMAA adjustment amount for 2021 at the time this document was created. The chart below reflects the 2019 IRMAA amounts. Check back with the Medicare website at https://www.medicare.gov for the 2021 IRMAA updates.

If your filing status and yearly income in 2017 was:		
Beneficiaries who file individual tax returns with income that is:	**Beneficiaries who file joint tax returns with income that is:**	**You pay monthly in 2019**
Less than or equal to $85,000	Less than or equal to $170,000	$0.00
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$12.40
Greater than $107,000 and less than or equal to $133,500	Greater than $214,000 and less than or equal to $267,000	$31.90
Greater than $133,500 and less than or equal to $160,000	Greater than $267,000 and less than or equal to $320,000	$51.40
Greater than $160,000 and less than or equal to $500,000	Greater than $320,000 and less than or equal to $750,000	$70.90
Greater than or equal to $500,000	Greater than $750,000 and less	$77.40

Plan Benefits

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

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

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

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

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

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

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 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 Caremark RX 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 Caremark. If you elect a Medicare drug plan and you have CVS Caremark prescription coverage then you will no longer be eligible for prescription coverage under CVS Caremark. If you are enrolled in the Kaiser Medicare Plus Supplement, then you do not have to elect Medicare Part D as it is automatic when enrolled in that plan.

If you do decide to join a Medicare drug plan and drop your current WSSC 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.

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 open.enrollment@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:	WSSC Water
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 30, 2019.

Legislative Information

ANNUAL DISCLOSURE NOTICE

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Our medical plans comply with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Coverage for these items may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Our plan neither imposes penalties (for example, reducing or limiting reimbursement) nor provides incentives to induce providers to provide care inconsistent with these requirements.

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

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

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

Our Medical Plans comply with these requirements.

HIPAA

Washington Suburban Sanitary Commission and its affiliated entities

NOTICE OF PRIVACY PRACTICES

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

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

The following entities, owned by or affiliated with WSSC 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.

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

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

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

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

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

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

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

UnitedHealth Wellness
www.myuhc.com

UnitedHealth Cancer Resource Services
1-866-936-6002

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

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

My Nurse Line
1-800-401-7396

Retiree Change of Address Form

This form will be used to update your address for WSSC Water insurance coverage AND for retirement records. We will notify your benefit plans (health, dental and vision – if applicable) of your new address. If you have a WSSC Credit Union account, you must contact them directly.

Retiree Name: _____

(please print)

Old Address Information:

Street Address: _____

Apartment Number: _____ County: _____

City, State, Zip Code: _____

New Address Information:

Street Address: _____

Apartment Number: _____ County: _____

City, State: _____ Zip Code: _____

Effective Date of New Address: _____

Please return the completed form in the enclosed envelope at your earliest convenience to:
WSSC Water, Human Resources Office, Benefits Division,
14501 Sweitzer Lane, Laurel, MD 20707 or Fax: 301-206-8720

Signature: _____ Date: _____

Group Life Insurance
Change of Beneficiary Form

Name (first name, middle initial, last name)		Social Security Number	Date of Birth
Retiree ID #	Occupation **RETIRED**	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

In accordance with the conditions of the Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), and designate as primary beneficiary(ies) and contingent beneficiary(ies), the following:

Primary Beneficiary Designation

Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address	City		State	Zip
Contact Phone: Home Phone	Cell Phone:			
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address	City		State	Zip
Contact Phone: Home Phone	Cell Phone:			
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address	City		State	Zip
Contact Phone: Home Phone	Cell Phone:			

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

Contingent Beneficiary Designation

Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address	City		State	Zip
Contact Phone: Home Phone	Cell Phone:			
Full Name (first name, middle initial, last name)	Social Security Number	Relationship	Date of Birth	Share - %
Street Address	City		State	Zip
Contact Phone**:** Home Phone	Cell Phone:			

Retiree Signature: _____ Date: _____

Signature of WSSC HR Representative: _____ Date: _____

Revised 2/2020