HEWT

Hanford Employee Welfare Trust

# Benefits Overview

## 2015

# BENEFITS OVERVIEW

**WELCOME!** Your employer is a sponsor of the Hanford Employee Welfare Trust (HEWT) which offers you a comprehensive benefits package.

Depending on the particular plan and/or level of coverage you elect, your employer may pay the full cost of the benefit, may share the cost with you or the total cost may be paid by you. It's an approach to benefits that supports Section 125 of the Internal Revenue Code, which allows you to design your own benefits program.

## BENEFITS Overview

- ***Health Care Benefits***
  Your employer pays the major share of the cost of the health plans, including medical, vision, and dental coverage for you and your family.
- ***Flexible Spending Accounts (FSA)***
  Two FSA's, Health Care and Dependent Day Care, allow you to set aside money on a pre-tax basis for the purpose of paying for IRS-allowable, unreimbursed health care and/or dependent care expenses.
- ***Life & Disability Plans***
  Your employer offers insurance plan options to help replace income for you and your survivors in the event of illness, injury, or death.
- ***Additional Benefits***
  Group Universal Life (GUL) and Long-Term Care (LTC) options are available. The company provides an Employee Assistance Program (EAP).

## 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 medical, dental, and FSA elections for the upcoming plan year.

## Eligibility

Regular full- or part-time employees of one of the HEWT sponsors who are working a minimum of 20 hours per week are eligible to participate in the HEWT benefit plans.

Eligibility begins on your first day of work or when you first become eligible, and ends at termination or when you are no longer eligible.

## Dependent Coverage

In addition to electing coverage for yourself, you can elect to cover eligible dependents. For the medical, dental, and supplemental Life and Personal Accident Insurance, your eligible dependents include your legal spouse, registered domestic partner and eligible children. For additional information regarding dependent eligibility, refer to Page 11.

## Changing Your Benefits

The Internal Revenue Service (IRS) states that employees enrolled in pre-tax benefit plans may only make benefit elections once a year. As such, your medical (including vision and prescription), and dental benefit choices are binding until the next annual enrollment. However, a Qualifying Life Event will allow you to make changes at anytime during the year. For any allowable change, you must notify HEWT Benefits Administration and provide the requested documents within 31 days of the event. The following events are the ONLY reasons you may change your Healthcare benefits during the plan year:

- Marriage/domestic partner certification
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan
- A significant change in your or your spouse's health coverage attributable to your spouse's employment
- Death of a spouse or dependent
- Loss of dependent status
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

Benefit 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 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.

## Group Health Options Plan

Group Health Options provides you with flexibility when seeking all 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 30 percent of remaining covered expenses up to an annual out-of-pocket limit.

Prescription drug benefits through Group Health include retail and home delivery services.

## 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 out-of-network services with somewhat higher deductibles and co-insurance. The plan includes a full spectrum of covered services and direct access to specialists without needing to obtain a referral.

Under the UnitedHealthcare PPO plan, Express Scripts, Inc will manage your prescription drug benefit. Retail and home delivery services are available.

# HEWT GroupHealth Options Medical Plan

## effective 1/1/2015

| Benefits | Inside Network | Out-of-Network |
|---|---|---|
| **Plan Deductible—Per Calendar Year (PCY)** | Individual deductible: $150<br>Family deductible: $300 | Individual deductible: $250<br>Family deductible: $500 |
| **Individual Deductible Carryover** | 4th quarter carryover applies. | 4th quarter carryover applies. |
| **Plan Co-insurance** | Plan pays 80%, you pay 20%. | Plan pays 70%, you pay 30% of the Usual, Customary and Reasonable (UCR) charges. |
| **Out-Of-Pocket Limit (PCY)** | Individual out-of-pocket limit: $1,150<br>Family out-of-pocket limit: $2,300 | Individual out-of-pocket limit: $2,875<br>Family out-of-pocket limit: $5,750 |
| **Pre-existing Condition (PEC) Waiting Period** | No waiting period for a PEC. | No waiting period for a PEC. |
| **Lifetime Maximum** | No lifetime maximum. | No lifetime maximum. |
| **Outpatient Services** (Office Visits) | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Hospital Services** | **Inpatient Services:** Deductible and co-insurance apply.<br>**Outpatient Surgery:** Deductible and co-insurance apply. | **Inpatient Services:** Deductible and co-insurance apply.<br>**Outpatient Surgery:** Deductible and co-insurance apply. |
| **Prescription Drugs** (Some Injectible Drugs may be Covered under Outpatient Services) | **Retail: (for a 30-day supply)**<br>Generic preferred: $20<br>Brand name preferred: $40<br>Non-preferred: $60 | **Retail: (for a 30-day supply)**<br>Generic preferred: $25<br>Brand name preferred: $45<br>Non-preferred: $65 |
| **Prescription Mail Order** | 2x prescription cost share per 90 day supply. | Not covered. |
| **Acupuncture** | Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan. Deductible and co-insurance apply. | No visit limit.<br>Deductible and co-insurance apply. |
| **Ambulance Services** | Plan pays 80%, you pay 20%.<br>Not subject to deductible. | Same as in-network. |
| **Chemical Dependency** | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Devices, Equipment and Supplies**<br>Durable medical equipment, Orthopedic appliances, Post-mastectomy bras limited to two (2) every six (6) months, Ostomy supplies, Prosthetic devices | Plan pays 80%, you pay 20%.<br>Not subject to deductible. | Plan pays 80%, you pay 20%.<br>Deductible applies. |
| **Diabetic Supplies** | Insulin, needles, syringes lancets, and test strips–see Prescription drugs. External insulin pumps, blood glucose monitors and supplies–see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered in full. | Insulin, needles, syringes lancets, and test strips–see Prescription drugs. External insulin pumps, blood glucose monitors and supplies–see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered in full. |
| **Diagnostic Lab and X-ray Services** | **Inpatient:** Covered under Hospital Services.<br>**Outpatient:** Deductible and co-insurance apply.<br>High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services. | **Inpatient:** Covered under Hospital Services.<br>**Outpatient:** Deductible and co-insurance apply.<br>High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services. |
| **Emergency Services** (Co-pay Waived if Admitted) | $125 co-pay. Deductible and co-insurance apply. | $125 co-pay. In-network deductible and in-network co-insurance apply. |

# HEWT GroupHealth Options Medical Plan (cont'd)

## effective 1/1/2015

| Benefits | Inside Network | Out-of-Network |
|---|---|---|
| **Hearing Exams (Routine)** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Hearing Hardware** | $400 per ear every 36 months. | Benefit shared with in-network. |
| **Home Health Services** | Covered in full. No visit limit. | Deductible and co-insurance apply. No visit limit. |
| **Hospice Services** | Covered in full. No visit limit. | Deductible and co-insurance apply. No visit limit. |
| **Infertility Services** | 50% diagnostic services & drugs, deductible and co-insurance apply. | Benefits shared with in-network. |
| **Manipulative Therapy** | Self-referred up to 20 visits per calendar year. Deductible and co-insurance apply. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Massage Services** | See Rehabilitation services. | See Rehabilitation services. |
| **Maternity Services** | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Mental Health** | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Naturopathy Services** | Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan. Deductible and co-insurance apply. | Deductible and co-insurance apply. No visit limit. |
| **Obesity-Related Surgery (Bariatric)** | Covered at cost shares when medical criteria is met. | Not covered. |
| **Organ Transplants**<br>Donor Search & Harvest | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Preventive Care**<br>Well-care physicals, immunizations, Pap smear exams, mammograms | Covered in full. | Deductible and co-insurance apply. |
| **Rehabilitation Services**<br>(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. | **Inpatient:** 60 days per condition per calendar year, deductible and co-insurance apply.<br>**Outpatient:** 60 visits per condition per calendar year.<br>Deductible and co-insurance apply. | **Inpatient:** Day limit shared with in-network. Deductible and co-insurance apply.<br>**Outpatient:** Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Skilled Nursing Facility** | Up to 60 days per calendar year, deductible and co-insurance apply. | Day limit shared with in-network benefit, deductible and co-insurance apply. |
| **Sterilization (Vasectomy, Tubal Ligation)** | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | **Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Temporomandibular Joint (TMJ) Services** | $1,000 per calendar year; $5,000 lifetime max.<br>**Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. | Shared with in-network.<br>**Inpatient:** Deductible and co-insurance apply.<br>**Outpatient:** Deductible and co-insurance apply. |
| **Tobacco Cessation**<br>See Pharmacy Benefit for Associated Drug Coverage | Quit for Life Program–covered in full. | Not covered. |
| **Routine Vision Care**<br>(1 Visit Every 12 Months) | Deductible and co-insurance waived. | Deductible and co-insurance apply. |
| **Optical Hardware**<br>Lenses, including contact lenses and frames | Not subject to deductible and co-insurance. Members age 19 and over limited to $165 per 24 months. Members under age 19 limited to 1 pair of frames and lenses per year. | Benefit limits shared with in-network. |

# UnitedHealthcare PPO Medical Plan
## effective 1/1/2015

| Benefits | Inside Network | Out-of-Network |
|---|---|---|
| **Plan Deductible—Per Calendar Year (PCY)** | Individual deductible: $325<br>Family deductible: $650 | Individual deductible: $425<br>Family deductible: $850 |
| **Plan Co-insurance** | Plan pays 80%, you pay 20% | Plan pays 60%, you pay 40% |
| **Out-Of-Pocket Limit (PCY) (RX excluded)** | Individual out-of-pocket limit: $1,350<br>Family out-of-pocket limit: $2,700 | Individual out-of-pocket limit: $3,500<br>Family out-of-pocket limit: $7,000 |
| **Lifetime Maximum** | No lifetime maximum. | No lifetime maximum. |
| **Office Visit/Urgent Care** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Outpatient Services** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Hospital Services Inpatient And Outpatient** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Prescription Drugs**<br>Covered through Express Scripts, Inc. | **Retail: (for a 30-day supply)**<br>Generic: $10<br>Brand name preferred: $35<br>Brand name non-preferred: $50<br>**Mail Order: (for a 90-day supply)**<br>Generic: $20<br>Brand name preferred: $70<br>Brand name non-preferred: $100<br>**Specialty Drug:** 20% co-insurance, at a minimum of $65 (or actual cost of the drug if less), maximum of $150.<br>**Out-of-Pocket Limit:** $1,750 | Contact Express Scripts, Inc. for reimbursement details |
| **Acupuncture** | Limited to 20 visits per calendar year. Deductible and co-insurance apply. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Ambulance (True Emergency)** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Chemical Dependency** | See Summary of Benefits and Coverage. | See Summary of Benefits and Coverage. |
| **Chiropractic Services** | Limited to 20 visits every calendar year. Deductible and co-insurance apply. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Devices, Medical Equipment DME), and Supplies (Prosthetics)** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Diagnostic Laboratory and X-Ray Services (Outpatient)** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Emergency Services** | $125 co-pay per visit. Deductible and co-insurance apply. | $125 co-pay per visit. In-network deductible and in-network co-insurance apply. |

# UnitedHealthcare PPO Medical Plan (cont'd)

## effective 1/1/2015

| Benefits | Inside Network | Out-of-Network |
|---|---|---|
| **Hearing Exam** | Limited to one exam every 12 months. Deductible and co-insurance apply. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Hearing Aids** | Limited to $300 every 36 months. Deductible and co-insurance apply. | Dollar limit shared with in-network. Deductible and co-insurance apply. |
| **Home Health** | Limited to 40 visits per calendar year. Deductible and co-insurance apply. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Infertility Services** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Maternity Services** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Mental Health** | See Summary of Benefits and Coverage. | See Summary of Benefits and Coverage. |
| **Naturopathy Services** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Obesity Surgery** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Organ Transplants** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Preventive Care** | Covered at 100%. Not subject to deductible. | Deductible and co-insurance apply. |
| **Rehabilitation Services (Occupational, Speech and Physical Therapies)** | Limits per calendar year: Physical, Speech, Occupational - 30 visits; Cardiac - 20 visits; Pulmonary - 20 visits. | Visit limit shared with in-network. Deductible and co-insurance apply. |
| **Skilled Nursing** | Limited to 60 days per calendar year. Deductible and co-insurance apply. | Days limit shared with in-network. Deductible and co-insurance apply. |
| **Sterilization (Vasectomy, Tubal Ligation)** | Deductible and co-insurance apply. | Deductible and co-insurance apply. |
| **Vision Care** | **Annual Exam:** $10 co-pay<br>**Optical Hardware:** Lenses covered every 12 months: $10 co-pay. Frames every 24 months. | **Annual Exam:** 85% of contracted charges. Maximum reimbursement in a calendar year is $165 for exam and hardware combined.<br>**Optical Hardware:** Frames and lenses every other year up to $165 total, including exam. |

# Dental Benefits

The HEWT offers two dental providers for dental coverage, Delta Dental of Washington and Willamette Dental. The plan you select will depend on the needs of you and your family.

Delta Dental of Washington provides the freedom to receive care from a participating Delta PPO Network dentist or from a dentist of your choosing. Services provided by Delta Dental are based upon a negotiated fee schedule and not the dentist's actual fee.

## HEWT–Buy-Up Plan

Delta Dental PPO
Program: #00522

| Delta Dental of Washington Plan Summary | Payment Levels | | |
|---|---|---|---|
| | Delta Dental PPO Dentist | Non-PPO Dentist | Out-of-Network Dentist |
| **Class I - Diagnostic & Preventive**<br>Exams, prophylaxis, fluoride, x-rays, sealants | 80% | 60% | 60% |
| **Class II - Restorative**<br>Restorations, endodontics, periodontics, oral surgery | 70% | 60% | 60% |
| **Class III – Major**<br>Crowns, dentures, partials, bridges, and implants | 50% | 40% | 40% |
| **Annual Maximum Per Person**<br>Benefit period: (Jan 1 - Dec 31) | $1,500 | $1,500 | $1,500 |
| **Deductible (Waived on Class I)**<br>Per person/per benefit period<br>Annual family maximum | $50<br>$100 | $50<br>$100 | $50<br>$100 |
| **Orthodontia**<br>Adults & dependent children<br>Lifetime maximum per enrollee | 50%<br>$1,200 | 50%<br>$1,200 | 50%<br>$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*

*Please Note: This is a brief summary of benefits only and does not constitute a contract. Please feel free to call Delta Dental's 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

# Dental Benefits (cont'd)

Willamette Dental is a multi-specialty group 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 in Richland 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 1-855-4DENTAL (1-855-433-6825).

Group Number: Wa79; Plan ID: HEWT

## Willamette Dental

| Benefit | Co-Payment |
|---|---|
| **Annual Maximum** | No annual maximum* |
| **Deductible** | No deductible |
| **General Office Visit** | $20 per visit |
| **Diagnostic and Preventative Services** | |
| **Routine and Emergency Exams** | Covered at 100% |
| **All X-rays** | Covered at 100% |
| **Teeth Cleaning** | Covered at 100% |
| **Fluoride Treatment** | Covered at 100% |
| **Sealants** | Covered at 100% |
| **Head and Neck Cancer Screening** | Covered at 100% |
| **Oral Hygiene Instruction** | Covered at 100% |
| **Periodontal Charting** | Covered at 100% |
| **Periodontal Evaluation** | Covered at 100% |
| **Restorative Dentistry** | |
| **Fillings (Amalgam)** | Covered at 100% |
| **Stainless Steel Crown** | Covered at 100% |
| **Porcelain-Metal Crown** | $120 |
| **Prosthetics** | |
| **Complete Upper or Lower Denture** | $170 |
| **Bridge (per Tooth)** | $120 |

| Benefit | Co-Payment |
|---|---|
| **Endodontics and Periodontics** | |
| **Root Canal Therapy – Anterior** | $50 |
| **Root Canal Therapy – Bicuspid** | $75 |
| **Root Canal Therapy – Molar** | $100 |
| **Ossious Surgery (per Quadrant)** | $140 |
| **Root Planing (per Quadrant)** | Covered at 100% |
| **Oral Surgery** | |
| **Routine Extraction (Single Tooth)** | Covered at 100% |
| **Surgical Extraction** | $50 |
| **Orthodontia** | |
| **Pre-Orthodontic Service** | $150** |
| **Comprehensive Orthodontia** | $1,500 |
| **Miscellaneous** | |
| **Local Anesthesia (Novocain)** | Covered at 100% |
| **Dental Lab Fees** | Covered at 100% |
| **Nitrous Oxide** | $10 per Visit |
| **After Hours Emergency Care** | $20 per Visit |

**Out of Area Emergency Care Reimbursement up to $100**

*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.

# Flexible Spending Accounts—FSAs

Your employer allows you to direct a portion of your pay through pre-tax payroll deductions to a Health Care and/or Dependent Care FSA. The FSAs are administered by UnitedHealthcare.

- ***Health Care FSA (HC FSA)***

  You may contribute up to $2,550 per plan year into a Health Care FSA. You can begin to use all or some of the total amount elected as soon as the plan year begins.

  These pre-tax funds may be used to pay for IRS-allowed health care expenses not reimbursed by your medical and/or dental plans. Eligible expenses include deductibles, co-insurance, co-payments, vision and hearing care expenses.

  If by the end of the plan year you do not use all of the money in your HC FSA, you may carryover up to $500 of the remaining balance to your HC FSA the following plan year.

- ***Dependent Care FSA (DC FSA)***

  You may contribute up to $5,000 per plan year ($2,500 if you are married and both you and your spouse elect the benefit) into a Dependent Care FSA.

  Only the amount contributed to the account at the time of a claim is available for reimbursement.

  Eligible expenses include, but are not limited to, payments to daycare centers, preschool costs (up to, but not including, kindergarten), after school care and elderly care.

  If by the end of the plan year you have not used all of the money in your DC FSA, IRS Regulations require you to forfeit the remaining balance.

# Life and Disability Plans

Life and Disability plans, as administered by CIGNA, are an important part of your financial security and that of your family's.

- ***Basic Life and Accidental Death and Dismemberment Insurance (for you)***

  All eligible employees, bargaining and non-bargaining, can elect basic life insurance equal to two times their annual base salary. The employee cost of this benefit is .2% of their monthly base salary. Non-bargaining employees have the option to elect basic life insurance equal to one times their annual base salary. There is no employee cost for this benefit.

  When you reach age 65 your life insurance benefit will be reduced by 8%. Each year thereafter, it will be reduced by that same dollar amount until the benefit reaches one-half of the life insurance benefit you had on the day before your 65th birthday.

  With the election of basic life insurance, Accidental Death & Dismemberment (AD&D) of one times the annual base salary is provided at no cost to the employee.

- ***Dependent Life Insurance (for your family)***

  This plan offers life insurance for eligible dependents. Employee premium rates are based on the elected coverage level. The employee must be enrolled in basic life insurance to choose for this benefit. Spouse life insurance elections can be no more than 50% of your basic life benefit.

- ***Personal Accident Insurance (for you and your family)***

  Your employer offers accidental death and dismemberment coverage for the employee and family, up to 10x the annual base salary, to a maximum of $750,000. Employee premium rates are based on the elected coverage level.

- ***Business Travel Insurance (for you)***

  Your employer provides benefits for accidental death or dismemberment which occurs while traveling on Company approved business. There is no employee cost for this benefit.

- ***Short-Term Disability (for you)***

  Short-Term Disability pays a weekly benefit of 60% of basic earnings up to a maximum of $4,000 per week when you are unable to work due to a non-work related injury or illness. The duration of this benefit is 180 days, starting from when you first became disabled. You pay for 50% of the monthly short-term disability premiums with after tax dollars. The cost of the program is based on your individual salary.

- ***Long-Term Disability (for you)***

  If you remain disabled for 180 consecutive calendar days due to any one disability, injury, or illness, you will be eligible to apply for Long-Term Disability benefits. The monthly benefit is 50% of your basic earnings, to a maximum of $4,000 per month. There is no employee cost for this benefit.

# Dependent Eligibility

As discussed on Page 2 of this overview, eligible dependents may be covered by your medical, dental, and supplemental Life and Personal Accident plans. Below is a summary of the eligibility requirements for dependents, listed by plan type. For more information refer to the applicable Summary Plan Description or Certificate.

## MEDICAL AND DENTAL PLANS

**Important:** No person can be covered more than once in a HEWT medical/vision or dental plan. For example, an individual cannot enroll as an employee participant, and also be covered as a dependent of another HEWT employee or retiree.

**Your eligible dependents include:**

- *Your legal spouse*, as recognized by Washington State law.
- *Your domestic partner*, as recognized by Washington State (one partner must be at least 62 years old).
- *Your eligible children* are: natural children; legally adopted children; stepchildren; and other children where the employee or spouse has legal guardianship, custody, or conservatorship evidenced by a court order.

**Dependent children under the Medical insurance plans Group Health and UnitedHealthcare:**
*Your children*, under age 26 are eligible, unless in the active military service. The coverage for an adult child will run through the month they reach their 26th birthday.

**Dependent children under Willamette Dental:**
*Your children*, under age 26 are eligible, unless in the active military service. The coverage for an adult child will cease when they reach their 26th birthday.

**Dependent children under Delta Dental:**
*Your unmarried children* up to age 23. Children between age 19 and 23 are eligible if you provide over 50 percent of their support and maintenance and they are not:

- in the active military service, or
- employed full-time, or
- eligible for any other group dental benefits through their employer

## DEPENDENT LIFE INSURANCE

- *Your legal spouse*, as recognized by Washington State law.
- *Your domestic partner*, as recognized by Washington State (one partner must be at least 62 years old).
- *Your eligible children* are: unmarried, 15 days of age but less than 23 years old; child born to or legally adopted by you, or stepchildren living with you.

## PERSONAL ACCIDENT INSURANCE (PAI)

- *Your legal spouse*, as recognized by Washington State law.
- *Your domestic partner*, as recognized by Washington State (one partner must be at least 62 years old).
- *Your eligible children* are: unmarried, from live birth to 23 years old; child born to or legally adopted by you, or stepchildren living with you, or child for whom the Employee is a legal guardian as long as the child resides with the employee and depends on the employee for financial support (the employee is eligible to claim the dependent on income tax returns).

## DEPENDENT COVERAGE BEYOND PLAN LIMITING AGE FOR DISABLED CHILDREN

Your disabled children may continue coverage if medically certified as disabled just prior (60 days) to the plans limiting ages. A disabled child is defined as a child:

1. not able to be self-supporting due to disability, and
2. principally dependent on the employee for support, and
3. covered as a dependent prior to limiting age, and
4. with proof of his condition and dependence submitted prior to limiting age

Additional conditions may apply. Proof that the child meets the conditions of incapacity and dependency must be provided to HEWT Benefits Administration prior to the child reaching the plans limiting age.

***It is the sole responsibility of the employee to verify current dependent eligibility (including disabled children). Any change in eligibility status must be reported to HEWT Benefits Administration immediately.***

***Should an ineligible dependent's coverage need to be cancelled retroactively, the employee may be held responsible for any paid services for the ineligible dependent and there may not be a refund of premiums.***

# Additional Benefits

## Group Universal Life

Group Universal Life is an optional, employee paid insurance. It provides portable coverage for employees and families. Additionally, this program offers a Cash Accumulation Fund. This program is currently underwritten by CIGNA and administered by Marsh. The cost for Group Universal Life is based on the amount of coverage and the covered individual's age. Your employer provides the option of an automatic payroll deduction.

## Long-Term Care

Long-Term Care is an optional, employee paid insurance. Long-Term Care services may include assistance with home health care, community-based care, and nursing home care. Coverage can be purchased for the employee, spouse, parents or grandparents. Premiums are based upon entry age. Your employer provides the option of an automatic payroll deduction.

## Employee Assistance Program (EAP)

The EAP is available to all employees, and those living in your household. The program is provided at no cost to you, is available 24 hours a day. It offers confidential counseling as well as tools and resources to help you manage the stress and strain of balancing personal needs with work responsibilities. The EAP can provide assistance with relationship problems, substance abuse, stress, grief, emotional difficulties and much more. To access services call United Behavioral Health at 1-800-788-5614, and identify yourself as a participant under the HEWT (Hanford Employee Welfare Trust). Additionally, information and resources can also be found by visiting LifeHelp's website at www.liveandworkwell.com. You will need to use the access code 702633.

# About this Document

The 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 plan documents and not the information contained in the Benefits Overview.

If there is any discrepancy between the description of the program as contained within 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 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.

HEWT Hanford Employee Welfare Trust



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