



Pacific Northwest
NATIONAL LABORATORY

*Proudly Operated by **Battelle** Since 1965*

2012 **Benefits** Guide



OPEN ENROLLMENT PERIOD: NOVEMBER 1-30, 2011
FOR COVERAGE EFFECTIVE JANUARY 1, 2012

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Important Notice of Summarized Information

This summary outlines the features of several benefit 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 2012 BENEFITS. This year, rates have changed but plan design remains the same, so we're taking the opportunity to help employees learn about the various benefits we offer and how you can more fully use them to your advantage.

Actively Enroll in the Coverage of Your Choice

Mark your calendar for the month of November and actively enroll in your chosen 2012 benefit plans during Open Enrollment. To enroll, login to [MyHR](#), click Benefits, then Benefits Enrollment. To enroll your dependents, you will need the dependent's date of birth, Social Security number and address.

If you do not actively enroll, you will be automatically enrolled in [benefits based on your 2011 elections](#), except for your [Flexible Spending Accounts](#). You must enroll every year to participate in the Flexible Spending Accounts.

2012 Highlights

There are no plan design changes for 2012. The structure of the medical plans, dental plans and group accident insurance are staying the same for your 2012 benefits coverage. The rate changes reflect increases due to plan experience and alignment with financial targets.

Reminders

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

- [2012 HIPAA Notice of Privacy Practices](#)
- [Notice of Special Enrollment Rights](#)
- [Medicaid and the Children's Health Insurance Program](#) (CHIP)
- [2012 Notice of Creditable Coverage](#)

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Remember to
take time during
November 1-30 to
enroll in your
2012 benefits!

Membership Cards

If you are continuing coverage in the PNNL medical, dental or FSAs again for 2012, keep your current identification cards as they will remain effective.

Membership cards are distributed to staff members newly enrolled in the following plans:

- Anthem Medical Plans
- CVS Caremark Prescription Drug Benefits
- PayFlex Flexible Spending Accounts (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 2012 Medical and Dental Benefits Rates

Even in the face of rising health care costs and our organization-wide challenge of operating more efficiently, PNNL will still absorb the majority of the cost increases while offering you a reasonable premium and a very competitive benefits package.

The monthly premium rates for the medical and dental plans can be found in the separate 2012 Benefits Rates Chart found on the intranet. To get a complete overview of your options, be sure to review the rates for the different plans along with the 2012 Medical Plan Comparison that provides detailed information about the co-payment, co-insurance and coverage amounts.



We're Here to Help

We want every staff member to understand the total value of being a PNNL employee. To do this, we are dedicated to helping you understand the plans and programs that contribute to a rewarding work life at PNNL.

Please contact the [Benefits Office](#) throughout the Open Enrollment period to meet in person, talk over the phone or correspond via e-mail.

Benefits Office

Pacific Northwest National Laboratory

902 Battelle Boulevard, ROB 1286

P.O. Box 999, MS K1-34

Richland, WA 99352

509-375-6361

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

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



OPEN ENROLLMENT

Summary and Schedule

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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

- Transfer to a different 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 Daycare 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.

2012 Open Enrollment Schedule

October 11

Detailed Open Enrollment information regarding 2012 benefits and rates (posted on the intranet only), medical comparison, and additional informational handouts will be available on the following Benefits websites:

- Intranet: <https://hr.pnl.gov/openenrollment>
- Internet: <http://benefits.pnnl.gov/openenrollment>
- NOTE: Staff without access to either the intranet or Internet websites may contact the Benefits Office for a paper copy.

October 27

Benefits Fair, 11:30 a.m. – 4 p.m., EMSL 1075/1077

Breakout Sessions, 8 a.m. – 4:30 pm, EMSL Auditorium

Caremark	8 – 9 a.m.	Vanguard	12:30 – 1:30 p.m.
Anthem	9:30 – 10:30 a.m.	EAP	2 p.m. – 3 p.m.
Delta	11 a.m. – 12 p.m.	PayFlex	3:30 – 4:30 p.m.

Employees and family members are welcome to attend the Benefits Fair and Breakout sessions. Administrators will be hosting a presentation and Q&A during the breakout sessions.

November 1

Open Enrollment Begins

Online enrollment available on MyHR

Home mailing of Benefits Matter Issue #2

November 3

Open Enrollment Brown Bag, 10 – 11 a.m. and 1 – 2 p.m.

EMSL Auditorium

November 30

Open Enrollment Ends at 11:59 p.m. This is the last day for staff to make changes and enrollments.

December 30

All dependent verification for newly enrolled dependents must be received by the Benefits Office by 5 p.m. PT.



You automatically receive prescription drug and vision coverage if you are enrolled in a PNNL medical plan.

IMPORTANT REMINDERS

Before You Enroll

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You can also choose not to participate in any or all of PNNL's medical, dental, or group accident plans.



Don't forget to notify the Benefits Office of your "life event" and complete your enrollment change form within 31 days.

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.

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.*

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 the Benefits Office.

Notification must be received within 31 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.

Qualifying Life Events

- Marriage 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 full-time to salaried-less-than-full-time or hourly 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 PNNL's medical plans 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 PNNL's 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 PNNL's group accident plans 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

PNNL requires proof of eligibility for any **newly added** dependents enrolled in a PNNL sponsored plan. **Dependent verification must be provided by December 30 in order for your added dependents to have coverage on January 1, 2012.**

Proper Documentation

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

1. The first page of your 2010 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 – enrolled in a PNNL-sponsored plan.

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



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.

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 2011)

Your Natural, Adopted or Stepchild:

- A photocopy of the child's birth certificate showing the employee as the parent, or for medical, the employee's spouse as the parent.
- 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.
- 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 most recent 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 the Benefits Office at 509-375-6361 with questions about acceptable documentation.

Preparing to Enroll Online

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

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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.
- Have you reviewed dependent eligibility requirements because they vary by plan?
- Does your spouse's employer offer benefits?
- If you did not enroll for [dental coverage](#) last year, do you want to enroll this year?
- Do you want to enroll in a different [medical plan](#)?
- If you are currently enrolled in either the PPO or Network only medical plan and you do not make a new election, you will [continue with your current plan](#).
- Do you want to enroll in [Group Accident coverage](#), or to 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 the Benefits Office at 509-375-6361 for further instructions.

Default Elections

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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. For instance, if your current level of coverage is Employee & Spouse, your default coverage for 2012 will be Employee & Spouse. Review the chart below to see what this means to you:

Your Current Coverage	Your 2012 Default Coverage
Medical Coverage	
Anthem Network Only Plan	Anthem Network Only Plan
Anthem PPO Plan	Anthem PPO Plan
No medical coverage (waived)	No medical coverage (waived)
Dental Coverage	
PNNL Dental Plan (Delta Dental)	PNNL 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 2012
Group Accident Insurance	
Group Accident Insurance	Same coverage amount



Medical Plan Choices

Your medical benefits provide coverage for routine, preventive and emergency health care throughout the year. PNNL offers two separate plans which vary in their coverage, so review both plans before deciding which is best for you and your family.



Regardless of which plan you choose, you will receive prescription drug coverage administered by CVS Caremark and vision hardware coverage under Anthem Blue View Vision.

Anthem Network Only Plan

- Under this plan design, you must use a network provider in order to receive plan benefits. There are no benefits for non-network services except in the case of an emergency.
- This plan has higher monthly premiums than the Anthem PPO Plan.
- Individual and family deductibles will remain the same in 2012.
- The out-of-pocket maximum also will remain the same in 2012.
- Co-payment or co-insurance may apply depending on the type of services received. Please refer to the 2012 Medical Plan Comparison for details.
- Certain preventive care will be covered at 100 percent with no co-payment.

Anthem PPO Plan

- As a preferred provider organization (PPO) plan, the highest level of benefits is payable when you use [network providers](#). Benefits are also available for non-network services, but your cost share will be higher.
- This plan has lower monthly premiums than the Anthem Network Only Plan.
- Different levels of co-insurance are required for network and non-network covered services. Some services are covered with a co-payment only. Please refer to the 2012 Medical Plan Comparison for details.
- Certain preventive care will be covered at 100 percent with no co-payment.

Find Your Doctor

To determine if your doctor is in the Anthem network, visit [Anthem's website](#), go to "Find a Doctor" and follow the steps on the screen. If you are not a current member but know the plan information being offered by your company, you can add that information in "More Search Options." By entering the alpha prefix BZM under the "Your Insurance" section, this will allow you to search for doctors within PNNL's plans.

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" 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.



ANTHEM Quick Reference Guide

Anthem Customer Service

800-514-3021

5 a.m. – 4 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 2012 Medical Plan Comparison Chart

Features	Anthem Network Only Plan			Anthem PPO Plan					
				In-Network			Out-of-Network		
Annual Deductible	Tier I	Tier II/III	Tier IV	Tier I	Tier II/III	Tier IV	Tier I	Tier II/III	Tier IV
Annual Deductible	\$100	\$100/ \$300	\$100/ \$300	\$250	\$250/ \$500	\$250/ \$500	\$250	\$250/ \$500	\$250/ \$500
Out-of-Pocket Maximum	Tier I	Tier II/III	Tier IV	Tier I	Tier II/III	Tier IV	Tier I	Tier II/III	Tier IV
Out-of-Pocket Maximum	\$1,500	\$1,500/ \$3,000	\$1,500/ \$3,000	\$2,250	\$2,250/ \$4,500	\$2,250/ \$4,500	\$2,250	\$2,250/ \$4,500	\$2,250/ \$4,500
Lifetime Maximum	No lifetime maximum			No lifetime maximum			No lifetime maximum		
Co-insurance After Deductible	Plan pays 80% after deductible is met			Plan pays 80% after deductible is met			Plan pays 60% of Eligible Expenses (EEX) after deductible is met		
Office Visits	\$20 co-payment for primary care physician/ \$30 co-payment for specialist (no referral required to see a specialist)			\$20 co-payment for primary care physician or specialist (medical referral required for massage therapy only; otherwise no referral required to see a specialist)			Plan pays 60% of EEX after deductible is met		
Preventive Care	Plan pays 100%			Plan pays 100%			Not covered		
Hospital - Outpatient	Plan pays 100% after \$50 co-payment for outpatient surgery. All other outpatient services covered at 80% after deductible is met.			Plan pays 80% after deductible is met			Plan pays 60% of EEX after deductible is met		
Hospital - Inpatient	Plan pays 100% after \$100 co-payment			Plan pays 80% after deductible is met			Plan pays 60% of EEX after deductible is met		
Emergency Room	Plan pays 100% after \$150 co-payment, waived if admitted			Plan pays 100% after \$100 co-payment, waived if admitted			Plan pays 100% after \$100 co-payment, waived if admitted		
Urgent Care Provider	Plan pays 100% after \$50 co-payment			Plan pays 100% after \$25 co-payment			Plan pays 60% of EEX, after deductible is met		



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

Prescription Drug Benefits



Having a prescription drug benefit helps manage the cost of your prescription needs. Regardless of which medical plan you choose, your prescription drug coverage will be administered by [CVS Caremark](#). There are four components to your prescription drug program:

CVS Caremark Retail Program

When filling prescriptions for short-term, acute care medications, such as antibiotics, and when filling a new prescription for a new therapy, it is important that you use a [participating retail network pharmacy](#) to receive your full plan benefit. 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. Mail order is required for all [maintenance medications](#).

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.

Specialty drugs will continue to be filled through the Specialty Pharmacy Mail Order for a 30-day supply. The co-payment will remain \$80 per 30-day supply.

Your Prescription Drug Benefits

Type of Drug	Retail Co-payment		Mail Order Co-payment (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	The actual cost of Rx
	More than \$10	\$10 co-payment	\$20 co-payment
Formulary (Preferred) Brand	\$50 or less	The actual cost of Rx	The actual cost of Rx
	More than \$50	The greater of \$50 or 30% of Rx cost up to a maximum of \$80	The greater of \$100 or 30% of Rx cost up to a maximum of \$160
Non-Formulary (Non-preferred) Brand	\$70 or less	The actual cost	The actual cost of Rx
	More than \$70	The greater of \$70 or 30% of Rx cost up to a maximum of \$130	The greater of \$140 or 30% of Rx cost up to a maximum of \$260
Specialty Drugs*			\$80 for a 30-day supply Specialty Pharmacy Mail Order Only

CVS Caremark Value Generic Program

A select list of more than 100 generic medications called the [Value Generic Drug List](#) is available at a reduced co-payment amount of \$3.33 for a 30-day supply at any retail pharmacy in the Caremark national network, and \$9.99 for a 90-day supply through mail order. The list of drugs available on this program is comparable to those on other retailers' special programs, will be updated quarterly by Caremark and posted to their website as well as the Benefits intranet website.

How Much Will My Medicine Cost?

Your cost for [formulary and non-formulary drugs](#) is now determined by a co-insurance percentage. For instance, if you fill a prescription for a 30-day supply of a formulary drug and the cost of it is \$168, you would pay 30 percent of the total which is \$50.40.



When you choose a brand-name drug when a generic is available, you pay the co-insurance plus the difference in cost between the brand and the generic.

If the actual cost of the drug is less than the minimum co-payment amount, you will always pay the actual cost of the drug. So, if you fill a prescription for a 30-day supply of a formulary drug and the cost of it is \$48 and the minimum co-payment is \$50, you would only pay \$48.

To determine the cost of your medications, you can log in to [Caremark's website](#), click on the "Understand My Plan and Benefits" tab and enter your medication(s). If you are not registered on Caremark's site, the drug cost calculator is also available on [Caremark's customized site for PNNL employees](#).

Additional Resources

Go to the [Benefits intranet site](#), explore the [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
- [Value Generics list](#)

CVS CAREMARK Quick Reference Guide

Please use the resources below to find out more about filling your prescription through the retail pharmacy or the mail order program.

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 PNNL staff member and not currently enrolled in the CVS Caremark Program but that you will be, effective January 1, 2012. Also, provide the representative with the Universal ID Number, which is N20090101.*

*** The Pre-Enrollment Website is provided so you may find information about 2012 pharmacy benefits for PNNL before the plan's effective date.*

Vision Coverage

Anthem Blue View Vision Plan

If you enroll in a medical plan through PNNL, you will automatically receive exam coverage under the Anthem medical plan. Your vision hardware will be covered under a separate plan, the Anthem Blue View Vision Plan. While you can use a non-network provider, your benefits under the plan will be greater if your provider is part of the Anthem Blue View Vision network. The following chart provides a brief overview of your vision coverage.



You automatically receive vision coverage if you are enrolled in a PNNL medical plan.

Your Vision Plan Services and Coverage through Anthem Blue View Vision

	Anthem Network Only	Anthem PPO
Co-Payment		
Examination	In-network: Covered at 100% after \$30 co-payment Out-of-network: Not Covered	In-network: Covered at 100% after \$20 co-payment Out-of-network: Covered after the deductible at 60% of EEX

	Anthem Blue View Vision Provider Covered Amount	Non-Anthem Blue View Vision Provider Covered Amount
Co-Payment		
Materials (lenses and frames or contact lenses)	100% after \$20 co-payment	N/A
Standard Lenses (Pair)*		
Single Vision	100% after co-payment	Up to \$25
Bifocal	100% after co-payment	Up to \$40
Trifocal	100% after co-payment	Up to \$55
Lenticular	100% after co-payment	Up to \$80
Frame	Any frame up to \$130 retail value and 20% discount on the amount above \$130	Up to \$45
Contact Lenses **		
Elective	Up to \$130 retail value	Up to \$105
Medically Necessary	Covered at 100%	Up to \$210

* Standard plastic lenses up to 55 mm and all ranges of prescriptions.

** Contact lenses are in lieu of lens and frame allowances.



In addition to searching for providers, registering on [Anthem's website](#) also provides you with the ability to access your vision claims information.



Find a Vision Exam Provider

Visit [Anthem's website](#):

- Click on "Find A Doctor"
- Under "What are you looking for?" you will need to click on Doctor & Other Health Professional
- Then on the next drop down, you need to click on "Vision Specialists"
- Then enter your location information

Find a Vision Hardware Provider:

Visit Anthem's website:

- Click on "Find A Doctor"
- Under "What are you looking for?" you will need to click on **Vision**
- Select to search by "Vision Doctors/Optometrists" or "Facilities"

Frequency of Services

(based on a rolling timeline, not per calendar year)

Vision Exam	12 months
Lenses	12 months
Frames	24 months
Contact Lenses	12 months

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 BLUE VIEW VISION Quick Reference Guide

Anthem Blue View Vision Plan Customer Service

866-723-0515
5 a.m. – 4 p.m. PT
Monday – Friday

Anthem Website

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



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. Covered services will be paid according to the Plan of Benefits outlined below. You will need to pay your dentist and [submit your claim](#) yourself. Delta Dental will reimburse you for the amount covered by the plan.

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 "Enrollees" on the left-hand side of the page
- Under "Enrollees," click "Find a Provider"
- Click "Delta Dental"
- Select "Delta Dental PPO" or "Delta Dental Premier"
- You can search by physician name, location, or specialty



Delta Dental is in its second year serving as PNNL's dental claims administrator. Be sure to let your dentist know about the change, and check to see if your dentist is in the new, larger network.

You can print an ID card and access your coverage and claims information by logging on to the [Delta Dental website](#). Click "Enrollees," 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: <u>(\$60.80)</u>	Delta Pays 80% of the Maximum Approved Fee: <u>(\$73.60)</u>	Delta Pays 80% of the Non-participating Dentist Fee: <u>(\$74.40)</u>
	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	\$50 for individual / \$150 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%	
Class III Benefits			
Relines and Repairs - to bridges and dentures		50%	
Major Restorative Services - includes crowns		50%	
Prosthodontic Services - includes bridges and dentures		50%	
Implants - endosteal implants to replace missing teeth		50%	
Occlusal Guards		50%	
Class IV Benefits			
Orthodontic Services - includes braces		50%	

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

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 fees are lower than the fees for the network providers. Please see the chart for more information.



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.

- 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.

DELTA DENTAL Quick Reference Guide

Delta Dental Customer Service

800-524-0149
5:30 a.m. – 4:50 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-\$5,000 per year*

Eligible Expenses:

Examples of eligible expenses include 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.



Dependent Daycare 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 daycare 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 \$5,000 for each account. 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 can help [reduce your taxes](#) and increase your take-home pay. On average, people save 27 percent in taxes by paying their out-of-pocket health care and child and elder care expenses on a pre-tax basis through an FSA. This average is calculated assuming federal and Social Security taxes, and state taxes.

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](#).

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](#) dictated 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 2012, 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 [Day 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 2012 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. 3A00)



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



PNNL's Group Accident Insurance is insured 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

For Salaried and Salaried-less-than-full-time Staff

Single Level of Coverage	Family Level of Coverage
\$0.137/\$10,000	\$0.216/\$10,000

Filing Your Claim

To file a claim under the Group Accident Insurance, please contact the 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 the Benefits Office 30 days in advance of travel to War Risk Countries, or as soon as possible, if you wish to have coverage while traveling to or through these destinations. Failure to provide advance notice may result in a loss of coverage while in a War Risk Country. See the International Travel section on the Benefits website for more information.

**War Risk Countries are subject to change. Please contact the 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 2012 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
509-375-6361
8 a.m. – 5 p.m. PT
Monday-Friday

E-mail
ask.benefits@pnnl.gov



Employee Assistance Program



Although it is not a benefit you elect, the Employee Assistance Program (EAP), administered by OptumHealth (formerly United Behavioral Health), is a free and confidential counseling 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

EAP Website
www.liveandworkwell.com
24 hours a day, 7 days a week
(access code 12639)

**PNNL Onsite Counselor,
Jody McClellan**
509-372-4962
2 days a week

Resources

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 the Benefits Office throughout the Open Enrollment process to meet in person, talk over the phone or correspond via email.

OE12

Anthem (Medical and Vision Exam Plan)

Customer Service: 800-514-3021

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

www.anthem.com

Anthem Blue View Vision (Vision Hardware Plan)

Customer Service: 866-723-0515

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 (Dental Plan)

Customer Service: 800-524-0149

www.deltadentaloh.com

Employee Assistance Program (EAP)

Customer Service: 866-728-8403

www.liveandworkwell.com

(access code 12639)

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: 509-375-6361

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

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



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.

Network Only Plan – A type of medical plan in which the claims administrator (for example, Anthem) has contracted with physicians or health care organizations within a network. You must use a network provider in order to receive coverage. There is no coverage for non-network services except in the case of an emergency.

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.