



## CWA District 4 – RMC Newsletter – September 2009 – Vol. 8

### Medical Plan Changes for Legacy SBC Retirees

Bargaining having just been completed; this fall actively employed members and some retirees should expect to see changes in their open enrollment materials with regard to their Medical Plan. Changes will be effective 1/1/10, but can be reviewed in the enrollment package beginning this fall.

Which changes will affect you will depend on which Medical Plan you choose; however the primary changes you should look for are:

1. Monthly Premiums
2. Deductibles & Amount of
3. Co-pay or Co-Insurance Amounts
4. Out of Pocket Amounts
5. Prescription Copay Amounts
6. Disease Detection/Adult Physical (Preventative) Changes
7. HMO's reducing levels of benefits or increasing out of pocket/premium costs.

For Company Sponsored Medical Plans (not HMO's) - In General:

Those who **retired prior to 1/1/93** will not be affected by the changes and will continue with same plan they have today although copays on prescriptions and preventative care rules may change.

Retirees who are **Medicare eligible** will have a choice of 2 medical plan options, but may continue with the same plan they have today with some increases to Prescription deductibles and copays.

Those who **retired on or after 1/1/93** will be able to choose from 2 medical plan options (the plan they have today with a premium or a new alternative plan that does not have premiums, but will have increases in deductibles, coinsurances, out of pocket amounts and prescription increases.)

**Post 93, pre-Medicare retirees** who participate in the traditional (Company Sponsored) medical plan will be entitled to Health Reimbursement Account (HRA) deposits from the Company to help defray these additional costs (both in 2010 & 2011). If a retiree waives off their medical plan (perhaps to use a Spouses medical) or goes with an HMO plan; no Health Reimbursement is available. The HRA deposit for an Individual is \$850 in 2010 & \$150 in 2011. For a Family plan the HRA deposit in 2010 is \$1,700 and 2011 is \$300. Premiums (paid, on a post-tax basis) and other medical/dental bills can be reimbursed through the HRA until funds are exhausted. Funds will roll over year after year and gain interest.

**BE SURE TO WATCH & CAREFULLY READ ALL OPEN ENROLLMENT MATERIALS.** For Retirees; Which plan you choose will be your personal decision and should be made considering how you normally use the medical plan. It is envisioned that post 93 retirees may want to change their enrollment decisions each year depending on how or whether plan costs or usage change significantly and that Medicare Retirees would likely want to stay with the same medical plan they have today and not enroll with the new alternative plan.

### **Prescription Changes Effective January 1, 2010**

Besides the ever increasing costs of Prescription **Copays**; there are a couple of other changes retirees should know about:

Prescription **Deductibles** may increase depending on the Medical Plan you choose.

There will also be a new category of drugs called **Personal Choice**. This category of drugs are prescriptions that are not covered at all by the Company, but can be obtained through Caremark at a discount (so they tell us). The drugs in this category are primarily Diet, Fertility and Erectile Dysfunction Drugs and while some of these drugs may have been covered in the past; they will no longer be covered.

The other new option to be offered (at the Company's discretion) is an opportunity to use local **CVS Retail Drug Stores** to fill maintenance prescriptions without penalty. This option (effective 1/1/10) is **only at CVS Drug Stores** and can be cancelled if the trial doesn't work. **Reminder: Maintenance Drugs MUST otherwise be filled thru the Caremark Mail Order Plan after two (2) fills or will NOT BE COVERED AT ALL.**

### **Disease Detection/Preventative Changes Effective January 1, 2010**

Your current CHCP Medical Plan has previously had some Disease Detection/Adult Physical coverage, but in most cases was limited by age, frequency and dollars.

Beginning in January; as long as your Provider (Doctor, Hospital, etc.) codes your tests or physicals with a **"Preventative Code"**, your bills will be paid by the Company at no cost to you **as long as stay In-Network (PPO or HCN).** In other words; there is no deductible or coinsurance applied when a preventative code and in-Network provider is used. **Out of Network is NOT COVERED at all.** Providers or their billing clerks know which codes to use but you may have to explain the new change to avoid costly mistakes.

(Pre-Admission Testing remains covered after the deductible and coinsurance is met).