

OE13

Battelle


Pacific Northwest
NATIONAL LABORATORY
Proudly Operated by Battelle Since 1965

BARGAINING UNIT
2013 Benefits Guide



OPEN ENROLLMENT PERIOD: NOVEMBER 1-21, 2012
FOR COVERAGE EFFECTIVE JANUARY 1, 2013

What's Inside:

| | |
|---------------------------------------|----|
| Welcome | 3 |
| Open Enrollment Summary | 6 |
| Open Enrollment Schedule | 7 |
| Important Reminders Before You Enroll | 8 |
| Dependent Eligibility | 9 |
| Preparing to Enroll Online | 11 |
| Default Elections | 12 |
| Your Medical Plan | 13 |
| Vision Coverage | 16 |
| Prescription Drug Benefits | 17 |
| Dental Plan | 19 |
| Flexible Spending Account Choices | 22 |
| Group Accident Insurance Option | 25 |
| Employee Assistance Program | 27 |
| Resources | 28 |
| Glossary of Key Benefits Terms | 29 |

Important Notice of Summarized Information

This summary outlines the features of several benefits plans available to eligible staff members. While we have attempted to describe the benefits as accurately as possible, due to the relatively brief nature of this summary and the complexity of the plans that govern these benefits, some details may not be described or may be described only briefly. Consequently, any conflicts between this summary and the actual legal plan document will be controlled by the terms of the legal plan document, not this summary. Likewise, any confusion about the plans that arises from reading this summary should be resolved by referring to the actual legal plan document. Battelle reserves the right to amend the plans at its discretion.

Your benefits. Your choice.

WELCOME TO YOUR 2013 BENEFITS. Each fall, we focus on our annual benefits enrollment opportunity. This year, changes have been made to the Bargaining plan design and rates based on the Collective Bargaining Agreement between Battelle and HAMTC. For detailed information, please read your Benefits Guide, refer to the Medical Plan Summary, and attend the OE Benefits Fair.

Actively Enroll in the Coverage of Your Choice

Mark your calendar for November 1-21 and enroll in your chosen 2013 benefit plans during Open Enrollment. To enroll, PNNL staff can login to [MyHR](#), click Benefits, then Benefits Enrollment; Battelle staff can login to [Self Service](#), click My Benefits, then Open Enrollment.

If you do not actively enroll, you will be automatically enrolled in [benefits based on your 2012 elections](#), except for your [Flexible Spending Accounts](#). You must enroll every year to participate in the Flexible Spending Accounts.

Changes for 2013

There are some changes for 2013 to the medical plan based on the Collective Bargaining Agreement between Battelle and HAMTC. We've highlighted the changes on page 4. For detailed information about the changes, please refer to the corresponding sections within this guide or visit your component's Open Enrollment website:

PNNL Intranet: <https://hr.pnl.gov/openEnrollment>

PNNL Internet: <http://benefits.pnnl.gov/openenrollment>

Battelle Intranet: <https://infosource.battelle.org/sites/1400/1419>

Battelle Internet: <http://www.battelle.org/benefits>

**Contracted rates posted on the intranet sites only.*

OE13

CONFIRMATION
SUGGESTION:

Go to MyHR (PNNL) or Self Service (Battelle) and confirm that you are not making any changes by saving and submitting your elections anyway. You will receive a confirmation the following day which you can refer to and feel confident of your elections for 2013.

Remember to
take time during
November 1-21 to
enroll in your
2013 benefits!

2013 Highlights

- Medical and dental rates have changed to reflect increases due to plan experiences and alignment with financial targets.
- Due to health care reform, maximum contribution limits will be reduced to \$2,500 for the Health Care Flexible Spending Account (FSA). The Dependent Care FSA maximum contribution limit will remain the same at \$5,000 (\$2,500 for married couples filing separately).
- The Group Accident Insurance rates will increase to \$0.15/\$10,000 for single level coverage and \$0.25/\$10,000 for family level coverage.

| Description of Coverage | Anthem PPO Plan | |
|---------------------------------|---|---|
| | In-Network | Out-of-Network <i>(Services remain covered at 70% of EEX after deductible in addition to the co-pay shown below)</i> |
| Deductible | Not Applicable | Increase from \$200 to \$225 per person and \$400 to \$450 for family |
| Cosmetic Surgery (non-elective) | Co-pay increases from \$110 to \$115 per visit | Co-pay increases from \$110 to \$115 per visit |
| Hospital Inpatient* | Co-pay increases from \$110 to \$115 per admission | Co-pay increases from \$110 to \$115 per admission |
| Hospital Outpatient* | Co-pay increases from \$110 to \$115 per visit | Co-pay increases from \$110 to \$115 per visit |
| Organ Transplant | Annual Limit increases from \$1.2 million annual maximum benefit to unlimited | Prior Approval Required |
| Skilled Nursing Facility | Co-pay increases from \$110 to \$115 per admission | Co-pay increases from \$110 to \$115 per admission |

*Includes Inpatient and Outpatient services for Mental Health/Substance Abuse.

Reminders

Find the following legally required notices here and on the Benefits websites:

- [2013 HIPAA Notice of Privacy Practices](#)
- [Notice of Special Enrollment Rights](#)
- [Medicaid and the Children's Health Insurance Program](#) (CHIP)
- [2013 Notice of Creditable Coverage](#)
- 2013 Summary of Benefits and Coverage – Medical (available Nov. 1, 2012)
- 2013 Summary of Benefits and Coverage – EAP (available Nov. 1, 2012)

Identification Cards

If you are continuing coverage in the Bargaining medical (including prescription), dental or FSA plans again for 2013, keep your current identification cards as they will remain effective.

In January 2013, identification cards will be distributed to staff members newly enrolled in the following plans:

- Anthem Bargaining PPO Plan
- CVS Caremark Prescription Drug Benefits
- PayFlex Health Care Flexible Spending Account (debit card)
- Delta Dental Plan

Many key benefits terms, such as “co-payment” and “co-insurance,” are defined in the [glossary](#) at the end of this guide.

Your 2013 Medical and Dental Benefits Rates

The 2013 premiums are based on the Collective Bargaining Agreement between Battelle and HAMTC and can be found in the separate 2013 Benefits Rates Chart on the intranet. Be sure to review the rates along with the 2013 Medical Plan Summary that provides detailed information about the co-payment, co-insurance and coverage amounts.

We're Here to Help

We are available to help you understand the plans and programs that contribute to a rewarding work life at our organizations.

Please contact your component's Benefits Office throughout the Open Enrollment period with questions regarding your 2013 benefits.

Benefits Administration
Battelle Memorial Institute
505 King Avenue, A-194
Columbus, OH 43201
614-424-6351

Internal website:

<https://infosource.battelle.org/sites/1400/1419>

External website:

<http://www.battelle.org/benefits>

Benefits Office
Pacific Northwest National Laboratory
902 Battelle Boulevard, ROB 1286
P.O. Box 999, MS K1-34
Richland, WA 99352
509-375-6359

Internal website:

<https://hr.pnl.gov/openEnrollment>

External website:

<http://benefits.pnnl.gov/openEnrollment>

OPEN ENROLLMENT Summary

OE13

Open Enrollment Planning

During Open Enrollment, you can make new elections for the following plans:

- [Medical Plan](#)
- [Dental Plan](#)
- [Flexible Spending Accounts](#) (FSA)
- [Group Accident Insurance](#)
- [Employee Assistance Program](#) (EAP)

Your Choices

You have choices within each plan. These choices, or elections, are outlined below:

Medical Plan

- Enroll in or waive coverage
- Elect a new level of coverage (for example, change from [Employee Only to Employee + Spouse](#))
- Update eligible dependent information

Dental Plan

- Enroll in or waive coverage
- Elect a new level of coverage (for example, change from [Employee Only to Employee + Spouse](#))
- Update eligible dependent information

Flexible Spending Account (FSA)

- Make your contribution election for the Health Care Account
- Make your contribution election for the Dependent Care Account

Group Accident Insurance

- Enroll in or waive coverage
- Elect a new level of coverage (for example, change from Single to Family)



You must enroll every year to participate in the FSA.

OPEN ENROLLMENT Schedule

OE13

2013 Open Enrollment Schedule

October 23

Detailed Open Enrollment information regarding your 2013 benefits and rates (posted on the intranet only), medical summary, and additional informational handouts will be available on the following Benefits websites:

- Intranet:
PNNL: <https://hr.pnl.gov/openenrollment>
Battelle: <https://infosource.battelle.org/sites/1400/1419>
- Internet:
PNNL: <http://benefits.pnnl.gov/openenrollment>
Battelle: <http://www.battelle.org/benefits>
- NOTE: Staff without access to either the intranet or internet websites may contact your component's Benefits Office for a paper copy.

October 25

Benefits Fair, 9 a.m. – 3 p.m., EMSL 1075/1077

Breakout Sessions: EMSL Auditorium
Vanguard 9-10 a.m.
PayFlex 10-11 a.m.
Caremark 12-1 p.m.

Employees and family members are welcome to attend the Benefits Fair and Breakout Sessions.

November 1

Open Enrollment begins

Online enrollment available on [MyHR](#) (PNNL) and [Self Service](#) (Battelle)

November 21

Open Enrollment ends at 11:59 p.m. PT for PNNL staff and 8:59 PT for Battelle staff. This is the last day for staff to make changes and enrollments.

December 21

All dependent verification for newly enrolled dependents must be received by the Benefits Office by 5 p.m. PT for PNNL staff and 2 p.m. PT for Battelle staff.

IMPORTANT REMINDERS

Before You Enroll

Before you log on to enroll, make sure your decisions are made and you have the information you need to enroll. The following information outlines your choices and other items to remember for online enrollment.

OE13

Choosing Your Coverage Level

During Open Enrollment, you can elect medical, dental, and group accident coverage.* We offer four levels – or tiers – of coverage to our staff. You choose which tier fits you and your family's needs best. The tiers are:

Tier I – Employee Only

Tier II – Employee & Spouse

Tier III – Employee & Children

Tier IV – Family

**Please keep in mind that Group Accident Insurance coverage options are Single or Family.*

You can also choose not to participate in any or all of the bargained for medical, dental, or group accident plans.

Life Events and Changing Your Coverage

Under federal tax regulations, you may change your level of coverage during Open Enrollment, or throughout the year **only when you have a qualifying status change or “life event.”** These life events, as listed below, are important to report to your component's Benefits Office. Enrollment forms must be received within 31 calendar days of your life event. This is an IRS requirement. If you miss this deadline, your next opportunity to change your benefit elections will be during the next Open Enrollment period.

Don't forget to notify your component's Benefits Office of your “life event” and complete your enrollment change form within 31 calendar days.

Qualifying Life Events

- Marriage, registered partnership, or divorce
- Birth, adoption, or placement for adoption, or legal guardianship of a child
- Death of a covered dependent
- Dependent no longer meets eligibility criteria
- Gain or loss of coverage under a different plan
- Change in employment classification that affects cost or benefits eligibility (for example, changing from Bargaining to Non-bargaining status)

Dependent Eligibility Requirements

Check the following requirements to determine who in your family is eligible for coverage as a dependent under the different plans.

Dependent Eligibility for Medical Insurance

You may enroll your dependent(s) in the Bargaining medical plan if they are:

- Your spouse
- Your registered partner
- Your child until **age 26**, regardless of marital status or coverage under another employer-sponsored program

Dependent Eligibility for Dental Insurance

You may enroll your dependent(s) in the dental plan if they are:

- Your spouse
- Your registered partner
- Your unmarried child who resides with you and is your tax dependent until **age 23**

Dependent Eligibility for Group Accident Insurance

You may enroll your dependent(s) in the group accident plan if they are:

- Your spouse
- Your registered partner
- Your unmarried child who resides with you and is your tax dependent until **age 25**

A “child” for group accident plan purposes is your natural child, grandchild, stepchild or adopted child from the date of placement with you for adoption, who is primarily dependent on you for maintenance and support.

Dependent Verification and Proof of Eligibility for Dependents Added During Open Enrollment

Dependent verification for any **newly added** dependents enrolled in a bargained plan **must be provided by December 21 in order for your added dependents to have coverage on January 1, 2013.**

Proper Documentation

Please provide the following applicable documentation for your **newly added** dependent.

1. The first page of your 2011 1040 form, **and**
2. One of the following:
 - Page two of your 1040 form showing your signature, or “prepared by” if a third party did your taxes.
 - The electronic postmark page if you filed electronically.
 - The e-mail confirmation that your return was accepted if you filed electronically.
 - Or the e-file signature authorization if your tax preparer filed electronically on your behalf.

You will need to provide proof of eligibility for any **newly added** dependent(s) – spouse, registered partner or child – by December 21, 2012.

Please conceal income amounts and the first five digits of all Social Security numbers.

If your tax return does not list your newly added dependent, they may still qualify for coverage if you can provide one of the following documents:

Spouse:

- A photocopy of your marriage certificate (if you were married in 2012)

Your Natural, Adopted or Stepchild:

- A photocopy of the child's birth certificate showing the employee or the employee's spouse as the parent (for medical only).
- Legal documentation of adoption or placement for adoption.
- Court order or divorce decree dictating that the staff member provides health insurance for child, or
- Divorce decree establishing staff member's spouse as custodial parent or divorce decree establishing staff member's spouse must provide health coverage, and other documentation* establishing that child resides with the staff member.
- For Dental: You must provide documentation that your dependent is a tax dependent, or other documentation* to prove you provide residency and support. The health care reform legislation allowing child coverage under the medical plan regardless of whether or not they have other coverage does not extend to the dental plan.

"Other Child" Who Lives With You:

- Other documentation* acceptable to the Plan Administrator, such as legal guardianship or proof of residency and support.

Registered Partner:

- A photocopy of your Certificate of Registration for Domestic Partnership, and
- A photocopy of the 2011 tax returns for you and your partner.

* Examples of other documentation that show proof of residency and support include: copies of school or medical records showing the child's address matches the employee's address on file or a photocopy of a college tuition bill sent to the employee's home address with proof of payment.

Please call your component's Benefits Office with questions about acceptable documentation.

PNNL: 509-375-6359

Battelle: 614-424-6351

OE13

Registered partner for medical and dental is defined as same-sex persons living together who are not married who have obtained a Certificate of Registration for Domestic Partnership from their state or local government entity.

There are many key terms regarding your benefits mentioned throughout this guide. Please refer to the glossary, should you need clarification of a term to better understand your coverage.

Preparing to Enroll Online

Before signing in to [MyHR](#) (PNNL) or [Self Service](#) (Battelle), consider the following questions and have your answers ready for online submission.

OE13

Items to Consider:

- Review your Open Enrollment materials and share them with your family.
- Do you want to make contributions to a Health Care FSA and/or a Dependent Care FSA? You must enroll in the [Flexible Spending Account](#) (FSA) each calendar year to participate.
- They vary by plan so have you reviewed dependent eligibility requirements?
- Does your spouse's employer offer benefits?
- If you did not enroll for [medical coverage](#) or [dental coverage](#) last year, do you want to enroll this year?
- If you are currently enrolled in the Bargaining PPO medical plan and you do nothing, you will [continue with your current level of coverage](#).
- Do you want to enroll in [Group Accident coverage](#), or increase or decrease coverage?
- Participants electing Group Accident coverage may select either Single or Family coverage.

Required Dependent Information

After reviewing the [Dependent Eligibility Requirements](#) listed on the previous page, you may determine who in your family is eligible for coverage as a dependent under the different plans you are considering. The following information about each dependent will be required at the time of enrollment:

- Name
- Date of Birth
- Social Security number
- Address
- If married, date of marriage
- If a registered partner, date of registration

Plan provisions require that a dependent's Social Security number be on record as a condition of coverage. If your dependent does not have a Social Security number, contact your component's Benefits Office for further instructions:

PNNL: 509-375-6359

Battelle: 614-424-6351

Default Elections

OE13

If you do not actively enroll or make your elections or changes during this Open Enrollment period, by default you will be considered to have made the following elections of coverage, at your current level of coverage except for FSA which will be waived. For instance, if your current level of coverage is Employee & Spouse, your default coverage for 2013 will be Employee & Spouse. Review the chart below to see what this means to you:

| Your Current Coverage | Your 2013 Default Coverage |
|---------------------------------------|--|
| Medical Coverage | |
| Anthem Bargaining PPO Plan | Anthem Bargaining PPO Plan |
| No medical coverage (waived) | No medical coverage (waived) |
| Dental Coverage | |
| Bargaining Dental Plan (Delta Dental) | Bargaining Dental Plan (Delta Dental) |
| No dental coverage (waived) | No dental coverage (waived) |
| Flexible Spending Account | |
| Flexible Spending Account | No coverage – You must enroll if you want to participate in 2013 |
| Group Accident Insurance | |
| Group Accident Insurance | Same coverage amount |

Your Medical Plan

Your medical benefits provide coverage for routine, preventive and emergency health care throughout the year.



Anthem Bargaining PPO Plan

- As a preferred provider organization (PPO) plan, you have access to network and non-network providers.
- The highest level of benefits is payable when you use network providers.
- Your cost share will be higher for services rendered by non-network providers.
- The Plan deductible, applicable to non-network services only, will increase for 2013.
- The co-pay for inpatient and outpatient hospitalization, including non-elective Cosmetic Surgery, Skilled Nursing Facility, and Mental Health/Substance Abuse, will increase for 2013.
- The annual limit for Organ Transplant has been eliminated.
- In-network Preventive care is covered at 100 percent with no co-payment.

By enrolling in the Bargaining medical plan, you will also receive vision exam and hardware coverage and prescription drug coverage administered by CVS Caremark.

Find Your Doctor

To determine if your doctor is in the Anthem network, visit [Anthem's website](#), go to "Find a Doctor" and enter the required information. If you are not a current member, you can enter the alpha prefix BZM under the "What Insurance Plan Would You Like to Use" section. This will allow you to search for doctors within the network.

Ask A Nurse

When you have general health questions or need guidance for critical health concerns, call the Anthem 24-Hour Nurse Line at 888-596-9473 to speak confidentially to an experienced registered nurse.

Manage Your Medical Plan Online

In addition to searching for providers, registering on [Anthem's website](#) also provides you with the ability to access your claims and payment information, request a new ID card and view tools to help you make health management decisions.

When on Anthem's homepage, choose "Register Now" under "Member Log In." Enter your personal information, including your Member ID Number found on your ID card. For security reasons, you will also be asked to put in the security code that is shown. Click "Save & Continue" and enter a username and password, choose your notification preferences and confirm your registration. Helpful hints are given throughout your registration to help you finish each step. Look for them on the right-hand side of your computer screen.

Please be aware, if you wish to view information for your spouse and/or children who are older than 18, you must ask them to assign you viewing rights to their medical plans through Anthem's website.



When you register on Anthem's website, you can view your current claims information at any time.

ANTHEM Quick Reference Guide

Anthem Customer Service

800-514-3021
5 a.m. – 5 p.m. PT Monday – Friday

Anthem 24-Hour Nurse Line

888-596-9473
24 hours a day, 7 days a week

Anthem Website

www.anthem.com
24 hours a day, 7 days a week

At A Glance 2013 Medical Plan Summary

| Features | Anthem Bargaining PPO Plan | | | | | |
|--|--|---------------------------|-----------------------|---|---|---------------------------------------|
| | In-Network | | | Out-of-Network | | |
| Annual Deductible | Tier I \$0 | Tier II/III \$0 | Tier IV \$0 | Tier I \$225 | Tier II/III \$225/\$450 | Tier IV \$225/\$450 |
| Out-of-Pocket Maximum (In- and Out-of-network Combination) | Tier I \$0 | Tier II/III \$0 | Tier IV \$0 | Tier I \$1,000 | Tier II/III \$1,000/ \$2,000 | Tier IV \$1,000/ \$2,000 |
| Lifetime Maximum | Unlimited | | | Unlimited | | |
| Co-insurance After Deductible | Not Applicable | | | Plan pays 70% EEX co-insurance | | |
| Emergency Room | Covered at 100% after \$100 co-payment, waived if admitted | | | | | |
| Hospital - Inpatient | Covered at 100% after \$115 co-payment/admission | | | Plan pays 70% EEX after deductible is met and \$115 co-payment/admission | | |
| Hospital - Outpatient | Covered at 100% after \$115 co-payment/visit | | | Plan pays 70% EEX after deductible is met and \$115 co-payment/visit | | |
| Office Visits | \$25 co-payment for Primary Care Physician \$30 co-payment for Specialist | | | Plan pays 70% EEX after deductible is met and \$25 co-payment (Primary Care Physician) per visit, or \$30 co-payment per visit (Specialist) | | |
| Preventive Care | Covered at 100% | | | Not covered | | |
| Urgent Care Provider | \$25 co-payment | | | Plan pays 70% EEX after deductible is met and \$25 co-payment | | |

Please refer to the comprehensive [2013 Bargaining Medical Plan Summary](#) for further details.

Vision Coverage

Anthem Vision Exam and Hardware Coverage

If you enroll in the Bargaining medical plan, you will automatically receive vision exam and hardware coverage. You are free to go to either a network or non-network provider. However, you will save money and time by going to an in-network provider where the participating provider will submit the claims form on your behalf.



You automatically receive vision coverage if you are enrolled in the Bargaining medical plan.

| 2013 Bargaining PPO Plan | | |
|--|--|--|
| | In-Network | Out-of-Network |
| Examination One exam per calendar year | \$25 co-pay per visit | Covered at 70% of EEX after deductible and \$25 co-pay per visit |
| Lenses/Contacts and Frames | Covered in full up to a maximum benefit of \$165 per covered person once every 2 years | Covered in full up to a maximum benefit of \$165 per covered person once every 2 years |

Find a Vision Exam Provider

Visit Anthem's website at www.anthem.com:

- Click on "Find A Doctor"
- Under "What are you looking for?" click on Doctor/Medical Professionals
- Then, under Specialty click on "Optometry"
- Enter your location information
- Under "What insurance plan would you like to use?" enter the alpha prefix BZM. This will allow you to search for in-network providers.

Filing Your Claim

An in-network provider will file the claim on your behalf. If you visit an out-of-network eye doctor, you will need to obtain, complete and submit a [claim form](#).

ANTHEM Quick Reference Guide

Anthem Customer Service

800-514-3021
5 a.m. – 5 p.m. PT
Monday – Friday

Anthem Website

www.anthem.com
24 hours a day, 7 days a week

Prescription Drug Benefits

Having a prescription drug benefit helps manage the cost of your prescription needs. When you choose to enroll in the Bargaining medical plan, you will receive Prescription Drug Coverage administered by [CVS Caremark](#). There are three components to your prescription drug program:



Visit www.caremark.com/battelle to see if your prescription is on CVS Caremark's Formulary List

CVS Caremark Retail Program

When filling prescriptions for short-term, acute care medications, such as antibiotics, you will receive the highest level of plan benefits when you use a [participating retail network pharmacy](#). Most large chain and local retail pharmacies are part of the CVS Caremark retail network, including more than 64,000 participating pharmacies nationwide.

CVS Caremark Mail Order Program

The [CVS Caremark Mail Order Program](#) is a cost-effective and convenient choice for long-term medications. You will receive up to a 90-day supply delivered right to your door for a lower cost than you would pay for three 30-day fills at a retail pharmacy.

CVS Caremark Specialty Pharmacy Services

The CVS Caremark Specialty Pharmacy is designed for individuals who take medications for certain chronic or genetic conditions. If your medication qualifies for Specialty Pharmacy Services, CVS Caremark will notify you at the time you fill your specialty prescription. This benefit offers convenient delivery of your specialty medicines, personalized service, and educational support for your specific therapy. CVS Caremark assigns a team of professionals to help you successfully manage your condition and improve your quality of life. This service includes 24-hour phone access to a clinical pharmacist for consultation at no additional cost to you.

Don't forget to use the glossary of terms at the back of this guide for help.

Learn More at Caremark's Website

To learn which medications require [Prior Authorization](#) and which medicines have quantity limits, please visit www.caremark.com/battelle. You may also view the entire [CVS Caremark's Performance Drug List](#) (PDL) to see if your prescription is on the Formulary List.

Your Prescription Drug Benefits

| | In-Network Retail Program (30-day supply) You Pay | Out-of-Network Retail Program (30-day supply) You Pay | Mail Order Program (90-day supply) You Pay |
|------------------------|--|--|---|
| Generic | \$15 co-payment | \$15 co-payment then 40% | \$30 co-payment |
| Formulary Brand | \$30 co-payment | \$30 co-payment then 40% | \$60 co-payment |
| Non-Formulary Brand | \$45 co-payment | \$45 co-payment then 40% | \$90 co-payment |
| Specialty | | | Specialty drugs are available through mail order only and may require Specialty Guideline Management and/or have limitations that apply |

Additional Resources

Go to the [PNNL](#) or [Battelle](#) Benefits intranet site, explore the [PNNL](#) or [Battelle](#) public Benefits site, or [Caremark's website](#) for more information on:

- [Maintenance Medications](#) drug list and benefits
- [Prior authorization](#) process and the list of drugs that require prior authorization
- List of medications that don't qualify for benefits because there is an exact [over-the-counter equivalent](#)
- [Formulary drug](#) list, also called the Performance Drug List or "PDL" by Caremark

CVS CAREMARK Quick Reference Guide

PNNL Dedicated Customer Service Toll-Free Phone Line*
877-668-8993
24 hours a day, 7 days a week

CVS Caremark Website
www.caremark.com
24 hours a day, 7 days a week

Pre-Enrollment Website**
www.caremark.com/battelle
24 hours a day, 7 days a week

** If you are not a current member under CVS Caremark, be sure to inform the Customer Care Representative that you are a Bargaining staff member and not currently enrolled in the CVS Caremark Program but that you will be, effective January 1, 2013. Also, provide the representative with the Universal ID Number, which is N20090101.*

*** The Pre-Enrollment Website is provided so you may find information about 2013 pharmacy benefits for PNNL before the plan's effective date.*

Dental Plan

Delta Dental PPO Plan

If you are enrolled in the dental plan, you will be covered under Delta Dental PPO, a preferred provider organization (PPO) program. Delta Dental PPO provides you with access to two of the nation's largest networks of participating dentists: the Delta Dental PPO network and the Delta Dental Premier network.

Delta Dental PPO offers the widest selection of [participating dentists](#) available anywhere. You are free to go to any licensed dentist, regardless of whether that dentist participates in the Delta Dental programs. However, you are likely to save money and time by going to a dentist who participates in one of the two Delta Dental networks where the participating dentists submit the claim forms for you. If you go to a dentist who does not participate in the Delta Dental PPO or Delta Dental Premier network, you will still have benefits, but you will need to pay your dentist and [submit your claim](#) yourself. Delta Dental will reimburse you for the amount covered by the plan.



You can print an ID card and access your coverage and claims information by logging on to the [Delta Dental website](#). Click "Individuals/ Members," then "Consumer Toolkit" and register in the middle of the page.

The Difference Between Network and Non-participating Dentists

| | Delta Dental PPO Dentist | Delta Dental Premier Dentist | Non-participating Dentist |
|---|---|--|---|
| What is the payment based on? | The billed fee or the amount in your dentist local PPO Fee Schedule, whichever is less | The billed fee or the Maximum Approved Fee, whichever is less | The billed fee or the Non-participating Dentist Fee, whichever is less |
| Payment example of a Class II dental benefit (assuming deductible has been met) | Billed charges: \$100 | Billed charges: \$100 | Billed charges: \$100 |
| | PPO Fee Schedule amount: \$76 | Maximum Approved Fee: \$92 | Non-participating Dentist Fee: \$93 |
| | Delta Pays 80% of the PPO Fee Schedule: (\$60.80) | Delta Pays 80% of the Maximum Approved Fee: (\$73.60) | Delta Pays 80% of the Non-participating Dentist Fee: (\$74.40) |
| | Member Pays: \$15.20 | Member Pays: \$18.40 | Member Pays: \$25.60 |
| | The PPO dentist cannot charge you the \$24 difference between the PPO Fee Schedule amount and his/her fee | The Premier dentist cannot charge you the \$8 difference between the Maximum Approved Fee and his /her fee | Because the dentist does not participate, you are responsible for the difference between Delta's payment and his/her fee. |

Your Dental Plan Services and Coverage through Delta Dental

| | PPO Dentist | Premier Dentist | Non-participating Dentist* |
|--|--|-----------------|----------------------------|
| | Plan Pays | | |
| Class I Benefits | | | |
| Diagnostic and Preventive Services - includes exams, cleanings, fluoride, and space maintainers | | 100% | |
| Emergency Palliative Treatment - to temporarily relieve pain | | 100% | |
| Brush Biopsy - to detect oral cancer | | 100% | |
| Radiographs - X-rays | | 100% | |
| Deductible | \$25 for individual / \$75 for family | | |
| Class II Benefits | | | |
| Minor Restorative Services - includes fillings | | 80% | |
| Periodontic Services - to treat gum disease | | 80% | |
| Endodontic Services - includes root canals | | 80% | |
| Oral Surgery Services - extractions and dental surgery | | 80% | |
| Other Basic Services - misc. services | | 80% | |
| Occlusal Guards | | 80% | |
| Class III Benefits | | | |
| Relines and Repairs - to bridges and dentures | | 60% | |
| Major Restorative Services - includes crowns | | 60% | |
| Prosthodontic Services - includes bridges and dentures | | 60% | |
| Implants - endosteal implants to replace missing teeth | | 60% | |
| Class IV Benefits | | | |
| Orthodontic Services - includes braces | | 60% | |

* When you receive services from a Non-participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-participating Dentist Fee that will be paid for those services. This Non-participating Dentist Fee will likely be less than the fee charged by your dentist, and you will be responsible for the difference.



Find Your Dentist

If you would like the names of participating dentists near you, call Delta Dental's toll-free Customer Service department at 800-524-0149. You can also access the dentist directory on their [website](#).

To find in-network dentists

- Click "Find a Dentist" on the top right-hand side of the page
- Select "Delta Dental PPO or Premier Network"
- Under "Product Selection" choose "Delta Dental PPO" or "Delta Dental Premier"
- You can search by dentist name, location, or specialty

When you search for dental providers, you can search the Delta Dental PPO network or the Delta Dental Premier network. Both the PPO and Premier network providers will [submit claims](#) for you, and cannot bill you for any amount over the Delta fee schedule. You may experience greater cost savings by selecting a PPO dental provider since their negotiated fee schedule is lower than the fees for the Premier provider.

- The maximum annual benefit is \$1,500 per covered individual.
- The lifetime maximum benefit for orthodontia is \$1,500 per covered individual.
- Oral exams are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for covered individuals up to age 19.
- Implants and implant-related services are payable once per tooth in any five-year period.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Composite resin (white) restorations and porcelain crowns are optional treatment on posterior teeth.

Identification Cards

Once enrolled, Delta Dental will provide you with two identification cards which will include your member number. Although you will not need to show the cards to your dentist to receive dental treatment, you may wish to carry the cards with you for informational purposes since Delta Dental's toll-free telephone number and website are printed on the cards.

Adult children over the age of 23 are not eligible for dental coverage. The health care reform legislation extending coverage to these individuals under medical plans does not extend to stand-alone dental plans. However, when your child turns 23, their dental coverage will continue through the end of the calendar year in which they turn 23.

DELTA DENTAL Quick Reference Guide

Delta Dental of Ohio Customer Service

800-524-0149
5:30 a.m. – 5 p.m. PT
Monday – Friday

Delta Dental Website www.deltadentaloh.com

Flexible Spending Account Choices

The Flexible Spending Account (FSA) lets you pay certain health and dependent care expenses with before-tax dollars. You may choose to enroll in one or both of the following accounts:



Health Care FSA

This account allows you to pay eligible out-of-pocket medical, mental health, dental, vision and hearing expenses for you and your family on a before-tax basis.

Contribution Limits: \$120-\$2,500 per year*

Eligible Expenses:

Examples of eligible expenses include medical and dental deductibles, co-payments, and co-insurance, prescription drugs, vision care supplies such as contact lens cleaner, hearing aids and other medical supplies such as bandages or crutches. Most over-the-counter medicine and drugs are not considered eligible expenses without a prescription.

As a result of the Patient Protection and Affordable Care Act, beginning January 1, 2013, the employee contribution limit for Health Care FSAs will be reduced to \$2,500 per plan year.

Dependent Care FSA

This account allows you to pay for eligible dependent care expenses on a before-tax basis when such care permits you (and your spouse, if you are married) to work. Eligible dependent care expenses include child care and elder care.

Contribution Limits: \$120-\$5,000 per year*

Eligible Expenses:

Examples of eligible expenses include daycare for your child(ren) under age 13 or care for an adult dependent who is physically or mentally unable to care for him- or herself.

** The minimum amount you may contribute annually to either your Health Care FSA or Dependent Care FSA is \$120 and the maximum amount is \$2,500 for the Health Care FSA and \$5,000 for the Dependent Care FSA. If you are married and file separate tax returns, the most you can contribute to the Dependent Care FSA is \$2,500 each year.*

How You Can Save Money with an FSA

Your FSA allows you to set aside money on a pre-tax basis for eligible health care and dependent care expenses. This means that you can reduce your taxes and increase your take-home pay. You do not pay Federal Income, Social Security or state taxes on this money which means you could save approximately \$.30 on every dollar you contribute.



Eligible Items for Reimbursement Through an FSA

Some of the items that are eligible for reimbursement are listed below. This is a sampling of items, and is not a complete list. For additional information regarding eligible expenses visit the PayFlex member [website](#).

| Over-the-counter Items Requiring a Prescription for Reimbursement | Over-the-counter Items Eligible for Reimbursement without a Prescription |
|---|--|
| Acne medicine | Adhesive bandages |
| Allergy medicine | Braces and support |
| Cough, cold and flu medicine | Contact lens solutions and supplies |
| Eye drops | Contraceptives |
| Indigestion medicine | Diabetic supplies |
| Laxatives | Elastic bandages and wraps |
| Nasal sprays and drops | First aid supplies |
| Ointment for cuts, burns & rashes | Reading glasses |
| Pain relievers | Wheelchairs, walkers and canes |

The [Patient Protection and Affordable Care Act](#) dictates that health care debit cards, such as the PayFlex debit card, cannot be used to purchase over-the-counter drugs. If a health care debit card is used to pay for these items, the transaction will be denied at the point of sale. You will need to pay for the expense out-of-pocket and submit a [claim](#) along with a prescription to receive reimbursement.

For detailed information about how to use your FSA debit card, as well as how to file a claim, visit [PayFlex's website](#).

PAYFLEX Quick Reference Guide

PayFlex Customer Service

800-284-4885

5 a.m. - 5 p.m. PT Monday-Friday

7 a.m. - 12 p.m. PT Saturday

PayFlex Website

www.healthhub.com

Important FSA Reminders

Actively Enroll Every Year

If you want to participate in the Health Care FSA and/or the Dependent Care FSA for 2013, you must enroll during the Open Enrollment period, even if you currently participate.

Each Account is Separate

You may use only funds in your Health Care FSA to be reimbursed for eligible health care expenses, and you may use only funds in your Dependent Care FSA to be reimbursed for dependent care expenses. You may not transfer money from one account to the other.

Consider Your Contribution Amount

Once you enroll in an FSA, you may change your contribution amount only if you experience a “life event” (also called a “qualifying change in status”) as defined by the IRS. Consult the “[Before You Enroll](#)” section of this guide for more information.

Carefully Estimate Your Expenses

Any amount left in your accounts at the end of the plan year will be forfeited, so you should carefully estimate your eligible expenses for the year. Use the [Health Care expense planning worksheet](#) and the [Dependent Care expense planning worksheet](#) to better estimate how much you wish to contribute for the year.

Manage Your PayFlex FSA Online

Visit [PayFlex's member website](#) to plan for your 2013 enrollment, and to find the following tools and resources:

- [Savings calculators](#) to help you see how your spendable income would be affected by FSA contributions
- [Expense planning worksheets](#)
- Lists of [eligible and ineligible expenses](#)
- [Frequently asked questions](#)
- [Administrative forms](#) and publications
- An FSA tutorial
- Access to your personal account information, including account balances and claims status, once you're enrolled

** Your Member ID is your Employee ID without the "D" and is case sensitive if you have a letter (e.g. 3A000)*

** If you have never enrolled on Health Hub's website, you may also need the Employer ID#: 103642.*



Save your store receipts and Explanation of Benefits for the whole year – the IRS requires it!

If you use your debit card to pay for eligible medical expenses, PayFlex may still request documentation to substantiate the claim.

Group Accident Insurance Option



Group Accident Insurance is administered by Chubb Life Insurance. During open enrollment, you may elect coverage under the Group Accident Insurance Plan for yourself and your eligible dependents up to age 25. You may also change your coverage amounts. Each covered individual is insured for loss of life, limb, sight, speech, hearing, and permanent total disability due to an accident. You can elect from a minimum of \$20,000 to a maximum of \$750,000 in coverage, in multiples of \$10,000.

You may elect Single or Family coverage. If you wish to cover your family, you must elect Family coverage (covering spouse or registered partner and dependents). Coverage for a spouse or registered partner and/or dependents is a fixed percentage of the coverage elected for the staff member (i.e., the principal amount), depending upon the family size at the time of the incident. For example, under Family coverage, if you elect a \$100,000 loss-of-life benefit, the level of coverage is outlined in the chart below.

Group Accident Insurance Services and Coverage (Based on a \$100,000 loss-of-life benefit)

| Level of Coverage | Amount of Coverage | Example |
|---|--|----------------------|
| Staff Member's Loss of Life Coverage Amount | Principal Amount | \$100,000 |
| Spouse's or Partner's Coverage Amount No Children With Children | 60% of Principal Amount 50% of Principal Amount | \$60,000 \$50,000 |
| Each Dependent Child's Coverage Amount Single Married or Registered Partner | 20% of Principal Amount 10% of Principal Amount | \$20,000 \$10,000 |

Group Accident Rates

| Single Level of Coverage | Family Level of Coverage |
|--------------------------|--------------------------|
| \$0.15/\$10,000 | \$0.25/\$10,000 |

Filing Your Claim

To file a claim under the Group Accident Insurance, please contact your component's Benefits Office directly.

Coverage in War Risk Countries

The advance notice requirement for War Risk Countries is still in effect for Group Accident coverage. Contact your component's Benefits office 30 days in advance of travel to War Risk Countries if you wish to have coverage while traveling to or through these destinations. Failure to provide advance notice will result in a loss of coverage while in a War Risk Country.



**War Risk Countries are subject to change. Please contact your component's Benefits Office to confirm current War Risk Countries.*

Group Accident Default Elections

If you do not make elections or changes during this Open Enrollment period, the following default elections will be applied:

| Your Current Coverage | Your 2013 Default Coverage |
|-------------------------------------|-------------------------------------|
| Group Accident Coverage | Same Coverage Amount |
| No Group Accident Coverage (Waived) | No Group Accident Coverage (Waived) |

GROUP ACCIDENT INSURANCE Quick Reference Guide

PNNL's Benefits Office

509-375-6359
8 a.m. – 5 p.m. PT
Monday-Friday

E-mail

ask.benefits@pnnl.gov

Battelle's Benefits Administration

614-424-6351
5 a.m. - 2 p.m. PT
Monday - Friday

E-mail

bcobenefits@battelle.org

Employee Assistance Program

Although it is not a benefit you elect, the Employee Assistance Program (EAP), administered by OptumHealth, is a free and confidential work/life services resource available to you. While EAP provides resources for alcohol and drug abuse, stress, anxiety, and depression, it also provides resources for financial services, legal assistance, and work place issues.



How the EAP Works

In-person or over-the-phone counseling services are available 24 hours a day, seven days a week by calling OptumHealth at 866-728-8403 or visiting www.liveandworkwell.com. For phone service, a professional EAP counselor will listen supportively, conduct an assessment, and clarify your needs to find the right resource for you.

The website features resources and tools, including:

- Articles on work and life topics
- Life Stages Centers (parenting, elder, stress and anxiety, chronic conditions)
- Mental Health Condition Centers (alcohol & drug dependence, anxiety, eating disorders, ADHD, depression)
- Healthy Family (parents, kids, teens)
- Other self-service options you can explore, such as:
 - More than 100 financial calculators, such as reduction of credit card debt, retirement planning and mortgage comparisons
 - Online databases for child and eldercare resources, schools, camps, adoption agencies, etc.
 - Clinician lookup and certification features
 - Interactive, personalized self-assessments
 - Personal plan programs for stress, alcohol, drugs, steps to change, and smoking cessation
 - Private online consultation option
 - Message boards

EMPLOYEE ASSISTANCE PROGRAM Quick Reference Guide

EAP's Customer Service

866-728-8403
24 hours a day,
7 days a week

PNNL Onsite Counselor, Jody McClellan

509-372-4962
2 days a week

EAP Website

www.liveandworkwell.com
24 hours a day,
7 days a week
(access code: battelle)

Resources

OE13

There are many valuable resources available to help you learn more about the offered plans and to better understand your benefits choices. In addition to these resources, we want you to know that *we are here to help*. Please call on your component's Benefits Office throughout the Open Enrollment process to meet in person, talk over the phone or or correspond via e-mail.

Anthem (Medical and Vision Plan)

Customer Service: 800-514-3021

Anthem 24-Hour Nurse Line: 888-596-9473

www.anthem.com

CVS Caremark (Prescription Drug Benefits)

PNNL-dedicated Customer Service

Toll-free Line: 877-668-8993

www.caremark.com

www.caremark.com/battelle

Delta Dental of Ohio (Dental Plan)

Customer Service: 800-524-0149

www.deltadentaloh.com

Employee Assistance Program (EAP)

Customer Service: 866-728-8403

www.liveandworkwell.com

(access code battelle)

PNNL Onsite Counselor: Jody McClellan: 509-372-4962

PayFlex (Flexible Spending Account)

Customer Service: 800-284-4885

www.healthhub.com

PNNL's Benefits Office

Open Enrollment Hotline: 509-375-6359

Internet: <http://benefits.pnnl.gov/openEnrollment>

Intranet: <https://hr.pnl.gov/openEnrollment>

Battelle's Benefits Administration

Phone: 614-424-6350

Internet: <http://www.battelle.org/benefits>

Intranet: <https://infosource.battelle.org/sites/1400/1419>

Glossary of Key Benefits Terms

There are many key terms regarding your benefits mentioned throughout this guide. Please refer to this glossary, should you need clarification of a term to better understand your coverage.

Claims Administrator – The insurance organization with whom Battelle has contracted to process claims in accordance with the provision of Battelle’s self-insured plans. For example, Anthem is the claims administrator for the medical plans.

Co-insurance – A form of medical cost sharing that requires a covered person to pay a stated percentage of medical expenses after the deductible amount, if any, is paid.

Co-payment or Co-pay – A form of medical cost sharing that requires a covered person to pay a fixed dollar amount when a medical service is received.

Deductible – A fixed dollar amount that must be paid before the plan pays certain medical and dental benefits.

Dependent Care Flexible Spending Account (FSA) – This type of account allows you to pay for eligible dependent care expenses on a before-tax basis when such care permits you (and your spouse, if you are married) to be gainfully employed. Eligible dependent care expenses include child care and elder care.

Flexible Spending Account (FSA) – A Flexible Spending Account, or FSA, is an account in your name to which a set amount chosen by you is automatically deposited from your paycheck, specifically for health care or dependent care expenses. This type of account can help reduce your taxes and increase your take-home pay by paying out-of-pocket health care or dependent care expenses on a pre-tax basis.

Formulary Drugs – A drug formulary is a list of prescription drugs that are preferred by your health plan. The list can include both generic and brand-name drugs that have been approved by the US Food and Drug Administration (FDA). When a drug is listed by your health plan, it may be referred to as a “formulary drug” because it is found on the formulary list.

Generic Drugs – Once a brand-name medicine’s patent expires, a generic version of the same drug, containing the same active ingredients, can be made and sold. Generic drugs must meet the same quality and safety standards as their brand-name counterparts. Using generic drugs usually costs less.

Health Care Flexible Spending Account (FSA) – This type of account allows you to pay eligible out-of-pocket medical, mental health, dental, vision and hearing expenses for you and your family on a before-tax basis.

Network or Network Provider – A group of doctors, hospitals, or other health care providers who have contracted with a claims administrator (for example, Anthem) to provide services to covered members for less than their usual fees. Using network providers usually costs less.

Non-Formulary Drugs – A drug formulary is a list of prescription drugs that are preferred by your health plan. When a drug is not listed by your health plan, it may be referred to as a “non-formulary drug” because it is not found on the formulary list. Non-formulary drugs usually cost more and may not be covered or only partially covered by your plan.

Non-Network or Out-of-Network Provider – Physicians, hospitals, or other health care providers who have not contracted with a claims administrator (for example, Anthem) to provide services at a discount. Depending on the chosen plan, expenses incurred for services provided by non-network providers may not be covered.

Out-of-Pocket Maximum – The most you pay each year in deductibles, co-insurance, co-pays, and other expenses. After you reach the out-of-pocket maximum, the plan pays 100 percent of eligible expenses for the remainder of the year.

Over-the-Counter (OTC) Drugs – Medicine that can be purchased from a pharmacy or store without a doctor’s prescription.

Percent Co-insurance – The percent amount of the total cost of the prescription that you are responsible to pay. The dollar amount will vary depending on the cost of the items.

Preferred Provider Organization (PPO) Plan – A type of medical plan in which the provider (for example, Anthem) has contracted with physicians or health care organizations within a network. You may choose to work with any of the providers within this network with higher coverage from the plan, or you may choose to work with a provider outside of the network in which you receive less coverage and bear more expense.

Prescription – A written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Prescription Drugs – Medicine that requires a doctor’s prescription in order to be filled by the pharmacy.

Registered Partner – Same-sex persons living together who are not married who have obtained a Certificate of Registration for Domestic Partnership from a city or state.

Tier – The level of coverage that you choose as most-suitable for you and your family and your current situation.