Mid-Atlantic MEP PPO Side-by-Side—Current Plan and 9/14 MOU

| | Curren | Current Plan In-Network Out-of-Network | | 9/14 MOU | |
|------------------|---|--|---|--|--|
| | In-Network | | | In-Network Out-of-Network | |
| Contributions | | | 2 012: \$30/\$600 | | |
| | Noi | None | | | |
| | | | 2013: \$45/\$900 | | |
| | | | | ■ 2014: \$50/\$1000 | |
| | | | 2015 : \$55/\$1100 | | |
| Deductible | 40.00 | | 2010 4100 | | |
| Individual | ■ \$250 | | | ■ 2013: \$400 | |
| | ■ Retirees: based on retirement of | date | ■ 2014: \$450 | | |
| | | | ■ 2015: \$475 | | |
| | | | Retirees: based on retirement da | | |
| | | | Retired on or after January 1, 201 | 13: | |
| | | | same as active | and subjet in the control | |
| | | | | and out-of-network | |
| | | | | ■ 2013: \$250 - 2014: \$250 | |
| | | | | ■ 2014: \$250 - 2015: \$250 | |
| | | | | ■ 2015: \$250 | |
| Family | 2.5 x Inc | lividual | ■ Additional applied to out-of-networ 2.5 x Individual [2] | | |
| • | | Deductible applies to | | | |
| Hospital | None | certain services | Deductible applies | Deductible applies | |
| Carryover | Expenses applied during | | Expenses applied during October, November or | | |
| Carryover | December also apply to the | · | December also apply to the next year's deductible | | |
| Charges Excluded | ■ Copay for office visits | Te Hext year 3 deductible | Flat dollar copays paid for medical care | | |
| From Deductible | ■ Copays for visits to urgent care | facilities or | Copays for visits to urgent care facilities or | | |
| Trom Beddetible | emergency rooms | radimeres of | emergency rooms | | |
| | ■ Charges payable when pre-adr | nission testing is done | ■ Charges paid for failure to follow precertification | | |
| | on an inpatient basis and the inpatient admission is | | procedures | | |
| | not considered medically necessa | · · | | ■ Charges for services and supplies not covered by | |
| | | ■ Charges payable when select outpatient surgery is | | the Medical Plan | |
| | | performed on an inpatient basis and the admission is | | ■ Expenses for prescription drugs | |
| | considered not medically necessa | li i | | ■ Charges that exceed MAA, NNF or other Medical | |
| | Charges for services and supplied | • | Plan limits | | |
| | Medical Plan | • | ■ Amounts for LASIK services | | |
| | ■ Expenses for prescription drug | S | | | |
| | | ■ Charges that exceed R&C, NNF or other Medical | | | |
| | Plan limits | | | | |

| | Current P | Current Plan | | 9/14 MOU | |
|-----------------------|--|---|---|---|--|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | |
| Out-of-Pocket Maximu | | | | | |
| Individual | \$1,000 | | 2013: \$1,050 | | |
| | | | ■ 2014: \$1,100 ■ 2015: \$1,150 | | |
| | | | | | |
| | | | | rork | |
| 1 | | | | 2 013: \$950 | |
| | | | | 2014: \$900 | |
| | | | _ | 2015: \$900 | |
| | | | | Additional applied to out- | |
| | | | | of-network | |
| | | | | | |
| Family | Maximums are per individual p | er year; combined family | ily 2.5x Individual(2) | | |
| | max is not ap | plicable | | | |
| Charges Excluded | Copays for office visits, hospital charges, surgery, | | ■ Flat dollar copays paid for r | medical care | |
| From Out-of- | outpatient laboratory tests and outpatient x-rays | | Charges in excess of obesity | annual and infertility | |
| Pocket Maximum | Copays for visits to urgent care fa | ■ Copays for visits to urgent care facilities or | | | |
| | emergency rooms | | Charges for services and sup | oplies not covered by | |
| | Amounts paid to satisfy the deductible | | the Medical Plan | | |
| | Charges for services and supplies not covered by the | | Additional amounts paid for not following | | |
| | Medical Plan | | precertification program procedures | | |
| | • | Additional amounts paid for not following | | ■ Charges that exceed MAA, NNF or other Medical | |
| | 1. | precertification program procedures | | Plan limits | |
| | 1 | ■ Charges that exceed R&C, NNF or other Medical | | Expenses for prescription drugs Amounts for LASIK services | |
| | | Plan limits | | | |
| | | Expenses for prescription drugs | | | |
| Coinsurance Based On: | | | | | |
| I | 9 | easonable and | Network Negotiated Fee | Maximum Allowed | |
| | (NNF) | ustomary Charges (R&C) | (NNF) | Amount (MAA) | |

| | Current Plan | | 9/14 MOU | |
|-----------------------------|-----------------------------|-----------------------------|----------------------------|-------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Outpatient Treatment | | | | |
| Doctors' Home or | \$15 copay (\$5 copay | 80% covered after | \$20 copay (\$10 copay | 70% covered after |
| Office Visits | Medicare-eligible) | deductible; Reasonable | Medicare-eligible) | deductible |
| | | and Customary limits apply | | |
| Preventive Care | 100% covered, no | 100% covered, no | 100% covered, no | 100% covered, no |
| | deductible; age/frequency | deductible; age/frequency | deductible; age and | deductible; age and |
| | limits apply | limits apply; Reasonable | frequency provisions of | frequency provisions of |
| | | and Customary limits apply | the Affordable Care Act | the Affordable Care Act |
| | | | apply | apply |
| Routine Well-Baby | 100% covered, no | 100% covered, no | 100% covered, no | 100% covered, no |
| and Well-Child | deductible; age/frequency | deductible; age/frequency | deductible; age and | deductible; age and |
| Care (Pediatric | limits apply | limits apply; Reasonable | frequency provisions of | frequency provisions of |
| Exams) | | and Customary limits apply | the Affordable Care Act | the Affordable Care Act |
| | | | apply | apply |
| X rays and Lab | 100% covered, no | 100% covered (deductible | \$20 copay (\$10 copay | 70% covered after |
| Tests | deductible | applies if hospital charges | Medicare-eligible) | deductible |
| | | billed for diagnostic, no | | |
| | | deductible for preventive); | | |
| | | Reasonable and | | |
| | | Customary limits apply | | |
| Radiation Therapy/ | 100% covered, no | 100% covered, no | 90% covered after | 70% covered after |
| Chemotherapy/ | deductible hospital | deductible; Reasonable | deductible outpatient | deductible |
| Electroshock | outpatient; \$15 copay (\$5 | and Customary limits apply | facility; \$20 copay (\$10 | |
| Therapy/ | copay Medicare-eligible) | | copay Medicare-eligible) | |
| Hemodialysis | if done in physician's | | if done in physician's | |
| | office | | office | |
| Physical, | 80% covered of NNF4 | 80% covered after | 80% covered after | 70% covered after |
| Occupational and | after deductible | deductible; Reasonable | deductible; number of | deductible; number of |
| Speech Therapy | | and Customary limits apply | visits based on medical | visits based on medical |
| | | | necessity | necessity |

| | Current Plan | | 9/14 MOU | |
|----------------------------|------------------------------|------------------------------|-----------------------------|-----------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Licensed | 80% covered of NNF4 | 80% covered after | 80% covered after | 70% covered after |
| Chiropractor | after deductible; limited to | deductible; limited to \$750 | deductible; number of | deductible; number of |
| | \$750 per calendar year; | per calendar year; limit | visits based on medical | visits based on medical |
| | limit combined in- and | combined in- and out-of- | necessity; limited to \$750 | necessity; limited to \$750 |
| | out-of-network; \$750 limit | network; \$750 limit does | per calendar year; limit | per calendar year; limit |
| | does not apply to IBEW | not apply to IBEW local | combined in- and out-of- | combined in- and out-of- |
| | local 827; maintenance | 827; maintenance services | network | network |
| | services are not covered | are not covered; | | |
| | | Reasonable and | | |
| | | Customary limits apply | | |
| Home Health Care | 100% covered, no | 100% covered, no | 100% covered, no | 70% covered after |
| | deductible; | deductible; precertification | deductible; | deductible; |
| | precertification required; | required; limited to 120 | precertification required | precertification required |
| | limited to 120 visits per | visits per plan year1 | | |
| | plan year1 | | | |
| Inpatient Hospital Service | e | | | |
| Hospital Copay | None | None | None | None |
| Room and Board | 100% covered, no | 100% covered after | 90% covered after | 70% covered after |
| | deductible; no | deductible; limited to 120 | deductible | deductible; |
| | precertification required1 | days per admit; 80% | | precertification required |
| | | covered after the 120th | | |
| | | day; precertification | | |
| | | required1 | | |
| In-Hospital | 100% covered, no | 98% covered, no | 90% covered after | 70% covered after |
| Physician's Visits | deductible | deductible | deductible | deductible |
| X rays and Lab | 100% covered, no | 100% covered, no | 90% covered after | 70% covered after |
| Tests | deductible | deductible; Reasonable | deductible | deductible |
| | | and Customary limits apply | | |
| Maternity Care | 100% covered, no | 98% covered, no | \$20 copay (\$10 copay | 70% covered after |
| (Pre/Post Natal) | deductible | deductible | Medicare-eligible)—initial | deductible |
| | | | visit only | |
| Newborn Baby | 100% covered, no | 98% covered, no | 90% covered after | 70% covered after |
| Care | deductible | deductible | deductible3 | deductible3 |

| | Current Plan | | 9/14 MOU | |
|------------------------|-----------------------------|------------------------------|----------------------------|---------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Skilled Nursing | 100% covered, no | 100% covered, no | 100% covered, no | 70% covered after |
| Facilities | deductible; | deductible; precertification | deductible; | deductible; |
| | precertification required1 | required1; limited to 120 | precertification required | precertification required |
| | | days per admit; 80% | | |
| | | covered after deductible | | |
| | | after the 120th day; | | |
| | | Reasonable and | | |
| | | Customary limits apply | | |
| Birthing Centers | 100% covered, no | 100% covered after | 90% covered after | 70% covered after |
| | deductible; | deductible; precertification | deductible | deductible; |
| | precertification required | required | | precertification required |
| Hospice Care | 100% covered, no | 100% covered, no | 100% covered, no | 70% covered after |
| | deductible; | deductible; precertification | deductible; | deductible; |
| | precertification required; | required; lifetime limit of | precertification required | precertification required |
| | lifetime limit of 180 days, | 180 days, of which no | | |
| | of which no more than 60 | more than 60 days may be | | |
| | days may be for inpatient | for inpatient Hospice Care2 | | |
| | Hospice Care2 | | | |
| Surgery and Anesthesia | | | | |
| Second Opinions | 100% covered, no | 100% covered, no | \$20 copay (\$10 copay | 70% covered after |
| | deductible | deductible | Medicare-eligible) | deductible |
| Inpatient Surgery | 100% covered, no | 98% covered, no | 90% covered after | 70% covered after |
| | deductible; | deductible; precertification | deductible; | deductible; |
| | precertification required | required | precertification required | precertification required |
| Outpatient Surgery | 100% covered, no | 98% covered, no | 90% covered after | 70% covered after |
| | deductible | deductible | deductible outpatient | deductible |
| | | | facility; \$20 copay (\$10 | |
| | | | copay Medicare-eligible) | |
| | | | if done in the physician's | |
| | | | office | |
| Anesthesia | 100% covered, no | 98% covered, no | 90% covered after | 70% covered after |
| | deductible | deductible | deductible | deductible |

| | Current Plan | | 9/14 MOU | |
|------------------|---|-----------------------------|---|----------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Lifetime Maximum | | | | |
| Medical | No | ne | None | |
| Infertility | \$20,000 per family | \$20,000 per family | \$20,000 per family | \$20,000 per family |
| | (combined with | (combined with | (combined with | (combined with |
| | prescription drugs and for | prescription drugs and for | prescription drugs and for | prescription drugs and for |
| | both in-network and out- | both in-network and out-of- | both in-network and out- | both in-network and out- |
| | of-network); 100% | network); 80% covered | of-network); 90% covered | of-network); 70% covered |
| | covered after deductible5 | after deductible5; | after deductible4 | after deductible4; |
| | precertification required | precertification required | precertification required | precertification required |
| Obesity | Covered for medically necessary treatment of clinical | | Covered for medically necessary treatment of clinical | |
| | obesity when pre-authorized by claims administrator. | | obesity when pre-authorized by claims administrator. | |
| | Includes medically necessary nutritional counseling | | Includes medically necessary nutritional counseling | |
| | when prescribed by physician, up to \$500 per year | | when prescribed by physician, up to \$500 per year | |

| | Current Plan | | 9/14 MOU | |
|-------------------------|----------------------------|-------------------------------|------------------------|---------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Mental Health/Substance | | | | |
| Inpatient Mental | 100% covered after | 100% covered after | 90% covered after | 70% covered after |
| Health Care | deductible is met; limited | deductible is met; limited to | deductible | deductible; |
| | to 30 days; 80% covered | 30 days; 80% covered for | | precertification required |
| | for additional days; | additional days; | | |
| | precertification required | precertification required; | | |
| | | Reasonable and | | |
| | | Customary limits apply | | |
| Outpatient Mental | 80% covered after | 80% covered after | \$20 copay (\$10 copay | 70% covered after |
| Health Care | deductible is met3 | deductible is met; | Medicare-eligible) | deductible |
| | | Reasonable and | | |
| | | Customary limits apply3 | | |
| Inpatient | 100% covered after | 100% covered after | 90% covered after | 70% covered after |
| Substance Abuse | deductible is met; limited | deductible is met; limited to | deductible | deductible |
| Treatment | to 60 days per lifetime; | 60 days per lifetime; limits | | |
| | limits combined in- and | combined in- and out-of- | | |
| | out-of-network and | network and inpatient and | | |
| | inpatient and outpatient; | outpatient; each outpatient | | |
| | each outpatient visit | visit counts as one-half day | | |
| | counts as one-half day | toward limit; Reasonable | | |
| | toward limit3 | and Customary limits | | |
| | | apply3 | | |
| Outpatient | 100% covered after | 100% covered after | \$20 copay (\$10 copay | 70% covered after |
| Substance Abuse | deductible is met; limited | deductible is met; limited to | Medicare-eligible) | deductible |
| Treatment | to 60 days per lifetime; | 60 days per lifetime; limits | | |
| | limits combined in- and | combined in- and out-of- | | |
| | out-of-network and | network and inpatient and | | |
| | inpatient and outpatient; | outpatient; each outpatient | | |
| | each outpatient visit | visit counts as one-half day | | |
| | counts as one-half day | toward limit; Reasonable | | |
| | toward limit3 | and Customary limits | | |
| | | apply3 | | |

| | Current Plan | | 9/14 MOU | | |
|---------------------------|--------------------------------------|--|--|--|--|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | |
| Other Services | | | | | |
| Durable Medical | 80% covered of NNF4 | 80% covered after | 80% covered after | 70% covered after | |
| Equipment | after deductible | deductible; Reasonable | deductible; | deductible; | |
| | | and Customary limits apply | precertification required | precertification required | |
| | | | for items over \$5,000 | for items over \$5,000 | |
| Ambulance | 80% covered of NNF4 | 80% covered after | ■ 90% covered after deductible | if an emergency | |
| Services | after deductible | deductible; Reasonable | | | |
| | | and Customary limits apply | ■ 70% covered after deductible | if non-emergency | |
| Prosthetic Devices | 80% covered of NNF4 | 80% covered after | 80% covered after | 70% covered after | |
| | after deductible | deductible; Reasonable | deductible; | deductible; | |
| | | and Customary limits apply | precertification required | precertification required | |
| | | | for items over \$5,000 | for items over \$5,000 | |
| Urgent Care | \$15 c | opay | \$20 copay (\$10 copay Medicare-eligible) | | |
| Emergency Room | \$25 copay; copay v | \$25 copay; copay waived if admitted | | \$75 copay (\$25 copay Medicare-eligible); copay | |
| Care | | | waived if admitted | | |
| Footnotes | | | | | |
| | [1] To calculate the 120-day limit | , each day in a hospital | [1] Contribution amounts assume S | \$100 annual credit for | |
| | counts as a full day, each day in a | a skilled nursing | completion of Health Risk Assessment and \$600 annual credit for | | |
| | facility counts as one half-day, ar | nd each home health | non-tobacco user status. | | |
| | care visit counts as one-fifth of a | day. The 120-day limit | [2] Family amount can be any combination of family | | |
| | is a cumulative number for all in | oatient stays per Plan | members but an individual would never satisfy more | | |
| | year (and is a combination of all | inpatient hospital | than his/her own individual amount | | |
| | stays, stays in a skilled nursing fa | cility and home | [3] If newborn is not released with the mother a separate | | |
| | health care visits). | | deductible and coinsurance applies | | |
| | [2] After 180 days, up to an addit | tional 45 days may be | [4] Coverage includes advanced reproductive technology | | |
| | authorized, as determined by the | e claims administrator. | such as GIFT, ZIFT and artificial inse | emination | |
| | [3] Note: Class II Dependents and | [3] Note: Class II Dependents and Sponsored Dependents are not eligible for coverage for Substance Abuse or Outpatient Mental Health treatment | | | |
| | are not eligible for coverage for S | | | | |
| | Outpatient Mental Health treatn | | | | |
| | [4] Coinsurance applied to NNF of | or actual price if lower | | | |
| | than NNF. | | | | |
| | [5] Coverage includes advanced i | eproductive technology | | | |
| | such as GIFT, ZIFT and artificial ir | semination | | | |