

**Calendar Year 2005 Benefits Comparison – Retirees Medicare Eligible
Hanford Employee Welfare Trust (HEWT)**

BENEFITS			UnitedHealthcare PPO Medical Plan For Retirees Medicare Eligible (Over Age 65)
<u>Annual Out-of-Pocket Maximum</u>	\$2,000/\$6,000	In Network: \$2,000/\$6,000 Out-of-Network: \$6,000/\$18,000	\$750 per person, including Deductible
<u>Deductible – In Network Out-of-Network</u>	Covered in full. Not Applicable	In Network Covered in full Out-of-Network \$100 Medicare Deductible	\$100 per person per year
<u>Co-insurance In Network Out-of-Network</u>	Covered in full Not Applicable	Covered in full	85% / 15% for most services
<u>Office Visit/Urgent Care</u>	Covered in full	In Network Covered in full Out-of-Network: Medicare coverage Only	85% / 15% for most services
<u>Preventive care</u>	Covered in Full	In Network Covered in Full Out-of-Network Medicare Coverage Only	
<u>Lab & X-Ray Services</u>	Covered in full	In Network Covered in full Out-of-Network Medicare Coverage Only	85% / 15% for most services
<u>Chiropractic Care</u>	Covered in full	In Network Covered in full Out-of-Network Medicare Coverage only	85% / 15% for most services
<u>Prescription Drugs</u>	\$15 Generic/\$30 Brand 30-day Supply <u>Mail Order</u> \$30 Generic/\$60 Brand 90-day Supply (subject to formulary)	In Network \$15 Generic/\$30 Brand 30-day Supply <u>Mail Order</u> \$30 Generic/\$60 Brand 90-day Supply and (subject to formulary) Out-of-Network \$20 Generic/\$35 Brand 30-day Supply	(Provided by Express Scripts, Inc.) <u>Retail:</u> (up to a 30-day Supply): Generic \$7 Co-pay Brand Name Preferred \$25 Co-pay Brand, Non-preferred \$40 Co-pay <u>Mail Order</u> (up to 90-day supply) Generic \$14 Co-pay Brand Name Preferred \$50 Co-pay Brand, Non-preferred \$80 Co-pay

*85% indicates amount covered by the insurance company according to the contract that is considered reasonable and customary; 15% indicates amount covered by claimant.

Note: Benefits are covered only when Medicare criteria is met. This is a brief comparison only, not the contract. For more detailed information, please refer to the summary plan description of benefits and/or contract.

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<u>Inpatient Hospital</u>	Covered in full	In Network Covered in full Out-of-Network Covered in full	85% / 15% \$100 per admission.
<u>Outpatient Hospital</u>	Covered in full	In Network Covered in full Out-of-Network Medicare Coverage only	85% / 15%
<u>Emergency Care</u>	Covered in full (When medicare criteria is met.)	In Network Covered in full Out-of-Network: Medicare coverage only	85% / 15% \$75 Co-pay each visit
<u>Ambulance</u>	80/20% Co-insurance (not subject to deductible)	In Network 80/20% Co-ins Out-of-Network 80/20% Co-ins (not subject to deductible)	In- and Out-of-Network: Emergency: 80/20% Non-emergency: 60/40%
<u>Durable Medical Equipment & Supplies</u>	Covered in full	In Network Covered in full Out-of-Network Medicare Coverage only	85% / 15%
<u>Rehabilitation Services</u>	Covered in full	In Network Covered in full Out-of-Network Covered in full Inpatient only	85% / 15%

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<u>Mental Health Services</u>	Covered in full	In Network Covered in full Out-of-Network Medicare Coverage only Inpatient Covered in full	50%
<u>Chemical Dependency</u>	Covered in full	In Network Covered in full Out-of-Network Outpatient Medicare Coverage only Inpatient Covered in full	50%
<u>Routine Eye Exam and Refractions</u>	Covered in full	In Network Covered in full Out-of-Network: Covered in full	Not covered.
<u>Optical Hardware</u>	Not covered.	Not covered.	Not covered.

Note:

This document is intended only to provide a general comparison of the major provisions of the three medical plans offered in Calendar Year 2005 to retirees who retired on or before July 01, 1987, and their eligible dependents. It is not the Plan contract. It is provided as a tool to help retirees review their medical plan options. For details of the plans, consult the applicable Summary Plan Description or Certificate of Coverage, or contact Group Health Cooperative or UnitedHealthcare directly.