



17 October, 2008

HEALTH PLAN CHANGES

THERE'S A LOT WE KNOW AND A LOT WE DON'T

Tribune is planning another major change in its health insurance plans for next year (with sign-up to take place Nov. 10-21). It wants to drop ALL of the current health plans – the Blue Cross PPO, Cigna HMO and Kaiser HMO – and offer only one health plan, a UnitedHealthcare (UHC) PPO. The new PPO would have lower out-of-pocket costs than the current one for most participants, but higher out-of-pocket costs than the current HMOs. Most people in Blue Cross or Cigna would be able to keep their current doctors; those in Kaiser would have to change.

As for the other major component of costs, the premium, The Sun says it doesn't yet know what that will be. As Guild leaders told Sun labor relations officials when we met on Oct. 15, "We don't know how happy or how unhappy to be."

The Guild pressed strongly, at that meeting, for The Sun to continue to offer HMO choices. While they're more restrictive than PPOs, they generally cost less – for both the employee and for Tribune. Employees should be able to choose which type of coverage works best for them.

We also asked lots of questions, and got answers to some. Here are some key points we do know: Part-time employees, previously only eligible for HMOs, would be able to get PPO coverage. Domestic partner benefits are still available. Tribune is still charging the "spouse fee" of \$75 a month, but the Guild is challenging that as a contract violation. (There's an arbitration hearing next week; if the Guild wins the case, the fee would be canceled and those who paid would get refunds.) There will be meetings in November where folks from Tribune and UHC will explain the new plan to employees. There will also be a toll-free number to answer questions.

One note about the health care correspondence from Gerry Spector: his email contained a typographical error listing an incorrect amount for the first tier of prescription co-pay. The correct amount is \$20, as shown on the attachment to the email.

Gus Sentementes will be posting the Guild's written questions and the company's written answers on the Google groups list for Guild members. If you want to join the list, email Gus at gussentementes@gmail.com. You can also get copies of the documents by asking a shop steward or officer.

We'll get back to you again when we know more. If you've got questions, see a Guild officer. We'll give you an immediate answer if we can, or we'll research the question.

Under the contract, Tribune has the right to make most health changes without bargaining, although it has to provide notice to the Guild and meet with us to discuss the changes.

Not sure about the difference between an HMO and PPO? Don't know what co-insurance is? See the back of this bulletin.

-- Bill Salganik

Health Insurance 101

To understand the basics of the switch, here's a sort-of glossary:

HMO (Health Maintenance Organization): A health insurance plan which uses a network of participating providers (doctors, hospitals, labs, etc.). Generally, benefits are only paid for network care. Members choose a primary care doctor (sometimes called a

(over)

"gatekeeper") who coordinates care, and they need a referral from the primary care doctor to see a specialist.

PPO (Preferred Provider Organization): Like an HMO, it has a network of participating providers, but there is also a benefit paid when members use out-of-network providers. However, the out-of-network benefit is lower than for in-network care, meaning the patient picks up more of the cost. Even in-network care generally means higher out-of-pocket costs for the patient than in an HMO. Although it costs more, it's more flexible. Networks are generally larger than in HMOs, and you can see a specialist without getting a referral from your primary care doctor. In fact, you don't have to choose a primary care doctor.

Here are the types of costs we're talking about:

Premium is the amount paid each pay period (or month or week) to get coverage. The premium is split between Tribune and the employee. The Sun says it doesn't know what the 2009 premiums will be.

Out-of-pocket costs:

-- Deductible. The amount you have to pay before insurance coverage begins. The UHC PPO will have a family deductible of \$800 (compared to \$1,400 under the current Blue Cross PPO). That means you pay \$800 (to the doctor or other provider, not to the insurance company) before the insurance pays anything. Most HMOs don't have deductibles; most PPOs have them. After you've paid the deductible, the insurance picks up most of the cost, but you're responsible for co-payments and co-insurance.

-- Co-payment. A fixed amount you pay to the provider (such as \$20 for an office visit or \$50 for a prescription) when you use a service. Most HMOs and PPOs have these.

-- Co-insurance. Similar to a co-payment, but a percentage instead of a

fixed dollar amount. So, with UHC PPO, which has 85% co-insurance, if you got a \$200 service (after you'd paid your deductible), UHC would pay \$170 (85%) and you'd have to pay the other \$30 (15%).

-- Out-of-pocket maximum. The most you'd have to pay in a year. When costs go higher, the insurance picks up all of the excess. For UHC PPO, the out-of-pocket maximum would be \$2,400 per person and \$4,800 per family for in-network care and \$4,800 per person and \$9,600 per family for out-of-network care. (Most of these are higher in the Blue Cross PPO.) So if you needed a lot of care, even if you got it in network, you could be paying as much as \$4,800 yourself. That's what the total, including deductible, co-pays and co-insurance, would be.

One other thing you need to know, especially if you're switching from an HMO to the PPO:

Flexible Spending Account: This is untaxed money you can use to cover out-of-pocket charges. It's a great way to reduce your costs. This is how it works: You decide how much money you might need to cover your expenses for a year. After you indicate the amount when you sign up for insurance, Tribune calculates how much has to go in from each paycheck. You can use this money - -- now you get a debit card for transactions --- to pay for medical costs insurance doesn't cover, such as over-the-counter medications and laser eye surgery.

To have a Flex Account, you have to sign up during open enrollment, and decide how much money you want to put in each pay period. Consider this carefully; any money you haven't used by the end of the year goes to Tribune. (Don't blame Sam Zell for that; it's an IRS rule.) On the other hand, if it's December and you've got money left, you can buy an extra pair of eyeglasses or load up on over-the-counter meds.