

Freescale Medical Benefits

Q: How does the Build Your Own (BYO) coverage option work?

A: BYO offers the opportunity to design your own medical plan by making four decisions among the major features of the Freescale Medical Plan:

- Annual deductible and annual out-of-pocket maximums
- Coinsurance (the percentage of the expense the plan pays)
- Doctor's office visit coverage
- Prescription drug coverage

Q: What is a preferred provider organization (PPO)?

A: A preferred provider organization (PPO) is a health care plan designed to supply services at a discounted cost, by providing incentives for you to use designated health care providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by health care providers who are not part of the PPO network. The Freescale Medical Plan is a PPO.

Q: What is a network?

A: A network is a group of physicians, hospitals and other medical care professionals that a medical plan, like the Freescale Medical Plan, contracts with to deliver medical services to its participants.

Q: What is a deductible?

A: A deductible is a flat amount you pay each year before the Freescale Medical Plan begins paying benefits. For Freescale's Medical Plan, your annual deductible does not include amounts you pay for doctor's office visit copayments, behavioral health or vision treatment, or prescription drugs.

Q: What is an out-of-pocket maximum?

A. The out-of-pocket maximum is the annual limit you will pay for most eligible medical expenses after the deductible is met. It includes your deductible and coinsurance. It does not include your copayments, monthly contributions, benefit reductions, amounts greater than reasonable and customary charges or maximum benefits or any expenses the Plan doesn't cover.

Q: What is the annual contribution?

A: The annual contribution is the amount you pay each year to receive coverage for you and your eligible family members from a Freescale benefit plan.

Q: What is coinsurance?

A: Coinsurance is the percentage of covered expenses that the Freescale Medical Plan pays after you first meet your medical deductible. You pay the remaining percentage, plus any amounts above the reasonable and customary level.

Q: What is a copayment?

A: An office visit copayment is a flat fee that you pay for each network doctor office visit. This applies to primary doctors and specialists. Generally, you will pay a higher copayment to visit a specialist.

Q: What doctors are considered primary providers?

A: The following are the Freescale Medical Plan network primary providers:

- Family practitioner
- General practitioner
- Internist
- Behavioral health provider
- Nurse practitioner or certified nurse midwife—but only when billed by a primary physician's office
- Obstetrician/gynecologist (if provider has a office specialty such as Infertility, the doctor is considered a specialist)
- Pediatrician

*Note: all other providers are considered specialist (i.e., allergist, cardiologist)

Q: If I have the “zero deductible” and “no copayment office visit” choices, what do I pay when I have an office visit?

A: When you see a network physician – either a primary care or a specialty physician – the physician will charge you the negotiated network charge for the visit. The plan's benefit will be based on your coinsurance choice – either 90 percent or 80 percent of the negotiated network charge. The physician may ask you to pay the 10 or 20 percent of the network charge at the time of your visit. If the negotiated network charge for the office visit is \$100, you will pay either \$10 or \$20, depending on your coinsurance choice.

If you see a non-network physician, the plan will apply its non-network benefit levels. If you have not met your individual non-network deductible (\$400 under the “Zero Deductible” choice), the charges for the office visit (up to the reasonable and customary level) will apply toward your non-network deductible, and you will pay the physician the full cost of the office visit. If you have met your non-network deductible, the plan's benefit will be based on the non-network benefit under your coinsurance choice (70 or 60 percent).

Q: But suppose I have the “\$750 deductible” and “no copayment office visit” choices. What do I pay for that same office visit?

A: If you see a network physician: The physician will charge you the negotiated network charge for the visit. If this is your first covered expense of the year, you will pay the physician the full cost of the office visit, based on the negotiated network charge, up to \$750.

Once you have met your \$750 individual network deductible for the year, the plan's benefit will be based on your coinsurance choice, either 90 percent or 80 percent of the negotiated network charge. You pay the remaining 10 or 20 percent of the network charge.

If you see a non-network physician: Assuming this is your first covered expense for the year, you must pay the physician the full cost of the visit. The reasonable and customary charge for the visit will apply to your individual non-network deductible, which is \$1,500. Let's suppose that the non-network physician charges \$120 for the office visit, but the reasonable and customary charge is \$100. You would pay the physician \$120, but only \$100 would apply to your individual non-network deductible.

Once you meet your individual non-network deductible of \$1,500, the plan will begin paying benefits based on the non-network benefit under your coinsurance choice (70 or 60 percent of the reasonable and customary charge). You would pay any remaining charges. Amounts you pay above the reasonable and customary level do not apply to your annual deductible or out-of-pocket maximum.

Q: If I am in the middle of getting treatment from a Health Net network provider who is not in the Aetna network, will I have to switch to out-of-network benefits when my Aetna coverage begins?

A: As a temporary bridge to continue an active course of treatment with a non-network provider, you must apply for “Transition of Care” benefits. “Transition of Care” benefits are typically offered for no more than 90 days. When your transition period ends, you must use Aetna network providers in order to receive network benefits. Please contact Aetna's Customer Service at 800-626-1987 for more information.

Caremark Prescription Program

Q: If I use maintenance medicines, do I have to use the CVS/Caremark mail-order pharmacy?

A: Yes. In addition to receiving maintenance medicines in the mail, you have the option to fill a 90-day prescription at a retail CVS Pharmacy while maintaining the same mail order benefits and cost.

Q: What is the purpose of the step therapy program for prescription drugs?

A: The step therapy program is designed to help patients and their doctors find the medicine that is most effective in terms of both cost and medical results for the treatment of high cholesterol and stomach ulcers. You are required to try a generic drug for at least 30 days before using specific brand-name drugs. If you have questions about the treatments or drugs that are part of the Step Therapy Program, contact CVS/Caremark at 877-505-8360, or see www.caremark.com.

Q: What is the difference between brand and generic drugs? Why are there copay/coinsurance differences for various medications?

A: The primary difference between a brand-name drug and a generic drug isn't in the drug itself, but in who makes it and how long it has been on the market. A generic drug is the chemical copy of a brand-name prescription drug, and generally costs less than 50 percent of the cost of brand-name drugs. Generic drugs are dispensed in the same dosage, taken in the same way and packaged in the same unit strength as their brand-name counterparts.

For brand-name drugs, preferred drugs are medications selected by clinical experts after meeting clinical and therapeutic criteria. These drugs help reduce overall out-of-pocket expenses without compromising quality. They are more expensive than generic drugs but less expensive than non-preferred, brand-name drugs.

Q: What if there's no generic available for the medication that I take?

A: Ask your doctor if a generic of another brand-name medication that treats the same condition is appropriate for you. Or ask your doctor for a less expensive, brand-name drug. You should work with your doctor to decide the most appropriate treatment for you.

Q: Why do certain drugs require prior authorization?

A: Certain drugs that have the potential for inappropriate use or are subject to significant safety concerns require prior authorization before they will be covered under Freescale's prescription drug plan.

Q: How does prior authorization work?

A: If you are prescribed a drug that requires prior authorization for coverage, ask your doctor to call Caremark at 888-413-2723 after your enrollment. The best way to avoid inconvenience is to have your doctor call the prior authorization department **before** you go to the pharmacy. This prior authorization line is not for patient use.

Q: How does Caremark's specialty pharmacy services work?

A: Certain chronic and/or genetic conditions require specialty pharmacy products often in the form of injected or infused medicines. This program is designed to contain costs, while offering individual ongoing patient support and utilization management. If you need to take any of these medications, your doctor may contact Caremark Connect at 800-237-2767.

Q: Are compound medications included in the mandatory mail program?

A: Yes, if you need to refill a Compound medication more than twice it will be considered a maintenance medication and will require the use of mail order.

Q: What medical supplies are covered on the prescription benefit plan?

A. Medical supplies are not covered on the prescription benefit plan, however Diabetic supplies are covered. These do require mandatory mail after the 3rd fill.