

YOUR BENEFITS GUIDE – PRESCRIPTION DRUG PLAN OPTIONS



3. Prescription Drug Plan Options

Overview

Electric Boat retirees and spouses have two plan levels for their prescription drug needs in 2010 that can be combined with any of the medical plan alternatives. Both plans are administered by Health Net and Health Net refers to these plans as Health Net Orange Part D plans. You will not be able to enroll in the Electric Boat Retiree Prescription Plan alone; It must be chosen in conjunction with any of the 2010 Electric Boat Retiree Medical Plan Options.

The two prescription drug plan options are referred to as the **“Unlimited”** or Enhanced Medicare Part D program or the **“Limited”** Medicare Part D program. Generally speaking, the key difference in the two plan options is the existence of the “coverage gap” or for some, what is known as the “donut hole”. Under the standard Medicare Part D program, there is a period of time when a member is fully responsible for their prescription drug costs at such point in time that they reach the “initial coverage limit” and enter the “coverage gap” or “donut hole”. The Electric Boat “Unlimited” Prescription Drug Plan does not have a “coverage gap” or “donut hole”. Coverage is consistent throughout the year. The Electric Boat “Limited” Prescription Drug Plan does have the “coverage gap”, however, while members are in the “coverage gap” when enrolled in the “Limited” plan, Tier 1 generics continue to be covered at the Tier 1 generic copay and the cost of brands and other non-preferred drugs are paid in full by the member.

The following pages will illustrate further benefit differences between the two plans.

Eligibility

As previously described, retirees and spouses eligible and enrolled in any of the six Electric Boat Retiree Medical Plan Options are eligible for the Electric Boat Retiree Prescription Drug Plans. These plans are available regardless of where you live in the U.S.

However, the Electric Boat “Unlimited” Prescription Drug Plan, is only available upon you or your spouse’s initial eligibility. Retirees and/or spouses waiving enrollment into that program when first eligible can not enroll later unless they meet certain criteria.

Initial eligibility can be defined as your Medicare effective date, the day after which you lose pre-65 retiree benefit coverage through Electric Boat. Your Medicare coverage generally begins the 1st of the month of your 65th birthday. If you were born on the 1st of the month, your Medicare coverage begins the month prior. Your pre-65 retiree benefit coverage through Electric Boat will cease the day prior to your Medicare effective date.

You may become eligible for Medicare prior to 65 due to disability. If you are retired and enroll onto Medicare prior to age 65, you may enroll in the Electric Boat Retiree Medical and Prescription Drug Plan at that time. However, if you choose to wait until age 65 to enroll, your enrollment at age 65 will be considered your initial eligibility and you will be able to enroll in the Electric Boat “Unlimited” Prescription Drug Plan at that time.

Your spouse becomes initially eligible when he/she turns 65 and loses retiree coverage under the Electric Boat pre-65 retiree plan.

Electric Boat employees that retire at or after age 65 are considered initially eligible for these plans the first of the month following their date of retirement and upon enrollment into Medicare Part A and Part B. This eligibility also pertains to the newly retired employee’s spouse.

Electric Boat retirees and spouses can **defer** their enrollment into the Electric Boat Retiree Medical and Prescription Drug Plan and their initial eligibility if they are actively working and covered under their active employer or covered under another retiree medical and prescription drug plan.

If you waive your opportunity to enroll in the Electric Boat “Unlimited” Prescription Drug Plan when you are initially eligible, you will NOT be able to enroll in the future.

Making changes to your prescription drug plan

Once you enroll in a prescription drug plan for 2010, you can not make a change to your prescription drug coverage until the following open enrollment.

During open enrollment, you can choose to enroll in the Electric Boat “Limited” Prescription Drug Plan if you are not initially eligible and therefore, not eligible for the “Unlimited” prescription drug plan. If you have been eligible for Medicare Part D and chose not to enroll in **any** Medicare Part D plan, you may be subject to penalties equal to 1% of the national average 2010 Part D premium for each year you were eligible for Part D but did not enroll in a plan. If you fall into this situation, you may have to furnish a creditable coverage letter proving that you have had coverage that is equal to or better than Medicare Part D in order to avoid penalties.

These are not our rules, they are Medicare regulations.

If you are covered on the Electric Boat “Unlimited” Prescription Drug Plan, you can choose to opt down to the Electric Boat “Limited” Prescription Drug Plan during open enrollment.

If you choose to opt down to the “Limited” plan, you will not be able to enroll in the “Unlimited” plan at a later date.

Electric Boat Retiree Prescription Drug Plan Options

Option 1: Electric Boat Retiree “Unlimited” Drug Plan (Enhanced Medicare Part D Program)

The “Unlimited” or Enhanced Medicare Part D Plan has been available since January 1, 2006. In order to explain the enhancements in the Electric Boat “Unlimited” Retiree Prescription Drug Plan, it is best to first explain basic Medicare Part D benefits in general.

Medicare Part D has offered great relief to millions of Americans who have not had the benefit of being covered under any prescription drug plan. It is not a perfect system and is difficult to understand. However, it is an improvement over having no Medicare Prescription Drug coverage at all.

Medicare Part D became available through numerous insurance companies effective January 1, 2006. Each individual plan has slight variations in benefit and each one has a different formulary – a listing of covered generics, preferred brand drugs, non-preferred brand and generic drugs and a different list of exclusions. In a nutshell, for anywhere from about \$20 to \$100 a month, an individual can obtain a Medicare Part D plan from a variety of different private insurance companies that will generally consist of copayments (rather than the \$310 deductible as designed by Medicare in 2010) until such time total drug costs reach \$2,830. The \$2,830 is considered the “initial coverage limit” the point an individual reaches this amount in **total drug costs** for 2010. The individual then enters what has been referred to as the “coverage gap” or “donut hole”. The initial coverage limit is the total drug costs which consists of an individual’s copayments or costshare **PLUS** the amount paid out by the insurance company on their behalf.

While in the “coverage gap” or “donut hole”, under the Standard Part D benefit, an individual then becomes responsible for 100% of their prescription drug costs until such time as their total out-of-pocket costs (exclusive of premium payments) reaches \$4,550. Once a person reaches a total out-of-pocket of \$4,550 in 2010, the catastrophic benefit kicks in and the costshare becomes the greater of 5% or \$2.50 for generics and \$6.30 for brand name medications for the remainder of the calendar year. “Coverage gap” has become the words used to describe the period of time during which an individual essentially has no coverage. Out-of-pocket costs at the point someone enters the coverage gap will be different from one person to the next. The only part that is consistent is that you will not exit it until such time as you have invested \$4,550 out of your own pocket in addition to whatever is your monthly plan premium. Some plans cover preferred generics at the generic copay through the “coverage gap” or “donut hole”. These thresholds set by CMS (the Center for Medicare and Medicaid) change year to year. Each year we have seen an increase in the Standard Part D benefit with respect to the deductible, Initial Coverage Limit and True Out of Pocket Maximum (TROOP).

Standard Medicare Part D vs. the Electric Boat Retiree Unlimited Prescription Drug Plan

Really, there is one major difference between the Standard Medicare Part D benefit and the Electric Boat Retiree “Unlimited” Prescription Drug Plan available exclusively to Electric Boat Retirees, their spouse and surviving spouses.

This major difference is that our plan bypasses the “coverage gap.” In other words, in participating in this plan that costs \$106.50 per month, you will have simple copayments from the beginning to the end of the year without deductibles and without a “coverage gap”. The 2010 copays are \$15 for preferred generic drugs, \$40 for preferred brand drugs and \$60 for non-preferred drugs for a 30-day supply purchased at participating retail pharmacies. You also have the option of using the mail order program through CVS Caremark allowing you to purchase 90 day supplies and to save money on copays. The copays for a 90 day supply through the mail order program are \$30 for preferred generic drugs, \$80 for preferred brand drugs and \$120 for non-preferred drugs. Health Net is able to offer this unlimited enhanced Part D benefit at a reduced rate as a result of the fact that Medicare will be subsidizing a portion of the cost for this plan as it is a Medicare Part D plan but with greatly enhanced benefits. You will not be able to find a plan of this design as an individual. These types of plans are only available through employers or associations.

With the “Unlimited” Prescription Drug Plan, there are no deductibles, no maximums, and there is no coverage gap! You simply pay the applicable copay for preferred generic, preferred brand or non-preferred medications.

Option 2: Electric Boat Retiree “Limited” Prescription Drug Plan

Like the Unlimited Plan, the “Limited” Plan also qualifies as a Medicare Part D Plan. The “Limited” plan will include the exact same maximum copayment schedule and formulary as the Unlimited Plan - \$15 for preferred generic drugs, \$40 for preferred brand drugs, and \$60 for non-preferred drugs for 30-day retail prescriptions and \$30 for preferred generic drugs, \$80 for preferred brand drugs, and \$120 for non-preferred drugs for 90-day supplies through the mail order program.

However, under the “Limited” plan, once your retail drug expenses reach \$2,830 – you enter the “coverage gap” for brand name and non-preferred drugs and then become subject to 100% of the actual costs of your prescriptions until such time as your out-of-pocket costs reach \$4,550. The \$4,550 is reached by counting the sum of all of your copayments and outright payments for your prescriptions (by you). While you are in the “coverage gap,” you would continue to pay only the copayment for preferred generics but would pay 100% of the actual brand cost or the cost of non-preferred medications.

Once you reach the \$4,550 out-of-pocket level, you would then transition into the “Catastrophic” level and Medicare Part D kicks back in as your copayments become the greater of \$2.50 generics /\$6.30 for brands or 5% coinsurance.

This plan is probably the most comprehensive one of its kind that will be available on an individual basis. By being part of the Electric Boat Group Plan, Health Net is offering this to our members at a cost of \$34.50 per month!

Please be aware, however, if you choose the “Limited” plan now, you will NOT be allowed to change and enroll into the “Unlimited” plan in the future.

For the Electric Boat Retiree “Unlimited” Prescription Drug Plan, there is truly no other alternative like it available on an individual basis. With respect to the “Limited” Plan alternative, while there are similar plans available, you will likely find them to be significantly more expensive.

It is important that you review your medications and determine the copay that applies to each of them as well as whether or not a particular medication requires prior authorization, has quantity limits or has any type of step therapy requirement.

On the following pages, you will find the Top 50 brand name drugs taken by Electric Boat retirees and their spouses during 2009. The chart provides copay information and also indicates if the particular medication requires prior authorization, has quantity limits or requires step therapy. Some drugs will require prior authorization under the program. Prior authorization entails having your physician submit clinical information regarding your medical history in order to establish whether or not you meet medical criteria for approval from Health Net. Your physician can obtain the medical criteria by contacting Health Net directly or by working with our office. Most physicians are familiar with the process.

Please note that this is only a partial list. The Health Net 2010 Employer Group Comprehensive Formulary is available. A copy will be sent directly to you from Health Net. However, do not hesitate to contact us so we can assist you in determining how your drugs are covered and at what copay. We can also assist you in determining which drugs you are taking, if any, are subject to prior authorization, step therapy or quantity limits and we can work with your provider to assist you in the process.