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Important Information about Your Medicare D Prescription Benefit

Medicare-eligible participants in the United Healthcare Indemnity plan will continue to be enrolled in the prescription drug coverage unless you notify Harris within 21 days of receipt of this letter that you do not want to join this plan. This coverage is considered to be Medicare Part D coverage and continues to be provided to you through Express Scripts Insurance Company, who contracts with the federal government. This prescription drug coverage is at least as good as the standard Medicare prescription drug coverage, and is therefore considered Creditable Coverage.

What to do if you want to continue to participate in the Harris United Healthcare Medical Plan

If you want to participate in the Express Scripts Medicare D plan offered through Harris, *you don't need to take any action. You should have already received a new prescription ID card in the mail.* Please begin using this card on January 1, 2012. If you haven't received it, please contact Express Scripts at 888/251-2073.

What to do if you want to opt out of the Express Scripts Pharmacy Plan

If you would prefer to opt out of this plan, you may do so, but you will lose your medical coverage with Harris unless you change to another Harris-sponsored Medicare HMO, if available in your area. To opt-out of this coverage or change your healthcare election, notify the Harris Benefits Service Center in writing of your decision within 21 days of receipt of this letter. Otherwise, you will be enrolled into this Medicare Part D plan for 2012. If you choose to opt out of this coverage, you should consider joining a new prescription drug plan as soon as possible. If you decide not to join a prescription drug plan and have opted out of this coverage, you may be subject to a late enrollment penalty if you choose to join a Part D plan later.

Generally, Medicare limits when you can make changes to your coverage. You can join a new Medicare Prescription Drug Plan or Medicare Health Plan from **November 15 to December 31**. Coverage starts in January. You may not join a new plan during other times of the year except in special cases.

If Medicare decides that you need extra help with paying plan costs, you may join or leave a plan at any time. If Medicare decides that you no longer need extra help, you may make changes for two months after Medicare tells you about its ruling.

Important Information

This coverage is available to Harris Corporation's Medicare-eligible retirees and disabled employees, or those individuals who qualify for Medicare Part A and/or are enrolled in Medicare Part B.

The prescription drug benefit under Harris' United Healthcare Indemnity Plan is a Medicare drug plan. Your enrollment in the Harris Medical Plan assumes you are enrolled in Medicare Part A or Part B and does not impact your eligibility for that coverage.

You cannot be enrolled in more than one creditable Medicare Part D plan. If you have Medicare medical or drug coverage from any other source, you cannot participate in the Harris plan.

You must live within the service area to join this plan. The service area for this plan includes all 50 states and Puerto Rico.

As a participant in the Harris Medical Plan, you have the right to appeal plan decisions about payment or services if you disagree.

How to get help with drug plan costs

Medicare beneficiaries with low or limited income and resources may qualify for additional assistance. If you qualify, your medical plan premium and/or your drug costs at the pharmacy will be less. If you are not receiving this additional assistance, you should contact 1-800-MEDICARE (1-800-633-4227) to see if you might qualify.

How your coverage will work

To let you know how your coverage will work, the table on the following pages provides information on your benefits, including deductible, premium and cost-sharing information.

| Your Prescription Drug Benefit with Harris Corporation | |
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| Covered Drugs | This plan uses a formulary, or a list of drugs covered by your plan to meet patient needs. Express Scripts may periodically add or remove drugs; make changes to coverage limitations on certain drugs or change how much you pay for a drug. If there is a formulary change that limits your ability to fill a prescription, Express Scripts will notify you before the change is made. |
| Premium | Each month, each Medicare-eligible retiree will need to pay \$220 per individual, to continue participation in the United Healthcare medical plan, including the Express Scripts pharmacy benefit. |

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| Initial Coverage | <p>You will pay the following when you get your prescription drugs on an in-network basis:</p> <table border="1" data-bbox="516 218 1430 848"> <tr> <td colspan="2">RETAIL COPAYS</td> </tr> <tr> <td>Generic:</td> <td>\$7</td> </tr> <tr> <td>Formulary Brand:</td> <td>20% (Minimum - \$25; Maximum - \$75)</td> </tr> <tr> <td>Non-Formulary Brand:</td> <td>50% (Minimum - \$50; Maximum - \$100)</td> </tr> <tr> <td>High Cost Specialty</td> <td>50% (Minimum - \$50; Maximum - \$100)</td> </tr> <tr> <td colspan="2">RETAIL COPAYS (HARRIS FAMILY MEDICAL CENTER)</td> </tr> <tr> <td>Generic:</td> <td>\$5</td> </tr> <tr> <td>Formulary Brand:</td> <td>20% (Minimum-\$18.75;Maximum-\$56.25)</td> </tr> <tr> <td>Non-Formulary Brand:</td> <td>50% (Minimum-37.50;Maximum - \$75)</td> </tr> <tr> <td>High Cost Specialty</td> <td>50% (Minimum-37.50;Maximum - \$75)</td> </tr> <tr> <td colspan="2">MAIL ORDER COPAYS (up to 90-day supply)</td> </tr> <tr> <td>Generic:</td> <td>\$17.50</td> </tr> <tr> <td>Formulary Brand:</td> <td>20% (Minimum-\$62.50; Maximum-\$187.50)</td> </tr> <tr> <td>Non-Formulary Brand:</td> <td>50% (Minimum-\$125;Maximum - \$250)</td> </tr> <tr> <td>High Cost Specialty</td> <td>50% (Minimum-\$125;Maximum - \$250)</td> </tr> </table> <p>Note: A \$15 penalty applies to out-of-network claims. For 2012, you stay in this stage until the total cost of your Part D drug reaches \$2,930. Once you reach this limit, you move on to the Coverage Gap Stage.</p> | RETAIL COPAYS | | Generic: | \$7 | Formulary Brand: | 20% (Minimum - \$25; Maximum - \$75) | Non-Formulary Brand: | 50% (Minimum - \$50; Maximum - \$100) | High Cost Specialty | 50% (Minimum - \$50; Maximum - \$100) | RETAIL COPAYS (HARRIS FAMILY MEDICAL CENTER) | | Generic: | \$5 | Formulary Brand: | 20% (Minimum-\$18.75;Maximum-\$56.25) | Non-Formulary Brand: | 50% (Minimum-37.50;Maximum - \$75) | High Cost Specialty | 50% (Minimum-37.50;Maximum - \$75) | MAIL ORDER COPAYS (up to 90-day supply) | | Generic: | \$17.50 | Formulary Brand: | 20% (Minimum-\$62.50; Maximum-\$187.50) | Non-Formulary Brand: | 50% (Minimum-\$125;Maximum - \$250) | High Cost Specialty | 50% (Minimum-\$125;Maximum - \$250) |
| RETAIL COPAYS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Generic: | \$7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Formulary Brand: | 20% (Minimum - \$25; Maximum - \$75) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Non-Formulary Brand: | 50% (Minimum - \$50; Maximum - \$100) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High Cost Specialty | 50% (Minimum - \$50; Maximum - \$100) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RETAIL COPAYS (HARRIS FAMILY MEDICAL CENTER) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Generic: | \$5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| High Cost Specialty | 50% (Minimum-\$125;Maximum - \$250) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coverage Gap Stage | <p>Once the total cost of your Part D drugs reaches \$2,930, you move into the Coverage Gap. Your total drug costs include both the plan’s drug costs and your drug costs. You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700. This is the amount you must pay out-of-pocket to qualify for Catastrophic Coverage.</p> <p>Due to the secondary supplemental coverage outlined previously, your co-pays during the Coverage Gap Stage will remain the same as during the Initial Coverage Stage.</p> <p>The Medicare Coverage Gap Discount Program will provide manufacturer discounts on Part D applicable drugs, typically brand name drugs, in the coverage gap for members who are not already receiving “Extra Help.” A 50% discount on the negotiated drug price is available for those applicable drugs from manufacturers that have agreed to pay the discount. This discount will be provided to the plan on your behalf to help pay for drug costs. This amount will appear on your Explanation of Benefits (EOB) under other payments as “Medicare Coverage Gap Discount Program.” This amount will also apply to your out-of- pocket amount.</p> <p>You will continue to pay the same amount for your prescription drugs as you did during the Initial Coverage Stage. For specific co-pay detail refer to the “Initial Coverage Stage” section of this grid.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Catastrophic Coverage | <p>You qualify for the Catastrophic Coverage Stage when your true out-of-pocket costs, also known as TrOOP, have reached the limit set by CMS for the plan year. For 2012, that amount is \$4,700. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.</p> <p>Different costs apply to MOP and TrOOP. Because of this, you may reach the Catastrophic Stage (\$4,700 TrOOP) prior to reaching the plan's maximum out-of-pocket \$2,500 MOP). If you do reach the Catastrophic Stage prior to meeting your MOP, you will pay the greater of:</p> <ul style="list-style-type: none"> • \$2.60 for generic drugs and \$6.50 for all other drugs OR • 5% co-insurance <p>For more information on costs that are applied towards MOP and TrOOP, please refer to "How Does TrOOP Differ from MOP?" section of this document on page 3.</p> |
| Out-Of-Pocket Limit | <p>There is an annual Out-Of-Pocket limit of \$2,500 per individual applied to prescription drugs. After you reach that limit, you will not be responsible for further copayments or coinsurance, other than penalties, which still apply.</p> |
| In-Network Retail Pharmacy | <p>All retail pharmacies in your plan's network can provide you with a one-month or up to a 30-day supply of your prescription.</p> <p>Certain retail pharmacies may be able to provide you with a three-month supply of your prescription. To find out if your pharmacy offers a three-month or up to a 90-day supply, contact Express Scripts at the number located on the back of your ID card.</p> |
| Part B | <p>Medicare Part B drugs may be covered through your medical benefit. Check with United Healthcare for more information.</p> |
| Mail Order through Express Scripts' Home Delivery | <p>You may receive a three-month or up to a 90-day supply of maintenance drugs (drugs you take for a chronic condition, such as asthma) through our Home Delivery service.</p> |
| General Information/Restrictions | <p>In some cases, you may need to first try one drug to treat your medical condition before your plan will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from Express Scripts for certain prescription drugs.</p> |

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| Medication Therapy Management (MTM) Program | A Medication Therapy Management (MTM) Program is a service that your plan may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. If you have questions concerning our MTM Program, please contact Express Scripts' Customer Service at 888/251-2073. |
| Out-of-Network Pharmacies | Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy. Please contact Express Scripts at 888/251-2073. |

More information on your plan, including your costs and plan programs, is available in your other plan documents. Please refer to your other plan documents to learn more about your plan.

How Does TrOOP Differ from Out-of-Pocket Limit?

The maximum out-of-pocket is an amount set by the Harris Medical Plan. This amount can include your costs for both Part D and non-Part D eligible drugs. True out-of-pocket (TrOOP) is defined by CMS and cannot include costs for non-Part D eligible drugs. Additionally, discounts associated with the Coverage Gap Discount Program will count towards your true out-of-pocket (TrOOP) costs as if you had paid this amount but will not count towards your plan's maximum out-of-pocket amount.

About Express Scripts

Express Scripts Prescription Drug Plan is a standalone prescription drug plan with a Medicare contract.

All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply. This document is available in alternate formats or languages. For more information contact Customer Service at 888/251-2073.

Release of Information

By joining this Medicare prescription drug plan, you acknowledge that Harris Corporation will release your information to Medicare and other plans as necessary for treatment, payment and healthcare operations. You also acknowledge that the Harris Corporation drug plan will release your information, including your prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you have questions about the new plan or would like to opt out of this coverage, please review your plan documents or contact the Harris Benefits Service Center at 321/674-4275 or 800/225-4343, 7:45 – 6:00, ET, workdays.