2016 CONTRACT RETIREE INFORMATION

Changes to Contributions for Retirees with Net Credited Service Date Before August 3, 2008 and who retired after January 1, 1992 and *prior* to January 1, 2013 and who are enrolled in the EPO or an HMO.

Contributions for Pre-Retiree EPO/HMO Medical Coverage.

	2016	2017	2018	2019
Retiree Only	$114	$132	$153	$165
Retiree + 1	$175	$200	$230	$250
Retiree + Family	$228	$264	$306	$330

Changes to contributions for Retirees who retire *on or after* January 1, 2013 and who are enrolled in the HCN Option or the Health Care PPO (MEP) Option will pay a monthly contribution, on an after-tax basis, in the amounts below:

Contributions for Retiree Monthly Contributions for the PPO (MEP) or the HCN for Plan Year 2016 shall be as follows:

	Pre-Medicare Retiree Monthly Contribution	Medicare-Eligible Retiree Monthly Contribution
Retiree Only	$39.33	$19.66
Retiree + 1	$67.42	$33.71
Retiree +Family	$67.42	$33.71

For each Plan Year beginning on and after **January 1, 2017**, the Retiree Monthly Contribution shall be as follows:

	Pre-Medicare Retiree Monthly Contribution
Retiree Only	$39.33
Retiree + 1	$67.42
Retiree +Family	$67.42

****Medicare-Eligible - Medicare Advantage Begins in January 2017****

Retirees with Net Credited Service before August 3, 2008

i. Medicare-eligible Retirees

- Beginning 2017, Medicare-eligible retirees currently covered by the MEP PPO or HCN plans will be enrolled into new Medicare Advantage plans.
- Unlike traditional Medicare and the Verizon supplemental plan, the Medicare Advantage plan will provide full coverage under one card and one administrator.
- Deductibles under Medicare Advantage MEP/PPO plan will decrease between $4 and $33 annually depending on retirement date. There will be no deductible for the Medicare Advantage HCN plan.
- Plan designs are the same as the current Medicare Plans except the carryover deductible will not apply and a $15 specialist copay in the MEP plan.
- All doctors that accept Medicare will be covered as in-network.
- The Company and Union will work together to educate retirees about this change and ensure a smooth transition with a communications and outreach program funded by the company.
- There will be no premium contributions for covered retirees enrolled in Medicare Advantage programs.
- **Copays.** For 2016 the copays for Covered Retirees and their eligible dependents will be no greater than $10 for an office visit to a primary care provider (including OB-GYN), no greater than $15 for a specialist office visit and no greater than $25 for an emergency room visit, however, the applicable emergency room copay will be waived if the associate or eligible dependent is admitted to the hospital. For chiropractic services under the Health Care PPO, the copay for such Covered Retirees will be no greater than $20 for services with a licensed chiropractor on an out-of-network basis.

Changes for Covered Retirees Who Are Medicare Eligible Applicable Beginning January 1, 2017 – Medicare Advantage Program. Effective January 1, 2017, Medicare-eligible Covered Retirees and dependents will participate in the Company-sponsored Medicare Advantage plan(s). The Medicare Advantage plan(s) will be a fully-insured or self-insured benefit.

1) **HCN Benefit Changes.**

a. **Deductibles.** There will be no deductible.

b. **Out-of-Pocket Maximum.** The out-of-pocket expense maximum applicable to covered services or supplies during any calendar year will be $1,050 per individual. No family out-of-pocket expense maximum will separately apply. Amounts paid toward copays for Medicare covered services will apply towards the out-of-pocket maximum.

c. **Copays.** The copay for an office visit to a primary care provider (including OB-GYN) will be no greater than $10. The copay for a specialist office visit will be no greater than $15. The copay for each visit to an emergency room will be $25, however, the applicable emergency room copay will be waived if the associate or eligible dependent is admitted to the hospital.

d. **Chiropractic services.** To the extent that chiropractic services and supplies are covered by Medicare, the copay for each visit with a licensed chiropractor will be no greater than $10 and there will not be a maximum benefit per plan year. To the extent that covered chiropractic services or supplies are not covered by Medicare, the maximum benefit payable for such covered chiropractic services will continue to be limited to $750 per plan year per individual.

e. **Accidental injury dental services.** Dental services or supplies will be covered to the extent such services or supplies are covered by Medicare.

f. **Skilled Nursing Facility Services.** Skilled nursing facility services will be subject to a 120 day limit per benefit period (as defined by Medicare).

g. **Home Health Care.** The limit applicable to days of service (visit) for home health care will not apply.

2) **Health Care PPO Benefit Changes**

a. **Deductibles.**

(i) For Covered Retirees an annual deductible will apply for covered services or supplies per individual as set forth below. No family annual deductible will separately apply. To the extent that a Medicare-eligible Covered Retiree's 2015 annual individual deductible was:

- Between $25 and $54, the annual deductible will be $21 per individual.
- Between $55 and $83, the annual deductible will be $51 per individual.
- Between $84 and $99, the annual deductible will be $80 per individual.
- Between $100 and $124, the annual individual deductible will be $96 per individual.
- Between $125 and $149, the annual deductible will be $121 per individual.
- $150, the annual deductible will be $146 per individual.
- $200, the annual deductible will be $196 per individual.
- $250, the annual deductible will be $246 per individual.
- $475 or greater, the annual deductible will be $471 per individual.

(ii) Charges incurred and applied towards the deductible will be limited to charges incurred during the plan year to which the deductible applies and will not carry over from one plan year to the next.

b. **Out-of-Pocket Maximum**. The out-of-pocket expense maximum applicable to covered services or supplies during any calendar year will be $1,150 per individual. No family out-of-pocket expense maximum will separately apply. Amounts paid toward copays for Medicare covered services will apply towards the out-of-pocket maximum.

c. **Copays**. The copay for an office visit to a primary care provider (including OB-GYN) will be no greater than $10. The copay for a specialist office visit will be no greater than $15. The copay for each visit to an emergency room will be no greater than $25, however, the applicable emergency room copay will be waived if the associate or eligible dependent is admitted to the hospital.

d. **Chiropractic services**. To the extent that chiropractic services and supplies are covered by Medicare, there will not be a maximum benefit per plan year. To the extent that covered chiropractic services or supplies are not covered by Medicare, an aggregate limit of sixty (60) visits will apply (chiropractic service visits will not exceed 1 visit per day).

e. **Accidental injury dental services**. Dental services or supplies will be covered to the extent that such dental services and supplies are covered by Medicare.

f. **Physical, Occupational and Speech Therapy**. Provider and facility charges for outpatient physical, occupational and speech therapy will be covered at 90% after the deductible is met.

ii. Pre-Medicare Retirees

The HCN Option will be eliminated effective December 31, 2017 for Covered Retirees and their dependents who are not Medicare eligible. The HCN Option will not be offered in 2018 or any subsequent plan year for Covered Retirees and their dependents who are not Medicare eligible.

- Post January 1, 2013 Pre-Medicare retirees will have their premium contributions frozen at the 2016 level for the life of this contract and are subject to any additional contributions as a result of piercing the caps on the company's contribution for retiree health care.

Over the term of the contract the following terms will apply to Pre-Medicare retirees enrolled in the MEP PPO plan or HCN plan:

2016

- Pre-Medicare retirees enrolled in the MEP plan who are currently paying premium contributions as a result of piercing the caps on the company's contribution for retiree health care will not be required to pay premium contributions when the new plan goes into effect.

2017

- Pre-Medicare retirees who enroll in either the MEP plan or the HCN plan will be required to pay contributions in excess of the caps on the company's contributions towards retiree health care, if any.
- The HCN plan is currently projected not to exceed the caps on the company's contributions towards retiree health care.
- The Union and the Company will negotiate a "new" plan option that will not exceed the caps on the company's contributions for retiree health care.

2018

- Pre-Medicare retirees will have three options:
  - (1) Enroll in the MEP and be required to pay premium contributions equal to the amount in excess of the caps on the company's contributions toward retiree health care
  - (2) Enroll in the "new" plan that will be negotiated in 2017 that will not exceed the caps on the company's contribution toward retiree health care

which replaces the HCN option.

(3) Elect to receive an HRA in the amount of the caps on the company's contribution to health care which will be $15,447 for retiree coverage, $30,893 for retiree + 1 coverage, and $38,639 for family coverage. The retiree then will purchase health insurance on the open market. Any excess funds in the HRA after purchasing a plan can be used for health care expenses incurred during that calendar year (ex. copays, deductible, etc.).

2019

- Pre-Medicare retirees will have the same options that were available in 2018 except that the union has the right to bargain the "new" plan design on a yearly basis to keep the cost of the plan below the caps on the company's contribution toward retiree health care.

When you become eligible for Medicare you will be transitioned into Verizon's Medicare Advantage plans.

Prescription Drug Program

- **New Brand Drug Formulary**: After ratification, certain brand drugs in each treatment category will be designated as "preferred" by Express Scripts and subject to a lower copay. This "preferred" drug list will give Express Scripts leverage to bargain with the pharmaceutical companies for lower prices. Members taking "non-preferred" drugs will be notified of the savings available from switching to a preferred alternative approved to treat the same condition.

- **Compound Drug Pre-Authorization:** Certain pharmacies offer the service of altering the active ingredients of prescribed medications into new forms. Examples include removing dyes for allergic patients or putting the drug into a cream or lozenge form for patients that can't swallow pills. These services often increase the cost of the drug substantially. Pre-authorization will now be required before the plan

will cover a prescription filled as a compound. This will require the prescribing doctor to verify that the compound form is medically necessary. An appeals process will be established for any patient denied coverage for a compound drug.

<table>
<tr><th></th><th>Deductible</th><th>Generic</th><th>Preferred Brand</th><th>Non-Preferred</th><th>Brand w/ Generic Alternative</th></tr>
<tr><td>In-Network (30 day)</td><td>None</td><td>100% of Discounted Network Price (DNP), Max:
2016-18: $10
2019: $10.40</td><td>20% of DNP, Max:
2016-17: $30
2018: $31.80
2019: $33.71</td><td>30% of DNP, Max:
2016-17: $50
2018: $53
2019: $56.18</td><td rowspan="3">Generic copay amount plus 100% of cost difference between generic and brand</td></tr>
<tr><td>Out-of-Network (30 day)</td><td>$50</td><td>30% of DNP plus 100% of the cost difference between retail and DNP</td><td colspan="2">40% of DNP plus 100% of cost difference between retail and DNP</td></tr>
<tr><td>Mail Order (90 day)</td><td>None</td><td>100% of DNP, Max:
2016 – 18: $20
2019: $20.80</td><td>20% of DNP, Max:
2016-17: $60
2018: $63.60
2019: $67.42</td><td>30% of DNP, Max:
2016-17: $100
2018: $106
2019: $112.36</td></tr>
</table>

An annual out-of-pocket expense maximum under the Health Care PPO (MEP) Option will apply to prescription drugs purchased at **mail order pharmacies** of $786.52 for 2016 and 2017, and for each calendar year thereafter, the annual out-of-pocket expense maximum will increase by 6% for 2018 and again in 2019. Any expenses incurred as a result of a member paying the difference between the cost of a brand name and a generic drug when a generic equivalent is available will not count toward the out-of-pocket maximum.

From www.medicare.gov

13 things to know about Medicare Advantage Plans

1. You're still in the Medicare Program.
2. You still have Medicare rights and protections.
3. You still get complete Part A and Part B coverage through the plan.
4. You can only join a plan at certain times during the year. In most cases, you're enrolled in a plan for a year.
5. You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD).
6. You can check with the plan before you get a service to find out if it's covered and what your costs may be.
7. You must follow plan rules, like getting a referral to see a specialist to avoid higher costs if your plan requires it. The specialist you're referred to must also be in the plan's network. Check with the plan.
8. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
9. Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider.
10. If you join a clinical research study, some costs may be covered by your plan. Call your plan for more information.
11. Medicare Advantage Plans can't charge more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.
12. Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. This limit may be different between Medicare Advantage Plans and can change each year. You should consider this when choosing a plan.
13. If the plan decides to stop participating in Medicare, you'll have to join another Medicare health plan or return to Original Medicare.

Verizon Benefits Contact Info:

www.verizonbenefitsconnection.com or call 855-489-2367

If you have any questions please feel free to contact me at the Union Hall 413-734-0863 or my cell 413-427-1652
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Thank you,

John D. Rowley Sr.
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