

**Pacific Northwest National Laboratory
2013 Medical and Dental Plan Summary
For Retirees and LTD Retirees Over 2 Years
Not eligible for Medicare**



Pacific Northwest
NATIONAL LABORATORY

Proudly Operated by **Battelle** Since 1965

Levels of Coverage:

| | | | |
|--------------------------------------|---------|---------------------|----------|
| Employee Only | Tier I | Employee & Children | Tier III |
| Employee & Spouse/Registered Partner | Tier II | Family | Tier IV |

| Plan Name | Annual Deductible | Covered Expenses | | Annual Out-of-Pocket Maximum | |
|---|--|--|---------------------------------|------------------------------|-----------------------------|
| | | Plan Pays | You Pay | Tiers I & V | Tiers II, III, IV, VI & VII |
| Anthem Network Only Plan <i>Under this plan design, you must use a network provider in order for services to be covered. There are no benefits for non-network services except in the case of an emergency.</i> | \$150 per covered person, not to exceed \$450 per covered family | 100% after Co-pays or 80% of EEX* after deductible | Co-Pays or 20% after deductible | \$1,500 | \$1,500/\$3,000 |
| Medical Plan Lifetime Maximum | | | | | |
| Unlimited | | | | | |

*As indicated above, this Retiree Medical Plan pays a percentage of certain Eligible Expenses (EEX) after your covered expenses reach the individual or family deductible. Other services are covered in full after a co-pay. The out-of-pocket maximum does not apply to 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 co-pay and/or your share of the coinsurance for these expenses.

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

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 can be reviewed on-line at <http://benefits.pnnl.gov/retirees.stm>. Paper copies are available upon request from the Benefits Office.

| Delta Dental Plan | |
|---|---|
| Type of Service | Coverage (Based on Reasonable and Customary Charges) |
| Class I - Preventative | 100% |
| Class II - Minor Restorative | 80% (after deductible) |
| Class III - Major Restorative | 50% (after deductible) |
| Annual Deductible | \$50 per person/\$150 per family |
| Annual Maximum Limit Plan Will Pay Per Person | \$1,500 |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | | Anthem Network Only Plan |
|---|--|---|
| 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. |
| Cosmetic Surgery – Elective | Charges for elective cosmetic surgery. | Not covered. |
| Custodial Care | Charges for custodial care, nursing homes, convalescent homes or similar institutions. | Not covered. |
| Dental Services | Charges for dental work necessitated by accidental injury to natural healthy teeth while covered under this Plan. Routine dental work is covered under the PNNL Retiree Dental Plan administered by Delta Dental of Ohio. | Covered at 100% after Emergency Room or office visit co-pay. Co-pay amount dependent upon place of service. |
| Durable Medical Equipment (DME) | Charges for rental or purchase of durable medical equipment (DME). Some items require pre-certification. | Covered after the deductible at 80%. Cost of Hearing Aid not covered. (Discounts available – see “Health & Wellness” section on Anthem website.) |
| 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. Non-emergencies are not covered when using a Hospital Emergency Room. | <u>Hospital Emergency Room</u> : Covered in network and out-of-network at 100% after \$150 co-pay; co-pay waived if admitted. <u>Urgent Care Center</u> : Covered at 100% after \$50 co-pay. Not covered out-of-network. |
| 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. |
| Experimental Procedures, Investigational or Unproven Treatment/Supplies | For services, treatment or supplies which are experimental, investigative, or unproven in nature. | Not covered. |
| Hearing | Charges for examinations. | See Preventive Care Section. |
| Hospice Care | Hospice care that is recommended by a Physician and the care is received from a licensed hospice agency. | Covered at 100%. |
| Hospital – Inpatient | Charges for hospital bed and board, limited to the hospital’s most common semi-private daily rate. Some services require pre-certification. | Covered at 100% after \$100 co-pay per admission. |
| Hospital - Outpatient | Charges by a hospital for medical care and treatment on an outpatient basis. | Covered at 100% after \$50 co-pay for outpatient surgery. All other outpatient services covered at 80% after the deductible. |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | | Anthem Network Only Plan |
|---------------------------------------|--|--|
| Hospital – Preadmission Testing | Charges for preadmission testing prior to hospital confinement. | Covered at 100%. |
| Hospital Services/Supplies | Charges for hospital services and supplies (including anesthesia and its administration during hospital confinement). | Covered at 100%. |
| 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. |
| Mental Health/Substance Abuse (MH/SA) | Charges for eligible expenses rendered in a physician’s office or other appropriate facility, incurred because of mental health or substance abuse. Subject to coordination of care prior to inpatient admission. ADD, ADHD, developmental delays, autistic disease, learning disabilities, hyperkinetic syndromes, or mental retardation covered under mental health. | Inpatient: Covered at 100% after \$100 co-pay per admission. Outpatient: Covered at 100% after \$20 co-pay per visit. |
| 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. |
| Physician Services | Charges for professional services of physicians (unless practitioner is a family member). 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 (i.e. Minute Clinic, The Little Clinic, Take Care Health, etc.) | Covered at 100% after \$20 co-pay per visit with Primary Care Physician. Covered at 100% after \$35 co-pay per visit with a Specialist. <i>No referral required from Primary Care Physician to see a Specialist.</i> |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | Anthem Network Only Plan |
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| Prescription Drugs | <p>Drugs and medicines requiring a physician’s (or dentist’s) prescription for a specific illness and dispensed by a pharmacist.</p> <p>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.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;"></th> <th style="width:25%;"></th> <th style="width:25%; text-align: center;">Retail Co-payment (30-day supply)</th> <th style="width:25%; text-align: center;">Mail Order Co-payment (90-day supply)</th> </tr> <tr> <th style="text-align: center;">Type of Drug</th> <th style="text-align: center;">Cost of Medication</th> <th style="text-align: center;">What You Pay</th> <th style="text-align: center;">What You Pay</th> </tr> </thead> <tbody> <tr> <td>Value Generic</td> <td></td> <td>The actual cost of Rx or \$3.33 for a 30-day supply, whichever is less</td> <td>The actual cost of Rx or \$9.99 for a 90-day supply, whichever is less</td> </tr> <tr> <td rowspan="2">Generic</td> <td>\$10 or less</td> <td>The actual cost of Rx</td> <td rowspan="2">\$20 co-payment</td> </tr> <tr> <td>More than \$10</td> <td>\$10 co-payment</td> </tr> <tr> <td rowspan="2">Formulary (Preferred) Brand</td> <td>\$50 or less</td> <td>The actual cost of Rx</td> <td rowspan="2">The greater of \$100 or 30% of Rx cost up to a maximum of \$160</td> </tr> <tr> <td>More than \$50</td> <td>The greater of \$50 or 30% of Rx cost up to a maximum of \$80</td> </tr> <tr> <td rowspan="2">Non-formulary (Non-preferred) Brand</td> <td>\$70 or less</td> <td>The actual cost</td> <td rowspan="2">The greater of \$140 or 30% of Rx cost up to a maximum of \$260</td> </tr> <tr> <td>More than \$70</td> <td>The greater of \$70 or 30% of Rx cost up to a maximum of \$130</td> </tr> <tr> <td>Specialty Drugs*</td> <td></td> <td></td> <td>\$80 for a 30-day supply Specialty Pharmacy Mail Order Only</td> </tr> </tbody> </table> <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>For Retail and Mail Order: 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>Maintenance Medications: Medications listed on the CVS Caremark Maintenance Drug List must be ordered through <u>Mail Order</u>. However, when first starting the medication you are permitted to use <u>Retail</u> for the initial 34-day prescription and two 34-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 or co-insurance if they choose. You can access the Maintenance Drug list at www.Caremark.com/Battelle.</p> | | | Retail Co-payment (30-day supply) | Mail Order Co-payment (90-day supply) | Type of Drug | 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-payment | More than \$10 | \$10 co-payment | 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 | <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 no covered. (Discounts available – see “Special Offers” section on Anthem website.)</p> |
|-------------------------------------|--|--|--|--------------------------------------|--|--------------|--------------------|--------------|--------------|---------------|--|--|--|---------|--------------|-----------------------|-----------------|----------------|-----------------|-----------------------------|--------------|-----------------------|---|----------------|---|-------------------------------------|--------------|-----------------|---|----------------|--|------------------|--|--|--|---|
| | | Retail Co-payment (30-day supply) | Mail Order Co-payment (90-day supply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Drug | 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-payment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | More than \$10 | \$10 co-payment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Preventive Care | <p>Routine physical examinations including:</p> <p>Hearing screenings, colonoscopy and sigmoidoscopy, 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> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | | Anthem Network Only Plan |
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| Private Duty Nursing | Nursing services ordered by a physician and provided by or supervised by a registered nurse in your home. Benefits available only when skilled care is required. Custodial care is not covered. Services are not covered when the caregiver is a member of the retiree's or dependent's family. | Covered after the deductible at 80%. Coordination of care may be required. |
| Prosthetics and Orthotics | <u>Prosthetics</u> : Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part. Additional coverage includes but is not limited to: Initial pair of contact lenses or glasses (lenses and frames) following cataract surgery, one wig following cancer treatment not to exceed one per benefit period, breast prosthesis, initial (per side) and two brassieres following a mastectomy – per year or as medically necessary. <u>Orthotics</u> : The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function or movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting molding fittings and adjustments are included. Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements may be allowed for Member's under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired. | Covered after the deductible at 80%. |
| 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. |
| Reconstructive Surgery | 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. |
| Rehabilitation Services – Outpatient Therapy | Charges for the following therapies: physical, occupational, speech, pulmonary rehabilitation, and cardiac rehabilitation. | 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: <ul style="list-style-type: none"> • Physical – 30 visits • Occupational – 30 visits • Speech – 20 visits • Pulmonary – unlimited • Cardiac – unlimited |
| 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. Any person eligible for the Medicare program shall be considered covered by that program, to the full extent eligible, for purposes of this Plan. | Not covered. |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | | Anthem Network Only Plan |
|---|---|--|
| 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 accommodations. Some services require pre-certification. | Covered at 100% after \$100 co-pay. |
| 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. |
| Sterilization | Sterilization of a retiree or spouse. Reversal of sterilization not covered. | Covered at 100% after co-pay. Co-pay amount dependent on place of service. |
| 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. |
| 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 |
| 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. <u>Lenses (pair):</u> Covered once every 12 months (plastic lenses only) – <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 Trifocal – covered up to \$55 |

MEDICAL EXPENSES

| Description of Medical Plan Coverage | | Anthem Network Only Plan |
|--|---|--|
| Vision Hardware cont. | | Lenticular – covered up to \$80 Progressive – covered up to \$40 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. *Discounts can be used as often as you like while enrolled in the plan regardless of whether or not you are using your benefit. |
| 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. | 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. Covered after the deductible at 80% when performed through out-patient services. |

MANDATED MEDICAL BENEFITS

This plan pays benefits only for covered expenses (as defined in the Plan Document) which are more than the amount payable for the same expenses under Medicare.

| Description of Medical Plan Coverage | | Anthem Network Only |
|---|---|--|
| Mandated Health Benefits | 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: <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. This coverage would be made available to participants or beneficiaries who are receiving benefits in conjunction with a mastectomy and who elect breast reconstruction. | Covered. Co-pays for related services may apply and are subject to provisions consistent with other benefits under the Plan. |