

## **Questions and Answers Retiree Benefits 2009**

### **Chiropractic Benefit**

**Q. What services are covered under the chiropractic benefit?**

**A.** Chiropractic services must be medically necessary and restorative in nature to be covered. Examples of these services are as follows:

- Spinal manipulations
- Heat and ultrasound therapy
- Therapeutic modalities and activities
- Traction
- X-rays

**Q. What is the new chiropractic benefit limit for 2009?**

**A.** Chiropractic benefits will be limited to \$1,000 per person, per year.

**Q. Are there limits to the chiropractic benefit for maintenance treatments?**

**A.** The plan excludes coverage for maintenance care, which is considered therapy to maintain a level of performance instead of improving a patient's condition. Coverage is provided for medically necessary, active treatment of an illness or injury. Massage therapy is not a covered service.

**Q. Is there a limit to the number of visits I can have?**

**A.** There is no specific visit limit under the plan, as long as the visits continue to be medically necessary and the total dollars paid by the plan do not exceed \$1,000 per year, per person.

**Q. Is the \$1,000 limit based on submitted claim amounts?**

**A.** No. The \$1,000 limit is based on the actual claim dollars paid by the plan. This does not include participant coinsurance or deductible amounts.

**Q. What happens if I exceed the \$1,000 plan maximum?**

**A.** You will be responsible for any charges over the \$1,000 annual plan maximum.

**Q. If my chiropractor continues to perform treatments after I reach my \$1,000 benefit limit for the year, will the claims continue to be paid?**

**A.** No. The limit under the plan is for any service performed by a chiropractor.

**Q. Do pre-Medicare retirees need referrals from primary care physicians before going to a chiropractor?**

**A.** Yes. The Managed Care POS plan for pre-Medicare retirees and dependents requires you to have a referral from your in-network primary care physician before visiting a chiropractor. Failure to obtain a referral will result in your claim being processed at the out-of-network rate, even if the chiropractor is an in-network provider. Note that even with a referral, if you visit an out-of-network chiropractor, you will receive out-of-network benefits.

**Q. Is Medicare coverage considered primary for chiropractic care?**

**A.** Yes. Medicare is considered primary coverage for chiropractic care. Medicare-eligible individuals should submit their claims for chiropractic care to Medicare first. Aetna is considered the secondary coverage, and they will process chiropractic claims in accordance with DuPont's Maintenance of Benefits policy.

## Preventive Benefit

**Q. Is the shingles vaccine covered?**

**A.** Yes. Effective January 1, 2009, the shingles (Herpes Zoster) vaccine for adults age 60 and older is covered. This is a single dose vaccine, and it is covered at 100% as part of the medical plan prevention and wellness benefit. The doctor office visit copay, coinsurance, or deductible will apply. For individuals who are Medicare eligible, this vaccine will be covered under Medicare Part D and processed by Medco.

**Q. What other vaccines, immunizations, and preventive care is covered?**

**A.** Services, tests, and immunizations specified by DuPont are covered under the prevention and wellness benefit. You can find information on the DuPont prevention and wellness benefits by calling your medical plan carrier (such as Aetna) or visiting the DuPont Retiree Website at [www.retiree.dupont.com](http://www.retiree.dupont.com). Follow the steps listed below to learn more:

1. Click **Health Care**, in the far, left-hand column on the home page.
2. Click **Library**, in the far, left-hand column on the page.
3. When you see the Library page, scroll down and click **Retiree Preventative Health Benefits Brochure**. You then will see the *First Steps to Good Health* document that contains a list of covered services, tests, immunizations, and the corresponding age and frequency limitations.

## Dental Benefit

**Q. Are composite fillings covered by the plan if I participate in the Standard Dental Option instead of the Limited Dental Option?**

**A.** Both amalgam and composite fillings are covered by the plan. In the past, the same scheduled benefit applied to both types of fillings. Beginning January 1, 2009, different scheduled benefits will apply to amalgam fillings and composite fillings.

**Q. Are amalgam fillings safe?**

**A.** Amalgam fillings are still considered by the American Dental Association to be safe.

**Q. In 2009, how will my dental benefit claims be paid if I use a MetLife Preferred Dentist?**

**A.** When you visit a dentist participating in MetLife's Preferred Dentist Program (PDP), you receive care at fees that have been pre-negotiated by MetLife. Thus, using a MetLife Preferred Dentist can save you money. The MetLife PDP-negotiated fees apply to DuPont retirees participating in the Limited Dental Option, and also to those in the Standard Dental Option.

Effective January 1, 2009, there will be a revision to how the dental plan reimburses claims for restorative dental services (such as fillings, dentures, crowns, and bridges) performed in-network by a MetLife Preferred Dentist. If you participate in the Standard Dental Option, any restorative services will be reimbursed at 50% of the discounted PDP fee instead of at the scheduled benefit amount. If you participate in the Limited Dental Option, you pay 100% of the network-negotiated fee for restorative dental care.

Preventive and diagnostic dental services will continue to be reimbursed at 100% of the network-negotiated fee.

**Q. Can I save money by using a MetLife Preferred Dentist?**

**A.** Yes. Because in-network MetLife Preferred Dentists agree to accept negotiated fees, their charges are usually lower than those of non-network dentists. Plus, MetLife Preferred Dentists are contractually *not* permitted to bill you or the plan for any amounts over the negotiated rates.

**Q. How will my dental benefit claims be paid if I use a dentist who is not in the MetLife Preferred Dentist network?**

**A.** Out-of-network benefits for restorative services will remain the same in 2009 as they are today. Restorative services will continue to be reimbursed according to a scheduled amount, determined for your area, up to the annual maximum benefit provide by the plan. Preventive and diagnostic dental services will continue to be reimbursed at 100% of the reasonable and customary amounts for services performed by a non-MetLife Preferred Dentist.

**Q. How will the in-network dental restorative benefit compare to the out-of-network dental restorative benefit under the Standard Dental Option?**

**A.** The benefit you receive in-network for restorative dental services will equal 50% of the negotiated rate. The benefit you receive out-of-network will be approximately 50% of the area average charge, based on a scheduled amount. Both calculations are designed to adhere to the same cost-sharing proportion between you and the plan. Additionally, preventative and diagnostic dental services performed by an in-network dentist are reimbursed at 100% of the discounted PDP fee, while the preventative and diagnostic services performed out-of-network are reimbursed at 100% of reasonable and customary rates. Benefits under the Standard Dental Option are limited to the annual, per-person maximum of \$1,100.

## **Medical Benefit**

**Q. When do network negotiated rates apply and when do Reasonable and Customary (R&C) rates apply under the plan?**

**A.** For retirees who are not Medicare eligible, network-negotiated rates apply to individuals who are enrolled in the Managed Care POS Option and who use a preferred provider. To determine if your provider is a participating preferred provider, you should contact your medical plan vendor (such as Aetna, Cigna, BlueChoice of SC, Anthem, or Independent Health).

Should you seek services from a non-participating provider, or if you live outside the network service area and are enrolled in the Indemnity Option, R&C rates will apply. Individuals enrolled in the Indemnity Option may reduce their out-of-pocket cost by using a National Advantage Program provider. For additional information on the National Advantage Program, call Aetna at 1-800-445-7175.

For Medicare-eligible participants, the Medicare allowance is used as the basis of benefit calculations.

**Q. What should I do if I (or my spouse or other covered dependent) become Medicare eligible?**

**A.** Should you or any of your covered dependents become Medicare eligible, that individual will need to enroll in Medicare Part A and Part B at first eligibility. You will also need to call the MyInfo Service Center to report the Medicare eligibility, and to enroll in Part D if you wish to continue receiving prescription drug coverage through the DuPont medical plan. The MyInfo Service Center number is 1-877-MYINFO4 (1-877-694-6364). Your monthly premiums will be adjusted to reflect the accurate number of Medicare-eligible members.

## **Prescription Drug Benefit**

**Q. How is the prescription benefit changing in 2009?**

**A.** Effective January 1, 2009, your DuPont prescription drug benefit will be based on the type of medication you receive – generic, preferred brand, or non-preferred brand. A preferred brand is a brand-name prescription drug that is available for a lower cost than competing non-preferred brand-name drugs. You'll pay more if you use non-preferred drugs than you will if you use generics and preferred brands.

**Q. What do I do if I want to choose a different Medicare Part D plan and choose Medical Only coverage through DuPont?**

**A.** If you decide to decline the DuPont prescription coverage, call the MyInfo Service Center between November 15, 2008 and December 31, 2008. Tell the Service Center representative that you want to switch to Medical Only coverage as of January 1, 2009. The MyInfo Service Center number is 1-877-MYINFO4 (1-877-694-6364). Then, call the Medicare Part D plan that you have chosen and enroll in the other coverage. Note that a decision to decline DuPont prescription coverage applies to the retiree and all covered dependents, and it is irrevocable. A listing of Medicare Part D plans available in your area can be obtained from the Medicare Website at [www.medicare.gov](http://www.medicare.gov).

**Q. Will the deductible for my prescription drug coverage change in 2009?**

**A.** Yes. The deductible for the prescription drug coverage for 2009 will be \$295 per person. The increase of \$20 aligns with the Medicare Part D deductible set forth by the federal government. Your annual prescription drug deductible continues to be applied toward your annual prescription stop-loss.

**Q. How will the 2009 prescription benefit change affect the cost of my medication?**

**A.** In addition to how you order your prescription (using mail order instead of a retail pharmacy) your out-of-pocket cost will depend on whether you are using a generic, preferred, or non-preferred drug. Listed below are costs for each type, broken down by retail pharmacy and mail order.

- Your generics retail coinsurance will be 25% (\$7 min., \$100 max.)
- Your preferred-brand retail coinsurance will be 25% (\$20 min., \$100 max.)
- Your non-preferred retail coinsurance will be 45% (\$20 min., \$100 max.)
- Your mail order coinsurance for generics will be 25% (\$16 min., \$100 max.)
- Your mail order coinsurance for preferred brands will be 25% (\$45 min., \$100 max.)
- Your mail order coinsurance for non-preferred brands will be 45% (\$45 min., \$100 max.)

**Q. What is my share of the retail cost when there is no generic equivalent available?**

**A.** You pay a coinsurance of 25% for a preferred brand drug, or 45% for a non-preferred brand drug. Minimums and maximums apply. Refer to the following examples for more information.

**Example 1:**

- Preferred brand-name drug costs \$175 (no generic equivalent available)
- Coinsurance = 25% of \$175 = \$43.75 (higher than the \$20 minimum for brand-name drugs)
- You pay \$43.75

**Example 2:**

- Non-preferred brand-name drug costs \$275 (no generic equivalent available)
- Coinsurance = 45% of \$275 = \$123.75 (higher than the \$100 maximum for brand-name drugs)
- You pay \$100.00

**Q. How do I know whether my medication is a preferred or non-preferred brand?**

**A.** You can log on to Medco's Website to find out whether the medications you're taking will be considered generic, preferred, or non-preferred. Medicare-eligible individuals enrolled in Medicare Part D will need to visit a separate site than those who are not yet Medicare eligible. The websites are as follows:

- Pre-65 individuals: [www.medco.com/openenroll](http://www.medco.com/openenroll). Access code: NONMDRET11450
- Medicare Part D individuals: [www.medco.com/medd/dupont](http://www.medco.com/medd/dupont)

- Q. Does Medicare Part D have a separate formulary or preferred drug listing?**  
**A.** Yes. Medicare-eligible individuals will have a different listing for formulary, or preferred, drugs. Updated guides will be available on the Medco Website at [www.medco.com/meddd/dupont](http://www.medco.com/meddd/dupont).
- Q. Why is there a difference between the formulary or preferred brand listing for Medicare-eligible individuals?**  
**A.** The Medco Medicare Part D formulary list is designed to abide by the Centers for Medicare and Medicaid Services (CMS) guidelines. CMS guidelines do not allow for certain medications to be covered, so there is a variance from non-Medicare plans, such as the DuPont Plan.
- Q. How can I get this information if I don't have Internet access?**  
**A.** If you don't have Internet access, call Medco Member Services toll-free at 1-800-572-8695. Representatives are available 24 hours a day, 7 days a week, except on Thanksgiving Day and Christmas Day.
- Q. What should I do if my medication is considered non-preferred?**  
**A.** Visit Medco's My Rx Choices<sup>®</sup> prescription savings program at [www.medco.com/choices](http://www.medco.com/choices). Simply look up the name of a medication to find lower-cost alternatives and your potential savings. Then, print out the alternatives available and ask your doctor whether a lower-cost generic or preferred brand is right for you.
- Q. How can I lower the cost of my prescriptions?**  
**A.** Medco's online tool, My Rx Choices<sup>®</sup>, can help you find cost-effective medications. Log on to the My Rx Choices<sup>®</sup> Website to look up the name of your medication in the alphabetical list or type the name in the search box. Print out the list of available generic and preferred-brand alternatives to discuss with your doctor.
- Q. How do I request a new prescription for one of my cost-effective alternatives?**  
**A.** Review your My Rx Choices<sup>®</sup> search results with your doctor so that you can determine the most appropriate alternative for you together. Then, ask your doctor for a new prescription. If yours is a long-term drug, such as those used to treat high blood pressure or high cholesterol, be sure to get a prescription for a 90-day supply plus refills for up to one year (if appropriate). Then, mail your prescription to Medco's mail-order pharmacy, or have your doctor fax your prescription to Medco. You can download and print a physician fax from at [www.medco.com](http://www.medco.com).
- Q. Does member-pay-the-difference still apply?**  
**A.** Yes. If you receive a brand-name medication when a generic equivalent is available, you will be responsible for the difference in cost between the two drugs, in addition to your coinsurance. The difference between the brand and generic-equivalent medication price does not apply toward your annual out-of-pocket maximum (the stop-loss) or the \$100 per-fill maximum. An example of this policy is as follows:
- Non-preferred brand-name drug costs \$75 (generic equivalent costs \$40)
  - You choose the brand-name drug
  - Difference in the cost of drugs = \$75 - \$40 = \$35 (you pay this difference)
  - Copay = 25% of \$40 (cost of generic) = \$10 (higher than the \$7 minimum for generics)
  - Your total payment = \$35 + \$10 = \$45
- Q. What happens if I purchase maintenance drugs at retail for more than three months?**  
**A.** Long-term maintenance medications are less costly if they are purchased through the Medco mail-order service; therefore, your share of the price of these drugs is higher when you elect to fill them at the local retail pharmacy. Beginning in 2009, you will pay 45% of the discounted retail price or a minimum of \$45 (or the actual discounted price, if less) after you refill a maintenance medication three times. Your 45%, or \$45, share of the maintenance medication price does not apply toward your annual out-of-pocket maximum (the stop-loss) or \$100 per-fill maximum.