HEWT

Hanford Employee Welfare Trust

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, 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.

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

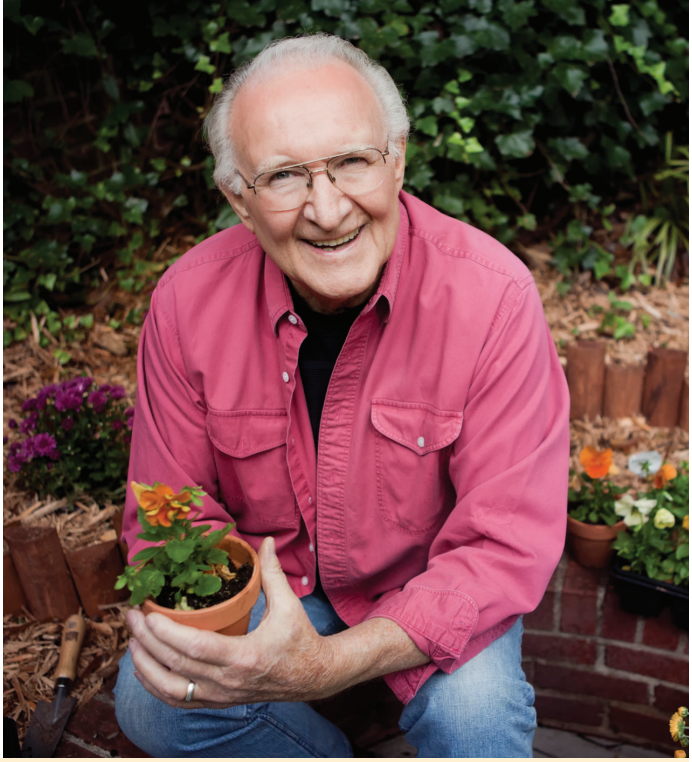
In addition to electing coverage for yourself, you can elect to continue coverage for your eligible dependents. For the medical and prescription drug plans, your eligible dependents include your legal spouse or domestic partner (if certain criteria are met) and children who were covered at the time of 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 annual 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 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 GroupHealth Options Medical Plan

Group Number: 6813900 Ref: RQ-99149

Benefits	Inside Network	Out-of-Network
Plan Deductible—Per Calendar Year (PCY)	Individual deductible: $200 Family deductible: $600	Individual deductible: $400 Family deductible: $1,200
Individual Deductible Carryover	4th quarter carryover applies.	4th quarter carryover applies.
Plan Co-insurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% of the Usual, Customary and Reasonable (UCR) charges.
Out-Of-Pocket Limit	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $6,000	Individual out-of-pocket limit: $6,000 Family out-of-pocket limit: $18,000
Pre-existing Condition (PEC) Waiting Period	No PEC.	No PEC.
Lifetime Maximum	$2 million.	$2 million.
Outpatient Services (Office Visits)	No co-pay. Deductible and co-insurance apply.	$5 co-pay. Deductible and co-insurance apply.
Hospital Services	**Inpatient Services:** Deductible and co-insurance apply. **Outpatient Surgery:** No co-pay. Deductible and co-insurance apply.	**Inpatient Services:** Deductible and co-insurance apply. **Outpatient Surgery:** $5 co-pay. Deductible and coninsurance apply.
Prescription Drugs (Some Injectible Drugs may be Covered under Outpatient Services)	**Retail: (for a 30-day supply)** Generic preferred: $20 Brand name preferred: $40 Brand name non-preferred: $60 **Mail Order: (for a 90-day supply)** Generic preferred: $40 Brand name preferred: $80 Brand name non-preferred: $120	Out of Network Retail Co-pays $25/$45/$65
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan. No co-pay. Deductible and co-insurance apply.	$5 co-pay. Deductible and co-insurance apply.
Ambulance Services	Plan pays 80%, you pay 20%.	Same as in-network.
Chemical Dependency	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. Deductible and co-insurance apply.
Devices, Equipment and Supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%. See Certificate of Coverage for additional information and requirements.	Covered at 80%. Deductible applies. See Certificate of Coverage for additional information and requirements.
Diabetic Supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic Lab and X-ray Services	**Inpatient:** Covered under Hospital Services. **Outpatient:** Deductible and co-insurance apply. 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. **Outpatient:** Deductible and co-insurance apply. 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.

HEWT GroupHealth Options Medical Plan (cont'd)

Group Number: 6813900 Ref: RQ-99149

Benefits	Inside Network	Out-of-Network
Emergency Services (Co-pay Waived if Admitted)	$150 co-pay. Deductible and co-insurance apply.	$150 co-pay. In-network deductible and co-insurance apply.
Hearing Exams (Routine)	No co-pay. Deductible and co-insurance apply.	$5 co-pay. Deductible and co-insurance apply.
Hearing Hardware	Not covered.	Not covered.
Home Health Services	Covered in full. No visit limit.	No visit limit. Deductible and co-insurance apply.
Hospice Services	Covered in full.	Deductible and co-insurance apply.
Infertility Services	Not covered.	Not covered.
Manipulative Therapy	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.
Massage Services	See Rehabilitation services.	See Rehabilitation services.
Maternity Services	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. Deductible and co-insurance apply.
Mental Health	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. 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. No co-pay. Deductible and co-insurance apply.	$5 co-pay. Deductible and co-insurance apply.
Obesity-Related Surgery (Bariatric)	Not covered.	Not covered.
Organ Transplants Donor Search & Harvest	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. Deductible and co-insurance apply.
Preventive Care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full.	Not covered. Routine mammograms: Deductible and co-insurance apply.
Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy) and Neurodevelopmental Therapy Visits are a Total of Combined Therapy Visits Per Calendar Year.	**Inpatient:** 60 days per calendar year. Deductible and co-insurance apply. **Outpatient:** 60 visits per calendar year. No co-pay. Deductible and co-insurance apply.	**Inpatient:** Day limits shared with in-network. Deductible and co-insurance apply. **Outpatient:** Visit limits shared with in-network. $5 co-pay. Deductible and co-insurance apply.
Skilled Nursing Facility	Up to 60 days per calendar year, deductible and co-insurance apply.	Day limits shared with in-network benefit, deductible and co-insurance apply.
Sterilization (Vasectomy, Tubal Ligation)	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. Deductible and co-insurance apply.
Temporomandibular Joint (TMJ) Services	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** No co-pay. Deductible and co-insurance apply.	**Inpatient:** Deductible and co-insurance apply. **Outpatient:** $5 co-pay. Deductible and co-insurance apply.
Tobacco Cessation See Pharmacy Benefit for Associated Drug Coverage	Quit for Life Program–covered in full.	Applicable cost shares apply.
Routine Vision Care (1 Visit Every 12 Months)	No co-pay. Deductible and co-insurance waived.	Not covered.
Optical Hardware Lenses, including contact lenses and frames	Not covered.	Not covered.

UnitedHealthcare PPO Medical Plan

Plan : #702633

Benefits	Inside Network	Out-of-Network
Plan Deductible - Per Calendar Year (PCY)	Individual deductible: $400 Family deductible: $800	Individual deductible: $600 Family deductible: $1,200
Plan Co-insurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Out-Of-Pocket Limit	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
Lifetime Maximum	$1,500,000 combined in- and out-of-network	$1,500,000 combined in- and out-of-network
Office Visit/Urgent Care	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Outpatient Services	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Hospital Services Inpatient And Outpatient	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
Prescription Drugs (Express Scripts, Inc.)	Individual out-of-pocket limit: $1,500 Family out-of-pocket limit: $2,500 **Retail: (for a 30-day supply)** Generic: $15 Brand name preferred: $35 Brand name non-preferred: $50 **Mail Order: (for a 90-day supply)** Generic: $30 Brand name preferred: $70 Brand name non-preferred: $100 Specialty drug: 20% co-pay minimum $65 maximum $150	Contact Express Scripts, Inc. for reimbursement details
Acupuncture	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.
Ambulance (True Emergency)	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 80%, you pay 20%, deductible applies.
Chemical Dependency	**Inpatient:** Plan pays 80%, you pay 20%, deductible applies after a $250 co-pay for inpatient services **Outpatient:** Plan pays 80%, you pay 20%, deductible applies.	**Inpatient:** Plan pays 60%, you pay 40%, deductible applies after $250 co-pay for inpatient services **Outpatient:** Plan pays 60%, you pay 40%, deductible applies.
Chiropractic Services	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.
Devices, Equipment and Supplies (DME Prosthetics)	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.

UnitedHealthcare PPO Medical Plan (cont'd)

Plan : #702633

Benefits	Inside Network	Out-of-Network
Diagnostic Lab and X-Ray Services (Outpatient)	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Emergency Services	$150 co-pay per visit, then Plan pays 80%, you pay 20%, and deductible applies.	$150 co-pay per visit, then Plan pays 80%, you pay 20%, and deductible applies.
Hearing Exam	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.
Hearing Aids	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.
Home Health	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.
Infertility Services	Not Covered.	Not Covered.
Maternity Services	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Mental Health	**Inpatient:** Plan pays 80%, you pay 20%, deductible applies after $250 co-pay for inpatient services. **Outpatient:** Plan pays 80%, you pay 20%, deductible applies.	**Inpatient:** Plan pays 60%, you pay 40%, deductible applies after $250 co-pay for inpatient services. **Outpatient:** Plan pays 60%, you pay 40%, deductible applies.
Naturopathy Services	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Obesity Surgery	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Organ Transplants	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Preventive Care	Covered at 100%.	Plan pays 60%, you pay 40%, deductible applies.
Rehabilitation Services (Occupational, Speech and Physical Therapies)	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.
Skilled Nursing	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.
Sterilization (Vasectomy, Tubal Ligation)	Plan pays 80%, you pay 20%, deductible applies.	Plan pays 60%, you pay 40%, deductible applies.
Vision Care	Not Covered.	Not Covered.
Hospice	Covered in full.	Deductible and and co-insurance apply.

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
Class I - Diagnostic & Preventive Exams, prophylaxis, fluoride, x-rays, sealants	80%	60%	60%
Class II - Restorative Restorations, endodontics, periodontics, oral surgery	70%	60%	60%
Class III – Major Crowns, dentures, partials, bridges, and implants	50%	40%	40%
Annual Maximum Per Person Benefit period: (Jan 1 - Dec 31)	$1,500	$1,500	$1,500
Deductible (Waived for Class I) Per person/per benefit period Annual family maximum	$50 $100	$50 $100	$50 $100
Orthodontia 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

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 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
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	**$20 per Visit**
Specialty Office Visit	**$30 per Visit**
Emergency Office Visit	**$50 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.

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
www.myuhc.com

WEB Provider Search:
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

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

EMAIL:
customer@ghc.org

Hanford Employee Welfare Trust—Benefits Administration

WEB:
www.hanford.gov/hr

EMAIL (off-site):
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

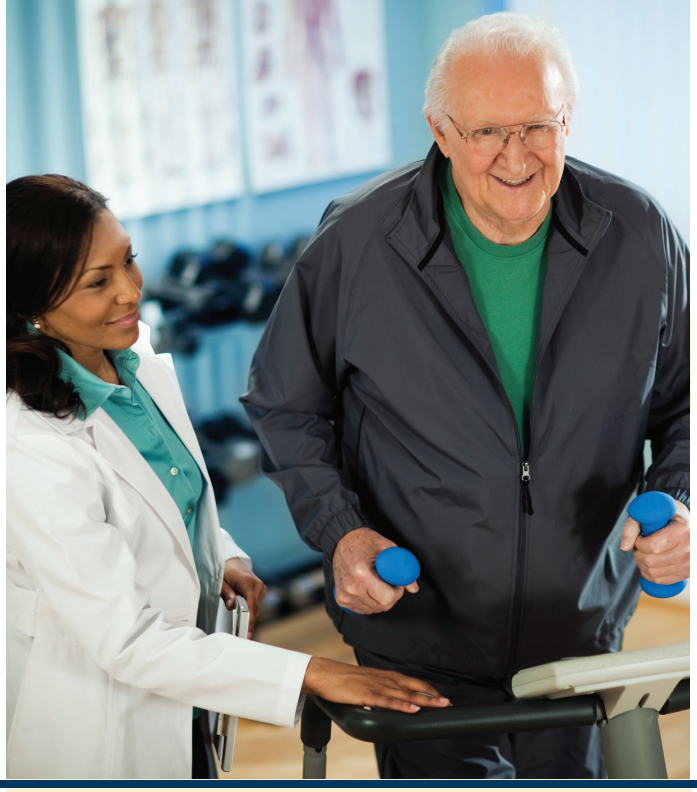
Paul Vinther, President
PO Box 768
Richland, WA 99452-0768
509-943-1747

Willis Towers Watson OneExchange

(Over-Age 65 Provider) 1-888-864-0764
www.medicare.oneexchange.com/HEWT

HEWT

Hanford Employee Welfare Trust



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.