New York New England MEP PPO Side-by-Side—Current Plan and 9/14 MOU

	Cur	rent Plan		0/14 MOU
Contributions	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	-		■ 2012: \$30/\$60 [1] ■ 2013: \$45/\$90 [1] ■ 2014: \$50/\$100 [1] ■ 2015: \$55/\$110 [1]	
Individual	■ \$250 ■ Retirees: based on retireme	ent date	■ 2013: \$400 ■ 2014: \$450 ■ 2015: \$475 ■ Retirees: based on retirement date ■ Retired on or after January 1, 2013: same as active Combined in- and out-of-network	
		-x	4	■ 2013: \$250 ■ 2014: \$250 ■ 2015: \$250
amily	2.5 x	Individual	, = ,	■ Additional applied to out-of-network
Hospital	None	Deductible applies to certain services	Deductible applies	(Individual [2] Deductible applies
Carryover	Expenses applied during Octo apply to the ne	ober, November or December also ext year's deductible	TO THE STATE OF THE PROPERTY O	er, November or December also apply to year's deductible

	Current Plan		0/14 N6011	
Charges Excluded From	In-Network	Out-of-Network	9/14 MOU	
Deductible	■ Copay for office visits ■ Copays for visits to urgent car ■ Charges payable when pre-actinpatient basis and the inpatient medically necessary ■ Charges payable when select on an inpatient basis and the admedically necessary ■ Charges for services and supping Plan ■ Expenses for prescription druge Charges that exceed R&C, NNI	re facilities or emergency rooms dmission testing is done on an tadmission is not considered outpatient surgery is performed lmission is considered not elies not covered by the Medical	In-Network Flat dollar copays paid for media Copays for visits to urgent care for Charges paid for failure to follow Charges for services and supplies Expenses for prescription drugs Charges that exceed MAA, NNF or Amounts for LASIK services	acilities or emergency rooms precertification procedures not covered by the Medical Plan

	- Color Colo	nt Plan	0	/14 MOU
	In-Network	Out-of-Network	In-Network	
Out-of-Pocket Maximum	(Calendar Year)		TIPINETWORK	Out-of-Network
Individual	Maximums are per individual per year; combined family max is not applicable		■ 2013: \$1,050 ■ 2014: \$1,100 ■ 2015: \$1,150 Combined In- and out-of-network	■ 2013: \$950 ■ 2014: \$900 ■ 2015: \$900
Family			2.5x	Additional applied to out-of-network Individual [2]
Charges Excluded From Out-of-Pocket Maximum Coinsurance Based On:	not applicable Copays for office visits, hospital charges, surgery, outpatient laboratory tests and outpatient x-rays Copays for visits to urgent care facilities or emergency rooms Amounts paid to satisfy the deductible Charges for services and supplies not covered by the Medical Plan Additional amounts paid for not following precertification		 Charges for services and suppli 	nual and infertility lifetime maximums es not covered by the Medical Plan of following precertification program or other Medical Plan limits
omsurance based Un:	Network Negotiated Fee (NNF)	Reasonable and Customary Charges (R&C)	Network Negotiated Fee (NNF)	Maximum Allowed Amount (MAA)

		nt Plan	7	14 MOH
Outpatient Treatment	In-Network	Out-of-Network	In-Network	14 MOU
Oddpadent Treatment			DENECWORK	Out-of-Network
Doctors' Home or Office Visits	\$15 copay (\$5 copay Medicare- eligible)	80% covered after deductible Reasonable and Customary limits apply		70% covered after deductible
Preventive Care	100% covered, no deductible;	1000	1	Ľ
	age/frequency limits apply	100% covered, no deductible age/frequency limits apply; Reasonable and Customary limits apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
Routine Well-Baby and	100% covered, no deductible;	100%		
Well-Child Care (Pediatric Exams)	age/frequency limits apply	100% covered, no deductible; age/frequency limits apply; Reasonable and Customary limits apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
K rays and Lab Tests	100% covered, no deductible		11 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	
	20070 COVETEU, NO BEOLECTIBLE	100% covered (deductible applies if hospital charges billed for diagnostic, no deductible for preventive); Reasonable and Customary	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible
ladiation Therapy /	100% covered, no deductible	TODY - CONTROL OF TOTAL		
Chemotherapy / Electroshock Therapy / Hemodialysis	hospital outpatient; \$15 copay (\$5 copay Medicare-eligible) if done in physician's office	100% covered, no deductible; Reasonable and Customary limits apply	90% covered after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in physician's office	70% covered after deductible
hysical, Occupational	80% covered of NNF [4] after	80% covered after deductible;		
nd Speech Therapy	deductible	Reasonable and Customary limits apply	80% covered after deductible; number of visits based on medical necessity	70% covered after deductible; number of visits based on medical necessity

S	Curren	t Plan	9/1	4 MOU
	In-Network	Out-of-Network	In-Network	Out-of-Network
Licensed Chiropractor	80% covered of NNF [4] after deductible; limited to \$750 per calendar year; limit combined in-and out-of-network; \$750 limit does not apply to IBEW local 827; maintenance services are not covered	80% covered after deductible; limited to \$750 per calendar year; limit combined in- and out-of-network; \$750 limit does not apply to IBEW local 827; maintenance services are not covered; Reasonable and Customary limits apply	80% covered after deductible; limited to 60 visits per calendar year (not to exceed 1 visit per day); limit combined in- and out-of- network	\$20 copay plus difference between \$92 flat fee and cost of service; limited to 60 visits per calendar year (not to exceed 1 visit per day); limit combined in- and out-of-network
Home Health Care	100% covered, no deductible; precertification required; limited to 120 visits per plan year [1]	100% covered, no deductible; precertification required; limited to 120 visits per plan year [1]	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Inpatient Hospital Service				
Hospital Copay	None	None	None	None
Room and Board	100% covered, no deductible; no precertification required [1]	100% covered after deductible; limited to 120 days per admit; 80% covered after the 120th day; precertification required [1]	90% covered after deductible	70% covered after deductible; precertification required
In-Hospital Physician's Visits	100% covered, no deductible	98% covered, no deductible	90% covered after deductible	70% covered after deductible
X rays and Lab Tests	100% covered, no deductible	100% covered, no deductible; Reasonable and Customary limits apply	90% covered after deductible	70% covered after deductible
Maternity Care (Pre/Post Natal)	100% covered, no deductible	98% covered, no deductible	\$20 copay (\$10 copay Medicare- eligible)—initial visit only	70% covered after deductible
Newborn Baby Care	100% covered, no deductible	98% covered, no deductible	90% covered after deductible [3]	70% covered after deductible [3]

11 11 11 11 11 11 11 11 11 11 11 11 11	Curren	nt Plan	9/14	MOU
8 15	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing Facilities	100% covered, no deductible; precertification required [1]	100% covered, no deductible; precertification required [1]; limited to 120 days per admit; 80% covered after deductible after the 120th day; Reasonable and Customary limits apply	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Birthing Centers	100% covered, no deductible; precertification required	100% covered after deductible; precertification required	90% covered after deductible	70% covered after deductible; precertification required
Hospice Care	100% covered, no deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice	100% covered, no deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Surgery and Anesthesia				
Second Opinions	100% covered, no deductible	100% covered, no deductible	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible
Inpatient Surgery	100% covered, no deductible; precertification required	98% covered, no deductible; precertification required	90% covered after deductible; precertification required	70% covered after deductible; precertification required
Outpatient Surgery	100% covered, no deductible	98% covered, no deductible	90% covered after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in the physician's office	70% covered after deductible
Anesthesia	100% covered, no deductible	98% covered, no deductible	90% covered after deductible	70% covered after deductible

	Current Plan		9/14 MQU	
	In-Network	Out-of-Network	11-11-11	
Lifetime Maximum		OST OF RELIGION	In-Network	Out-of-Network
Medical	No	ne		
Infertility			10-7/1/1 1 14-65 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	None
, and the second	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 100% covered after deductible [5] precertification required	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 80% covered after deductible [5]; precertification required	both in-network and out-of- network): 90% covered after	\$20,000 per family (combined with prescription drugs and for both in network and out-of-network); 70% covered after deductible [4]; precertification required
Obesity	Possession in the second second in the second secon		authorized by claims administr	reatment of clinical obesity when pre rator. Includes medically necessary libed by physician, up to \$500 per yea

		nt Plan	54	
Mental Health/Substance	In-Network	Out-of-Network	In-Network 9/14	1 MOU
Inpatient Mental Health				Out-of-Network
Care	100% covered after deductible is met; limited to 30 days; 80% covered for additional days; precertification required	is met; limited to 30 days; 80% covered for additional days; precertification required; Reasonable and Customary limits apply	90% covered after deductible	70% covered after deductible; precertification required
Outpatient Mental Health Care	80% covered after deductible is met [3]	80% covered after deductible is met; Reasonable and Customary limits apply [3]	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible
Inpatient Substance	100% covered after deductible is	100% covered after deductible		
Abuse Treatment	met; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient	is met; limited to 60 days per lifetime; limits combined in-	90% covered after deductible	70% covered after deductible
	out-of-network and inpatient and outpatient; each outpatient i	is met; limited to 60 days per lifetime; limits combined in-	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible

		nt Plan	9/1	4 MOU
Other Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment	80% covered of NNF [4] after deductible	80% covered after deductible; Reasonable and Customary limits apply	The state of the s	70% covered after deductible; precertification required for items ove \$5,000
Ambulance Services	80% covered of NNF [4] after deductible	80% covered after deductible; Reasonable and Customary limits apply	 90% covered after deductible if a 70% covered after deductible if r 	n emergency on-emergency
Prosthetic Devices	80% covered of NNF [4] after deductible	80% covered after deductible; Reasonable and Customary limits apply	80% covered after deductible; precertification required for items over \$5,000	70% covered after deductible; precertification required for items ove \$5,000
Jrgent Care	\$15 c	Opav	600 440	
mergency Room Care potnotes	[1] To calculate the 120-day limit, each day in a hospital counts as a full day, each day in a skilled nursing facility counts as one half-day, and each home health facility counts as one half-day, and each home health care visit counts as one-fifth of a day. The instance of the second se		\$20 copay (\$10 co	pay Medicare-eligible) eligible); copay waived if admitted
			HRA and \$600 annual credit for nor [2] Family amount can be any comb individual would never satisfy more	ination of family members but an than his/her own individual amount the mother a separate deductible and

New York New England HCN Side-by-Side—Current Plan and 9/14 MOU

	Curren	t Plan		10U 9/14/2012
	In-Network	Out-of-Network	In-Network	Out-of-Network
ontributions	No	ne	■ 2012: \$30/\$60 [1] ■ 2013: \$45/\$90 [1] ■ 2014: \$50/\$100 [1] ■ 2015: \$55/\$110 [1]	
ndividual	None	\$250	None	■ 2013: \$700 ■ 2014: \$700 ■ 2015: \$725
amily	None	N/A	None	2.5x Individual [2]
lospital arryover	None	Deductible applies	None	Deductible applies
harges Excluded From Deductible	 Amounts paid for in-network care Copays for visits to urgent care facilities or emergency rooms Amounts payable when pre-admission testing is done on an inpatient basis and the inpatient admission is considered not medically necessary 		■ Amounts paid for in-network c ■ Flat dollar copays paid for med t ■ Amounts payable when pre-ad the inpatient admission is consid	lical care mission testing is done on an inpatient basis ar
	 ■ Amounts payable for a covered surperformed on an inpatient basis and necessary ■ Charges for services and supplies necessary ■ Expenses for prescription drugs ■ Charges that exceed R&C, NNF or continuous 	gery when the surgery is is not considered medically ot covered by the Medical Plan	Amounts payable for a covered inpatient basis and is not consider	d surgery when the surgery is performed on an ered medically necessary les not covered by the Medical Plan s

	Current	Plan	Mo	OU 9/14/2012
	In-Network	Out-of-Network	In-Network	Out-of-Network
ut-of-Pocket Maximums (C	alendar Year)			The state of the s
ndividual	None	\$1,500	■ 2013: \$1,000 ■ 2014: \$1,000 ■ 2015: \$1,050 Combined	in- and out-of-network
	Marino		-	\$800 additional applied to out-of-network
amily	Maximums are per individual per year; combined family max is not applicable		ž 2.5x Individual [2]	
-Pocket Maximum	applicable t- Copays for office visits, hospital charges, surgery, outpatient laboratory tests and outpatient x-rays Copays for visits to urgent care facilities or emergency rooms Amounts paid to satisfy the deductible Charges for services and supplies not covered by the Medical Plan Additional amounts paid for not following precertification program procedures Charges that exceed R&C, NNF or other Medical Plan limits Expenses for prescription drugs		 Flat dollar copays paid for medic Charges for services and supplie 	cal care s not covered by the Medical Plan following precertification program
pinsurance Based On:	Network Negotiated Fee (NNF)	Reasonable and Customary Charges (R&C)	Network Negotiated Fee (NNF)	Maximum Allowed Amount (MAA)

	Current I	Plan	MOU	J 9/14/2012
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Treatment				
octors' Home or Office isits	\$15 copay (\$5 copay Medicare- eligible)	80% covered; after deductible; Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare- eligible) (PCP)/ \$25 copay (\$15 copay Medicare-eligible) (Specialist)	70% covered after deductible
reventive Care	\$15 copay (\$5 copay Medicare- eligible)	80% covered, no deductible for routine physical exams and related tests; Reasonable and Customary limits apply	100% covered; age and frequency provisions of the Affordable Care Act apply	80% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
outine Well-Baby and Well- hild Care (Pediatric Exams)	\$15 copay (\$5 copay Medicare- eligible)	80% covered, no deductible for routine physical exams and related tests; Reasonable and Customary limits apply	100% covered; age and frequency provisions of the Affordable Care Act apply	80% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
rays and Lab Tests	100% covered; \$15 copay (\$5 copay Medicare-eligible) if done in physician's office	80% covered; after deductible; Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible
adiation Therapy / hemotherapy / lectroshock Therapy / emodialysis	100% covered hospital outpatient; \$15 copay (\$5 copay Medicare-eligible) if done in physician's office	80% covered; after deductible; precertification required; Reasonable and Customary limits apply	90% covered hospital outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in the	70% covered after deductible; precertification required
hysical, Occupational and peech Therapy	100% covered; \$15 copay (\$5 copay Medicare-eligible) for evaluations; number of visits based on medical necessity	80% covered; after deductible; number of visits based on medical necessity; Reasonable and Customary limits apply	90% covered; \$20 copay (\$10 copay Medicare-eligible) for evaluations; number of visits based on medical necessity	70% covered after deductible; number of visits based on medical necessity
censed Chiropractor	\$15 copay (\$5 copay Medicare- eligible); limited to \$750 per calendar year; limit combined in- and out-of- network; \$750 limit does not apply to IBEW Local 827; maintenance services not covered	80% covered after deductible; limited to \$750 per calendar year; limit combined in- and out- of-network; \$750 limit does not apply to IBEW local 827; maintenance services are not covered; Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare- eligible); number of visits based on medical necessity; limited to \$750 per calendar year; limit combined in- and out-of-network; maintenance services not covered	70% covered after deductible; number of visits based on medical necessity; limited to \$750 per calendar year; limit combined in and out-of-network; maintenance services not covered

	Current I	Plan	MOU 9/14/2012	
	In-Network	Out-of-Network	In-Network	Out-of-Network
lome Health Care	100% covered; precertification required; limited of 120 visits per plan year [1]	80% covered after deductible; precertification required; limited to 120 visits per plan year [1]; Reasonable and Customary limits apply	100% covered; precertification required; limited to 120 visits per plan year [3]; limit combined in- and out-of-network	70% covered after deductible; precertification required; limited to 120 visits per plan year [3]; limit combined in and out-of-network
patient Hospital Service				
ospital Copay	None	None	None	None
oom and Board	100% covered	80% covered after deductible; precertification required; Reasonable and Customary limits apply	90% covered	70% covered after deductible; precertification required
n-Hospital Physician's Visits		80% covered after deductible; Reasonable and Customary limits apply	90% covered	70% covered after deductible
rays and Lab Tests	100% covered	80% covered after deductible; Reasonable and Customary limits apply	90% covered	70% covered after deductible
laternity Care (Pre/Post atal)	\$15 copay (\$5 copay Medicare- eligible)—initial visit only	80% covered after deductible; Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare- eligible)—initial visit only	70% covered after deductible
ewborn Baby Care	100% covered	80% covered after deductible; Reasonable and Customary limits apply	90% covered	70% covered after deductible
killed Nursing Facilities	100% covered; precertification required; limited to 120 days per plan year [1]	80% covered after deductible; precertification required; limited to 120 days per plan year [1]; Reasonable and Customary limits apply	100% covered; precertification required; limited to 120 days per plan year [3]; limit combined in- and out-of-network	70% covered after deductible; precertification required; limited to 120 days per plan year [3]; limit combined in- and out-of-network
irthing Centers	100% covered	80% covered after deductible; Reasonable and Customary limits apply	90% covered	70% covered after deductible; precertification required

	Current I	Plan	Mou	9/14/2012
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice Care	100% covered; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care [2]	80% covered after deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care [2]; Reasonable and Customary limits apply	100% covered; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care [4]	70% covered after deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care [4]
iurgery and Anesthesia				
iecond Opinions	100% covered; PCP referral required	Not covered	\$20 copay (\$10 copay Medicare- eligible) (PCP) / \$25 copay (\$15 copay Medicare-eligible) (Specialist)	Not covered
npatient Surgery	100% covered; precentification required	80% covered after deductible; precertification required [4]; Reasonable and Customary limits apply	90% covered; precertification required	70% covered after deductible; precertification required
Outpatient Surgery	100% covered hospital outpatient; \$15 copay (\$5 copay Medicare-eligible) If done in physician's office	80% covered after deductible; precertification required; Reasonable and Customary limits apply	90% covered; \$20 copay (\$10 copay Medicare-eligible) (PCP) / \$25 copay (\$15 copay Medicare-eligible) (Specialist) if done in the physician's	70% covered after deductible; precertification required
nesthesia	100% covered	80% covered after deductible; Reasonable and Customary limits apply	90% covered	70% covered after deductible
ifetime Maximum //edical				
nfertility	None			None
	\$20,000 per family (combined with prescription drugs); 100% covered [6]; precertification required	Not covered	\$20,000 per family (combined with prescription drugs); 90% covered [5] precertification required	Not covered
Ibesity	Not covered except \$500 annual maximum per participant for nutritional counseling	Not covered	Not covered except \$500 annual maximum per participant for nutritional counseling	Not covered

	Current I	Plan	MOU 9	MOU 9/14/2012	
and the second s	In-Network	Out-of-Network	In-Network	Out-of-Network	
ental Health/Substance A	buse i la maria de la companya de l				
patient Mental Health are	100% covered; precertification required	80% covered after deductible; precertification required; Reasonable and Customary limits apply [5]	90% covered	70% covered after deductible; precertification required	
utpatient Mental Health are	\$15 copay (\$5 copay Medicare- eligible) [3]	80% covered after deductible; Reasonable and Customary limits apply [3]	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible	
patient Substance Abuse reatment	100% covered; limited to 60 days per lifetime; limits combined in- and out- of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit [3]	80% covered after deductible limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit; Reasonable and Customary limits apply [3]	90% covered	70% covered after deductible; precertification required	
utpatient Substance buse Treatment	\$15 copay (\$5 copay Medicare- eligible); limited to 60 days per lifetime; limits combined in- and out- of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit [3]	80% covered after deductible; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit; Reasonable and Customary limits apply [3]	\$20 copay (\$10 copay Medicare- eligible)	70% covered after deductible	

		ent Plan	MOL	J 9/14/2012
Other Services	In-Network	Out-of-Network	In-Network	Out-of-Network
urable Medical Equipment	100% covered	80% covered after deductible; Reasonable and Customary limits apply	90% covered; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
mbulance Services	■ 100% covered emergency use ■ 80% covered; Reasonable and Customary limits apply for other covered ambulance services		■ 90% covered if an emergency ■ 80% covered if non-emergency	55,000
rosthetic Devices	100% covered	80% covered after deductible	90% covered; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
rgent Care	\$15	сорау	\$20 copay (\$10°	copay Medicare-eligible)
mergency Room Care	1			are-eligible); copay waived if admitted
3	[4] For certain surgical procedures expenses, if the procedure is perfoinpatient admission is not medicall covered of the NNF, subject to the expense maximum. [5] For IBEW-represented associate health care is limited to 30 days pe	rator. Sponsored Dependents are not Abuse and Outpatient Mental Health and associated x-ray, lab and other rmed on an inpatient basis and the y necessary, the Plan pays 60% deductible, and the of-pocket es: Out-of-network inpatient mental	would never satisfy more than his/he [3] Every day in a skilled nursing facil home health care visits will count as [4] After 180 days, up to an additional by the claims administrator.	ity will count as one half day, every five

NYNE MEP Health Care PPO (MEP HCP) Side-by-Side—Company Proposals

	Company Proposal. Northe AC MEP	HC MEP.	Tenatative Agreement
	In Network 1911 Diff. of Energotic 1911	in [©] Network	Oul-of-Network
Contributions	■ 2012: \$32.50/\$75/\$115₁ ■ 2013: \$35/\$80.85/\$125₁ ■ 2014: \$37.50/\$87.50/\$125₁ ■ 2015: no proposal	■ 2012: \$30/\$60₁ ■ 2013: \$45/\$90₁ ■ 2014: \$50/\$100₁ ■ 2015: \$55/\$110₁	
Deductible Individual	\$1,000	■ 2013: \$400 ■ 2014: \$450 ■ 2015: \$475 ■ Retirees: based on retired on or after January Combined in- and out-of-retired on out-of-retired out-of-retired on out-of-retired out-of-r	uary 1, 2013: same as active
		_	■ 2013: \$250 ■ 2014: \$250 ■ 2015: \$250 ■ Additional applied to out-of-network
Family	■ 3,000t₂	■ 2.5× Individual 2	■ 2.5× Individual 2
Hospital Carryover	Deductible applies Deductible applies	Deductible applies Expenses applied during	Deductible applies
	Gompany Proposal Not the HC MEP	December also apply to t	he next year's deductible
	29-Jun Gut-of:Network	He MER	Figure 12 Sep 12 Out of Network

Charges Excluded From Deductible	 Charges paid for Expenses for pres Charges paid for Charges in exces Plan limits 	Copays for visits to urgent care facilities or emergency rooms Charges paid for failure to follow precertification procedures Expenses for prescription drugs Charges paid for non-covered services and supplies Charges in excess of, MAA, NNF, or other Medical		■ Flat dollar copays paid for medical care ■ Copays for visits to urgent care facilities or emergency room ■ Charges paid for failure to follow precertification procedures ■ Expenses for prescription drugs ■ Charges paid for non-covered services and supplies ■ Charges in excess of MAA, NNF, or other Medical Plan limits ■ Amounts for LASIK services	
	Compa	eny Proposal = Not the HC MEP		Tenatative Agreement	
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Out-of-Pocket Maximums (Calend Individual	dar	2,000	■ 2013: \$1,050 ■ 2014: \$1,100 ■ 2015: \$1,150 Combined in- and out-of	f-network	
¥	- x		ion .	■ 2013: \$950 ■ 2014: \$900 ■ 2015: \$900 Additional applied to out- of- network	
Family		6,000²		2.5x Individual₂	

Charges Excluded From Out-of-Pocket Maximum	Copays for Office Visits Charges in excess of obesity annual and infertility lifetime maximums Charges for services and supplies not covered by the Medical Plan Additional amounts paid for not following precertification program procedures Charges that exceed MAA, NNF or other Medical Plan limits Expenses for prescription drugs Amounts for LASIK services		■ Flat dollar copays paid for medical care ■ Charges in excess of obesity annual and infertility lifetime maximums ■ Charges for services and supplies not covered by the Medical Plan ■ Additional amounts paid for not following precertification program procedures ■ Charges that exceed MAA, NNF or other Medical Plan limits ■ Expenses for prescription drugs ■ Amounts for LASIK services	
Coinsurance Based On:	Network Negotiated Fee (NNF)	Maximum Allowed Amount (MAA)	Network Negotiated Fee (NNF)	Maximum Allowed Amount (MAA)
	20 H	Noethe HC MEP.	2010 S	ative Agreement pp-12 ¹ Out-of-Network
Outpatient Treatment				
Doctors' Home or Office Visits	\$15 copay - 80% covered after deductible home visits	70% covered after deductible	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Preventive Care	100% covered, no deductible;	100% covered, no deductible;	100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies	100% covered, no deductible; age and frequency provisions o the Affordable Care Act applies
Routine Well-Baby and Well-Child Care (Pediatric Exams)	100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies	100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies	100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies	100% covered, no deductible; age and frequency provisions o the Affordable Care Act applies

X rays and Lab Tests	\$15 copay	60% covered after deductible	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Radiation Therapy/ Chemotherapy/ Electroshock Therapy/ Hemodialysis	80% covered, after deductible outpatient facility; \$15 copay if done in the physician's office	60% covered after deductible	90% covered after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible if done in physician's office	70% covered after deductible
Physical, Occupational and Speech Therapy	80% covered after deductible;\$15 copy for provider charges;Limited to 30 visits per calendar year	60% covered after deductible; number of visits based on medical necessity	80% covered after deductible; number of visits based on medical necessity	70% covered after deductible; number of visits based on medical necessity
Licensed Chiropractor	\$15 copay, limited to 12 visits per calendar year, limits combined in and out of network	60% covered after deductible; limited to 12 visits per calendar year;limits combined in and out of network		\$20 copay plus difference between \$92 flat fee and cost of service; limited to 60 visits per calendar year (not o exceed 1 visit per day); limit of ombined in- and out-of-network
	Company Proposa	II Not the HC-MEP	He MEP Tenal	 ative Agreement
	in-Network	in-III	In-Network	ep-1/2/
Home Health Care	100% covered, no deductible; limited to 52 visits per calendar year	60% covered, no deductible; precentification required	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Inpatient Hospital Service				
Hospital Copay	None	None	None	None
Room and Board	80% covered, after deductible	60% covered, after deductible;	90% covered after deductible	70% covered after deductible; precertification required
In-Hospital Physician's Visits	80% covered, after deductible	60% covered, after deductible	90% covered after deductible	70% covered after deductible
X reys and Lab Tests	90% covered, after deductible	60% covered, after deductible	90% covered after deductible	70% covered after deductible
Maternity Care (Pre/Post Natal)	\$15 copay (\$10 ; initial visit only	60% covered, after deductible	\$20 copay (\$10 copay Medicare eligible)—Initial visit only	70% covered after deductible
Newborn Baby Care	90% covered, after deductible	60% covered, after deductible	90% covered after deductible4	70% covered after deductible.
Skilled Nursing Facilities	100% covered, no deductible; precertification required	60% covered, after deductible, precentification required	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Birthing Centers	80% covered, after deductible	60% covered, after deductible; precertification required	90% covered after deductible	70% covered after deductible; precertification required

100% covered, no deductible; precertification required	60% covered, after deductible; precertification required	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
StEronov	S0% savand affactadustible	\$20 coppy/\$10 coppy	70% covered after deductible
313 copay	100% covered, alter deductible	Medicare-eligible	70% covered after deductible
80% covered, after deductible; precertification required	60% covered, after deductible; precertification required	90% covered after deductible; precertification required	70% covered after deductible; precertification required
		ENTRY THE PERSON NAMED IN COLUMN TO SERVICE AND ADDRESS OF THE PERSON NAMED ADDRESS OF THE PERSON NAMED ADDRESS OF THE PERSON NAMED ADDRES	alive Agreement Pp=12-73-43-43-44-44-44-44-44-44-44-44-44-44-44
In-Network	Out-of-Network 25 12	In-Network	<u>Oudor</u> Network
80% covered, after deductible outpatient facility; \$15 copay if done in the physician's office	60% covered, after deductible	90% covered, after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in the physician's office	70% covered after deductible
80% covered, after deductible	60% covered, after deductible	90% covered after deductible	70% covered after deductible
		2.00	one .
with prescription drugs and for both in-network and out-of-network); 50% covered after deductibles precertification required	with prescription drugs and for both in-network and out-of- network); 50% covered after deductibles; precertification required	with prescription drugs and for both in-network and out-of- network); 90% covered after deductibles precertification required	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 70% covered after deductibles precertification required
No	orie	prescribed by a doctor and furr	necessary nutritional counseling hished by a licensed dietician or to \$500 a year
80% covered, after deductible	60% covered, after deductible; precertification required	90% covered after deductible;	70% covered after deductible; precertification required
	Precertification required Company Proposa 29-71 In-Network 80% covered, after deductible outpatient facility; \$15 copay if done in the physician's office 80% covered, after deductible No. \$15,000 per family (combined with prescription drugs and for both in-network and out-of-network); 50% covered after deductibles precertification required	80% covered, after deductible; precertification required Company Proposal: Not the IIC MEP (Out-of-Network) 80% covered, after deductible outpatient facility; \$15 copay if done in the physician's office None \$15,000 per family (combined with prescription drugs and for both in-network and out-of-network); 50% covered after deductibles precertification required None	Medicare-eligible 80% covered, after deductible; precertification required Company Proposal Not the HC-MEP Company Proposal Not the HC-MEP ROW covered, after deductible outpatient facility; \$15 capay if done in the physician's office 80% covered, after deductible outpatient facility; \$15 capay if done in the physician's office None \$15,000 per family (combined with prescription drugs and for both in-network and out-of-network); 50% covered after deductibles precertification required None None \$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 50% covered after deductibles; precertification required None None None Not covered except medically represcribed by a doctor and furrinutritionist up 80% covered, after deductible None Not covered except medically represcribed by a doctor and furrinutritionist up 80% covered, after deductible; 90% covered after deduct

Outpatient Mental Health Care	\$15 copay	60% covered after deductible	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Inpatient Substance Abuse Treatment	80% covered, after deductible	60% covered after deductible	90% covered after deductible	70% covered after deductible
	Gompany Proposa	I - Not the HC MEP	HC MER - Tena	tative Agreement
	29月	un 11	19-5	ep-12
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Substance Abuse Treatment	\$15 copay	60% covered after deductible	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Other Services				
Durable Medical Equipment	80% covered after deductible; precertification required for items over \$5,000	60% covered after deductible; precertification required for items over \$5,000	80% covered after deductible; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
Ambulance Services	80% covered after deductible	60% covered after deductible	■ 90% covered after deductible ■ 70% after deductible if non-er	
Prosthetic Devices	80% covered after deductible; precertification required for items over \$5,000	60% covered after deductible; precertification required for items over \$5,000	80% covered after deductible; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
Urgent Care	\$100	copay	\$20 copay (\$10 copay Medicare	religible)
Emergency Room Care		y waived if admitted	\$75 copay (\$25 copay Medicare-eligible); copay waived if admitted	
Footnotes				

of HRA and \$600 annual credit for non- tobacco user status. ² Family amount can be any combination of family members but	i Contribution amounts assume \$100 annual credit for completion of HRA and \$600 annual credit for non-tobacco user status. 2 Family amount can be any combination of family members but an individual would never satisfy more than his/her own individual amount 3 Coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination 4 If newborn is not released with the mother a separate deductible and coinsurance applies.
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New York New England Prescription Drug Side-by-Side

	\$ The state of the	rent Plan	9/14	MOU
Annual Retail Deductible	In-Network	Out-of-Network	In-Network	Out-of-Network
 Applies per person per calendar year Generic Drugs Brand Name Drugs 	None None	\$50 combined for generic and brand drugs	None None	\$50 combined for generic
Maximum Benefit Per Calendar Year	None	None	None	and brand drugs
Lifetime Maximum Benefit	None	None	None	None
Annual Out-of-Pocket Maximum (per person) Retail Rx		None		None one
Supply—therapy for up to	30 days	30 days	30 days	
Basis for Out-of-Network Cost	Not applicable	Not applicable	Not applicable	30 days
Patient Copays Mark Applies to: Mark Generic Drugs	Original Rx and refills	Original Rx and refills	Original Rx and refills	Not applicable Original Rx and refills
Generic Drugs	■ 15% of DNP ■ Maximum \$25/Rx	Pay full cost, then file claim	■ 2013: Lower of \$8 copay or DNP ■ 2014: Lower of \$8 copay or DNP	■ 30% of DNP cost plus 100% of the difference between

	Current Plan		9/14 MOU		
W Brand Name Drugs Sively C	In-Network	Out-of-Network	In-Network	Out-of-Network	
■ Brand Name Drugs - Single Source and Multi- Source (Applies to Associates and Pre-Medicare Retirees) ■ Single Source Brand Name Drugs (Applies to	■ N/A	■ N/A	■ 30% of DNP ■ Maximum - 2013: \$25/Rx - 2014: \$25/Rx - 2015 & beyond: increases 6% per year ■ Cost difference between generic and brand cost when generic equivalent is	■ 40% of DNP cost plus 100% of the cost difference between the retail cost and the DNP ■ Deductible applies ■ 30% of DNP plus cost difference between generic and brand cost when generic equivalent is available [1]	
Medicare Retirees only)	■ N/A	N/A	5% per year ■ 50% of DNP cost for maintenance drugs after 3	■ 40% of DNP cost plus 100% of the cost difference between the retail cost and the DNP ■ Deductible applies ■ 50% of DNP cost for maintenance drugs after 3 fills ■ Pay full cost, then file claim	
Multi-Source Brand Name Drugs (Applies to Medicare Retirees only)	■ N/A	m N/A	■ 40% of DNP ■ Maximum: - 2013: \$30/Rx - 2014: \$30/Rx - 2015: \$30/Rx ■ 50% of DNP cost for maintenance drugs after 3 fills (Rx maximum does not	■ 40% of DNP cost plus 100% of the cost difference between the retail cost and the DNP ■ Deductible applies ■ 50% of DNP cost for maintenance drugs after 3 fills ■ Pay full cost, then file claim	

	Current Plan		9/14 MOU		
prince to a second	In-Network	Out-of-Network	In-Network	Out-of-Network	
■ Single-Source Brand Name Drugs	■ 20% of DNP ■ Maximum \$40/Rx	 ■ 20% of retail cost ■ Maximum \$45/Rx ■ Deductible applies ■ Pay full cost, then file claim 	₩ N/A	■ N/A	
Patient Copays Multi-Source Brand Name Drugs	■ 30% of DNP ■ Maximum \$55/Rx	 30% of retail cost Maximum \$55/Rx Deductible applies Pay full cost, then file claim 	■ NA	a N/A	
Mail Order	If physician prescribes ι name drug copaγ will app	DAW, the multi-source brand sly.			
Out-of-Pocket Maximum	\$400	+	2013 - \$600 [1] 2014 - \$700 [1]		
Supply—therapy for up to	90 days		2015 - \$700 [1]		
Patient Copays Generic Drugs	■ Lower of \$8 copay or DNP		90 days 2013: Lower of \$16 copay or DNP 2014: Lower of \$16 copay or DNP 2015: Lower of \$18 copay		
Brand Name Drugs - Single Source and Multi-Source (Applies to Associates and Pre-Medicare Retirees)	j∎ N∕A		■ 30% of DNP ■ Maximum - 2013: \$50/Rx - 2014: \$50/Rx - 2015 & beyond: increases 6% per year ■ Cost difference between generic and brand cost when generic equivalent is available (Rx maximum does	TOTAL CONTROL OF THE PARTY OF T	

	Current Plan		9/14 MOU		
- Cleate Course True	In-Network	In-Network Out-of-Network In-Network		Out-of-Network	
E Single Source Brand Name Drugs (Applies to Medicare Retirees only)	■ N/A	5	■ 30% of DNP ■ Maximum: - 2013: \$50/Rx - 2014: \$50/Rx - 2015 & beyond: increases		

	Current Plan		9/1/	MOU
- Maja c	In-Network	Out-of-Network	In-Network	
Multi-Source Brand Name Drugs (Applies to Medicare Retirees only)	m N/A		■ 40% of DNP ■ Maximum: - 2013: \$60/Rx - 2014: \$60/Rx	Out-of-Network —
Single-Source Brand Name Drugs	■ Lower of \$17 copay or DNP	-	= 2015: \$60/Ry = N/A	S
Multi-Source Brand Name Drugs ootnotes	■ Lower of \$25 copay or DNP ■ If physician prescribes DAW, the multi-source brand name drug copay will apply		■ N/A	
outhores			 [1] Charges incurred due to the name drug and a generic alterthe maximum. [2] Does not apply for brand regeneric equivalent and the enthe employee is medically unaversion of the medication 	rnative will not count towards names where there is a nployee's doctor certifies that

Verizon New York / New England Wage and Health Care Calculation

Administrative Assistant (AA), Weekly Wage: \$1,020.50

HCN	2012	2013	2014	2015	Total
New Wage Dollars	\$298	\$1,817	\$3,384	\$4,359	\$9,858
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$53	-\$1,993	-\$2,177	-\$2,378	-\$6,601
Total New Dollars	\$245	\$673	\$1,207	\$1,981	\$4,107
MEP PPO	2012	2013	2014	2015	Total
New Wage Dollars	\$298	\$1,817	\$3,384	\$4,359	\$9,858
The state of the s					
HRA Payments	\$0	\$850	\$0	\$0	\$850
HRA Payments New Health Care Dollars	\$0 -\$51	\$850 -\$2,104	\$0 -\$2,295	\$0 -\$2,502	\$850 -\$6,951

Operator, Weekly Wage: \$1,022.50

HCN

HCN	2012	2013	2014	2015	Total
New Wage Dollars	\$299	\$1,820	\$3,391	\$4,367	\$9,877
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$53	-\$1,993	-\$2,177	-\$2,378	-\$6,601
Total New Dollars	\$246	\$677	\$1,213	\$1,990	\$4,126
MEP PPO	2012	2013	2014	2015	Total
New Wage Dollars	\$299	\$1,820	\$3,391	\$4,367	\$9,877
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	Sac-22.56	42	Same and the same	20	2000 0000
	-\$51	-\$2,104	-\$2,295	-\$2,502	-\$6,951

\$566

\$1,096

\$1,865

\$3,776

\$249

Representative, Weekly Wage: \$1,262.50

Total New Dollars

HEN	2012	2013	2014	2015	Total
New Wage Dollars	\$369	\$2,247	\$4,187	\$5,392	\$12,196
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$53	-\$1,993	-\$2,177	-\$2,378	-\$6,601
Total New Dollars	\$316	\$1,104	\$2,009	\$3,015	\$6,444

MEP PPO	2012	2013	2014	2015	Total
New Wage Dollars	\$369	\$2,247	\$4,187	\$5,392	\$12,196
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$51	-\$2,104	-\$2,295	-\$2,502	-\$6,951
Total New Dollars	\$319	\$994	\$1,892	\$2,890	\$6,094
CSA, Weekly Wage: \$1,284.00).				
HCN	2012	2013	2014	2015	Total
New Wage Dollars	\$376	\$2,286	\$4,258	\$5,484	\$12,403
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$53	-\$1,993	-\$2,177	-\$2,378	-\$6,601
Total New Dollars	\$322	\$1,143	\$2,081	\$3,107	\$6,652
MEP PPO	2012	2013	2014	2015	Total
New Wage Dollars	\$376	\$2,286	\$4,258	\$5,484	\$12,403
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$51	-\$2,104	-\$2,295	-\$2,502	-\$6,951
Total New Dollars	\$325	\$1,032	\$1,963	\$2,982	\$6,302
Field Tech / COT, Weekly Wag	e: \$1,491.50 2012	2013	2014	2015	Total
New Wage Dollars	\$436	\$2,655	\$4,946	\$6,370	\$14,408
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$53	-\$1,993	-\$2,177	-\$2,378	-\$6,601
Total New Dollars	\$383	\$1,512	\$2,769	\$3,993	\$8,656
MEP PPO	2012	2013	2014	2015	Total
New Wage Dollars	\$436	\$2,655	\$4,946	\$6,370	\$14,408
HRA Payments	\$0	\$850	\$0	\$0	\$850
New Health Care Dollars	-\$51	-\$2,104	-\$2,295	-\$2,502	-\$6,951
	*	4-1-0	Y - 1 - 3 - 7	72,502	70,000

Number of incidental Days Taken	Number of Employees	Percent Incidental Days Taken
Ó	13009	29%
1	1368	3%
2	3004	7%
3	1859	4%
4	2474	5%
5	5114	11%
6	1,701	4%
7	1483	3%
8	1132	2%
9	1261	3%
10	2015	4%
11-15	3774	8%
>15	7324	16%
	45518	