November 2011 Tentative National Agreement

Between the

IBEW and the NCCC

SUMMARY OF THE HEALTH AND WELFARE CHANGES

With the PEB's recommendations, the Plan's health and welfare provisions will be amended in the areas of "**In-Network"** benefits under the Managed Medical Care Program (MMCP) and the Plan's Prescription Drug Card and Mail Order Prescription Drug Programs. Additionally, Prescription Drug Card and Mail Order Prescription Drug Programs rules will apply only to individuals who become eligible for the National Early Retirement Major Medical Plan (ERMA), coverage on or after July 1, 2012. There are no changes to the out-of-network services under MMCP or benefits under the Comprehensive Health Care Benefit.

Cost Sharing

The current monthly employee contribution will remain frozen at $200 for six and one half years – through June 30, 2016. If a new agreement is not reached by then, the monthly contribution will rise by only $30 on July 1, 2016 to $230. It will stay at $230 until a new agreement is reached.

As a result of this freeze, employees will be paying significantly less than 15% of Plan costs by 2016. It is estimated that without the freeze, the 15% formula would have resulted in employees paying in 2016 anywhere from $3,360 to $4,260 a year, depending on the rate of medical inflation.

Annual Deductible

Annual deductibles will be $200 per individual and $400 family, as phased in below:

- Effective July 1, 2012, $100 per individual and $200 per family
- Effective January 1, 2013, $150 per individual and $300 per family
- Effective January 1, 2014, $200 per individual and $400 per family

The annual deductible applies to in-network services under MMCP where a fixed copayment does not apply.

The annual family deductible applies no matter how many covered family members there are.

What is the individual annual deductible?

The annual individual deductible is the maximum amount an individual will have to pay in a calendar year before the Plan applies payments. The annual deductible applies to only "in-network" services provided under MMCP where a fixed-copayment does not apply. This amount applies separately to each Covered Family Member each calendar year. The amounts will be based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark).

What is the family annual deductible?

The family deductible is the maximum amount the employee and his/her eligible dependents will have to pay in any calendar year before the Plan applies payments. The annual family deductible applies to only "in-network" services provided under MMCP where a fixed-copayment does not apply. The amounts will be based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark). The annual family deductible applies no matter how many covered family members there are.

How does the deductible work?

For a single employee seeking "in-network" services under MMCP where a fixed-copayment does not apply, i.e., $20/35 per office visit, he/she will be responsible for the first $100, for calendar year 2012, of any charges before the Plan initiates payment.

For example, an individual receives an MRI at a cost of $1,000. Applying the discounted rates, the final charge for the MRI may be $500. Using this example, the individual would be responsible for the first $100, in calendar year 2012. After meeting the individual deductible, the Plan will begin to pay benefits.

For a family of two or more, each individual seeking "in-network" services under MMCP where a fixed-copayment does not apply, i.e., $20/35 per office visit, may be responsible for a portion of the family deductible until the annual deductible is met. The deductible can be applied separately to each covered family member but no more than the annual deductible per individual. For example, in 2012 the annual family deductible is $200. If an employee pays $50 towards his annual deductible, his spouse pays $50 towards her annual deductible, and a dependent child pays $100 towards his/her annual deductible, the annual family deductible for 2012 would be met. Having met the total family deductible, any other eligible dependents will not be required to pay anything towards an annual deductible.

However, once the deductible is reached, payments towards the annual out-of-pocket maximums will begin to apply.

Coinsurance – Out-of-Pocket Maximums

Coinsurance of 5% will apply for "in-network" services under MMCP where a fixed-dollar copayment does not apply i.e., $20/35 per office visit, up to the below annual out-of-pocket maximums, on a phased in basis as described below:

Effective July 1, 2012, $500 per individual and $1,000 per family
Effective January 1, 2013, $750 per individual and $1,500 per family
Effective January 1, 2014, $1,000 per individual and $2,000 per family

Once the out-of-pocket maximum is reached, no coinsurance charges will be applied.

The family out-of-pocket maximum applies no matter how many covered family members there are.

What are the annual out-of-pocket maximums?

There are two annual out-of-pocket amounts. There is an individual out-of-pocket maximum and a family out-of-pocket maximum. These amounts apply to "in-network" services under MMCP where a fixed copayment does not apply, i.e., $20/35 per office visit. The amounts will be based on the contracted "in-network" provider discount charge with your insurance company (United Healthcare, Aetna or Blue Cross Blue Shield Highmark). The family out-of-pocket maximum applies no matter how many covered family members there are.

Copayments and deductible payments do not apply to the out-of-pocket maximums -- they must be paid in addition. Only the 5% coinsurance charges apply towards the annual out-of-pocket amounts.

How do the annual out-of-pocket amounts work?

For a single employee, once he/she reaches his/her annual deductible for "In-network" services, charges where a fixed-copayment does not apply, i.e., $20/35 per office visit, will be subject to 5% coinsurance until the coinsurance amount reaches the out-of-pocket maximum. Once the maximum out-of-pocket amount is reached, the Plan will pay 100% of the contracted amount for "in-network" services that normally require coinsurance. Therefore, after the phased in period, a single employee will be financially responsible for an annual total out-of-pocket amount of $1,200 before the Plan pays benefits at 100%. However, even when the maximum is reached, employees will still pay customary copayments ($20/$35).

Using the same example above of an individual receiving an MRI at a cost of $1,000 with a discount charge of $500, the individual will pay the first $100 for calendar year 2012. Once the deductible is met, the remaining $400 would be subject to the 5% coinsurance. The 5% on $400 would be $20. The total out-of-pocket amount paid by the individual for this MRI would be $120, of which $20 would go towards the 2012 annual out-of-pocket maximum of $500.

If a member receives a subsequent MRI with the same pricing configurations, the 5% would be on $500 or $25.

For a family of two or more, once the family deductible is reached, in-network services under MMCP where a fixed copayment does not apply, i.e., $20/35 per office visit, will be subject to 5% coinsurance until the coinsurance amount reaches the family out-of-pocket maximum. The annual out-of-pocket maximum can be applied separately to each family member but no more than $500 per individual for calendar year 2012. For example, if an employee incurs services in the amount of $10,000, 5% or $500 will be applied towards the family's maximum. Once the remaining $500 towards the $1,000 2012 family maximum is applied by one or more of the employee's dependents, the Plan will pay 100% of the contracted amount for "in-network" services under MMCP outside of the fixed copayments. Therefore, a family will be financially responsible for an annual total out-of-pocket amount of $1,500 for 2012 before the Plan pays benefits at 100%. Again, even when the maximum is reached, employees will still pay the customary copayments ($20/$35). **It is estimated that only approximately 1-2% of the population, 400,000, will reach the out-of-pocket maximum.**

Other Copayments for In-Network Services under MMCP

- Emergency Room Copayment – increased to $75 from $50, but shall not apply if the visit results in admission to the hospital.

- Urgent Care Center Copayment – reduced to $20 from $25 per visit.

- Convenient Care Clinics – the fixed-dollar copayment of $20 currently applied to an office visit has been reduced to $10 for Convenient Care Clinics.

Prescription Drug Program Copayments

Retail Pharmacy Prescription Drug copayments for 21-day supply or less:
- Generic Drugs – decreased from $10 to $5
- Brand Name (Non-Generic) Drugs on Formulary List – increased from $20 to $25
- Brand Name (Non-Generic) Drugs not on Formulary List – increased from $30 to $45

Mail Order Prescription Drug copayments for 22 to 90-day supply
- Generic Drugs – decreased from $20 to $5
- Brand Name (Non-Generic) Drugs on Formulary List – increased from $30 to $50
- Brand Name (Non-Generic) Drugs not on Formulary List – increased from $60 to $90

Over 70% of prescriptions filled under the National Plan are generic. Thus, the reduction in generic copayments from $10 to $5 retail and $20 to $5 mail order will immediately save members a significant amount of out-of-pocket prescription drugs costs.

Reducing the generic copayments to $5 will significantly benefit many Plan employees and their dependents.

Prescription Drug Plan Rules – Apply to active employees and to individuals who become eligible for the National Early Retirement Major Medical Benefit Plan (ERMA) coverage on or after July 1, 2012

To ensure drug safety and that patients are taking the correct medication, certain drug rules will be applied to prescriptions for formulary brand drugs and non-formulary brand name medications. Interactions between drugs could cause harmful side effects or even death. With these programs, members and their doctors will be assured that the patient is taking the appropriate medication at the appropriate dosage, with no adverse drug interactions and that drugs are being taken for the correct medical condition or diagnosis.

Prior Authorization

If a physician prescribes a medication shown on the list of drugs requiring prior authorization, a temporary 3-5 day supply may be dispensed at the retail pharmacy, after which approval is required by the pharmacy benefit manager based on clinical documentation from the physician prior to allowing the medication to be dispensed for the full supply. If the pharmacy benefit manager disagrees and finds the medication not warranted, the physician has a right to appeal on the patient's behalf. The physician must submit evidence and support of the medication to the pharmacy benefit manager for further review and consideration. The list of affected drugs is shown in Exhibit C of the agreement and is attached for your reference.

Only a fraction of participants covered under the Plan will be impacted by the prior authorization rule. Of over 400,000 covered lives, approximately 917 participants (less than nine tenths of a percent) could potentially be impacted. Prior authorization targets the very expensive oral and injectable specialty drugs for the most complex and serious illnesses. In some instances, the cost of a single specialty drug can cost the Plan over $500,000 per year.

Duration/Quantity Limitations

If a physician prescribes medication that exceeds the recommended dose based on FDA labeling, national guidelines, best practices and evidence-based medicine, the patient's physician would be required to provide information to the pharmacy benefit manager for review to determine if the medication can be authorized at the prescribed dosage. Only 3% of Plan participants will be affected by this change.

Drug Step Therapy

Drug Step Therapy promotes the use of generics or preferred brand drugs listed in a specific drug therapeutic category. For example, certain medications for Sleep Apnea, Depression or Migraines are subject to step therapy. With the use of generic and preferred brand name medication, members will save on out-of-pocket expenses. The affected drugs are listed in Exhibit C of the Agreement and is attached for your reference. Only 3% of Plan participants will be affected by this change.

When a physician prescribes a drug where a generic or preferred brand name drug is available, the patient's physician will be contacted to request a change in medication. After trying the medication, if the patient's physician disagrees with the recommended medication change, the physician can provide information to the pharmacy benefit manager that deems the patient to be "intolerant" of the substituted medications. The pharmacy benefit manager must agree with the physician's argument; if the pharmacy benefit manager deems the physician's prescribed medication as not authorized, the member will be subject to 100% of the cost of the non-preferred drug.

For those under ERMA, the above drug rules will not apply to current retirees and/or individuals who become eligible for ERMA coverage prior to July 1, 2012. These drug rules will only apply to individuals who become eligible for ERMA coverage on or after July 1, 2012.

The following four programs are entirely voluntary and up to the Plan participant whether he/she uses them:

Personalized Medicine – This **voluntary** program provides that people taking Warfarin (blood thinner) and/or Tamoxifen (breast cancer drug) may be tested in order to determine whether the medication best fits the individual's medical condition.

In the case of Warfarin, the test will allow your doctor to more accurately prescribe a proper dosage level, resulting in fewer complications, including unnecessary hospitalizations caused by the typical trial and error prescribing of this drug.

For Tamoxifen, the test will show whether the drug will work on a breast cancer patient. A simple test can be used to determine if an individual's body can actually metabolize the drug.

This Personalized Medicine program is completely voluntary and will enhance patient safety and clinical outcomes.

Generic Rx Advantage Program – This program allows members and/or their dependents to receive a full copay **waiver** of a 3-month supply for new generic prescriptions at the Medco Pharmacy, including any brand prescription (retail or mail) submitted as a generic at mail; retail generic prescriptions moved to mail; or new generic prescriptions submitted at mail.

Centers of Excellence (COE) Resource Services - These **voluntary** programs expand the current Transplant and Congenital Heart Disease programs available to members and their dependents.

The programs promote Quality of Care, by encouraging treatment at institutions with demonstrated favorable clinical outcomes and that have a high volume of procedures and patients within the specific disease or condition.

Bariatric Resource Services – provides a national Centers of Excellence network **for** preferred bariatric surgery centers and hospitals.

Cancer Resource Services – provides interventions and support by experienced Cancer Nurse Advocates, clinical consulting with cancer specialists, combined with an extensive nationwide COE network.

Kidney Resource Services – provides a large network of dialysis facilities, which meet strict quality outcomes with kidney nurse specialists assisting patients. Maximizes quality outcomes for patients by utilizing these COEs to reduce the length of inpatient confinements. Extended use of home-based dialysis and direct contracting for expensive mail-order specialty drugs add to patient convenience and reduce costs.

Treatment Decision Support – Enhanced one-to-one coaching for individuals facing potential procedures that have been carefully targeted as having varied treatment practices and inconsistent patient outcomes. The voluntary program provides information on the patient's specific medical condition, their treatment options, and the clinical and cost ramifications of their treatment choices while simultaneously helping to decrease surgical rates and increase referrals to high quality and efficient health care providers. The expected results can include improved outcomes and lower overall costs. The program normally targets back pain, keen/hip replacement, benign prostate disease, prostate cancer, benign uterine conditions, hysterectomy, breast cancer, coronary artery disease and bariatric surgery.

Other

Radiology Notification Program – This program promotes the use of current radiology standards and guidelines, limits an individual's exposure to radiation, and will have **no** financial impact on a member. This program will require an in-network physician and/or provider to notify the insurance company when certain outpatient advanced imagining procedures are prescribed. Such notification by the physician is limited to CT, MRI, PET and Nuclear Medicine, including Nuclear Cardiology.

Radiology services that take place in an emergency room, observation unit, urgent care center, or during an inpatient stay will not require notification.

Final decision authority regarding the performance of the radiology procedure rests with the ordering physician.

The member has no financial responsibility in the event notification is not provided by the physician/provider.

DEFINITIONS

Coinsurance - A stated percentage (5%) of medical expenses for "in-network" services under MMCP after the deductible amount, if any, is paid. After any deductible amount and coinsurance are paid, the Plan is responsible for the rest of the reimbursement for covered benefits.

Copayment (Medical) - A fixed dollar amount for a specific medical service. For example, the Plan provides these services with a fixed dollar amount office visit $20/$25, emergency room $75, urgent care facility $20, and convenient care clinic $10. Other services under the Plan may also have a fixed dollar amount.

Convenient Care Clinics - Facilities typically located in a high-traffic retail stores, supermarkets, or pharmacies that provide affordable treatment for uncomplicated minor illness and/or preventative care to consumers. Radiological services are not covered under the Plan when performed at a convenient care clinic.

Copayment (Prescription) - A fixed dollar amount for drugs purchased at retail or through mail order based on three tiers - generic, formulary brand name and non-formulary brand name drugs. Retail drugs for generic $5, Formulary Brand Name $25, Non-Formulary Brand Name $45. Mail Order for generic $5, Formulary Brand Name $50, Non-Formulary Brand Name $90.

Deductible - A fixed dollar amount paid for "in-network" services under MMCP during the benefit year before the Plan starts to make payments for covered "in-network" medical services. The Plan has both individual and family deductibles.

Formulary drugs. These are drugs approved by the health care provider. Drugs not approved by the health care provider are non-formulary drugs.

Generic drugs. These are drugs that are not under patent. Once a drug's patent has expired, the Plan provides for a $5 copayment.

Name-brand drugs. These are drugs that once were, or still are, under patents.

Out-of-pocket Maximum - The maximum dollar amount a member is required to pay out of pocket during a year. Until this maximum is met, the plan and member share in the cost of covered expenses which do not have a fixed copayment. After the maximum is reached, the Plan pays all covered expenses.