



washington river
protection solutions

PO Box 850
Richland, WA 99352

October 26, 2015

2015-LR-240

Mr. David E. Molnaa, President
Hanford Atomic Metal Trades Council
Post Office Box 898
Richland, WA 99352

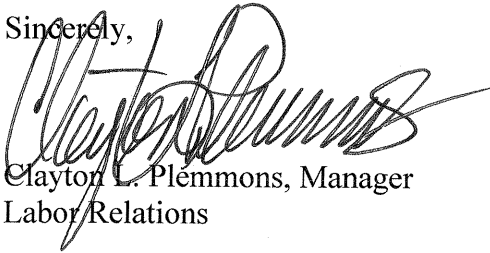
Dear Mr. Molnaa,

2015 WASHINGTON RIVER PROTECTION SOLUTIONS, LLC/HANFORD ATOMIC METAL TRADES COUNCIL WAGE RE-OPENER AGREEMENT

Attached for your concurrence are the documents representing the agreement reached between Washington River Protections Solutions, LLC (WRPS) and the Hanford Atomic Metal Trades Council (HAMTC) during the recent Wage Re-Opener Negotiations.

WRPS appreciates the efforts of HAMTC in reaching an agreement that will provide stability as we move forward in completing the work scope under our contract with the Department of Energy.

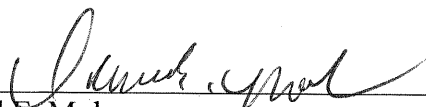
Sincerely,



Clayton L. Plemmons, Manager
Labor Relations

CLP:SJB

Concurrence:


David E. Molnaa
Hanford Atomic Metal Trades Council

10/26/15
Date

2015 WAGE & BENEFIT REOPENER SETTLEMENT

The parties did meet beginning September 14, 2015 as specified in Section 6D, Article XIX to reach agreement on wage rates for 2016 and 2017, and health plan items (excluding pension and savings plan) for 2017 and 2018. In addition, the parties agreed to open the CBA for the limited purposes of negotiating and reaching agreement on a one year extension to the current CBA and to negotiate and reach agreement on those particular CBA Articles impacted from such agreement.

The parties have agreed to the following:

Article XIX, Section 6

Effective November 14, 2016, a general wage increase of two percent (2.0%) will be added to each employee's paid wage rate.

Effective November 13, 2017, a general wage increase of two percent (2.0%) will be added to each employee's paid wage rate.

Effective November 12, 2018, a general wage increase of two percent (2.0%) will be added to each employee's paid wage rate.

Article XX, Section 8

If by March 1, 2017 and/or March 1, 2018, the excise tax provisions of the Affordable Care Act (ACA), as it applies to the Cadillac Tax, are demonstrated by the Employer to cause liability based on the applicable health benefits provided to bargaining unit employees by the Hanford Employee Welfare Trust, bargaining unit employees shall be subject to the provisions of the Memorandum of Understanding, Health Insurance, dated October 26, 2015, which by this reference is made part of this Agreement.

Memorandum of Understanding, Health Insurance attached.

Article XXVIII, Section 1

This Agreement shall become effective the thirteenth day of January, 2014 and shall continue in full force and effect through the tenth day of November, 2019. This Agreement will continue year-to-year thereafter unless notice is given in writing by the Employer or the Council not more than ninety (90) days or not less than sixty (60) days prior to November 10, 2019 of its desire to modify, amend or terminate this Agreement.

Attachment E

No change to employee contribution percentage for medical, vision or dental coverage. Twenty-four percent (24%) for medical and vision and twenty-five percent (25%) for dental. 2017 and 2018 maximum employee contribution dollars will be based on a twelve (12%) escalation consistent with 2013-2016. 2019 maximum employee contribution dollars will be based on a thirteen percent (13%) escalation.

Attachment F

See attachment

Administrative Efficiency Changes

HAMTC employees participating in the HEWT have the option to elect a spouse/domestic partner only, dependent only, or combined spouse/domestic partner + dependent coverage level. In addition, the HEWT provides greater coverage level options for the spouse/domestic partner which range from \$10,000 to \$40,000 and provides a \$5,000 coverage level for each dependent child (for ages 15 days to 23 years).

See attachment

Hanford Atomic Metal Trades Council

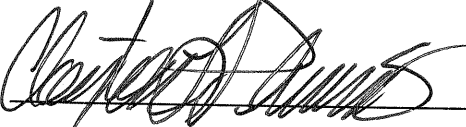


10/26/15

David E. Molnaa
President, HAMTC

Date

Washington River Protection Solutions



10/26/15

Clayton L. Plemmons
Manager, Labor Relations

Date

MEMORANDUM OF UNDERSTANDING HEALTH INSURANCE

The parties agree that the Health Insurance provisions of Attachment E and F of the 2014 Labor Agreement between the Hanford Atomic Metal Trades Council and Washington River Protection Solutions, LLC (jointly referred to here as “the Agreement”), are subject to the following additional agreements and understandings, which are intended by the parties to supersede any inconsistent provision of the Agreement:

1. If by March 1, 2017, and/or March 1, 2018, the Employer demonstrates that the health benefits provided to bargaining unit employees under the Hanford Employee Welfare Trust (HEWT) will incur liability under the excise tax provisions of the Affordable Care Act (ACA) for 2018 or 2019, bargaining unit employees shall effective on January 1, 2018 or January 1, 2019 after the next Annual Benefits Enrollment, move:
 - a. to a modified plan if accepted by the Council not later than June 30, 2017, and/or June 30, 2018, (or the next business day), in which the plan offered to bargaining unit employees is demonstrated to trigger ACA excise tax liability. A modified plan’s projected total costs shall not be less than 95% of the total cost limit for ACA excise tax purposes. The Employer shall accept the modified plan accepted by the Council provided it is within ACA limits for avoidance of the excise tax, legal, and the benefits stated therein are available through the Hanford Employee Welfare Trust.
 - b. if the Council has not notified Washington River Protection Solutions, LLC of its acceptance of a modified plan by June 30 (or business day immediately after June 30 if it is not), to any insurance plan provided by the Employer to its non-represented employees on the same basis as for non-bargaining unit employees and as amended by the Employer thereafter.
2. Bargaining unit employee contributions for coverage under any modified plan (Section 1.a and 1.b) will be at the same percentages as stated in the Agreement.
3. Provided it may legally do so, the Employer will not include vision plan costs in determining whether the ACA excise tax applies to the bargaining unit plan unless vision is required to be included in the medical plan offering.
4. The following are applicable to determination and Council acceptance of a modified bargaining unit plan:
 - a. The Employer shall not later than March 1 (or business day immediately preceding March 1 if it is not) provide the Council with all information about particular plan aspects that contributed to the Employer’s determination that the ACA excise tax will be triggered, as well as the same kind of detailed health care pricing information that the Employer receives from its consultant for structuring

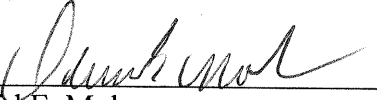
non-bargaining unit plans, along with at least, but not limited to, four options for bringing plan costs under the ACA excise tax limit.

- b. Should the Employer fail to provide the information specified in paragraph a immediately above by March 1 (or business day preceding if appropriate), the deadlines stated in Section 1 for the Council's acceptance of a modified plan shall be extended by the same number of business days that the Employer is late in providing the information.
- c. A modified bargaining unit plan shall remain in existence unless and until a subsequent ACA excise tax notice might be necessary.


IN WITNESS HEREOF, the parties have caused their names to be subscribed to this Memorandum of Understanding by their duly authorized representatives this 26th day of October, 2015.

Hanford Atomic Metal Trades Council

Washington River Protection Solutions, LLC



David E. Molnaa
President, HAMTC



Clayton L. Plemmons
Labor Relations Manager

ATTACHMENT E

Washington River Protection Solutions, LLC

The employee medical, including vision contributions for calendar years 2016-2019		
	Group Health Options	UnitedHealthcare
January 2016	24%	24%
January 2017	24%	24%
January 2018	24%	24%
January 2019	24%	24%

Built-in cap based on plan design changes and 12% premium escalation for 2016-2018 and 13% for 2019.

Group Health Options

	2015 Premiums	2016 Projected Premiums with Escalation @ 12%	2016 Employee Contribution (%)	2016 Maximum Employee Contribution (\$)
Employee	\$ 621.29	\$ 695.84	24%	\$ 167.00
Employee +1	\$ 1,136.94	\$ 1,273.37	24%	\$ 305.61
Employee + >1	\$ 1,907.34	\$ 2,136.22	24%	\$ 512.69

	2016 Projected Premiums	2017 Projected Premiums with Escalation @ 12%	2017 Employee Contribution (%)	2017 Maximum Employee Contribution (\$)
Employee	\$ 695.84	\$ 779.35	24%	\$ 187.04
Employee +1	\$ 1,273.37	\$ 1,426.18	24%	\$ 342.28
Employee + >1	\$ 2,136.22	\$ 2,392.57	24%	\$ 574.22

	2017 Projected Premiums	2018 Projected Premiums with Escalation @ 12%	2018 Employee Contribution (%)	2018 Maximum Employee Contribution (\$)
Employee	\$ 779.35	\$ 872.87	24%	\$ 209.49
Employee +1	\$ 1,426.18	\$ 1,597.32	24%	\$ 383.36
Employee + >1	\$ 2,392.57	\$ 2,679.68	24%	\$ 643.12

	2018 Projected Premiums	2019 Projected Premiums with Escalation @ 13%	2019 Employee Contribution (%)	2019 Maximum Employee Contribution (\$)
Employee	\$ 872.87	\$ 986.34	24%	\$ 236.72
Employee +1	\$ 1,597.32	\$ 1,804.97	24%	\$ 433.19
Employee + >1	\$ 2,679.68	\$ 3,028.03	24%	\$ 726.73

The Maximum Monthly Contributions are based on a projected 12% increase in the premium for health plans for years 2016-2018 and 13% for 2019. In the event the premium increase is less than the projected escalation rate (12%/13%), the Employee Contributions will be based on the percents specified for each plan. In the event the premium increase is greater than the projected escalation rate (12%/13%), the Employees Contributions will be based on the Maximum Employee Monthly Contribution rate specified in this document.

UNITED HEALTHCARE (UHC)

	2015 Premiums	2016 Projected Premiums with Escalation @ 12%	2016 Employee Contribution (%)	2016 Maximum Employee Contribution (\$)
Employee	\$ 1,025.19	\$ 1,148.21	24%	\$ 275.57
Employee +1	\$ 2,002.24	\$ 2,242.51	24%	\$ 538.20
Employee + >1	\$ 2,874.69	\$ 3,219.65	24%	\$ 772.72

	2016 Projected Premiums	2017 Projected Premiums with Escalation @ 12%	2017 Employee Contribution (%)	2017 Maximum Employee Contribution (\$)
Employee	\$ 1,148.21	\$ 1,286.00	24%	\$ 308.64
Employee +1	\$ 2,242.51	\$ 2,511.61	24%	\$ 602.79
Employee + >1	\$ 3,219.65	\$ 3,606.01	24%	\$ 865.44

	2017 Projected Premiums	2018 Projected Premiums with Escalation @ 12%	2018 Employee Contribution (%)	2018 Maximum Employee Contribution (\$)
Employee	\$ 1,286.00	\$ 1,440.32	24%	\$ 345.68
Employee +1	\$ 2,511.61	\$ 2,813.00	24%	\$ 675.12
Employee + >1	\$ 3,606.01	\$ 4,038.73	24%	\$ 969.30

	2018 Projected Premiums	2019 Projected Premiums with Escalation @ 13%	2019 Employee Contribution (%)	2019 Maximum Employee Contribution (\$)
Employee	\$ 1,440.32	\$ 1,627.56	24%	\$ 390.61
Employee +1	\$ 2,813.00	\$ 3,178.69	24%	\$ 762.89
Employee + >1	\$ 4,038.73	\$ 4,563.77	24%	\$ 1,095.30

The Maximum Monthly Contributions are based on a projected 12% increase in the premium for health plans for years 2016-2018 and 13% for 2019. In the event the premium increase is less than the projected escalation rate (12%/13%), the Employee Contributions will be based on the percents specified for each plan. In the event the premium increase is greater than the projected escalation rate (12%/13%), the Employees Contributions will be based on the Maximum Employee Monthly Contribution rate specified in this document.

WILLAMETTE DENTAL

	2015 Premiums	2016 Projected Premiums with Escalation @ 5%	2016 Employee Contribution (%)	2016 Maximum Employee Contribution (\$)
Employee	\$ 39.04	\$ 40.99	25%	\$ 10.25
Employee +1	\$ 78.23	\$ 82.14	25%	\$ 20.54
Employee + >1	\$ 146.55	\$ 153.88	25%	\$ 38.47

	2016 Projected Premiums	2017 Projected Premium with Escalation @ 5%	2017 Employee Contribution (%)	2017 Maximum Employee Contribution (\$)
Employee	\$ 40.99	\$ 43.04	25%	\$ 10.76
Employee +1	\$ 82.14	\$ 86.25	25%	\$ 21.56
Employee + >1	\$ 153.88	\$ 161.57	25%	\$ 40.39

	2017 Projected Premiums	2018 Projected Premium with Escalation @ 5%	2018 Employee Contribution (%)	2018 Maximum Employee Contribution (\$)
Employee	\$ 43.04	\$ 45.19	25%	\$ 11.30
Employee +1	\$ 86.25	\$ 90.56	25%	\$ 22.64
Employee + >1	\$ 161.57	\$ 169.65	25%	\$ 42.41

	2018 Projected Premiums	2019 Projected Premium with Escalation @ 5%	2019 Employee Contribution (%)	2019 Maximum Employee Contribution (\$)
Employee	\$ 45.19	\$ 47.45	25%	\$ 11.86
Employee +1	\$ 90.56	\$ 95.09	25%	\$ 23.77
Employee + >1	\$ 169.65	\$ 178.13	25%	\$ 44.53

The Maximum Monthly Contributions are based on a projected 5% increase in the premium for health plans for 2016-2019. In the event the premium increase is less than 5%, the Employee Contributions will be based on the percents specified for each plan. In the event the premium increase is greater than 5%, the Employees Contributions will be based on the Maximum Employee Monthly Contribution rate specified in this document.

ATTACHMENT F

BENEFITS	GH Options 2012	GH Options 2013	GH Options 2014	GH Options 2015	GH Options 2016	GH Options 2017	GH Options 2018	GH Options 2019
Annual Out-of-Pocket Maximum	In Network: \$1,150/\$2,300 Out: \$2,875/\$5,750	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Deductible – In-Network	In Network: \$150/\$300	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Deductible – Out-of-Network	Out: \$250/\$500 (Deductible included in out of pocket limit.)	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Coinsurance – In Network	In-network: 80%/20%	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Coinsurance – Out-of-Network	Out: 70%/30%	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Office Visit/Urgent Care	In Network: 80%/20% Out: 70%/30%	No Change	No Change	No Change	No Change	No Change	No Change	No Change

ATTACHMENT F

<p>Preventive care Well adult and well child physicals, immunizations, pap smears, mammograms and prostate/<i>colorectal</i> cancer screening.</p>	<p>No change In Network – covered in full Out: Covered at the Plan Coinsurance to a \$150 maximum per Member (\$300 per Family Unit) per calendar year. Routine mammography services are covered at the Plan Coinsurance after the annual deductible is satisfied. Coinsurance does not apply to the Out-of-Pocket Limit.</p>	<p>No change</p>	<p>In Network – covered in full Out: No co-pay, deductible and co-insurance apply</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
<p>Lab & X-Ray Services</p>	<p>In Network: 80%/20% Out: 70%/30%</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>

ATTACHMENT F

Chiropractic Care	In Network: 80%/20% Out: 70%/30% Visits: 20 per year	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change	
Prescription Drugs	In Network: Retail: \$15 Generic/\$35 Brand 30 day supply Mail-order: \$30 Generic/\$70 Brand 90 day supply Subject to formulary Allergy Serum - No Change Out: \$20 Generic, \$45 Brand Not subject to deductible	No Change	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	Three-Tier Rx Plan In Network Retail: \$20/\$40/\$60 (generic/formulary brand/non- formulary) Mail Order: \$40/\$80/\$120 (90 day supply) Subject to formulary Allergy Serum -- No Change Out-of-Network: \$25/\$45/\$65 Not subject to deductible	No Change
Inpatient Hospital	In Network: 80%/20% Out: 70%/30%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change	
Outpatient Hospital	In Network: 80%/20% Out: 70%/30%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change	
Maternity Services	In Network: 80%/20% Out: 70%/30%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change	

ATTACHMENT F

	\$110/20% and Deductible In and Out of Network.	No Change	\$125/20% and Deductible In and Out of Network	\$125/20% and Deductible In and Out of Network	\$150/20% and Deductible In and Out of Network	No Change	No Change	No Change
Emergency Room Care (Hospital)		No Change				No Change	No Change	No Change
Ambulance	Plan pays 80%/ Employee pays 20%	No Change				No Change	No Change	No Change
Durable Medical Equipment & Supplies	In Network: 80%/20% Out of Network: 70%/30%	No Change				No Change	No Change	No Change
Rehabilitation Services • Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under. MHCN and Community Provider benefit limits are combined and cannot be duplicated. sixty (60) visits per condition per calendar year after the annual Deductible is satisfied.	In Network: <u>Outpatient:</u> 80/20% Visits: No Change <u>Inpatient:</u> 80/20% Coinsurance Visits: No Change Out of Network: <u>Outpatient:</u> 70%/30% Visits: No Change <u>Inpatient:</u> 70%/30% Visits: No Change	No Change				No Change	No Change	No Change
Mental Health Services <u>Outpatient</u>	In Network No Copay, deductible and coinsurance apply 80%/20% Out of Network No Copay, deductible and coinsurance apply 70%/30%	No Change				No Change	No Change	No Change

ATTACHMENT F

<p><u>Inpatient</u></p>	<p>In Network Deductible and coinsurance apply 80%/20% Out of Network Deductible and coinsurance apply 70%/30%</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
<p>Chemical Dependency Dollar Limit based on State Maximum Benefit</p>	<p>In Network: 80%/20% Out: 70%/30%</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
<p>Vision Exam</p>	<p>In Network: Covered in full Out: Covered up to \$50 annually</p>	<p>No Change</p>	<p>In Network: Covered in full Out: Coinsurance</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
<p>Optical Hardware</p>	<p>Covered up to \$165 once every 24/months per member</p>	<p>No Change</p>	<p>Covered up to \$165 once every 24/months per member Members under age 19 limited to 1 pair of frames and lenses per year</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>

ATTACHMENT F

BENEFITS	United Healthcare PPO 2012	United Healthcare PPO 2013	United Healthcare PPO 2014	United Healthcare PPO 2015	United Healthcare PPO 2016	United Healthcare PPO 2017	United Healthcare PPO 2018	United Healthcare PPO 2019
Annual Out-of-Pocket Maximum	In Network \$1,350/\$2,700 Out of Network: \$3,500/\$7,000	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Deductible – In-Network Deductible – Out-of-Network	In Network: \$325 / \$650 Out of Network: \$425 / \$850	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Coinsurance – In Network Coinsurance – Out-of-Network	In Network: 80/20% Out of network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Office Visit/Urgent Care	In Network: 80/20% Out of network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Preventive care *Wellness medical care. *Well-baby and well-child care. *Routine well-woman examinations, including pap smears, pelvic examinations and mammograms *Routine well man exams, including PSA tests. *Routine wellness care. *Immunizations, may not include shingles.	In Network: Currently no co-pay for preventive/wellness care. Must be coded as such exclusively. Out of Network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change

ATTACHMENT F

Lab & X-Ray Services	In Network: 80/20% Out of network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Chiropractic Care	In Network: 80/20% Out of Network: 60/40% Visits: 20 total	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Prescription Drugs	Express Scripts, Inc Retail (30 day supply): \$7 generic /\$30 brand name preferred/\$45 brand non- preferred.	No Change	Express Scripts, Inc Retail (30 day supply): \$10 generic /\$35 brand name preferred/ \$50 brand non- preferred.	Express Scripts, Inc Retail (30 day supply): \$10 generic / \$35 brand name preferred/ \$50 brand non- preferred/20% with min out of pocket \$65 and max out of pocket \$150 Specialty drug.	Express Scripts, Inc Retail (30 day supply): \$10 generic /\$35 brand name preferred/ \$50 brand non- preferred/20% with min out of pocket \$65 and max out of pocket \$150 Specialty drug.	Express Scripts, Inc Retail (30 day supply): \$10 generic /\$35 brand name preferred/ \$50 brand non- preferred/20% with min out of pocket \$65 and max out of pocket \$150 Specialty drug.	No Change	No Change	No Change
	Mail (90-day supply): \$14/\$60/\$90 No deductible \$1500 Maximum out of Pocket Step Therapy Program	Mail (90-day supply): \$20/\$70/\$100 No deductible \$1500 Maximum out of Pocket Step Therapy Program Prior Authorization	Mail (90-day supply): \$20/\$70/\$100 No deductible Maximum Out- of-Pocket \$1,750 Individual/\$2,750 Family Step Therapy Program Prior Authorization	Mail (90-day supply): \$20/\$70/\$100 No deductible Maximum Out- of-Pocket \$1,750 Individual/\$2,750 Family Step Therapy Program Prior Authorization	Mail (90-day supply): \$20/\$70/\$100 No deductible Maximum Out- of-Pocket \$1,750 Individual/\$2,750 Family Step Therapy Program Prior Authorization	Mail (90-day supply): \$20/\$70/\$100 No deductible Maximum Out- of-Pocket \$1,750 Individual/\$2,750 Family Step Therapy Program Prior Authorization	No Change	No Change	No Change

ATTACHMENT F

Inpatient Hospital	In Network: 80/20% Out of Network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Outpatient Hospital	In Network: 80/20% Out of Network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Maternity Services	In Network: 80/20% Out of Network: 60/40%	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Emergency Room Care (Hospital)	\$110 per visit plus 20% after deductible	No Change	\$125 per visit plus 20% after deductible	\$125 per visit plus 20% after deductible	\$150 per visit plus 20% after deductible	No Change	No Change	No Change	No Change
Ambulance	80/20% after deductible	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change
Durable Medical Equipment & Supplies	In Network: 80/20% after deductible Out of Network: 60/40% After deductible	No Change	No Change	No Change	No Change	No Change	No Change	No Change	No Change

ATTACHMENT F

<p>Rehabilitation Services Any combination of PPO Network and PPO Non-Network Benefits is limited as follows:</p> <ul style="list-style-type: none"> • 30 visits of physical therapy per calendar year. • 30 visits of occupational therapy per calendar year. • 30 visits of speech therapy per calendar year. • 20 visits of pulmonary rehabilitation therapy per calendar year. • 20 visits of cardiac rehabilitation therapy per calendar year. <p>Out-of-Area Benefits are limited as follows:</p> <ul style="list-style-type: none"> • 30 visits of physical therapy per calendar year. • 30 visits of occupational therapy per calendar year. • 30 visits of speech therapy per calendar year. • 20 visits of pulmonary rehabilitation therapy per calendar year. • 20 visits of cardiac rehabilitation therapy per calendar year. 	<p>In Network: <u>Outpatient:</u> 80/20% Visits: 30/CY 20 for Cardiac and Pulmonary</p> <p><u>Inpatient:</u> 80/20% Visits: 30/CY 20 for Cardiac and Pulmonary</p> <p>Out of network: 60/40%</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
---	--	------------------	------------------	------------------	------------------	------------------	------------------	------------------

ATTACHMENT F

<p>Mental Health Services</p>	<p><u>In Network:</u> <u>Outpatient:</u> \$15 co-pay/visit Individual \$5 co-pay/visit Group Limited to 60 visits/yr combined with Chemical Dependency <u>Inpatient:</u> Covered 100% Limited to 60 days/yr combined with Substance Abuse</p>	<p>No Change</p>	<p><u>Outpatient:</u> 80%/20% coinsurance & deductible applies <u>Inpatient:</u> 80%/20% coinsurance & deductible applies Out of Network: <u>Outpatient:</u> 60%/40% coinsurance & deductible applies <u>Inpatient:</u> 60%/40% coinsurance & deductible applies</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
-------------------------------	--	------------------	---	------------------	------------------	------------------	------------------	------------------

ATTACHMENT F

<p>Chemical Dependency</p>	<p><u>Inpatient:</u> In Network: 100/0% coinsurance 60 days per year</p> <p>Out of Network: 50% Coinsurance 20 days per year Max \$5000/year</p> <p><u>Outpatient:</u> In Network: \$15 individual/ \$5 group Maximum 60 visits/yr</p> <p>Out of Network: 50% substance abuse up to 25 visits per year.</p>	<p>No Change</p>	<p><u>Inpatient:</u> In Network: 80%/20% coinsurance & deductible applies</p> <p>Out of Network: 60%/40% coinsurance & deductible applies</p> <p><u>Outpatient:</u> In Network: 80%/20% coinsurance & deductible applies</p> <p>Out of Network 60%/40% coinsurance & deductible applies</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
----------------------------	---	------------------	---	------------------	------------------	------------------	------------------	------------------

ATTACHMENT F

<p>Vision Exam</p>	<p>In-network: UHC VISION Annual Exam : \$10 co-pay Out of network: Exam annually. 85% of R&C. Maximum reimbursement in a calendar year is \$165 for exam and hardware combined.</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>
<p>Optical Hardware</p>	<p>In-network: UHC VISION Lenses- every 12 months: \$10 co-pay. Frames – every other year Out of network: Frames and lenses every other year. Up to \$165.00 total (including exam)</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>	<p>No Change</p>

ATTACHMENT F
Willamette Dental of Washington

Benefit	2016		2017		2018		2019	
	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*	No Annual Maximum*
Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible
Office Visit Co-payment	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit	\$20 per visit
Diagnostic and Preventative Services								
Routine and Emergency Exams	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
All X-rays	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Teeth Cleaning	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Fluoride treatment	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Head and Neck Cancer Screening	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Oral Hygiene Instructions	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Periodontal Screening	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Periodontal Maintenance	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Restorative Dentistry and Prosthetics								
Fillings	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Permanent Crowns	\$120	\$120	\$120	\$120	\$120	\$120	\$120	\$120
Complete Upper or Lower Denture	\$170	\$170	\$170	\$170	\$170	\$170	\$170	\$170
Bridge per tooth	\$120	\$120	\$120	\$120	\$120	\$120	\$120	\$120
All lab fees	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Endodontics and Periodontics								
Root canal therapy - anterior	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Root canal therapy - bicuspid	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75
Root canal therapy - molar	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
Osseous Surgery - per quadrant	\$140	\$140	\$140	\$140	\$140	\$140	\$140	\$140
Root Planing - per quadrant	Fully Covered	Fully Covered	Fully Covered	Fully Covered	Fully Covered	Fully Covered	Fully Covered	Fully Covered
Oral Surgery								
Routine extraction - single tooth	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Surgical extraction	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50

ATTACHMENT F

Orthodontia				
Pre-orthodontic service	\$150**	\$150**	\$150**	\$150**
Comprehensive Orthodontia	\$1,500	\$1,500	\$1,500	\$1,500
Miscellaneous				
Local Anesthesia (Novocain)	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Nitrous Oxide (per visit)	\$10	\$10	\$10	\$10
After-hours emergency care	\$20	\$20	\$20	\$20
Missed appointment fee	\$20	\$20	\$20	\$20
Out of area emergency care reimbursement up to	\$100	\$100	\$100	\$100
TMJ	1,000 annual maximum/ \$5,000 lifetime maximum*	1,000 annual maximum/ \$5,000 lifetime maximum*	1,000 annual maximum/ \$5,000 lifetime maximum*	1,000 annual maximum/ \$5,000 lifetime maximum*
** Fee credited toward comprehensive orthodontic co-payment if patient accepts treatment plan.				

**Current 2015
Dependent VTL Plan**

- A: Spouse-\$5,000, Each Child-\$100 / \$1,000
- B: Spouse-\$10,000, Each Child-\$200 / \$2,000
- C: Spouse-\$15,000, Each Child-\$300 / \$2,000
- D: Spouse-\$20,000, Each Child-\$300 / \$2,000
- E: Spouse-\$25,000, Each Child-\$300 / \$2,000
- F: Spouse-\$30,000, Each Child-\$300 / \$2,000
- S: Spouse-\$10,000:
- T: Spouse-\$20,000:
- U: Spouse-\$30,000:
- V: Spouse-\$40,000:
- W: Each Child-\$5,000
- SW: Spouse-\$10,000, Each Child-\$5,000
- TW: Spouse-\$20,000, Each Child-\$5,000
- UW: Spouse-\$30,000, Each Child-\$5,000
- VW: Spouse-\$40,000, Each Child-\$5,000

**Proposed
Dependent VTL Plan**

- S: Spouse-\$10,000:
- T: Spouse-\$20,000:
- U: Spouse-\$30,000:
- V: Spouse-\$40,000:
- W: Each Child-\$5,000
- SW: Spouse-\$10,000, Each Child-\$5,000
- TW: Spouse-\$20,000, Each Child-\$5,000
- UW: Spouse-\$30,000, Each Child-\$5,000
- VW: Spouse-\$40,000, Each Child-\$5,000

**Current 2015
Dependent VTL Plan**

- No current plan equivalent
- No current plan equivalent
- No current plan equivalent
- No current plan equivalent
- No current plan equivalent
- B: Spouse-\$10,000, Each Child-\$200 / \$2,000
- D: Spouse-\$20,000, Each Child-\$300 / \$2,000
- F: Spouse-\$30,000, Each Child-\$300 / \$2,000
- No current plan equivalent

**Non-Bargained
Monthly Cost**

- N/A
- \$1.96
- N/A
- \$3.89
- N/A
- \$5.68
- N/A
- \$6.34
- N/A
- \$7.84
- N/A
- \$9.38
- \$3.78
- N/A
- \$6.23
- N/A
- \$9.27
- N/A
- \$12.30
- N/A
- \$0.84
- N/A
- \$4.62
- N/A
- \$7.06
- N/A
- \$10.11
- N/A
- \$13.13
- N/A

**Proposed Plan
Monthly Cost**

- \$3.78
- \$6.23
- \$9.27
- \$12.30
- \$0.84
- \$4.62
- \$7.06
- \$10.11
- \$13.13

**Current
Monthly Cost**

- N/A
- N/A
- N/A
- N/A
- N/A
- \$3.89
- \$6.34
- \$9.38
- N/A

**Difference
Monthly Cost**

- \$3.78
- \$6.23
- \$9.27
- \$12.30
- \$0.84
- \$0.73
- \$0.72
- \$0.73
- \$13.13

