

**Pacific Northwest National Laboratory
and Battelle Memorial Institute
2013 Bargaining Unit Medical Plan Summary
per the Collective Bargaining Agreement of
Battelle and HAMTC**



Levels of Coverage:

Tier I Employee Only

Tier II Employee & Spouse/Registered Domestic Partner

Tier III Employee & Children

Tier IV Family

	Deductible			Covered Expenses		Annual Out-of-Pocket Maximum (includes deductible)		
	Tier I	Tier II & III	Tier IV	Plan Pays	You Pay	Tier I	Tier II & III	Tier IV
In-Network	Not Applicable	Not Applicable	Not Applicable	100% after co-pay	\$25 Office Visit \$25 Chiropractor \$30 Specialist Office Visit \$115 Hospital	Not Applicable		
Out-of-Network	\$225	\$225/\$450	\$225/\$450	70% EEX** after deductible & applicable co-pay	Co-pay Plus 30%	\$1,000 per person \$2,000 per family		
Lifetime Maximum								
Anthem Bargaining Unit PPO				Unlimited				

As indicated above, the Anthem Bargaining Unit PPO Plan pays Out-of-Network benefits at a percentage of allowable or Eligible Expenses (EEX) ** after your covered expenses reach the individual or family deductible. The Out-of-Pocket maximum does not apply to co-pays or charges in excess of allowable or EEX**. The Out-of-Pocket maximum also does not apply to retail or mail order drug purchases, co-pays and differentials for brand drug purchases at retail where a generic is available. You are always responsible for your share of the coinsurance and co-payments for these expenses. The participant is not responsible for charges by Network providers over and above the contracted allowable charges.

This benefit description is part of and is intended to serve as an update to the current Summary Plan Descriptions (SPD). Benefits are described more fully in the SPD, which is available for review on the PNNL Benefits website and the Battelle Benefits website.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of the Summary Plan Description, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Summary Plan Description and obtain any required Prior Authorization or Precertification.

Benefits under the above mentioned Plans will be paid only if the Plan Administrator (or its delegate) in its discretion decides that the applicant is entitled to them.

MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Anthem Bargaining Unit PPO Plan	
		In-Network	Out-of-Network
Allergy Testing and Treatment	Charges for exam, testing and serum. See also Injections.	Covered in full. (See Physicians Services if exam is provided)	Covered at 70% of EEX after deductible. (See Physicians Services if exam is provided)
Alternative Medicine	Naturopathy, Acupuncture, and Biofeedback.	Covered in full after \$25 co-pay per visit.	Covered at 70% of EEX after deductible and \$25 co-pay per visit.
Ambulance (Emergency Only)	Charges for professional ambulance services (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition.	Covered in full after \$100 co-pay.	
Chiropractors		Covered in full after \$25 co-pay. Limited to 52 maximum visits per calendar year.	Covered at 70% of EEX after deductible and \$25 co-pay per visit. Limited to 52 maximum visits per calendar year.
Community Wellness Services and Nicotine Dependency	Charges for classes and programs that promote positive health and lifestyle choices.	Covered in full up to maximum benefit of \$250 per person per calendar year.	
Cosmetic Surgery (Non-Elective)	Charges for reconstructive surgery when necessitated by disease or accidental injury while covered under the Plan, or a congenital defect of a dependent child who has been covered under this Plan from birth. See "Medical Expenses Not Covered."	Inpatient: Covered in full after \$115 co-pay per admission. Outpatient: \$115 co-pay per visit. Office visit: \$25 co-pay per visit. Specialist office visit: \$30 co-pay per visit	Inpatient: Covered at 70% of EEX after deductible and \$115 co-pay per admission. Outpatient: Covered at 70% of EEX after deductible and \$115 co-pay per visit. Office visit: Covered at 70% of EEX after deductible and \$25 co-pay per visit. Specialist office visit: Covered at 70% EEX after deductible and \$30 co-pay per visit.
Dental (Accident Only)	Charges for dental work necessitated by accidental injury to natural healthy teeth while covered under this Plan. Dental work must be performed within 12 months of injury. Coverage under Anthem will also cover TMJ services and equipment.	Covered as any other condition.	
Durable Medical Equipment (DME)	Charges for rental or purchase of durable medical equipment (DME).	Covered at 100% of EEX. Physician Services co-pay may apply.	Covered at 70% of EEX after deductible. Physician Services co-pay may apply.
Education and Training	Charges in connection with custodial care, education or training, including orthoptic or vision training.	Covered in full up to maximum benefit of \$250 per person per calendar year. (Available in and out-of-network).	
Emergency Care - Hospital	Emergency care obtained from a Hospital Emergency Room.	\$100 co-pay per visit Co-pay waived if admitted.	

MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Anthem Bargaining Unit PPO Plan	
		In-Network	Out-of-Network
Emergency Care – Urgent Care Center or Physician Office Visit	Emergency care obtained from Urgent Care Center or from the office of a Physician.	\$25 co-pay per visit.	Covered at 70% of EEX after deductible and \$25 co-pay per visit.
Hearing	Charges for routine hearing exam and test.	Hearing screening covered at 100%. One exam and test per person per calendar year. Hearing aids not covered.	Hearing screening covered at 70% of EEX after the deductible and \$25 co-pay per visit. One exam and test per person per calendar year. Hearing aids not covered.
Hospital – Inpatient	Charges for hospital bed and board, limited to the hospital’s most common semi-private daily rate. See Mental Illness/Substance Abuse for other limitations. Some services require pre-certification.	Covered in full after \$115 co-pay per admission.	Covered at 70% of EEX after deductible and \$115 co-pay per admission.
Hospital - Outpatient	Charges by a hospital for medical care and treatment on an outpatient basis. See Mental Illness/Substance Abuse for other limitations. Some services require pre-certification	\$115 co-pay per visit.	Covered at 70% of EEX after deductible and \$115 co-pay per visit.
Hospital – Preadmission Testing	Charges for preadmission testing prior to hospital confinement.	See hospital benefits.	
Infertility	Charges for diagnosis and treatment of infertility.	Not covered.	
Injections (Therapeutic)	Charges for allergy shots, antibiotic injections, etc.	Covered in full. (See Physicians Services if exam is provided)	Covered at 70% of EEX after deductible. (See Physicians Services if exam is provided)
Laboratory and X-rays	Diagnostic x-rays and laboratory services; x-rays, radium, and radioactive isotope treatment; oxygen and other gases and administration thereof; blood transfusions and blood not donated or replaced; anesthesia and its administration; and prosthetic appliances.	Covered in full. Physician Services co-pay may also apply.	Covered at 70% of EEX after deductible. Physician Services co-pay may also apply.
Maternity Benefit	Charges for pregnancy expenses. <i>Not available for dependent children.</i>	Prenatal office visits: Covered in full after \$25 co-pay for initial visit. See Hospital Inpatient and Laboratory and X-rays for coverage of other expenses.	Prenatal office visits: Covered at 70% of EEX after deductible and \$25 co-pay for initial visit. See Hospital Inpatient and Laboratory and X-rays for coverage of other expenses.

MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Anthem Bargaining Unit PPO Plan	
		In-Network	Out-of-Network
Mental Health/Substance Abuse (MH/SA)	Mental Health/Substance Abuse (MH/SA): Charges for services rendered in a physician's office or other appropriate facility, incurred because of mental illness or substance abuse. Some services require pre-certification.	<u>Mental Health / Substance Abuse</u> Inpatient: Covered in full after \$115 co-pay per admission. Outpatient: Covered in full after \$25 co-pay per visit.	<u>Mental Health / Substance Abuse</u> Inpatient: Covered at 70% of EEX after deductible and \$115 co-pay per admission. Outpatient: Covered at 70% of EEX after deductible and \$25 co-pay per visit.
Organ Transplant	Charges for organ transplants. Pre-certification may be required.	Covered as any other condition with no annual maximum.	Prior approval required.
Physician Services	Charges for professional services of physicians (unless practitioner is a family member).	\$25 co-pay per visit.	Covered at 70% of EEX after deductible and \$25 co-pay per visit.
Prescription Drugs	Drugs and medicines requiring a physician's prescription for a specific illness and dispensed by a pharmacist. The Prescription Drug Program is offered through CVS Caremark. Certain prescription benefits may require Specialty Guideline Management and/or have limitations that apply. Benefits are not available for all drugs. <u>For Retail and Mail Order:</u> If you elect a brand name drug when a generic is available, you will be responsible for both your co-pay and the price difference between the brand name and the generic drug. There is no coordination of benefits for prescription drugs.	<u>Retail (30-day supply)</u> <u>You Pay</u> Generic: \$15 co-pay Formulary Brand Name: \$30 co-pay Non-Formulary Brand Name: \$45 co-pay <u>Mail order (90-day supply)</u> Generic: \$30 co-pay Formulary Brand Name \$60 co-pay Non-Formulary Brand Name: \$90 co-pay Specialty drugs are available through mail order only and may require Specialty Guideline Management and/or have limitations that apply.	<u>Retail (30-day supply)</u> <u>You Pay</u> Generic: \$15 co-pay then 40% Formulary Brand Name: \$30 co-pay then 40% Non-Formulary Brand Name: \$45 co-pay then 40%
Rehabilitation Therapy (CT, OT, PT, MT, RT, ST)	Rehabilitation services must be performed by a licensed therapy provider, under the direction of a physician. Cardiac Therapy, Occupational Therapy, Physical Therapy, Massage Therapy, Respiratory Therapy, and Speech Therapy. Some services require pre-certification.	Inpatient: Covered in full after \$100 co-pay up to a maximum benefit of 60 days for all therapies combined. Outpatient: Covered in full after \$25 co-pay per visit up to a maximum benefit of 45 visits for all therapies combined.	Inpatient: Covered at 70% of EEX after deductible and \$100 co-pay up to a maximum benefit of 60 days for all therapies combined. Outpatient: Covered at 70% of EEX after deductible and \$25 co-pay per visit up to a maximum benefit of 45 visits for all therapies combined.

MEDICAL EXPENSES COVERED

Description of Medical Plan Coverage		Anthem Bargaining Unit PPO Plan	
		In-Network	Out-of-Network
Skilled Nursing Facility	Charges by a qualified special care facility for medical care and treatment, with charges for accommodations not in excess of the rate of the facility's most common rate for semi-private accommodations. Some services require pre-certification.	Covered in full after \$115 co-pay per admission up to a maximum benefit of 120 inpatient days per calendar year if admitted within 14 days of hospitalization.	Covered at 70% of EEX after deductible and \$115 co-pay per admission up to a maximum benefit of 120 inpatient days per calendar year if admitted within 14 days of hospitalization.
Specialist Services	Charges for professional services of specialist (unless practitioner is a family member).	\$30 co-pay per visit.	Covered at 70% of EEX after deductible and \$30 co-pay per visit.
Sterilization	Sterilization of an employee or spouse. Dependent children not covered. Reversal of sterilization not covered.	Covered as any other condition.	
Vision	Charges for vision exams and eyeglasses or contact lenses.	Exam: \$25 co-pay per visit. One exam per calendar year. Lenses/contacts and frames: Covered in full up to a maximum benefit of \$165 per covered person once every 2 years.	Exam: Covered at 70% of EEX after deductible and \$25 co-pay per visit. One exam per calendar year. Lenses/contacts and frames: Covered in full up to a maximum of \$165 per covered person once every 2 years.
Wellness/Preventive Care	Includes immunizations, annual physical, colon screenings and mammograms.	Covered in full.	Not covered.

MANDATED MEDICAL BENEFITS

Description of Medical Plan Coverage		In-Network	Out-of-Network
Mandated Health Benefits	<p>Federal law requires group health plans to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy if agreed to by the patient and attending physician:</p> <ul style="list-style-type: none"> ● Reconstruction for the breast on which the mastectomy was performed. ● Surgery or reconstruction of the other breast to produce a symmetrical appearance. ● Prostheses, and ● Physical complications for all stages of a mastectomy, including swelling associated with the removal of lymph nodes. <p>This coverage would be made available to participants or beneficiaries who are receiving benefits in conjunction with a mastectomy and who elect breast reconstruction.</p>	Covered as required by law.	Covered as required by law.
Mandated Maternity Benefits	<p>The Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for normal or vaginal delivery or less than 96 hours for a cesarean section. However, the Plan does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan shall not require that a provider obtain authorization from the Plan of prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).</p>	Covered as required by law.	Covered as required by law.