

Pacific Northwest National Laboratory 2013 Anthem Medical Plan Comparison Non-Bargaining



Levels of Coverage:

Employee Only
Employee & Spouse/Registered Partner

Tier I
Tier II

Employee & Children
Family

Tier III
Tier IV

Plan Name		Annual Deductible			Covered Expenses		Annual Out-of-Pocket Maximum (Includes deductibles for the PPO and Network Only Plans)		
		Tier I	Tier II & III	Tier IV	Plan Pays	You Pay	Tier I	Tier II & III	Tier IV
Anthem Network Only Plan	Network Only	\$150	\$150/\$450	\$150/\$450	100% after Co-Pay or 80% Allowable	Co-Pay or 20% Coinsurance after deductible	\$1,500	\$1,500/\$3,000	\$1,500/\$3,000
Anthem PPO Plan	Network	\$400	\$400/\$800	\$400/\$800	100% after Co-Pay or 80% Allowable	Co-Pay or 20% Coinsurance after deductible	\$2,250	\$2,250/\$4,500	\$2,250/\$4,500
	Out-of-Network				60% EEX**	40% Coinsurance after deductible			
Lifetime Maximum									
Anthem Network Only Plan				Unlimited					
Anthem PPO Plan				Unlimited					

**As indicated above, the Anthem Network Only Plan and the Anthem PPO Plan pays a percentage of allowable or Eligible Expenses (EEX) ** after your covered expenses reach the individual or family deductible. Under the Network Only Plan, the out-of-pocket does not apply to charges in excess of allowable or EEX. Under the PPO Plan, the out-of-pocket maximum does not apply to co-pays or charges in excess of allowable or EEX. Under both the Network Only and PPO Plan, the out-of-pocket maximum 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 SPDs, which are available for review on the PNNL 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		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
Ambulance	Charges for professional ambulance services to or from the nearest hospital.	Covered in-network and out-of-network after the deductible at 80% for emergency only.	Covered at 100% for emergency only.	Covered at 100% for emergency only.
Cosmetic Surgery – Elective	Charges for elective cosmetic surgery.	Not covered.		
Dental Services	Charges for dental work necessitated by accidental injury to sound, natural healthy teeth while covered under this Plan.	Covered at 100% after emergency room or office visit co-pay. Co-pay amount dependent upon place of service.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Durable Medical Equipment (DME)	Charges for rental or purchase of durable medical equipment (DME). Some items may require pre-certification.	Covered after the deductible at 80%.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Education and Training	Charges in connection with custodial care, education or training, including orthoptic or vision training.	Not covered.		
Emergency Health Services	Emergency care, including Hospital Emergency Room, Alternate Facility, or Urgent Care Center.	<u>Hospital Emergency Room</u> : Covered at 100% for in-network and out-of-network after \$150 co-pay; co-pay waived if admitted. Non-emergencies are not covered. <u>Urgent Care Center</u> : Covered at 100% after \$50 co-pay. Not covered out-of-network.	<u>Hospital Emergency Room</u> : Covered at 100% after \$100 co-pay; co-pay waived if admitted. Non-emergencies are not covered. <u>Urgent Care Center</u> : Covered at 100% after \$30 co-pay.	<u>Hospital Emergency Room</u> : Covered at 100% after \$100 co-pay; co-pay waived if admitted. Non-emergencies are not covered. <u>Urgent Care Center</u> : Covered after the deductible at 60% of EEX.
Excess of Eligible Expenses (EEX)	For charges made which are in excess of EEX charges as determined by this Plan.	Participant not responsible for charges by Network providers over and above the contracted allowable charges.	Participant not responsible for charges by Network providers over and above the contracted allowable charges.	Participant responsible for charges above EEX.
Experimental Procedures, Investigational or Unproven Treatment or Supplies	For services, treatment or supplies which are experimental, investigative, or unproven in nature.	Not covered.		

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
Hospice Care	Hospice care that is recommended by a physician and the care is received from a licensed hospice agency.	Covered at 100%.	Covered at 100%.	Covered at 100% of EEX.
Hospital – Inpatient	Charges for hospital bed and board, limited to the hospital’s most common semi-private daily rate. See “Mental Health/Substance Abuse” for other limitations. Some services require pre-certification.	Covered at 100% after \$100 co-pay per admission.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Hospital - Outpatient	Charges by a hospital for medical care and treatment on an outpatient basis. Some services require pre-certification.	Outpatient surgery covered at 100% after \$50 co-pay. All other outpatient services covered after the deductible at 80%.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Hospital – Preadmission Testing	Charges for preadmission testing prior to hospital confinement.	Covered at 100%.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Infertility Services	Covers diagnosis of infertility in a physician’s office only.	Office visits and tests are covered at 100% after \$20 or \$35 co-pay up to diagnosis or 80% after the deductible if outpatient. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist.	Office visits and tests are covered at 100% after \$20 or \$35 co-pay up to diagnosis. Covered after the deductible at 80% at any other place of treatment. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist.	Covered after the deductible at 60% of EEX.
Injections	Charges for injections received in a Physician’s office when no other health service is received; for example, allergy immunotherapy.	Covered at 100% after \$20 or \$35 co-pay. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist. Allergy Injections covered at 100% <i>For immunizations, see Preventive Care.</i>	Allergy Injections covered at 100%. Physicians Services co-pay may apply. Other injections covered after the deductible at 80%. <i>For immunizations, see Preventive Care.</i>	Covered after the deductible at 60% of EEX. <i>For immunizations, see Preventive Care.</i>

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
Maternity Benefit	Charges for pregnancy expenses for female staff member or dependents of staff member. Coverage for pregnancy ceases when Plan coverage terminates.	<p>First pre-natal visit is subject to \$20 or \$35 co-pay. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist.</p> <p>See “Hospital – Inpatient” and “X-ray/Laboratory” for coverage of other expenses.</p> <p>Dependent children are covered.</p> <p><i>Note: Staff must enroll newborns in plan within 31 calendar days beginning on the date of birth.</i></p>	<p>First pre-natal visit is subject to \$20 or \$35 co-pay. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist.</p> <p>See “Hospital – Inpatient” and “X-ray/Laboratory” for coverage of other expenses.</p> <p>Dependent children are covered.</p> <p><i>Note: Staff must enroll newborns in plan within 31 calendar days beginning on the date of birth.</i></p>	<p>Covered after the deductible at 60% of EEX for initial visit.</p> <p>See “Hospital – Inpatient” and “X-ray/Laboratory” for coverage of other expenses.</p> <p>Dependent children are covered.</p> <p><i>Note: Staff must enroll newborns in plan within 31 calendar days beginning on the date of birth.</i></p>
Mental Health/Substance Abuse (MH/SA)	<p>Charges for eligible expenses rendered in a physician’s office or other appropriate facility, incurred because of mental health or substance abuse.</p> <p>Some services require pre-certification.</p>	<p>Inpatient: Covered at 100% after \$100 co-pay per admission.</p> <p>Outpatient: Covered at 100% after \$20 co-pay per visit.</p>	<p>Inpatient: Covered after the deductible at 80%.</p> <p>Outpatient: Covered at 100% after \$20 co-pay per visit.</p>	<p>Inpatient: Covered after the deductible at 60% of EEX.</p> <p>Outpatient: Covered after the deductible at 60% of EEX.</p>
Nutritional Counseling	Behavioral counseling and education provided by a registered dietician in an individual session for obesity and to promote a healthy diet.	Covered at 100% after \$35 co-pay.	Covered after deductible at 80%.	Covered after the deductible at 60% of EEX.
Obesity Surgery	Charges for or in connection with surgeries related to obesity and weight loss programs.	Not covered.		

		MEDICAL EXPENSES				
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan			
		Network Only	Network	Out-of-Network		
Physician Services	Charges for professional services of physicians (unless practitioner is a family member).	Covered at 100% after \$20 co-pay per visit with Primary Care Physician.	Covered at 100% after \$20 co-pay per visit with Primary Care Physician.	Covered after the deductible at 60% of EEX.		
		Covered at 100% after \$35 co-pay per visit with a Specialist. No referral required from Primary Care Physician to see a Specialist.	Covered at 100% after \$35 co-pay per visit with a Specialist. Written physician referral required for massage therapy only.			
		Below is a listing of standard Primary Care Physicians (PCP) by Anthem. Providers not listed as a PCP are considered Specialists. <ul style="list-style-type: none"> ▪ Advanced Registered Nurse Practitioner ▪ Nurse Practitioner ▪ Nurse Practitioner Pilot Program ▪ Obstetrics ▪ Gynecology ▪ General Practice ▪ Family Practice Internal Medicine ▪ Obstetrics/Gynecology ▪ Pediatrics ▪ Physician Assistant ▪ Retail Clinics 				
Prescription Drugs	Drugs and medicines requiring a physician's (or dentist'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, including medications that have an exact over-the-counter equivalent.				
		Type of Drug	Retail Co-pay		Mail Order Co-pay (90-day supply)	
			Cost of Medication	What You Pay		What You Pay
		Value Generic		The actual cost of Rx or \$3.33 for a 30-day supply, whichever is less		The actual cost of Rx or \$9.99 for a 90-day supply, whichever is less
		Generic	\$10 or less	The actual cost of Rx		\$20 co-pay
			More than \$10	\$10 co-pay		
		Formulary (Preferred) Brand	\$50 or less	The actual cost of Rx		The greater of \$100 or 30% of Rx cost up to a maximum of \$160
			More than \$50	The greater of \$50 or 30% of Rx cost up to a maximum of \$80		
Non-formulary (Non-preferred) Brand	\$70 or less	The actual cost		The greater of \$140 or 30% of Rx cost up to a maximum of \$260		
	More than \$70	The greater of \$70 or 30% of Rx cost up to a maximum of \$130				
Specialty Drugs*				\$80 for a 30-day supply Specialty Pharmacy Mail Order Only		

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
		<p>*Specialty drugs are available through mail order only for a 30-day supply and may require Specialty Guideline Management and/or have limitations that apply.</p> <p><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.</p> <p><u>Maintenance Medications:</u> Medications listed on the CVS Caremark Maintenance Drug List must be ordered through Mail Order. However, when first starting the medication you are permitted to use Retail for the initial 30-day prescription and two 30-day refills. Participants may choose to fill maintenance medications at a CVS Retail Pharmacy and receive an 84- to 90-day supply for their mail order co-pay instead of ordering through mail order. Please note that in order to fill an 84- to 90-day supply of a covered medication at a CVS Retail Pharmacy, your prescription must be written for 84- to 90-days with applicable refills. Participants may still elect to use mail order for any covered medication and pay the mail order co-pay if they choose.</p>		
Preventive Care	Routine physical examinations including: Hearing screenings, colonoscopy and sigmoidoscopy, immunizations, Pap smears, pelvic exams and mammograms once per calendar year unless deemed necessary by your provider, well-woman, well-man and well-child services.	<p>Covered at 100%.</p> <p>Screenings outside doctor's office covered at 100%.</p> <p>Hearing examinations are limited to one examination per member per year.</p> <p>Cost of Hearing Aid not covered. (Discounts available – see "Special Offers" section on Anthem website.)</p>	<p>Covered at 100%.</p> <p>Screenings outside doctor's office covered at 100%.</p> <p>Hearing examinations are limited to one examination per member per year.</p> <p>Cost of Hearing Aid not covered. (Discounts available – see "Special Offers" section on Anthem web site.)</p>	Not covered.
Private Duty Nursing	<p>Nursing services ordered by a physician and provided or supervised by a registered nurse in your home. Benefits available only when skilled care is required. Custodial care is not covered. It is not covered when the caregiver is a member of the retiree's or dependent's family.</p> <p>Pre-certification is required.</p>	Covered after the deductible at 80%.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.
Provider Relationship	For services rendered by a person who is an immediate relative of or who ordinarily resides with the covered person requiring treatment.	Not covered.		

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
Reconstructive Procedures	Charges for reconstructive surgery only when necessitated by disease or accidental injury while covered under the Plan. The primary purpose must be to restore physiologic function for an organ or body part.	Covered the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.	Covered the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.	Covered after the deductible at 60% of EEX.
Rehabilitation Services – Outpatient Therapy	Charges for the following therapies: physical, occupational, speech, pulmonary rehabilitation, cardiac rehabilitation. Some services require pre-certification.	Covered at 100% after \$35 office co-pay. Covered after the deductible at 80% for Cardiac Rehab performed in an outpatient facility. Annual Therapy Limits: Physical – 30 visits Occupational – 30 visits Speech – 20 visits Pulmonary – unlimited Cardiac – unlimited	Covered at 100% after \$35 office co-pay. Covered after the deductible at 80% for Cardiac Rehab performed in an outpatient facility. Annual Therapy Limits: Physical – 45 visits Occupational – 45 visits Speech – 45 visits Pulmonary – unlimited Cardiac – unlimited <i>This benefit includes massage therapy – written physician referral required.</i> *Annual maximum benefit of 45 visits per person for all therapies combined. <i>Pulmonary and cardiac rehabilitation are not included in the 45 visit maximum.</i>	Covered after the deductible at 60% of EEX. Annual Therapy Limits: Physical – 45 visits Occupational – 45 visits Speech – 45 visits Pulmonary – unlimited Cardiac – unlimited <i>This benefit includes massage therapy – written physician referral required.</i> *Annual maximum of 45 visits per person for all therapies combined. <i>Pulmonary and cardiac rehabilitation are not included in the 45 visit maximum.</i>
Reimbursement	To the extent that the person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any other source.	Not covered.		
Sexual Dysfunction	Charges for or in connection with sexual dysfunction.	Not covered, including medication.		
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	Covered at 100% after \$100 co-pay.	Covered after the deductible at 80%.	Covered after the deductible at 60% of EEX.

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
	accommodations. Some services require pre-certification.			
Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy	Benefits available when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services.	Covered at 100% after \$35 co-pay. Spinal manipulation coverage up to a maximum of 12 visits per year.	Covered at 100% after \$35 co-pay per visit. <ul style="list-style-type: none"> ▪ Acupuncture covered to a maximum benefit of 24 visits per year, Network and Out-of-Network combined. ▪ Chiropractic covered a maximum benefit of 24 visits per year, Network and Out-of-Network combined. 	Covered after the deductible at 60% of EEX. <ul style="list-style-type: none"> ▪ Acupuncture covered to a maximum benefit of 24 visits per year, Network and Out-of-Network combined. ▪ Chiropractic covered a maximum benefit of 24 visits per year, Network and Out-of-Network combined.
Sterilization	Sterilization of an employee or spouse. Reversal of sterilization not covered.	Covered at 100% after co-pay. Co-pay amount dependent on place of service.	Consultations covered at 100% after co-pay. Co-pay dependent on place of service. Surgical Procedure covered after the deductible at 80% (outpatient hospital benefits).	Consultations covered after the deductible at 60% of EEX. Surgical Procedure covered after the deductible at 60% of EEX (outpatient hospital benefits).
Transplant Services	Covered for certain organ and tissue transplants when ordered by a physician. Pre-certification required prior to admission.	Covered at 100% for bone marrow, heart, heart/lung, liver, lung, pancreas, or kidney/pancreas for adults if transplant services are received at Blue Quality Centers for Excellence. Pediatric covered transplants include bone marrow, heart and liver. Kidney and cornea transplant services paid as any other service under medical.	Covered at 100% for bone marrow, heart, heart/lung, liver, lung, pancreas, or kidney/pancreas for adults if transplant services are received at Blue Quality Centers for Excellence. Pediatric covered transplants include bone marrow, heart and liver. Kidney and cornea transplant services paid as any other service under medical.	Not covered.
Vision Exam	Eye exams received from a health care provider in the provider's office. <u>Provider:</u> Anthem Medical	<u>Eye Exam ONLY:</u> Covered once every 12 months. <u>In-Network:</u> Covered at 100% after \$35 co-pay. <u>Out-of-Network:</u> Not Covered.	<u>Eye Exam ONLY:</u> Covered once every 12 months. Covered at 100% after \$35 co-pay.	<u>Eye Exam ONLY:</u> Covered once every 12 months. Covered after the deductible at 60% of EEX.
Vision Hardware	Charges for eyeglasses or contact lenses. <u>Provider:</u> Anthem Blue View Vision	<u>Frames:</u> Covered once every 24 months – <ul style="list-style-type: none"> • <u>In-Network:</u> Up to \$130 retail allowance for any frame and 20% discount for any amount over retail allowance. • <u>Out-of-Network:</u> Covered up to \$45 <u>Contacts (in lieu of glasses):</u> Covered once every 12 months – <ul style="list-style-type: none"> • <u>In-Network:</u> Up to \$130 allowance for all elective contacts, medically necessary contacts are covered in full. • <u>Out-of-Network:</u> Up to \$105 allowance for all elective contacts, medically necessary contacts are covered up to \$210. 		

		MEDICAL EXPENSES		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem PPO Plan	
		Network Only	Network	Out-of-Network
		<p><u>Lenses (pair)</u>: Covered once every 12 months (plastic lenses only) –</p> <ul style="list-style-type: none"> <u>In-Network</u>: One pair of standard single vision, bifocal, trifocal, or lenticular lenses is covered in full after \$20 co-pay. Progressive lenses are covered up to the bifocal amount after the \$20 co-pay. <u>Out-of-Network</u>: Single Vision – covered up to \$25 Bifocal – covered up to \$40 Progressive – covered up to \$40 Trifocal – covered up to \$55 Lenticular – covered up to \$80 <p>Additional discounts ranging from 10% to 45% may be available off the retail prices of frames, lenses, contacts, sunglasses and eyewear accessories when using a network provider.</p> <p>*Discounts can be used as often as you like while enrolled in the plan regardless of whether or not you are using your benefit.</p>		
Workers' Compensation, Government Hospital, Payments Prohibited by Law and Payments Not Required	Charges for or in connection with a sickness or injury for which a person is entitled to benefits under Workers' Compensation or similar law. Charges for treatment in a hospital owned or operated by the U.S. Government, and for which no charge is made. Charges for which payment from the Plan is prohibited by any law applicable to the person at the time the charges are incurred. Charges, which the person is not legally required to pay, or which would not have been made if no insurance existed.	Not covered.		
X-ray/Laboratory	Diagnostic x-ray and laboratory examination; x-ray, radium and radioactive isotope treatment; oxygen and other gases and administration thereof; blood transfusions and blood not donated or replaced; anesthesia and its administration.	<p>Covered at 100% after \$20 or \$35 co-pay if billed in conjunction with physician office visit. The co-pay is determined by the type of provider seen – Primary Care Physician (PCP) or Specialist.</p> <p>Covered after the deductible at 80% when performed through outpatient services.</p>	Covered after the deductible at 80%. Physicians Services co-pay may apply.	Covered after the deductible at 60% of EEX. Physicians Services co-pay may apply.

		MANDATED MEDICAL BENEFITS		
Description of Medical Plan Coverage		Anthem Network Only Plan	Anthem Premier PPO Plan	
		Network Only	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>	<p>Covered. Co-pays and coinsurance for related services may apply and are subject to provisions consistent with other benefits under the Plan.</p>	<p>Coverage for breast reconstruction and related services are covered after the deductible at 80% and are subject to provisions consistent with other benefits under the Plan.</p>	<p>Coverage for breast reconstruction and related services are covered after the deductible at 60% of EEX and are subject to provisions consistent with other benefits under the Plan.</p>
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>	<p>Covered as required by law.</p>		