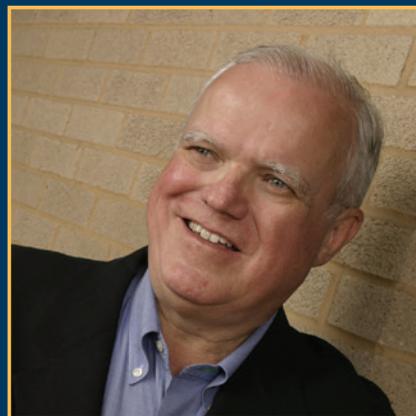
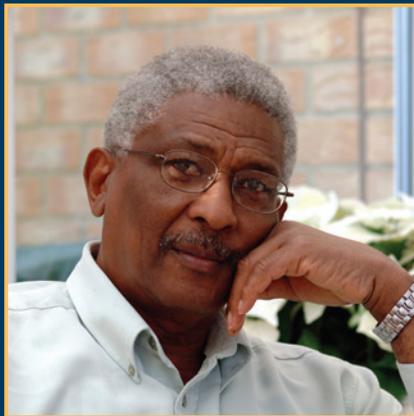


*Hanford Employee Welfare Trust*

# HEWWT

## RETIREE BENEFITS OVERVIEW



# RETIREE BENEFITS OVERVIEW



**WELCOME!** As a retiree, or a spouse of a retiree in the Hanford Employee Welfare Trust (HEWT), you are eligible to enroll from a deferred status or make changes to your current retiree medical elections on an annual basis. The HEWT offers you the flexibility to choose from two medical plans which we are confident will meet your specific needs for the upcoming calendar year. We look forward to continuing our relationship with you throughout the next year!

## RETIREE BENEFITS OVERVIEW

Included in the package are:

- **Health Care Benefits**  
The HEWT pays the major share of the cost of the medical and prescription plans for you and your eligible dependents.
- **Life & Insurance Plans**  
The HEWT offers insurance plan options which you elected at the time you retired. These benefits are payable to you or your beneficiary in the event of your or your spouse's death.

## UPDATE OF INFORMATION

If you have a change to your beneficiaries or would like to update your address, please contact 509-376-6962, email us at [Benefits-HEWT@rl.gov](mailto:Benefits-HEWT@rl.gov), or send your changes to:

Hanford Employee Welfare Trust  
Attn: Benefits Administration  
PO BOX 650 H2-23  
Richland, WA 99352

## PLAN YEAR

Each plan year begins on January 1 and ends on December 31. In the Fall, you will have the opportunity to change your elections for the following plan year.

## ELIGIBILITY

As a participant in this plan, you are eligible to participate until you reach age 65 and become eligible for Medicare, at which time, you may be eligible for a Medicare supplement plan also available through the HEWT.

## OPPORTUNITY TO OPT OUT

A one-time opt-out option is available to you as a participant in the HEWT post-retirement medical benefits. After opting out, you may re-enroll in coverage within 31 days following a qualifying life event or during an annual open enrollment period, which is effective January 1 of the following calendar year. If coverage is dropped again for any reason, you may not re-enroll in medical coverage.

## DEPENDENT COVERAGE

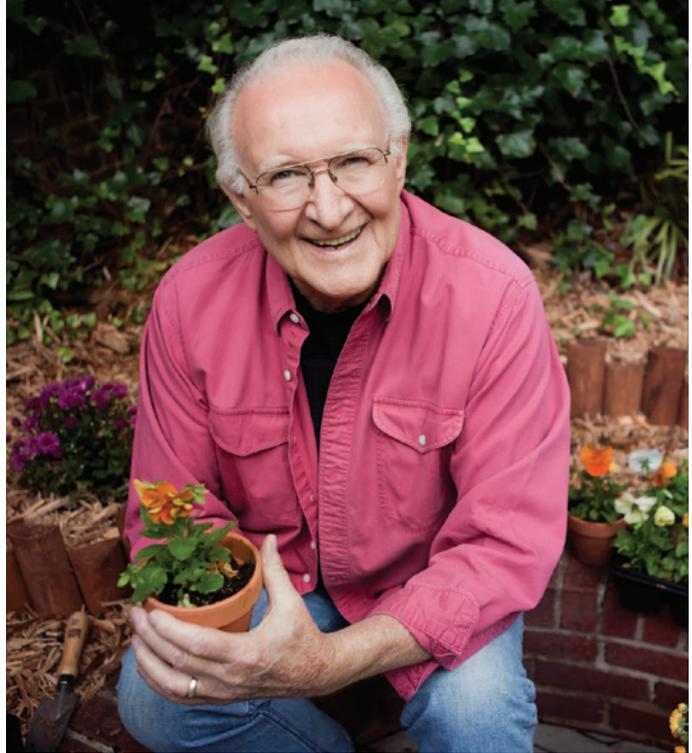
In addition to electing coverage for yourself, you can elect to continue coverage for your eligible dependents. For the medical and prescription drug plans, your eligible dependents include your legal spouse or domestic partner (if certain criteria are met) and children who were covered at the time of your retirement. If your eligible dependent(s) are age 65 or older, coverage may continue under the HEWT's Medicare supplement plan.

## CHANGING YOUR BENEFITS

Retirees enrolled in these post-tax benefit plans may only make benefit elections once a year. As such, your medical and prescription benefit choices are binding until the next open enrollment. The following special circumstances are the **ONLY** reasons you may change your benefits during the plan year:

- Divorce, legal separation or annulment
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan (applicable if previously "opted-out")
- A significant change in your or your spouse's health coverage attributable to your spouse's employment (applicable if previously "opted-out")
- Death of a spouse or dependent
- Loss of dependent status
- Becoming eligible for Medicare or Medicaid during the year

These special circumstances often referred to as “Qualifying Life Events” or life event changes, will allow you to make changes at any time during the year in which they occur. For any allowable change, you must notify the HEWT of the event and provide the requested documents within 31 days of the event to avoid a lapse in coverage. Changes that are requested due to a “change of mind” or financial hardship without a Qualifying Life Event, are not allowed until the next annual open enrollment period.



## **MEDICAL BENEFITS**

Coverage choice, cost and convenience are factors each of us considers important when selecting a medical plan. You may choose between two medical plans, whichever one best meets your needs and the needs of your family. The plans cover the same types of services, but differ in how they share costs with you and how they provide access to care. Each option is summarized below and within the Medical Plan Summary on the following page.

### **OPTION 1 – GROUP HEALTH OPTIONS PLAN**

Group Health Options provides you with flexibility when seeking covered medical services by allowing you to receive care within or outside of the Group Health network. You will be required to elect a primary care physician (PCP), and you will maximize your coverage by having care provided or referred by your PCP. This plan offers members a combination of in-network managed services and out-of-network services, which can be from any qualified provider. In-network services usually require co-insurance after the deductible is met. Out-of-network services are subject to a higher annual deductible and a co-insurance payment, typically 40 percent of remaining covered expenses up to an annual out-of-pocket limit.

### **OPTION 2– UNITEDHEALTHCARE PPO PLAN**

UnitedHealthcare PPO has access to a broad network of physicians and hospitals nationwide. The traditional plan design offers two levels of coverage – a higher level of benefits apply for in-network services, and a lower level of benefits is available for non-network services with somewhat higher deductibles, co-insurance and co-payments. The plan includes a full spectrum of covered services and direct access to specialists without the need to gain approval from a primary care doctor.

The company chosen to manage your prescription-drug benefit under the UnitedHealthcare PPO, Express Scripts, Inc., offers you a website tool with round-the-clock assistance, savings opportunities and important health information.



# HEWT GROUP HEALTH OPTIONS MEDICAL PLAN (CONT'D)

Group Number: 6813900/6227500

Ref: RQ-33021

BENEFITS	INSIDE NETWORK	OUT-OF-NETWORK
<b>Emergency Services</b> (Co-pay Waived if Admitted)	\$125 co-pay. Deductible and co-insurance apply.	\$125 co-pay. Deductible and co-insurance apply.
<b>Hearing Exams (Routine)</b>	No co-pay. Deductible and co-insurance apply.	\$5 co-pay. Deductible and co-insurance apply.
<b>Hearing Hardware</b>	Not covered.	Not covered.
<b>Home Health Services</b>	Covered in full. No visit limit.	No visit limit. Deductible and co-insurance apply.
<b>Hospice Services</b>	Covered in full.	Deductible and co-insurance apply.
<b>Infertility Services</b>	Not covered.	Not covered.
<b>Manipulative Therapy</b>	Self-referred up to 10 visits per calendar year. No co-pay. Deductible and co-insurance apply.	Visit limits shared with in-network. \$5 co-pay. Deductible and co-insurance apply.
<b>Massage Services</b>	See Rehabilitation services.	See Rehabilitation services.
<b>Maternity Services</b>	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> No co-pay. Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> \$5 co-pay. Deductible and co-insurance apply.
<b>Mental Health</b>	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> No co-pay. Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> \$5 co-pay. Deductible and co-insurance apply.
<b>Naturopathy Services</b>	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan. No co-pay. Deductible and co-insurance apply.	\$5 co-pay. Deductible and co-insurance apply.
<b>Obesity-Related Surgery (Bariatric)</b>	Not covered.	Not covered.
<b>Organ Transplants</b> Donor Search & Harvest	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> No co-pay. Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> \$5 co-pay. Deductible and co-insurance apply.
<b>Preventive Care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full.	Not covered. Routine mammograms: Deductible and co-insurance apply.
<b>Rehabilitation Services</b> (Occupational, Speech and Physical Including Services for Neurodevelopmentally Disabled Children Age Six and Under). Rehabilitation Visits are a Total of Combined Therapy Visits Per Calendar Year.	<b>Inpatient:</b> 60 days per calendar year. Deductible and co-insurance apply. <b>Outpatient:</b> 60 visits per calendar year. No co-pay. Deductible and co-insurance apply.	<b>Inpatient:</b> Day limits shared with in-network. Deductible and co-insurance apply. <b>Outpatient:</b> Visit limits shared with in-network. \$5 co-pay. Deductible and co-insurance apply.
<b>Skilled Nursing Facility</b>	Up to 60 days per calendar year, deductible and co-insurance apply.	Day limits shared with in-network benefit, deductible and co-insurance apply.
<b>Sterilization (Vasectomy, Tubal Ligation)</b>	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> No co-pay. Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> \$5 co-pay. Deductible and co-insurance apply.
<b>Temporomandibular Joint (TMJ) Services</b>	\$1,000 per calendar year; \$5,000 lifetime max. <b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> No co-pay. Deductible and co-insurance apply.	Shared with in-network. <b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> \$5 co-pay. Deductible and co-insurance apply.
<b>Tobacco Cessation</b> See Pharmacy Benefit for Associated Drug Coverage	Free & Clear Program—covered in full.	Not covered.
<b>Routine Vision Care</b> (1 Visit Every 12 Months)	No co-pay. Deductible and co-insurance waived.	Not covered.
<b>Optical Hardware</b> Lenses, including contact lenses and frames	Not covered.	Not covered.

# UNITEDHEALTHCARE PPO MEDICAL PLAN

Plan : #702633

BENEFITS	INSIDE NETWORK	OUT-OF-NETWORK
<b>Plan Deductible - Per Calendar Year (PCY)</b>	Individual deductible: \$400 Family deductible: \$800	Individual deductible: \$600 Family deductible: \$1,200
<b>Plan Co-insurance</b>	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
<b>Out-Of-Pocket Limit</b>	Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$4,000	Individual out-of-pocket limit: \$4,000 Family out-of-pocket limit: \$8,000
<b>Lifetime Maximum</b>	\$1,500,000 combined in- and out-of-network	\$1,500,000 combined in- and out-of-network
<b>Office Visit/Urgent Care</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Outpatient Services</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Hospital Services Inpatient And Outpatient</b>	Plan pays 80%, you pay 20%, deductible applies after a \$250 co-pay for inpatient services	Plan pays 60%, you pay 40%, deductible applies after \$250 co-pay for inpatient services
<b>Prescription Drugs</b>	Covered through Express Scripts, Inc. <b>Retail: (for a 30-day supply)</b> Generic: \$15 Brand name preferred: \$35 Brand name non-preferred: \$50 <b>Mail Order: (for a 90-day supply)</b> Generic: \$30 Brand name preferred: \$70 Brand name non-preferred: \$100	Contact Express Scripts, Inc. for reimbursement details
<b>Acupuncture</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to 20 visits per calendar year.	Plan pays 60%, you pay 40%, deductible applies. Limited to 20 visits per calendar year.
<b>Ambulance (True Emergency)</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 80%, you pay 20%, deductible applies.
<b>Chemical Dependency</b>	<b>Inpatient:</b> Plan pays 80%, you pay 20%, deductible applies after a \$250 co-pay for inpatient services <b>Outpatient:</b> Plan pays 80%, you pay 20%, deductible applies.	<b>Inpatient:</b> Plan pays 60%, you pay 40%, deductible applies after \$250 co-pay for inpatient services <b>Outpatient:</b> Plan pays 60%, you pay 40%, deductible applies.
<b>Chiropractic Services</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to 20 visits every calendar year.	Plan pays 60%, you pay 40%, deductible applies. Limited to 20 visits every calendar year.
<b>Devices, Equipment and Supplies (DME Prosthetics)</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Diagnostic Lab and X-Ray Services (Outpatient)</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Emergency Services</b>	\$125 co-pay per visit, then Plan pays 80%, you pay 20%, and deductible applies.	\$125 co-pay per visit, then Plan pays 80%, you pay 20%, and deductible applies.

# UNITEDHEALTHCARE PPO MEDICAL PLAN (CONT'D)

Plan : #702633

BENEFITS	INSIDE NETWORK	OUT-OF-NETWORK
<b>Hearing Exam</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to one exam every 12 months.	Plan pays 60%, you pay 40%, deductible applies. Limited to one exam every 12 months.
<b>Hearing Aids</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to \$300 every 36 months.	Plan pays 60%, you pay 40%, deductible applies. Limited to \$300 every 36 months.
<b>Home Health</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to 40 visits per calendar year.	Plan pays 60%, you pay 40%, deductible applies. Limited to 40 visits per calendar year.
<b>Infertility Services</b>	Not Covered.	Not Covered.
<b>Maternity Services</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Mental Health</b>	<p><b>Inpatient:</b> Plan pays 80%, you pay 20%, deductible applies after \$250 co-pay for inpatient services.</p> <p><b>Outpatient:</b> Plan pays 80%, you pay 20%, deductible applies.</p>	<p><b>Inpatient:</b> Plan pays 60%, you pay 40%, deductible applies after \$250 co-pay for inpatient services.</p> <p><b>Outpatient:</b> Plan pays 60%, you pay 40%, deductible applies.</p>
<b>Naturopathy Services</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Obesity Surgery</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Organ Transplants</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Preventive Care</b>	Covered at 100%.	Plan pays 60%, you pay 40%, deductible applies.
<b>Rehabilitation Services (Occupational, Speech and Physical Therapies)</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to 30 visits per calendar year, 20 visits for Cardiac and Pulmonary.	Plan pays 60%, you pay 40%, deductible applies. Limited to 30 visits per calendar year, 20 visits for Cardiac and Pulmonary.
<b>Skilled Nursing</b>	Plan pays 80%, you pay 20%, deductible applies. Limited to 60 days per calendar year.	Plan pays 60%, you pay 40%, deductible applies. Limited to 60 days per calendar year.
<b>Sterilization (Vasectomy, Tubal Ligation)</b>	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
<b>Vision Care</b>	Not Covered.	Not Covered.



## DENTAL BENEFITS FOR COBRA PARTICIPANTS ONLY

Dental coverage for retirees is only available through COBRA continuation coverage if the retiree had dental coverage at the time of retirement.

The HEWT offers two dental providers for dental coverage, Delta Dental of Washington and Willamette Dental.

### HEWT-BUY-UP PLAN

Program #00522

DELTA DENTAL OF WASHINGTON	PAYMENT LEVELS		
	DELTA DENTAL PPO DENTIST	NON-PPO DENTIST	OUT-OF-STATE DENTIST
<b>Class I - Diagnostic &amp; Preventive</b> Exams, prophylaxis, fluoride, x-rays, sealants	80%	60%	60%
<b>Class II - Restorative</b> Restorations, endodontics, periodontics, oral surgery	70%	60%	60%
<b>Class III – Major</b> Crowns, dentures, partials, bridges, and implants	50%	40%	40%
<b>Annual Maximum Per Person</b> Benefit period: (Jan 1 - Dec 31)	\$1,500	\$1,500	\$1,500
<b>Deductible (Waived for Class I)</b> Per person/per benefit period Annual family maximum	\$50 \$100	\$50 \$100	\$50 \$100
<b>Orthodontia</b> Adults & dependent children Lifetime maximum per enrollee	50% \$1,200	50% \$1,200	50% \$1,200

MySmile® personal benefits center is a unique online tool that provides personalized strategies for employees to use to improve their oral health. It is accessed through the Delta Dental of Washington Web site [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com)

Please Note: This is a brief summary of benefits only and does not constitute a contract. You will receive a benefits booklet that completely details your PPO dental benefits. Please feel free to call the Customer Service Department if you have any questions.

Delta Dental of Washington  
PO Box 75983  
Seattle, WA 98175-0983

Customer Service Toll-free (800) 554-1907  
Monday – Friday 8 a.m. to 5 p.m., Pacific Standard Time



Willamette Dental is a multi-specialty group practice that practices evidence based dentistry. Members receive their care at a Willamette Dental office with highly credentialed dentists, hygienists and dental assistants. Local offices are located in Richland, Kennewick and Yakima.

This plan offers no annual maximums, no deductibles, no waiting periods and extensive coverage on preventative services. For more information on your plan, please contact Willamette Dental's Customer Service department at 800-360-1909.

Group Number: Z148; Plan ID: HEWT

WILLAMETTE DENTAL			
BENEFIT	CO-PAYMENT	BENEFIT	CO-PAYMENT
Annual Maximum	No annual maximum*	<b>Endodontics and Periodontics</b>	
Deductible	No deductible	Root Canal Therapy – Anterior	\$50
General Office Visit	\$15 per visit	Root Canal Therapy – Bicuspid	\$75
<b>Diagnostic and Preventative Services</b>		Root Canal Therapy – Molar	\$100
Routine and Emergency Exams	Covered at 100%	Ossious Surgery (per Quadrant)	\$140
All X-rays	Covered at 100%	Root Planing (per Quadrant)	Covered at 100%
Teeth Cleaning	Covered at 100%	<b>Oral Surgery</b>	
Fluoride Treatment	Covered at 100%	Routine Extraction (Single Tooth)	Covered at 100%
Sealants	Covered at 100%	Surgical Extraction	\$50
Head and Neck Cancer Screening	Covered at 100%	<b>Orthodontia</b>	
Oral Hygiene Instruction	Covered at 100%	Pre-Orthodontic Service	\$150**
Periodontal Charting	Covered at 100%	Comprehensive Orthodontia	\$1,500
Periodontal Evaluation	Covered at 100%	<b>Miscellaneous</b>	
<b>Restorative Dentistry</b>		Local Anesthesia (Novocain)	Covered at 100%
Fillings (Amalgram)	Covered at 100%	Dental Lab Fees	Covered at 100%
Stainless Steel Crown	Covered at 100%	Nitrous Oxide	\$20 per Visit
Porcelain-Metal Crown	\$120	Specialty Office Visit	\$30 per Visit
<b>Prosthetics</b>		Emergency Office Visit	\$50 per Visit
Complete Upper or Lower Denture	\$170	<b>Out of Area Emergency Care Reimbursement up to \$100</b>	
Bridge (per Tooth)	\$120	*TMJ has a \$1000 annual maximum/\$5000 lifetime maximum	

\*\* Fee credited towards comprehensive orthodontic co-payment if patient accepts treatment plan.

Willamette Dental of Washington, Inc.

This plan provides extensive coverage of services and supplies to prevent, diagnose and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.



## HEWT CONTACT INFORMATION

### UNITEDHEALTHCARE, INC. MEDICAL PLAN

**PHONE:**

Customer Service & Claims Center: 1-866-249-7606  
Pre-Admission Review: 1-866-249-7606

**FAX:**

1-801-567-5499

**ADDRESS:**

PO Box 30555  
Salt Lake City, UT 84130-0555

**WEB:**

[www.unitedhealthcare.com](http://www.unitedhealthcare.com)  
[www.myuhc.com](http://www.myuhc.com)

**WEB Provider Search:**

[www.provider.uhc.com](http://www.provider.uhc.com)

### EXPRESS SCRIPTS, INC. PHARMACEUTICAL SERVICES

**PHONE:**

Retail & Home Delivery Prescription Drugs–  
UnitedHealthcare Plan: 1-800-796-7518

**WEB:**

[www.express-scripts.com](http://www.express-scripts.com)

### GROUP HEALTH OPTIONS, INC.

**PHONE:**

Customer Service & Claims: 1-888-901-4636  
Group Health Mail Order: 1-800-245-7979

**ADDRESS:**

PO Box 34383  
Seattle, WA 98124-1383

**WEB:**

[www.ghc.org](http://www.ghc.org)

**EMAIL:**

[customer@ghc.org](mailto:customer@ghc.org)

### HANFORD EMPLOYEE WELFARE TRUST— BENEFITS ADMINISTRATION

**WEB:**

<http://msa.hanford.gov/hr>

**EMAIL (off-site):**

[Benefits-HEWT@rl.gov](mailto:Benefits-HEWT@rl.gov)

**EMAIL (on-Site):**

^Benefits-HEWT

**Benefits HelpLine:**

509-376-6962

**ADDRESS:**

Hanford Employee Welfare Trust  
Benefits Administration  
PO Box 650, H2-23  
Richland, WA 99352

### MEDICARE ADMINISTRATION

**PHONE:**

Medicare: 1-800-633-4227

### HEALTHY AGES (KADLEC HOSPITAL SPONSORED)

**PHONE:**

Assistance with Medicare Medical Claims  
Monday-Thursday (8:00 am – 4:00 pm): 509-942-2700

### HANFORD RETIREE ASSOCIATION (HRA)

Paul Vinther, President

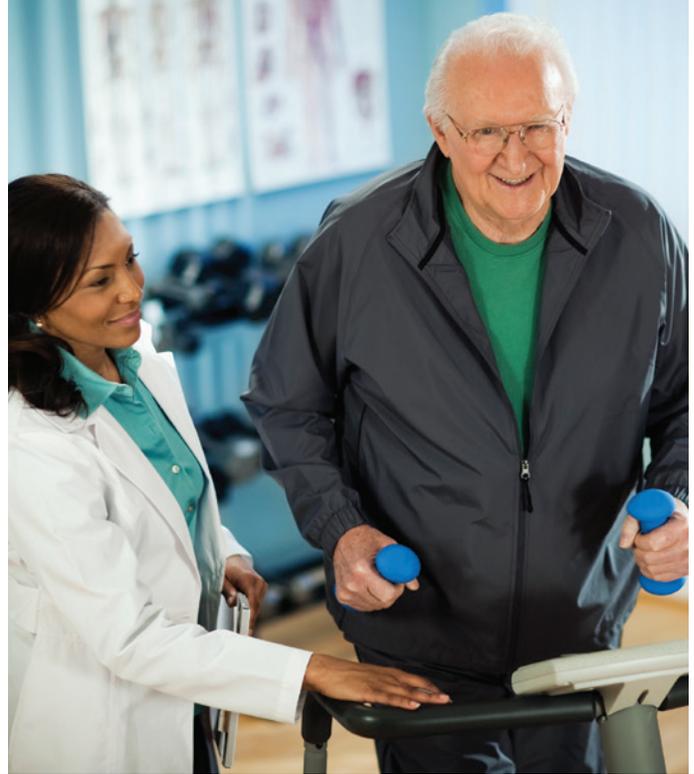
PO Box 768

Richland, WA 99452-0768

509-943-1747

# *Hanford Employee Welfare Trust*

# HEWT



## ABOUT THIS RETIREE BENEFITS OVERVIEW DOCUMENT

The Retiree Benefits Overview describes the highlights of the HEWT benefits in non-technical language. Your specific rights to benefits under the plan are governed solely and in every respect by the official documents and not the information contained in the Retiree Benefits Overview.

If there is any discrepancy between the description of the program as contained within Retiree Benefits Overview and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for more detailed plan information. Any of these benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by the HEWT.

