2. Medical Plan Options

Overview

The Electric Boat Retiree Medical and Prescription Drug Plan offers four (4) medical plan options for Electric Boat retirees and spouses residing anywhere in the United States. All four plans allow you to reside and travel in every state throughout the country while maintaining the exact same level of coverage.

This program offers one Medicare Supplement plan option - a Group Retiree Plan G through United American Insurance Company and three Medicare Advantage PPO plan options through Anthem Blue Cross and Blue Shield. These plans are explained in greater detail and compared in benefits, premium and out-of-pocket costs on pages to follow in this benefit guide.

Any of these four (4) medical plan options can be chosen alongside any of the three (3) prescription drug plan options, described in ***Section 3. Prescription Drug Plan Options.***

Eligibility

Electric Boat retirees, spouses and surviving spouses enrolled in both Medicare Part A and Part B are eligible for these programs. All four (4) retiree medical plans are available to you as long as you reside in the United States.

Retirees and spouses do not have to elect the same medical plan option. Each member can choose the medical plan that best fits their needs.

There are no pre-existing condition exclusions or limitations to enroll in any of these plans.

Making changes to your retiree medical plan option

All members can elect to make a change to their retiree medical plan option once a year during our annual open enrollment. Open enrollment begins on November 1st of each calendar year and members of the plan can elect to make a plan change for January 1st of the following calendar year.

United American Insurance Company
Since 1947

2024 Electric Boat Medical Plan Options
United American Group Retiree Plan G

The United American Group Retiree Plan G is identical in benefits to a "Plan G" under the Federal standardized Medicare supplement plans. Because this is a group plan available only to eligible Electric Boat retirees and spouses, it is referred to as a "Retiree Medical Plan" or "Group Retiree Plan" G.

United American has been committed to the Medicare market since Medicare was introduced in the 1960s. The company has been a leader in providing group retiree Medicare Supplement plans since 1996. They are a financially sound company with an A (excellent) or A+ rating for more than 45 years with A.M. Best Company and publicly traded as Globe Life Inc. To learn more about United American you may visit **https://www2.unitedamerican.com/about .**

The United American Group Retiree Plan G is not an HMO or a Medicare Advantage Plan. You can visit all your physicians without needing a referral. A doctor does not have to choose to participate with United American. There is not a provider network. You will be able to see any Medicare provider or hospital of your choice throughout the country. All hospitals participate in Medicare except for Veteran's Hospitals. Under this program, your providers will bill Medicare; Medicare will pay their portion of the claim and transmit the remainder of the claim to United American to process as the secondary payer.

The United American Group Retiree Plan G will cover your Part A deductible and coinsurance for all Medicare Part A covered services. Medicare Part A covered services include your inpatient room & board charges at an acute care hospital, mental health institution or in a skilled nursing facility. Medicare Part A services may include prescription drugs administered during your inpatient stay as well as physical therapy or other types of therapies and skilled services you receive while admitted. With respect to your Medicare Part B services, you will be responsible for the Medicare Part B deductible only. Once you satisfy your Medicare Part B deductible, which is **$240 in 2024**, Medicare will pay 80% for all your Medicare Part B covered expenses and your United American Group Retiree Plan G will cover the 20% balance of those claims. In this process, while some providers may bill United American, most simply bill Medicare, await the payment from Medicare and then wait for the balance to come along from United American. Providers should not be collecting any copayments or fees from you along the way unless it is for a service that is not covered by Medicare.

Your Medicare Part B covered services include most of your inpatient physician charges as well as all your outpatient services. This would include visits to your internist or specialists, inpatient and outpatient medical and surgical procedures, physical therapy and other outpatient rehabilitation and therapies, lab and x-ray, diagnostic testing, preventive screenings and exams and many other outpatient services and medical supplies.

Most Medicare participating providers accept the Medicare fee schedule as payment in full. This means that these providers "accept Medicare assignment." Some providers do not accept the Medicare fee schedule as payment in full, and therefore, do not accept Medicare assignment. Providers that do not accept assignment are allowed to charge an additional fee of up to 15% above the Medicare allowed amount. This is considered the "excess" or "limiting" charge. The United American Group Retiree Plan G covers the 15% excess charge providers that do not accept Medicare assignment are allowed to charge their Medicare patients.

With that said, the only out-of-pocket expense that you incur under this program for any and all Medicare covered service is the Medicare Part B deductible ($240 in 2024).

Otherwise, all Medicare covered charges will be paid in full by Medicare and the United American Group Retiree Plan G.

When you visit a doctor or hospital, you will show your red, white and blue Medicare card and your United American Group Retiree Plan G member ID card.

If you travel or spend time away from home, your coverage will be the same wherever you go within the U.S.

Medicare does not cover you while traveling outside of the country. The United American Group Retiree Plan G does provide some foreign travel coverage. For urgent or emergent claims incurred within the first 60 days of each trip outside of the country, United American will pay 80% up to a $50,000 lifetime benefit maximum and subject to a $250 deductible.

In general, all claims are processed electronically so the system is virtually paperless.

The United American Group Retiree Plan G offers an additional benefit beyond Original Medicare - a membership in the Silver & Fit program. The Silver & Fit exercise and healthy-aging program provides access to over 14,000 fitness centers and select YMCAs across the country. A directory of participating fitness centers and facilities in your area and more information regarding the Silver & Fit program can be found on their website at **https://www.silverandfit.com/.**

2024 Electric Boat Medical Plan Options
Anthem Medicare Preferred PPO Plans

Through Anthem Blue Cross and Blue Shield, we have three additional medical plans available to retirees and spouses living anywhere in the U.S. These Anthem Medicare Preferred PPO plans are Medicare Advantage Plans. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private insurance companies and approved by Medicare. These Medicare Advantage plans function differently than the United American Group Retiree Plan G and offer a higher level of benefits at a lower premium cost.

In a nutshell, Medicare Advantage Plans, like the Anthem Medicare Preferred PPO plans, are made possible due to a financial arrangement between Medicare and the insurance companies that have contracted to provide Medicare benefits. When you join a Medicare Advantage Plan, Medicare pays a monthly subsidy to the plan and the plan provides benefits that are equal to or better than those under Original Medicare. Medicare Advantage Plans often offer extra coverage above and beyond Original Medicare, such as vision, hearing and other health and wellness programs.

Unlike the United American Group Retiree Plan G where coverage is secondary to Medicare, the Anthem Medicare Preferred PPO plan becomes the sole payer of all covered benefits on behalf of Medicare. The Anthem Medicare Preferred PPO plans provide a single source of coordinated care and coverage for all of your Medicare Part A (Hospital) and Medicare Part B (Medical) services. Therefore, when you are enrolled in any of the Anthem Medicare Preferred PPO plans, you only show providers your Anthem Medicare Preferred PPO member ID card and your provider bills the plan directly. Members of these plans do not need to show their red, white and blue Medicare card.

The Anthem Medicare Preferred PPO has a network of contracted providers that is national in scope and provides the same level of coverage in all 50 states as well as other U.S. territories such as Puerto Rico, Washington D.C., Guam, U.S. Virgin Islands, American Samoa and the Northern Mariana Islands. The name of this national Blue Cross and Blue Shield plan most recognized by providers is ***National Access Plus***. These plans are PPO plans, which stands for Preferred Provider Organization, and were specifically designed to provide the same exact level of coverage regardless of whether your providers participate in the network or not.

The providers that participate in the Anthem Medicare Preferred PPO network through ***National Access Plus*** have contracted with Anthem or their local Blue Cross Blue Shield affiliate and have agreed to a negotiated fee for their services. Non-participating or "non-network" providers are paid at 100% of the Medicare fee schedule less any member copayments, coinsurance or deductibles if any apply.

Non-network providers who participate in Original Medicare but do not accept Medicare assignment may balance bill the plan up to applicable federal and state limiting charges. These balance billed charges are considered "excess charges" and these charges are covered under the PPO plans as well. Members of these plans are not liable for balance billed amounts.

Your provider must simply bill Anthem Blue Cross and Blue Shield or their local Blue Plan in the state where you access care. You will have the same member cost share regardless of whether you see network or non-network providers.

These PPO plans are open access plans which means no referrals are required for members to see specialists.

The three Anthem Medicare Preferred PPO Plans, which we refer to as the High Option, Base Option and Low Option plans, work exactly the same from an administrative standpoint; however, they do differ in premium and in cost shares paid by you as a member of the plan.

The High Option plan, for example, has the highest monthly premium of the three plans; however, all covered services are paid at 100%. The Base Option plan is lower in monthly premium but there are small copays for some services. The Low Option plan is even lower in monthly premium, however, it has a small calendar year deductible and coinsurance for many services.

The Anthem Medicare Preferred Base Option and Low Option PPO plans include an annual out-of-pocket maximum protecting members of the plan by limiting their financial exposure in any given year for covered medical expenses.

Network providers are required to request prior authorization for some services covered under the plan based on their contract with Anthem Blue Cross and Blue Shield or their local Blue Cross affiliate. Non-network providers are encouraged to seek prior authorization for some services covered under the plan, however, prior authorizations are not required.

The Anthem Medicare Preferred PPO plans offer some enhancements to Original Medicare benefits, such as:

- **The Medicare required inpatient 3 day hospital stay is waived** prior to accessing covered services in a skilled nursing facility.
- **Unlimited hospital days**
- **Annual routine physical exams** are covered in addition to the Medicare-covered "Annual Wellness Visit."
- **Routine hearing exams** are covered up to a $70 maximum benefit annually.
- **Routine eye exams are covered, refraction included** – a $70 maximum annual benefit through **Blue View Vision** and $100 towards eyewear every two years.
- **A $1,500 hearing aid benefit** is available every three years through **Hearing Care Solutions.**
- **Routine foot care** is covered up to **twelve (12)** visits per year in addition to Medicare-covered foot care.

- **Healthy meal deliveries** after an inpatient stay – 14 meals per qualifying event - 56 max annually – or for other qualifying reasons such as low BMI (18.5 or under) or high BMI (25 or higher) or A1C level of more than 9.0 as determined by your medical provider.
- **The Silver Sneakers Fitness Program** – a free basic membership to participating centers in your area. This benefit also includes SilverSneakers LIVE & On-Demand online classes and access to the SilverSneakers Mobile app - SilverSneakers GO.
- **Routine transportation** - covers up to 12 one-way trips annually to medical visits, the pharmacy and even to a Silver Sneakers location! A trip is limited to 60 miles. Benefit is available through Access2Care - trips can be scheduled by calling **1.888.479.3249.**
- A **24-hour Nurse Help Line** is available seven days a week at **1.800.700.9184**.
- **Sydney Health mobile app** provides easy access to digital ID cards, benefit information, claims data, finding providers and other helpful health & wellness tools. The mobile app provides Live Chat capabilities with Anthem Blue Cross Blue Shield representatives.
- **Video doctor visits** are covered at NO cost through LiveHealth Online accessed at **www.livehealthonline.com** or via the LiveHealth online mobile app.
- **Anthem disease and care management programs**
- **Diabetes education and prevention programs**
- **House Calls program** through Matrix Medical Network
- **Cancer Care Navigator program -** helps members understand their cancer diagnosis and treatment plans and designed to improve the patient experience and improve quality outcomes.
- **COVID Concierge Care program -** features remote monitoring and support of members with long-haul symptoms of Covid-19 through direct connections with a clinician via text or email. Members can access evidence-based educational tools and wellness content to help self-manage symptoms. This program provides easy access to a care management team to support long-haulers and high risk members - giving them a convenient way to improve the recovery experience.
- **Special Offers @ Anthem** – discount programs for vision wear, hearing aids, weight loss programs, alternative wellness products, vitamins, allergy products and much more!
- **Expanded foreign travel benefit** – emergent or urgent care while traveling outside of the U.S. for a period less than six months through Blue Cross Blue Shield Global Core program. Plan covers inpatient care up to a maximum of 60 days (per lifetime). There is no benefit maximum for emergent and urgent outpatient care. Provider reimbursements are based on the Medicare fee schedule. The BCBS Global Core representatives can be reached at **1.800.810.2583** or by calling collect at **1.804.673.1177** - 24 hours a day; 7 days a week; 365 days a year.

The Anthem Blue Cross Blue Shield member services team is available by calling 1.833.848.8730 Monday through Friday from 8am to 9pm EST, except holidays.

The comparison chart on the following pages illustrates the premium cost and benefit differences between the United American Group Retiree Plan G and the Anthem Blue Cross and Blue Shield Medicare Preferred High, Base and Low PPO medical plans being offered in 2024.